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## America's Health Care System: Condition Critical

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## AMERICA'S HEALTH CARE SYSTEM: CONDITION CRITICAL

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### I. INTRODUCTION

The American health care system is a paradox of plenty and of deprivation. On the one hand, it is clear that the U.S. system *can* provide the best care in the world, measured in terms of sophistication, the use of technology, and the availability of both human and structural resources. Yet it is also clear that for tens of millions of Americans, that sophisticated care might just as well be part of some other country's health system, because they are denied health coverage and, all too often, the care that it is intended to ensure.

Unlike all other developed countries (except for South Africa), the United States does not guarantee even basic health care availability to its residents. As a result, on any given day, some 36 million Americans (about 17% of the under-65 population) lack health care

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\* U.S. Senator from West Virginia.

insurance coverage. More than a quarter million West Virginians, 70,000 of them children, have no insurance on any given day. When measured over a period of time, almost twice that many (some 63 million nationally) lack coverage for a significant period. And being uninsured makes a difference. Although many of those without coverage are able to get treatment for emergency conditions, they get no preventive care, and when admitted to a hospital get less care even though they are, on average, sicker than those with insurance.

Further, virtually no one in the United States at any age has any protection against the potentially devastating consequences of the need for long-term care for chronic conditions.

The other paradox is that this fatally flawed system does not come cheap: the national bill for this patchwork coverage in 1991 was \$738 *billion* (or more than \$2,900 per person), at least a third more per capita than any other country. That price tag is expected to increase by almost \$80 billion in 1992.

## II. WHO ARE THE UNINSURED

Although people with no health insurance cut across the demographic spectrum, a few general observations can be helpful.

*They are earning a disproportionately low-income.* Almost two-thirds of the uninsured live in families with incomes under twice the federal poverty level (the poverty line for a family of four is about \$13,000). Only one in five of the uninsured has income greater than three times the poverty level.

*They are disproportionately young.* Nearly half are under age 25, and more than a fourth are children under 18.

*Most are connected to the labor force.* Even though most Americans get health care coverage through their jobs, the uninsured somehow miss out. Three-fourths of them are either workers or in the family of a worker. The smaller the firm, the less likely it is to offer insurance coverage to its workers as a fringe benefit. Half of the uninsured workers are employed by firms with fewer than 25 employees.

In addition to those with *no* coverage, millions more have inadequate coverage. If being "underinsured" means running a sub-

stantial risk of spending 10% of your income or more on a costly illness, then another 20 million Americans are *underinsured*.

### III. CURRENT COVERAGE PATTERNS

The Medicare program, a national program with no income limitations for eligibility, covers virtually all Americans over age 65 and those with severe and permanent disabilities.

America has three ways for providing health insurance for those not able to participate in Medicare. About three-fourths of Americans, not including senior citizens, get their coverage through the workplace. Some low-income Americans get coverage through the Medicaid program, funding for which is shared by the federal and state governments. Both of these systems are flawed and eroding. The other option for coverage, the purchase of individual coverage, is the most expensive and least dependable; more than half of all those with individual policies are classed as "underinsured." The first two options are discussed in detail below.

#### A. *Job-Based Health Insurance*

That most Americans look to their employers for health insurance coverage is an accident of history. President Franklin Roosevelt decided *not* to propose a governmental health plan as part of his New Deal initiative that launched the Social Security system. Harry Truman did propose a national plan, but it was not adopted by Congress. Meanwhile, employers began offering health coverage to their workers during World War II as a substitute for wage increases, which were largely prohibited. Now, though there is no requirement that firms offer health coverage, almost 140 million Americans receive protection through their jobs or the job of a family member.

But employers are feeling the impact of health care inflation that has run at twice the rate of general inflation over the last decade. Premium increases of almost 50% over the two-year period from 1987-1989 have stricken even the most well-intentioned employers with doubt about how long they can sustain current coverage levels. Most labor-management disputes over the past several years have had health care at their heart, and real wage growth has been in-

hibited as dollars are siphoned off to pay the spiraling bill for existing health coverage.

Here are two statistical sign posts of why health care cost increases are threatening the structure of our job-based system of protection and building a constituency for reform among both businesses and their workers: (1) corporate health care costs are now *equal* to after-tax corporate profits; and (2) between 1980 and 1987, Americans' real household income rose \$1,500 a year while household health care costs rose \$1,400 a year.

For small employers, the situation is even worse. Not only do they face high insurance costs — higher ones than for larger firms (for a variety of reasons) — but they must also cope with increasingly tight “underwriting” by insurers. Insurance companies routinely try to cover only *healthy* groups, and charge exorbitant premiums for groups with unhealthy members. Risks are not shared, or managed, as often as they are avoided.

That also translates into millions of Americans who can not leave their current jobs, or are forced to take a different one, because of a sick child or spouse with a “preexisting condition.” One recent poll concludes that 37% of all Americans have taken or kept a job because of health benefits. They are, in effect, “chained” to their work stations.

### *B. Medicaid Shortcomings*

If you are poor in America, chances are three out of five you *don't* get coverage through the Medicaid program, though that is its purpose. You may be dirt-poor, yet not be poor enough. In some states, the income eligibility is set at less than 20% of the poverty line, under \$200 a month for a family of three. Such a standard is unconscionable on its face. Alternatively, you may not fall into the correct category of family arrangement (men and childless couples are ineligible in most states), or you may be too young (being age 65 or over constitutes a coverage category).

#### 1. Long-term Care

Medicaid provides the only major government funding source for care of chronic conditions. Almost exclusively it consists of care

in an institution, a nursing home. To qualify for assistance, people must “spend down” their entire life savings and contribute all current income except for a monthly personal needs amount that is most commonly just \$30 a month. The other major source for long-term care funding (the largest single source) is the savings of patients and their families. This reflects the structure of the Medicaid program and the virtual nonexistence of quality, affordable private long-term care insurance coverage.

States provide up to half of the funds for Medicaid, and have wide latitude over how much service is provided. Thus the current fiscal difficulties in most areas of the country, coupled with the fact that Medicaid is one of the fastest growing items in state budgets, translate into further squeezes on coverage under Medicaid. Altogether, these difficulties have produced more calls for change than at any time in past decades.

States, such as West Virginia, can take steps on their own. For example, in 1978 West Virginia's infant mortality rate was more than 15 deaths per thousand births — one of the highest rates in the country. With the help of the state legislature, the health care community, and the people of this state, I set out as Governor to change that. And despite West Virginia's relative poverty, we worked together on this terrible scourge. By 1988, our infant mortality rate had dropped almost by half. Only one other state was as successful during this period. In all my years of public service, this is one of my proudest achievements. Yet the crisis in health care respects no state's boundaries. Just as the dire consequences of inaction will be felt by America as a whole, so too must we demand national leadership to address this problem.

#### IV. A PROPOSAL FOR REFORM: BUILDING UPON THE FOUNDATION OF THE PEPPER COMMISSION REPORT

In 1990 the Pepper Commission, which I was proud to chair, released a report and a set of recommendations that would radically reform the system. Although critics claimed it was “dead on arrival,” I have since joined with Senate Majority Leader George Mitchell and other health care leaders to introduce a bill constructed on the strong foundation of the Pepper Commission report. Our bill

will both control costs and guarantee basic health protection for every American.

The basis of the bill is compromise and shared sacrifice which, taken together, can salvage a workable system. We build on the current employment-based system. Insurance companies would be prohibited from profiting by screening out the sick and "cherry-picking" the healthy. Employers would be required to cover their workers or pay for their coverage in a public program. Doctors and hospitals would be subject to strict cost containment measures. A Federal Health Expenditure Board would mediate negotiations between hospitals and doctors and those who pay for health care. An agreement would yield binding rates; otherwise, the Board would set advisory rates.

Other proposals have been introduced by my colleagues in the House of Representatives that build similarly on our employment-based system. Some of my Senate Republican colleagues moved late last year to introduce legislation aimed at expanding coverage and, to a very limited degree, limiting cost increases. Coincidentally or not, the Republican proposal was introduced just days after Harris Wofford's stunning, come-from-behind victory in the Pennsylvania Senate race last fall. Not only does their proposal stop well short of guaranteeing affordable, quality health coverage for all Americans, it takes only modest steps to rein in costs: reforming the small group insurance market, reforming the medical liability system, research into the outcomes of certain treatment patterns, preventive measures, and encouraging "managed care" plans to help ensure that care is only delivered when needed, and in the least expensive appropriate way. All of those are worthy steps, but the crisis demands bolder and more dramatic action. With health care costs projected to reach \$1.8 trillion to \$2 trillion by the year 2000, we literally cannot afford to shy away from significant cost controls.

Some advocates of comprehensive reform would replace our current system with a government-run national health insurance plan. If we were starting from scratch to build a system of coverage, that might indeed be an attractive option. But we do not have that luxury. There is a health care coverage system in place that combines private and public sector programs. Shifting so many people and

dollars from the private sector to the public would be so disruptive as to be politically impossible in the near future.

The proposal I have put forward does, indeed, entail new government spending, and new spending by those businesses that do not now provide coverage to their workers. By contrast, it has been estimated that, under my plan, businesses that currently provide coverage would save about \$15 billion a year. The plan proposed by Republican Senators carries a price tag of \$150 billion over five years (on the same order of magnitude as my health care proposal), yet would neither provide universal coverage nor effectively contain health care costs.

By sharing costs fairly among business, government, and families, our plan costs the taxpayer less than any other approach to universal coverage.

With regard to long-term care, a "social insurance"-style program, like Medicare, would cover comprehensive home care benefits and limited nursing home stays to Americans of all ages who need help in performing ordinary activities of daily living. The new program would also ensure that no American would ever again have to spend their entire life savings on a lengthy nursing home stay by protecting substantial amounts of income and savings before requiring payment by the nursing home resident. Those with high incomes and assets to protect would be able to obtain private insurance much improved over most of today's policies for that purpose.

Some critics of a comprehensive approach point to the continuing fiscal difficulties of both the federal government and most of the states and predict that no action is possible on so ambitious an agenda. I offer three observations in rebuttal.

First, there is growing evidence that the American people are demanding this kind of wholesale reform. Not only do 89% of Americans believe that fundamental change is required, but large numbers are beginning to perceive the crisis as affecting them and their families personally. And although two-thirds believe their insurance would take care of major costs today, more than 60% are not confident the same will be true tomorrow. When pollster Celinda Lake asked Pennsylvanians a few months ago what their main con-

cern would be if they were unemployed, it was not finding another job, but trying to regain insurance coverage.

This combination of fear and concern over the cost of insurance and care also tends to move Americans toward a willingness to pay part of the bill, even in the form of higher taxes. A 1990 *Los Angeles Times* survey asked people whether they would be willing to pay increased taxes for health reform. Only 35% were willing to pay more than \$100 a year "to support expanded health coverage for all Americans." Yet when the Pepper Commission report was released a few months later, Gallup polled voters on whether they would be willing to pay enough additional taxes to cover the cost of the Commission's acute care reform plan (about \$150 a year). The response was overwhelmingly positive: 74% "yes" to just 22% "no," and the pollsters told us it was in large part attributable to the question's reference to *both* "hold[ing] down health insurance costs and extend[ing] basic health care coverage to all Americans."

The second reason to be hopeful about the prospects for reform is that we have shown that some modest progress is possible. Three measures in the 1990 budget agreement actually reflected the Pepper Commission recommendations. At the same time Congress was acting to reduce the federal deficit, protection was expanded for pregnant women and children. Medicaid now covers all pregnant women and children under age 6 with income below one and one-third times the poverty line. By the year 2002, all children in families with incomes below the poverty level will also be covered. Congress also enacted reforms to the Medicare supplemental insurance market that will protect the elderly from the kind of "cherry-picking" that our broader plan seeks to eliminate for all. Additionally, Congress enacted Medicare coverage for mammograms, reflecting the Commission's strong emphasis on preventive services. So Congress can act, and with the cooperation and leadership of the President, much more ambitious steps are possible.

Finally, there is the simple proposition that we will act to reform the health care system because we must. The current system is, as Office of Management and Budget Director Richard Darman has declared, not fiscally sustainable. We cannot afford to spend a third or more of our Gross Domestic Product on health care as current

trends would indicate. We cannot afford, economically or morally, to allow the number of people without coverage in America to grow by 25% in the coming decade as it did in the previous one.

I pledge my best efforts to bring that action about swiftly, and to ensure that it is both decisive and comprehensive.

