National Health Insurance:

The Care and Feeding of Medi-Business

The idea of national health insurance came in with a bang in the early Seventies. By 1971 no fewer than 13 bills representing every major interest in the health system, and ranging from the all-encompassing Kennedy-labor bill to the very minimal AMA Medicredit bill, were facing Congress. Many predicted that national health insurance would be a reality within a year or two, and certainly it would be a major issue in the 1972 presidential campaign.

Yet prophecy is a risky vocation and suddenly it seemed like the fires under national health insurance had died out. It was hardly mentioned in the 1972 campaign. Only in 1974 did it begin once more to gain momentum.

Why is national health insurance (NHI) once again on the legislative agenda? Is it because over 20 million people have no private or governmental insurance at all? Because private insurance and Medicare pay only 40 percent of the average person's health bill, often leaving hundreds or thousands of dollars in expenses not covered when sickness strikes? Because medical bills are the number one cause of personal bankruptcy in the U.S. today?

No. NHI has other functions. On the simplest level, it could be a feather in someone's political cap—for Nixon, desperately looking for a visible social program to save his skin, or for Kennedy, uncertainly eying the top job. For the AMA and insurance companies, 1974 is a good year for NHI because 1975 could bring a far more liberal Congress and therefore a more threatening bill. And in the form now presented, NHI is a boondoggle for the medical-industrial complex—the hospitals, insurance companies, nursing homes, medical supply and hospital construction industries, and all the other corporations that profit from sickness and death.

But aside from these non-health considerations, will NHI make good health care more accessible to the majority of Americans? Will it at least reduce sickness and pain until a more sane health-care system comes of age? The answer can only be a very weak "perhaps."

by Ronda Kotelchuck and Thomas Bodenheimer

[A MELANCHOLY HISTORY]

For most of us, national health insurance is a thick and confusing stack of documents containing endless legal and financial terms. But behind the fine print lie concepts that are more important than the details of the bills themselves. To appreciate these concepts, it's worth taking a look at the history and present structure of health care finances.

The concept of national health insurance has been around for a long time. Almost 100 years ago European governments began to pay for the health care of their citizens. In the United States a small group of liberal professionals started the fight for NHI in 1912. But by 1920 the idea had been killed by insurance companies, AMA doctors and conservative labor leaders.

A second round of NHI discussion began with the social security legislation of the 1930s. At least ten proposals reached Congress between 1939 and 1950. In 1949 the AMA, fearing government control over doctors' fees, hired the public relations firm of Whitaker and Baxter to wage a nationwide advertising campaign. Building on the intense McCarthyism of the period, Whitaker and Baxter equated NHI with socialism and placed full-page ads in newspapers and magazines that pictured Government destroying the sacred doctor-patient relationship. The AMA shelled out $5 million in successful advertising and lobbying, and NHI remained a dead issue throughout most of the 1950s.

In spite of inaction on national health insurance, the health care system as a whole changed markedly by 1960. Through the Forties and Fifties, a giant private health insurance industry came into being, composed of Blue Cross, Blue Shield and commercial companies such as Aetna, Occidental and Connecticut General. These companies offer considerable hospital protection to working families who can afford to buy policies and are in a generally healthy age group. But the companies fail to pay most medical bills outside the hospital. And people who fall chronically ill or lose their jobs lose their insurance as well.

Low-income people, of course, can't afford insurance, and the companies don't want to insure the elderly because of their high rate of illness. So a new drive for national health insurance began around 1960, concentrating on the poor and the elderly. In 1965 Congress passed Medicare for those over 65 and Medicaid for people unable to work.

Medicare takes money from people's paychecks, under Social Security, and uses it to pay medical bills of the elderly. Medicare is limited, paying on the average only half of these bills. Though a step forward for people who pile up thousands of dollars in hospital costs, it ignores a sizeable portion of the bills charged in doctors' offices. People over 65 pay an average of $400-500 each year in medical bills not covered by Medicare. With the rise in medical costs over the last decade, that is more than the average senior citizen paid in total health costs before Medicare was passed.

Medicaid must also be judged harshly, for it has failed to meet the needs of the 40 million poor people in the country (the government defines "poor" as a family of four earning less than $4,300). More than 20 million of them are not covered at all. Those who are covered receive limited services. And Medicaid patients have a hard time finding doctors and dentists who will see them. In one Los Angeles county hospital, 23 percent of outpatients switched to private doctors right after Medicaid was passed, but 12 months later most of these patients chose to come back to the county hospital. Other studies confirm that private medicine has failed to care for many of the poor even when paid to do so. Yet city and county hospitals, which used to treat people free, increasingly are charging for their services. (See "Hospitals for Sale," RAMPARTS, February 1974.) Thus low-income people may actually have a harder time finding care than they did before Medicaid arrived.

Medicare and Medicaid have been principal causes of skyrocketing medical costs. Hospitals, doctors and nursing homes are allowed to decide how much to charge, and they are paid through private insurance intermediaries, usually Blue Cross and Blue Shield, who make no attempt to control these charges. The first year after Medicare and Medicaid started, hospital costs were up 19 percent and doctor fees 7 percent. In the first six years of the programs, medical prices increased by over 40 percent compared to an increase of 20 percent in the six years before the programs started. And the fees didn't go up just for Medicare and Medicaid patients: they rose for all of us.

Medicare and Medicaid were a financial shot in the arm for the health industry. Doctors' average incomes now top $40,000, with many specialists earning over $100,000. The insurance intermediaries expanded their business by $10 billion a year, including several hundred million for "administrative expenses." This means high executive salaries (Blue Cross President Walter McNerney earns $80,000), new buildings, newspaper and radio ads and Congressional lobbying. Medical equipment and drug companies increased their sales and profits. Nursing home stocks boomed. Hospitals added on new beds at a rate three times greater than the population increase. As a result, 25 percent of hospital beds are now empty, upping the rates to all patients.

In short, Medicare and Medicaid—our country's first taste of national health insurance—though designed to help the patient, have largely profited doctors, hospitals and medical businesses.

[NIXON'S "HEALTH" PLAN]

Although a broad range of national health insurance bills floated through Congress in 1971, by 1974 the processes of political compromise were well at work. Three bills—that of the Nixon Administration, Long-Ribicoff, and Kennedy-Mills—emerged as front-runners, with their similarities far greater than their differences. The final NHI law will be a mixture of various bills, rather than the passage of one. And NHI won't arrive in one big leap; it's likely to come step by step over the next decade. But to understand the concepts behind NHI, a closer look at the Nixon bill is most useful.

Nixon's plan is called the Comprehensive Health Insurance Plan (CHIP), and its intent is to enable each American to buy a private health insurance policy covering a specific set of medical services—if he or she wishes, and can afford it. CHIP would make insurance available through three programs. Under the Employee Health Insurance Plan (EHIP),

Illustration by Sandy Huffaker

full-time employees could purchase health insurance by paying 35 percent of the estimated $600 annual premium for a family of four (approximately $210), while employers would be required to contribute the rest. (Later the employee share would decrease to 25 percent.) Under the Assisted Health Insurance Plan (AHIP), the poor, unemployed, and those considered high medical risks could purchase health insurance with premiums subsidized on a graduated scale, according to income. Finally, the elderly could purchase premiums, again with government assistance according to income, in an expanded Medicare program.

Unfortunately, the Comprehensive Health Insurance Plan itself is not nearly as impressive as its name. First of all, it does *not* automatically guarantee health insurance to everyone. Instead, it is completely voluntary; only if people join and pay their share of premium costs will they be covered. Hence it promises to leave large numbers of people uncovered. First to fall between the cracks will be the marginally-employed and part-time workers. EHIP does not require employers to offer health insurance until employees have worked 90 days, and does not require coverage of part-time workers at all. Such workers may seek insurance through AHIP, but only by paying much of the $600 premium themselves. This will surely act as an incentive for employers to hire part-time workers and those who do not require health insurance.

In addition, the cost of purchasing health insurance will fall most heavily on lower-income workers, who in a financial pinch may decide to risk not being insured. And many elderly may actually stand to lose under Nixon's new program. Presently Medicare provides hospitalization automatically, and if elderly persons want coverage for physician cost in addition, they must pay a premium of $6.30 a month. Under CHIP *all* health insurance coverage for the elderly will be voluntary and will depend upon payment of premiums.

In fact, CHIP is not really health insurance at all. It is primarily catastrophic illness insurance—that is, useful mainly when families or individuals have a devastating illness that would otherwise result in catastrophic debts. This aid is not insignificant, since illness is the primary cause of personal bankruptcy in this country. But CHIP pretends to offer much more, an offer on which it cannot deliver.

CHIP incorporates a system of out-of-pocket payments which make it unlikely that the ordinary, healthy family will benefit from its insurance. In addition to the initial $210 a year that a family must pay for its premium, it must also pay the first $150 of medical expenses *per family member* (called a deductible), up to a total of $450 per year. Thus the family could end up spending $660 before receiving any assistance whatever from its health insurance. The same is true of CHIP's drug benefits. Consumers benefit only after paying the first $50 for drugs each year. Once a family has spent $450, it's still not home free. It must still pay 25 percent of the succeeding costs (called co-insurance) up to a maximum of $1500. Only then does CHIP take over and pay all costs. (For the poor—individuals making less than $5,000 per year and families making less than $7,000—co-insurance and deductibles are graduated according to income, although co-insurance never drops below 10 percent.)

This system of deductibles and co-insurance is called cost sharing by the government. It is designed to act as a "disincentive"—to discourage consumers from misusing or overusing the health system and to create an incentive for them to seek out the least expensive care. This analysis, of course, ignores the fact that a sick person is not like a grocery shopper. A sick person has little to say about when he needs services, what kind, and which facilities he uses. The system also gives the lie to CHIP's supposed concern for preventive and pediatric medicine; a child could take advantage of preventive benefits only after having been sick enough to require the first $150 in medical expenses.

Clearly, health-care financing under CHIP would be enormously regressive, particularly for the lower-income worker. The estimated $210 employee share of premium cost would be the same for the $7,000-a-year worker and the $70,000-a-year executive, even though it comprises 3 percent of the worker's salary and 0.3 percent of the executive's salary.Likewise, the maximum out-of-pocket expense of $1,500 would be 21 percent of this worker's income—easily enough to throw a family into bankruptcy—while it would be only 2 percent of the executive's income.

Even when benefits were ultimately paid, CHIP would not be free at the point of delivery, nor would it guarantee one class of care. These promises were undercut by a provision that would certify providers as fully participating, associate participating or non-participating. Associate participating providers (excluding institutions) would be free to charge EHIP patients (wage-earners) direct, individual fees above and beyond those paid for by their insurance. For EHIP patients, this would make a sham of services being free at the point of delivery or of their having a maximum liability for medical expenses. For the poor and elderly, it would mean discrimination as usual, since they would clearly be less profitable to treat than EHIP patients.

CHIP would come down hard on the consumer who defaults on his out-of-pocket costs. It would guarantee that he gets no care whatsoever. Presently, if a patient has outstanding bills, a particular hospital or doctor may turn him away. But he can still seek services from other providers. Under CHIP all services would be paid for through a medical "credit card" issued by a private health insurance company and all out-of-pocket expenses would be owed that company. CHIP would allow the company to cancel a "credit card" if debts are not paid within 90 days, thus cutting off access to all participating medical services.

Finally, administration of CHIP's "national" health insurance would not really be national. The federal role would be limited to establishing eligibility standards, defining the benefit package, and administering Medicare—as it does now. Left to individual states would be such crucial issues as regulation of insurance companies, review of rates received by insurance companies and medical providers, certification of providers and administration of cost-control mechanisms. The federal government would have to approve state plans for doing these things, but with 50 separate state plans and administrations, problems of federal supervision would be unspeakably complex. And states would apparently have the option of deciding whether they even wished to participate in CHIP.

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I.

Death of an Illusion

"America's past is no longer a guide to its future. The people sense this even if the politicians do not. The feeling is widespread that the nation has committed fundamental errors for which it must now pay."

Throughout the country there is deep disquiet. The mood is not of panic, nor even of tangible fear. It is, rather, a general anxiety, a growing sense that something has gone very wrong with the United States and that, whatever it is, it lies deep in the foundations and is becoming worse.

Watergate, of course, contributes to the unease, with its sorry exposure of the miserable, corrupt inner workings of the political process, and the visible deterioration in constitutional relations between the Congress and the Presidency. Of themselves, these are enough to anger and bewilder a people. Yet the nation seems to sense that these are not causes but consequences, symptoms of a deeper malaise.

America's past is no longer by simple repetition a guide to its future. The people sense this even if the politicians do not. The feeling is widespread that, not only recently but over many years past, the nation has committed fundamental errors for which it must now pay, politically and economically. The people will pay the price—sullenly perhaps, but pay it nonetheless—if the nation's problems are presented to them in their reality, and if the need for sacrifices and changes which events will demand of them is clearly demonstrated. But instead, in the excitement of the constitutional crisis, the real problems of the nation—the fundamental, non-transient issues—go almost undiscussed.

Matters are not helped when the Vice-President of the United States bumbles out that, if the citizens express their alarm electorally, a "legislative dictatorship" might result—however *that* might be construed. (Were it not unthinkable, one could suspect that Mr. Ford had dipped too deeply into Plato.) Nor is the public assisted towards understanding when Senators Kennedy, Mondale, et al, hoist up their pole the discredited banner of tax reduction, of priming the pump, as a universal solvent for social diseases. The old cliches are being revived by the Democrats, the disproven nostrums spooned out.

The truly frightening reality is that the alternatives currently presented are the Democrats' policy of fostered inflation, obscured by the technical manipulation of statistics, and the Republicans' policy of unrestrained power to the big corporations (with their grotesque and insatiable lust for profits). That the electorate will repudiate the latter

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