

Stephanie Woolhandler and David Himmelstein **Healthcare Reform 2.0**

THE HEALTH CARE REFORM PROCESS EXPOSED HOW CORPORATE influences render the US government incapable of making policy on the basis of evidence and the public interest.”¹ This statement, featured on the December 2009 cover of one of the world’s most important medical journals, *The Lancet*, shortly before the passage of the Obama health reform bill, highlights the major current problem in health policy. The problem is not the state’s domination of the human body, but the state’s abdication to corporate America of its obligations regarding the health of the human body.

What role did the health industry play in the Obama health reform? Insurance firms donated hundreds of millions of dollars to Democrats as well as to Republicans. They then donated another \$100 million dollars to an ad campaign opposing the bill. So while the Democrats embraced the centrist mandate-style reform (a reform first proposed by President Richard Nixon in an effort to block Senator Ted Kennedy’s single-payer bill in 1971), the advertising campaign (which appeared under the name of the US Chamber of Commerce but was actually paid for by the insurance industry) opposed it from the right. The insurance industry’s funding of both the right and center of the reform debate was aimed at shutting out voices to the left of the administration. Meanwhile, the Pharmaceutical Manufacturers of America (PharMA) donated more than \$100 million to a campaign supporting reform, which promises to expand the market for their products, while eschewing price controls. The Senate framework on which President

Barack Obama's reform was based was written by Liz Fowler, the former vice president for public policy for Wellpoint/Anthem, the nation's largest private insurer.

Obviously, our health system has grave problems requiring reform. These problems are epitomized by the unrelenting growth in the number of uninsured Americans over the past several decades. Our research group at Harvard published a study in 2009 showing that 45,000 Americans die annually due to lack of health insurance—about 1 death per 1,000 uninsured people (Wilper 2009: 2289–2295). That is not only an indictment of the current state of the health system, but also very worrisome in the context of the Obama reform. If Obama's plan works as hoped (that is, if everything goes right), it will still leave 24 million people uninsured when it is fully implemented in 2019, according to the Congressional Budget Office (CBO 2009). Twenty-four million uninsured Americans is simply unacceptable. Meanwhile, the safety-net hospitals on which these uninsured (and many underinsured) people will continue to rely will suffer a \$36 billion cut to help pay for the reform. On a brighter note, community health centers are slated to receive an extra \$1 billion annually due to an amendment submitted by the country's only socialist senator, Bernie Sanders of Vermont.

THE PROBLEMS IN US HEALTH CARE FINANCE ARE NOT RESTRICTED to the uninsured; our fragmented, inadequate payment system causes tremendous suffering among insured Americans as well. Research we undertook with colleagues at Harvard Law School and Ohio University found that more than half of all US bankruptcies are due, at least in part, to medical illness or medical bills (Himmelstein and Warren 2005; Himmelstein and Thorne 2009: 741–746). This headline from our study was widely cited in the 2009–2010 health reform debate. But another of our findings received much less attention—in the overwhelming majority of medical bankruptcies, the patient had health insurance, at least when they first got sick. In our most recent data on bankruptcy

filers in 2007, 78 percent of those whose illness caused a medical bankruptcy had health insurance. In some cases patients started the illness with insurance, only to lose it along with their job after they became sick. In many more cases, people had insurance—usually private health insurance—which they held on to throughout the bankrupting illness. Yet they were bankrupted anyway by gaps in their coverage, like copayments, deductibles, and uncovered services.

Others have found similar results. Surveys by the Commonwealth Fund found that even among Americans who were insured all year, 16 percent report being unable to pay their medical bills, 15 percent had been called by a collection agency about medical bills, 10 percent changed their way of life to pay medical bills, and 10 percent were paying off medical bills over time (Doty 2008).

To summarize, about one-third of Americans are inadequately insured, either completely uninsured or underinsured, such that a major illness would likely bankrupt them. They are often denied care, and they are sicker and die younger than the well-insured.

At the same time that many are denied access to vital care, we have tremendous overuse of medical services in this country. The Dartmouth Group has documented huge variations in health spending in different regions of the country; high-cost areas (such as Florida, New York City, or Boston) have health care spending 60 percent higher than low cost areas, like Minnesota or Northern California after adjusting for the health of the population (Dartmouth Health Atlas). One very high spending area is along the border between Texas and Louisiana, Cameron Parish, Louisiana, and the contiguous Jefferson County, Texas. There, per capita spending is nearly twice what it is in Rochester, Minnesota, home of the Mayo Clinic. One of us (SW) grew up and went to medical school in Louisiana, and can say with 100 percent certainty that the quality of medical care is not higher in Cameron Parish than it is at the Mayo Clinic. And indeed that was exactly the conclusion of the Dartmouth Group authors: the quality of care is actually higher in parts of the United States that spend less per capita.

Why do some regions have higher medical costs than others? The Dartmouth Group, which has been doing geographic-based health policy analyses for decades, has explored the causes of this higher spending. Much of it is explained by Roemer's Law (first enunciated by the late public health scholar, Milton Roemer), which tells us that if there is an empty hospital bed, it will be filled; if there is an idle surgeon, he/she will soon operate (Shain and Roemer 1959: 71–3). And that is precisely what the Dartmouth Group has found; areas with more specialists, more hospitals, more machines, tend toward overtreatment. The lower-spending areas are more primary care-oriented and have a lower density of specialist care. We need good specialist care; patients should have access to expensive scanners and high-technology treatments when they need them, but in the United States we are oversupplied with specialized resources. High-technology care such as CT scans and cardiac stents are overused in situations where they are unnecessary, even harmful. So, overtreatment exists in the United States side by side with medical deprivation; we are rationing medical care in the face of a surplus of medical resources.

One resource available in a surplus is administrators, whose numbers have grown many-fold faster than the ranks of other health personnel (Himmelstein and Lewontin 1996: 172–8). This is a direct consequence of the growth of profit-driven health maintenance organizations (HMOs) and insurers, whose roles have been expanded by the 2010 national health reform.

Profit-driven HMOs are the problem, not the solution. This was demonstrated in the only randomized control trial of health insurance coverage, which compared HMO care to free fee-for-service care. After three to five years, lower-income people with chronic medical conditions who were randomized to HMOs had a risk of dying 21 percent higher than those randomized to free fee-for-service care (Ware 1986: 1017). Historically, there have been some fairly good nonprofit HMOs, including the one in Seattle, which was studied in that experiment.

However, virtually all of the growth of HMOs in the past few decades has been in the investor-owned sector. The old style, nonprofit HMOs, which had pluses and minuses relative to fee-for-service health insurance, have been eclipsed by investor-owned plans, the instrument by which Wall Street has come to dominate American medical care. This shift to for-profit organizations has occurred despite strong evidence that the quality of care in for-profit HMOs is lower than in their nonprofit counterparts. In a study we published in the *Journal of the American Medical Association* (Himmelstein, Woolhandler, and Hellander 1999), we found that for every one of the fourteen quality indicators then being collected, the quality of care was higher in nonprofit plans than in investor-owned HMOs.

OF COURSE, SOME PEOPLE DO EXTREMELY WELL IN HMOS—THEIR CEOs. Multimillion-dollar compensation packages have become the norm for HMO's CEOs (for example, the \$123 million received by Cigna's chief in 2009) (HCAN Report 2010). This is one contributor to HMO's very high overhead. The market-leading HMO's often have overhead of 21 percent or more. That means that for every dollar of premium, 21 cents stays with the insurance firm; only 79 cents ever goes to pay for a doctor, nurse, medication, or hospital. These huge costs are generated by running health care as a business rather than as a public service.

For years, Medicare, the federal insurance program that covers Americans over the age of 65, had overhead of only 3 percent. But seniors now have the option of signing up with an HMO and having their premium paid by Medicare. The overhead cost in these Medicare HMO's averages about 14 percent, fourfold higher than in traditional Medicare (GAO 2008; National Health Expenditure Accounts 2005). How can the private HMOs compete with the more efficient traditional Medicare plan? Private Medicare HMOs prosper by cherry-picking—that is, they selectively enroll the lowest-risk, lowest-cost patients and avoid the expensively ill. One important health policy concept is the “20–80 Rule”; 20 percent of patients (that is, the 20 percent of patients who

are seriously ill in a given year) account for 80 percent of total health spending. An HMO that is paid based on the average level of spending but successfully recruits only the healthiest people (who cost little) can make tremendous profits.

Research has consistently shown that HMOs behave in precisely this manner. A study of Medicare HMOs in south Florida (Morgan 1997: 169) found that Medicare enrollees who were subsequently recruited to join a Medicare HMO had spending that was only 66 percent of the Medicare average, indicating that the HMO recruited much healthier than average seniors. Some patients left the HMO and returned to traditional Medicare. In the months after leaving the HMO, the cost of covering these former HMO enrollees was nearly twice the Medicare average. So the HMOs were cherry-picking healthy people, then spitting out the pits (those who got sick) back into traditional Medicare. And the taxpayers bear the burden of subsidizing HMO's exorbitant overhead and profit.

Every other developed nation has gotten to universal health care through some form of national health insurance, and all spend far less than we do on health care. In a study we published in the journal *Health Affairs*, we divided health spending into the publicly paid share and the privately paid share (Woolhandler 2002: 88–98). In the public portion, we included not only government expenditures for Medicare, Medicaid, Veterans Administration, and military, but also the benefit costs for public workers, such as teachers and FBI agents. We also included the so-called tax subsidy to private health insurance, which is money lost to federal, state, and local treasuries because health benefits are not taxable. When we calculated the public share of health spending in this inclusive way, we found that Americans are already paying, through our taxes, the full cost of national health insurance: over \$4,400 per capita in tax-supported spending in 2007. Yet we took, on average, an additional \$2,880 out of our pockets to pay privately, and still end up with a system that leaves 51 million Americans uninsured.

What do we get for this extra spending? We do not get longer life expectancy—our life expectancy is about two and a half years shorter than that of Canadians or major European nations (OECD 2010). We do not even get more scientific output on a per capita basis: 2 medical journal articles per 1,000 population in the United States versus 4 articles per 1,000 population in Sweden or Switzerland.

It is important to review evidence on Canada's national health program. Because of cultural and medical similarities, our group, Physicians for a National Health Program, often compares the United States to Canada, which has a single-payer Medicare-for-all program (Woolhandler, Himmelstein, and Angell 2003: 798–805). Under the Canada Health Act, a large federal block grant goes to each province that has a health insurance program that is universal, portable, covers all necessary care, and is run as a publicly administered nonprofit system. Public administration is necessary both to make the system fair and to generate administrative savings. Canada's government has not abdicated public responsibility for health as ours has.

If we compare health spending in the two countries, we find that health spending was virtually identical prior to the implementation of Canada's national health program, about 7 percent of GDP, but subsequently diverged, with US costs rising much more rapidly. Now the United States devotes 17 percent of GDP to health care vs. 11 percent in Canada. About half of the total difference is accounted for by the administrative simplicity and lower bureaucratic spending in Canada's single-payer system (Woolhandler and Campbell 2003: 768–775).

Computerization has been offered as a panacea to what ails US health care, including our high administrative costs. Can technology achieve similar savings on administration without the need to go to a full single payer reform? Not likely. In our study of the implementation of computerization in thousands of US hospitals, we found that those with electronic medical records actually had slightly more rapid increases in administrative costs (Himmelstein and Wright

2010: 40–46). Electronic medical records are a useful technology, if done right. But there is not a prayer they will significantly reduce costs.

IN PROJECTING THE IMPACTS OF THE REFORM ENACTED NATIONALLY in 2010, it is important to review what happened in Massachusetts, a state that since 2006 has been doing a test run of the model for national reform (Himmelstein and Woolhandler 2007: 251–257). In Massachusetts, citizens (and some legal residents) with incomes below the federal poverty line are covered by Medicaid. Those with incomes between 100 and 300 percent of poverty are eligible for a partial subsidy to help them purchase private insurance. Those with incomes above 300 percent of poverty are required to purchase insurance, but when it comes to paying for it, they are on their own. For a woman in her 50s, the premium for the least expensive mandated coverage available through the state’s insurance exchange (called the Connector) costs \$5,600 annually (MA Connector 2011). The policy carries a \$2,000 deductible; if the policyholder became sick, she would have to take another \$2,000 out of her pocket before the insurance paid a penny, and would be required to pay a 20 percent coinsurance for the next \$15,000 in health spending.

The punishments for refusing to purchase this expensive and skimpy insurance are substantial. If you violate child labor laws in Massachusetts, you can be fined \$50; domestic violence carries a fine of \$1,000, but being uninsured in Massachusetts carries a fine of \$1,212.

The Massachusetts health reform has encouraged and endorsed underinsurance; it has taken many people who were uninsured and transferred them to the ranks of being underinsured, as will happen nationally under the Obama reform (Himmelstein and Woolhandler 2010: 1778). During the health reform debate, President Obama said many times “if you like your current private insurance you can keep it”; he neglected to say that if you do not like your current job-based cover-

age you will have to keep it, because private insurance is mandated under the new bill and those who turn down job-based coverage will not be allowed to purchase insurance through the new insurance exchanges. The new mandated policies will be required to cover only 60 percent of health costs; the policies now available in Massachusetts illustrate what that means.

Not surprisingly, many people in Massachusetts still find themselves unable to afford care. According to a *Boston Globe* poll, during a one-year period, about 14 percent of Massachusetts families accumulate new medical debt, another 14 percent fail to fill a prescription because of costs, and 9 percent reporting postponing needed care (Lazar 2008). A recent poll of Massachusetts physicians from the Massachusetts Medical Society found that a plurality of the state's doctors now support a single-payer reform; few favor a Massachusetts-style plan (Massachusetts Medical Society 2010).

What does the American electorate think about single-payer health care? While many people are confused by the fog of political rhetoric, in polls that include an appropriate question, Americans strongly endorse the idea of “expanded and improved Medicare for All.” For instance, in a 2006 ABC poll that asked Americans “Would you support a system of government-funded health insurance paid for through taxes, like Medicare?” (ABC News 2006), a two-to-one majority endorsed the idea. So while the American people want an expanded and improved Medicare for All—that is, a single-payer system—corporations dead-set against single-payer reform have come to dictate the agendas of both political parties. Hence, the only way to win national health insurance is to build a popular movement to counter corporate power.

NOTES

1. Additional information, including the evidence on which this paper is based, is available on the website of Physicians for National Health Program (www.pnhp.org). We are a 17,000-member single-issue orga-

nization advocating single-payer nonprofit health insurance for the United States.

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