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Why U.S.-Style Health Reform Does Not Work and What to Do about It: Claudia Chaufan

The Story of Teresa

Teresa (I have changed the name of the protagonist of this story to protect her privacy) came to me in tears. The stack of bills—including hospital, doctors, and ambulance services claims—added up to slightly under $20,000, over a year's worth of her income. "Believe me, Dr. Claudia, I felt like I was going to die, like my abdomen would explode. I was so scared . . ." she said. "I barely managed to call my daughter, who saw me in that state and called the ambulance," she continued, adding almost apologetically: "I can assure you she gave the medics my insurance card. But they didn't look at it. They just took me to that clinic."

At the clinic, Teresa was rushed to the emergency department, where, as she relayed to me, medical personnel inserted an intravenous line (IV), performed a physical examination, ordered tests, and determined that her condition—likely due to a ruptured ovarian cyst—was stable. The whole ordeal took about four hours, including the time Teresa was kept under observation until she felt better, after which she left the hospital with a prescription for painkillers and instructions to follow up with her doctor.

So why those bills? Is Teresa uninsured? No, she is not. Is she an undocumented immigrant? No. She has a green card and is on her way to becoming a citizen. Yet, she is out of luck because her coverage is skimpy. She does not qualify for Medicaid (Medical in California), not because California

shunned the Medicaid expansion, but because she makes too much money to meet Medicaid's income eligibility criteria. And the plan she can afford, even with subsidies, requires that she shoulder 40 percent her medical bills. And it does not help that Teresa's plan does not include the providers and medical establishments where the ambulance took her.

Five months after the documented "date of service," I am still struggling to convince Teresa's providers that she cannot pay her bills upfront, not even with a "generous" discount (50 percent). Nor can she afford to be debt bound by monthly payments. Her children and grandchildren count on her economic support back in Latin America. So I have helped her fill out about 15 pages of forms, collect financial and other documentation, and file for "charitable care."

Incidentally, I have a medical degree and a PhD in sociology, and more years of education than I want to remember (or confess). I still fail to understand the "explanation of benefits," which I requested to sort out Teresa's coverage. Am I a case of "low health literacy"—described in leading medical journals (Sentell 2012) and official websites (DHHS 2014) as a "major" impediment to successful reform—unusual given my socioeconomic status? Do I need a "navigator"? (Kaiser Foundation, 2013). But I digress. I will spare readers other shocking details of Teresa's case. I suspect she is not alone (most Americans saddled by medical debt to the point of filing for bankruptcy have insurance).

Health Policy Hypes and (False) Hopes

Let me move on instead to examine whether the "solutions" usually proposed to the problems of restricted access, deteriorating quality, and spiraling costs—critical features of U.S. healthcare even after the implementation of major reform (Davis 2007, 2010; Davis 2014; Commonwealth Fund 2006; Thomson 2013)—would have helped Teresa. I will focus on electronic health records, medical homes, price transparency,

and wellness programs (there are many others, like health savings accounts, pay-for-performance, etc., but I will set those aside).

Would electronic health records have helped Teresa? Not really. In fact, Teresa's health information is carefully kept in an electronic health record in a medical home—her family doctor at an "in-network" clinic that is her usual source of care. But it is not there that the ambulance chose to take Teresa. In fact, neither Teresa nor her daughter speaks very good English, and the medics did not speak Spanish, and at any rate, they had tasks more urgent than figuring out whether the nearest medical establishment was in Teresa's "network."

What about price transparency? In all honesty, Teresa's bills were anything but "transparent." But what if they had been? Well, I think Teresa was in no position to comparison shop for prices, however transparent (nor were the medics on her behalf). Even at sharply discounted rates, those prices would be just too high for her. Nor, I imagine, was she in a position to challenge the doctors' judgment about the "cost-effectiveness" of the services received (nor, in my opinion, should she be required to). I will not bother the reader with the potential usefulness of wellness programs for this occasion. One does not need to be an expert to understand that they are irrelevant when dealing with a ruptured ovarian cyst.

So what, if anything, would have helped Teresa? Well, in my view, it would have helped her if she had been a Canadian immigrant, living under a single-payer system.

What Is Single Payer?

Single-payer national health insurance is a system in which a single public or quasi-public agency (or strictly regulated subsidiaries) organizes healthcare financing, that is, collects the money from users, purchases services in bulk, and negotiates rates and payment schemes with, and pays, providers. The delivery of care may remain or not in private hands. Nations

that have adopted single-payer systems cut across cultures, political ideologies, and levels of development. They include countries as different as the United Kingdom, Iceland, Taiwan, Spain, and Cuba. In fact, all wealthy nations with the exception of the United States, and many poor nations, have organized their healthcare systems as variants of single payer (Chaufan 2011).

The Expanded and Improved Medicare for All Act, HR 676, based on a physicians' proposal crafted by members of Physicians for a National Health Program and published in *JAMA*, would establish an American single-payer health insurance system (Woolhandler and Himmelstein 2002).

Under this system, all residents, documented or not, would be covered for all medically necessary services, including doctor, hospital, preventive, long-term care, mental health, reproductive healthcare, dental, vision, prescription drugs, and medical supplies. Dramatic overall savings would ensue from the system's power to purchase goods and services in bulk and thus negotiate prices with providers' associations, pharmaceutical companies, and medical device suppliers. Paper pushing that does not contribute to more or better care—preapprovals, approvals, marketing, determination of patient eligibility for services on the part of insurers and providers, denials, appeals—would be eliminated, and so would overpayments to private (Advantage) Medicare plans. Collectively, savings would amount to around $600 billion annually, more than enough to provide first dollar coverage for every U.S. resident (Friedman 2013; Hellander, Himmelstein, and Woolhandler 2013).

Even though taxes might slightly increase, most Americans would save money, time, and distress, as they would no longer be compelled to comparison shop for increasingly pricier and inscrutable plans, juggle with unpredictable (and unaffordable) out of pocket costs (premiums and out of pocket costs would disappear), or struggle to figure out which providers are "in network," as most providers in the country would find it convenient to join the system (See Table 3.1).

Table 3.1. Comparing Gains under ACA and Single Payer

	ACA	Single Payer
Universal Coverage	**NO.** More than 30 million remain uninsured (mostly citizens and documented residents) by 2024 and tens of millions underinsured	**YES**. Everybody is covered automatically at birth
Full Range of Benefits	**NO**. HHS provides "guidance" on "essential health benefits"; what counts as benefits decided on the basis of existing plans, i.e., by insurers themselves	**YES**. Covered for all medically necessary care
Choice of Doctors and Hospitals	**NO**. Insurance companies continue to restrict access through increasingly narrower networks of "preferred" (by them!) providers	**YES**. Patients can choose among any participating provider; most providers in the country would find it convenient to participate
Out of Pocket	**YES**. Varying degrees of copays and deductibles; trade-offs between lower premiums (even if ever increasing) and higher out of pocket expenses via "consumer-directed" plans	**NO**. Copays and deductibles eliminated
Savings	**NO**. Increases health spending by about $1.1 trillion	**YES**. Redirects $600 billion in administrative waste and inflated drug prices toward care; no net increase in health spending
Cost-Control/ Sustainability	**NO**. Preserves a fragmented system incapable of controlling costs; gains in coverage erased by rising out of pocket expenses, bureaucratic waste, and profiteering by private insurers and big pharma	**YES**. Large-scale cost controls through economies of scale to ensure that benefits are sustainable over the long term
Progressive Financing	**NO**. Costs are disproportionately paid by middle- and lower-income Americans and those families facing acute or chronic illness	**YES**. Premiums and out of pocket costs are replaced with progressive income and wealth taxes; 95 percent of Americans pay less

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But, Isn't Single Payer "Un-American"?

As a matter of fact, the United States has close to 50 years of experience with single-payer-like programs. One such case is Medicare, the publicly financed plan for older adults and persons with disabilities. Compared to the rocky rollout of the Affordable Care Act (ACA), the beginnings of Medicare were rather uneventful. Less than a year into becoming the law of the land in 1965, Medicare was paying the medical bills of over 19 million older adults (99 percent of those eligible for coverage) (SSA 2013)—with no websites, navigators, or the threat of financial penalties.

Because most seniors were already known to the Social Security Administration, Social Security numbers were used to enroll them for hospital services (Part A), and index cards were used for doctors' services (Part B). As a national social insurance program administered by the U.S. federal government, Medicare granted older adults full rights to the same comprehensive package of services and free choice of any participating provider. As a public program, it dispensed with the pursuit of profit, which is the lifeblood of commercial insurance, so the costs of marketing or of helping users navigate "coverage options"—substantial with the ACA (CaliforniaHealthine April 2013, May 2013)—were zero.

Providers gained independence in medical decision-making and the guarantee that their bills would get paid. There was, and there remains, much room for improvement—in access, coverage, quality, and cost control. But the relevant feature of Medicare was, and remains, its financial structure; the program is organized as a social insurance system. Social insurance spreads financial risk associated with illness across society to protect everyone. Enrollees pay according to their ability and are entitled to the same comprehensive package of services according to their medical needs. In contrast, the individual mandate, which requires millions of Americans to purchase

a commercial product—heavily subsidized by taxpayers[1]—and is the cornerstone of the ACA, has no precedent in U.S. history.

The Way Forward

As President Obama correctly pointed out, you can have universal coverage—and I would add no ugly surprises with unpayable medical bills for you or your loved ones—and you can have lower costs, but you need single-payer to have both. In fact, a mere three years before becoming a senator, Obama was on record supporting single payer. Sadly, as he advanced in his political career, he had a change of heart (*Barack Obama Promotes* 2013)—which is a topic for another article.

As Dr. Margaret Flowers, a pediatrician, and Kevin Zeese, an attorney and corporate watchdog, persuasively argue, there is reason to believe that what is now the law of the land will do little to put a check on the big drivers of the rising cost of U.S. healthcare—insurance conglomerates, big pharma, for-profit hospitals—which will necessarily undermine any attempt to provide equitable access to quality healthcare (Zeese and Flowers 2013). So I will close with their words:

> There was an easier, more politically popular route [than the ACA]. All that President Obama had to do was to push for what he once [said he] believed in, Medicare for All. By dropping two words, "over 65," the country could

[1]Taxpayers subsidize commercial health insurers in more than one way. These include (1) direct assistance for users to purchase "insurance products," (2) foregone revenues (i.e., certain payments to insurers are considered nontaxable income), and (3) enrolling sicker or poorer (usually both) segments of the population that insurers find unprofitable. In this latter case, often insurers will "accept" to take on this less profitable population in exchange for generous incentives. This is the case of private Medicare (Advantage) plans, which between 1985 and 2012 received around $300 billion, some 25 percent, over and above the cost of traditional (nonprivatized) Medicare.

> have gradually improved Medicare [and moved the country] toward the best healthcare in the world, rather than being mired at the bottom.

I could not agree more. I also agree with them that the task is to organize a mass movement that refuses to treat healthcare as a commodity like a cellphone and recognizes that ending the corporate domination of healthcare is part of breaking the domination of the corporate class over our government and our lives. If we do, we can recover our health, our democracy, and our dignity.

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