

Reality check for American dream

Recent US legislation is designed to expand coverage and to change the way health insurance is sold, but it does not address the health system's underlying problem: costs. Gary Humphreys reports.

“There’s a lot of confusion out there,” says Janet Witt, from the National Committee to Preserve Social Security and Medicare, the scheme that provides insurance to people aged over 65. Witt has been trying to explain what President Obama’s health-reform legislation means. It has not been easy. “There are a lot of rumours,” says Witt. The legislation itself is nearly a thousand pages long and will take years to implement. Its impact will depend partly on how individual states – many of them hostile to change – put it into effect.

The law extends insurance coverage to 32 million previously uninsured Americans. This extension will be paid for by increasing premiums, imposing new taxes and making cuts to Medicare. Almost all Americans will be obliged to get coverage by 2014 or face being fined.

From 2013, individuals earning more than US\$ 200 000 a year and households earning more than US\$ 250 000 will pay higher Medicare contributions, while high-income taxpayers will start paying a 3.8% tax on income such as dividends and interest. There will also be a 40% tax on so-called “Cadillac plans” – those with an annual cost exceeding US\$ 10 200 for individuals or US\$ 27 500 for families (not including optical and dental benefits). The self-employed and those working in small business will be among the main beneficiaries of the reforms.

Other immediate changes to Medicare include free preventive services, such as screenings for colon, prostate and breast cancer. Senior citizens caught in a Medicare funding gap for prescription drugs (referred to as the “doughnut hole”) will receive a one-off rebate of US\$ 250 and, from 2011, they will be eligible for a 50% discount on brand-name pharmaceuticals.

A notable change will be reductions in subsidies to Medicare Advantage, a scheme introduced in 1997 to promote the use of private insurers within the main Medicare programme. Offered by private health insurance companies, Medicare Advantage plans are funded partially by Medicare and partially by charging members an additional monthly premium

to cover extra items such as prescription drugs, dental and optical care. Currently 24% of Medicare beneficiaries participate in Medicare Advantage plans. However, average Medicare payments to private insurers under this scheme are estimated at between 9–13% more than what would have been paid in the traditional programme. The reform will reduce these excess subsidies to the private insurers while concurrently offering bonus payments to insurers that score well in a quality rating system.

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Patricia Nemore, a senior policy attorney at the Center for Medicare Advocacy in Washington DC, welcomes these changes. “Medicare Advantage was unfair to the taxpayers because part of it was funded by general revenues, and it was unfair to every single Medicare beneficiary because they were paying their

premiums but were not all enrolled in Medicare Advantage,” she says.

Revenue from these changes will allow the government to increase participation in Medicaid, a means-tested programme serving people on low-incomes or with certain disabilities. This will increase coverage to an extra 20 million people and increase Medicaid eligibility in some states by 50% or more.

But Professor Randy Ellis, a health economist at Boston University and supporter of the reforms, warns: “We have now increased the number of people eligible for Medicaid without changing the number of doctors or beds.” However, Dr Robert Wachter, at the University of California San Francisco Medical Center, says increased Medicaid enrolment will not necessarily pose a problem. If the reform encourages people to use primary care, hospital use may not be significantly increased.

Just as dramatic as the extension of coverage is the change to how health insurance will be sold. From 2014, private insurance will be sold in state-based “exchanges”. Insurers will be unable to reject applicants based on health status or increase premiums beyond regulated levels. Policies sold through the exchanges must cover hospitalizations, doctor visits,



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New health reforms will extend coverage to 32 million previously uninsured Americans.

prescription drugs, maternity care and certain preventive tests.

A major flaw in the American system has been that many people – particularly the self-employed and those working for small employers – have not had access to large group insurance. Risk pooling ensures that each contributor to a scheme does not individually carry the risk of having to pay for health care. The larger the pool of contributors, the cheaper the insurance.

Linda Blumberg, a health policy expert at the Washington-based Urban Institute, believes that, while falling short of some people's desire for a "public option" (i.e. a government-run health insurance plan), "the new law will improve access for people who have been disadvantaged by the system – especially those without access to group coverage". Many people have had access only to small group-rated or individual risk-rated plans that are either more expensive than large group plans or provide limited benefits. In addition, people with this insurance risk large premium increases or losing coverage if their health deteriorates (e.g. if a person is diagnosed with an illness in 2010, they may lose coverage or face paying higher premiums for this condition in 2011).

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Robert Zirkelbach

"Fundamental to the whole concept of risk pooling is to have a large group of people with different risks so that the pooling enables cross-subsidy from the healthy to the sick," says Joseph Kutzin, health financing specialist at the World Health Organization. "As it currently stands, the individual and small group market in the United States works directly contrary to this principle."

So why is this going to take another four years? Blumberg cites the size and complexity of the task and less obvious congressional reasons – a 10-year budget cycle. "By holding off reform until 2014, you don't have to show a full 10 years of costs," she says. The delay makes the plan look cheaper than it is.

Some things are changing straight away. For example, insurers can no longer refuse coverage for children, deny coverage

to children with pre-existing illnesses or set lifetime coverage limits. Dependent adults younger than 26 will remain covered by their parents' policy if they are not offered health coverage at work. Small companies (with 25 or fewer employees with an average wage of up to US\$ 50 000) can get tax credits to offset up to 35% of the cost of premiums this year, rising to 50% in 2014.

On 1 July, US\$ 5 billion in federal funds become available for a high-risk insurance pool. This is a way to provide coverage for the people most in need, but who are currently excluded unless they can afford to pay very high premiums.

The high-risk pool is of great interest to many who are too young to qualify for Medicare and too well off to qualify for Medicaid – people like Carol Klapste, a 58-year-old woman living in rural Wisconsin. She has a thyroid problem, precisely the type of "pre-existing" condition that private insurers can refuse to cover. Until last year, Carol was covered by her architect husband James's employer-sponsored policy. Since James lost his job, the Klapstes have continued coverage under a scheme that allows employees to stay insured for 18 months after losing their job if they meet the full cost. But this will end soon, leaving Carol Klapste with the much more expensive option of taking individual coverage.

So now, the Klapstes, like millions of others, are hoping to get into the high-risk pool where they will be able to survive until 2014 – precisely what it is designed to do. But Blumberg warns some people risk being disappointed: "There's some lack of understanding on how restrictive [the high-risk pool] is," she says, referring to the requirement that people must have been uninsured for six months before application, a rule designed to prevent people dropping more expensive coverage. The high-risk pool is designed, in other words, to help people who have no coverage. "It's not perfect," admits Blumberg, "but at least it's something."

Robert Zirkelbach, a spokesman for America's Health Insurance Plans, the industry's lobby, has expressed concern about what he sees as the reform bill's absence of provisions for reducing health-care costs. According to the Organisation for Economic Co-operation and Development (OECD), the USA spends US\$ 7290 per capita on health care. This is more than any other country, roughly two and a half times the average of other high-income countries. High health-care costs are driven



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The USA has the highest health-care costs in the world.

by a system in which doctors are paid more for supplying a higher volume of services and consumers have no incentive to limit spending either when their insurer pays the bills.

According to the Congressional Budget Office, health-care reform will cost US\$ 938 billion over a decade but increased taxes and fees and billions of dollars in Medicare payment cuts will shrink the federal budget deficit by US\$ 143 billion over 10 years. Beyond that, the issue of rising medical costs is largely unaddressed. There are plans to establish a board to oversee Medicare spending, but it is unlikely to start applying the brakes for several years.

The prospect of ballooning costs is a problem for several reasons. As Zirkelbach points out, costs drive insurance premiums. "If costs continue to skyrocket then insurance will be unaffordable," he says. In other words, if the private-for-profit insurers have to make big payouts to providers, they will have to raise premiums accordingly. There are provisions for government to step in if people cannot afford to pay for insurance, but the penalties for refusing to buy (US\$ 95 in the first years) are perceived to be too low to encourage participation. Some American corporations are talking about dumping their employee insurance packages, preferring to pay the fines.

Without participation, the system would run into trouble. "There is widespread agreement that, for the market reforms to work ... you need to get everybody participating in the health-care system, otherwise you will just have a system where people will wait until they are sick to purchase insurance, which drives up costs for everybody else," Zirkelbach says. ■