

Why does Universal Health Coverage Not Exist in the United States? A Physician's Perspective

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ABSTRACT

Universal Health Coverage does not exist in the United States for two reasons: (1) there is a general unwillingness to dismantle the historically grown framework of the most complex mix of public and private sector health coverage and (2) mere cost considerations. The first concern can be abated by establishing a Universal Health Coverage system which retains many or most of the grown U.S. health infrastructure. The two proposed pathways presented herein comprise either (1) a leveled solution through Medicare-expansion for the uninsured only or (2) a more complex solution through a national, 2-tier healthcare system for all Americans. Both pathways are based on solid financing without major tax increases by using existing and/or yet untapped funding sources. For the sake of forming a more perfect union as stated in the Constitution, Universal Health Coverage in the United States must no longer be an illusion that continues to haunt our society in the 21st century.

Keywords: Universal Health Coverage, Medicare-expansion, 2-tier Health Insurance, Health Policy, Health Economics.

INTRODUCTION

The United States has the world's largest economy but remains the only major industrialized country without some sort of a National Health Insurance (NHI) system. Instead, its health system is fragmented, opaque and too costly. Despite the 2010 landmark enactment of the Patient Protection and Affordable Care Act (ACA) with subsequent enrollment of millions of formerly uninsured Americans, true Universal Health Coverage remains a dubious specter with an uncertain future. In 2022, 27.6 million Americans of all ages did not have health insurance [1]. The uncompensated cost for healthcare services to the uninsured even after ACA enactment averaged \$42.4 billion per year between 2015 and 2017 [2]. Sadly, most uninsured Americans are people of color and people from low-income families with at least one worker in the family [3]. Aside from personal tragedies falling upon uninsured Americans including bankruptcy, poor medical care, declines in overall health, potentially life-threatening conditions, emotional and mental hardship, pending bills have to be paid eventually by someone. The bulk of these unpaid bills "are compensated through a web of complicated funding streams, financed largely with public funds from the federal government, states and localities [3]." In the end it is the common taxpayer who pays for the lack

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of Universal Health Coverage. Hence, it is in the best interest of our society as a whole to elicit financially sound pathways to accomplish the long-awaited objective of Universal Health Coverage in the United States.

The issue of Universal Health Coverage is always being linked to the question of whether it is a human right vs. a privilege. The notion that healthcare is a right is in fact an argument for universal coverage through a system that requires additional, mandatory, taxpayer-financed participation. In that regard, it is a resource-extracting (i.e., negative) but at the same time a freedom-preserving (i.e., positive) right.

How could it happen that the wealthiest country in the world has so miserably failed over time in developing a Universal Health Coverage system that provides health insurance to all Americans? The answer lies in the historically grown and unique framework of the undoubtedly most complex mix of public and private sector health coverage that ranges from no health insurance to the best in the world.

BACKGROUND

Historical Developments in the 19th and 20th centuries

The foundations of modern health care in the United States were laid during the 19th century. Pivotal developments included the founding of the American Medical Association (AMA) in 1847 (which created standards for medical education and a code of medical ethics) and the U.S. Nursing Corps in 1861, improvements in surgical procedures under anesthesia and creation of Ambulance Corps during the Civil War, advances in diagnosing and controlling infectious diseases, and the fledgling beginnings of the pharmaceutical industry. These 19th century developments provided the fundament for the complex health care system that evolved in the 20th century.

However, at the beginning of the 20th century, health care in the United States was still a cottage industry: doctors were mostly solo practitioners with student assistants (“apprentices”); hospitals were single, independent entities and mostly non-profit; long-term care for the elderly was largely home-based; and pharmaceutical and medical device manufacturing was small business. All healthcare spending accounted for only 0.25% (!) of the Gross Domestic Product (GDP) and represented a minute part of the economy [4].

Yet since the early 20th century, the demand for access to health care continuously increased, as did its cost. From 1933 to 1960, health care spending still peaked at only 1% of the GDP [4]. By then, it had become apparent that a system was needed that provided health insurance to patients that could afford medical care, and compensation to providers for their services.

The U.S. health care system evolved differently from that of most other developed nations due to the quintessential American preference for combined private and public funding of (1) providing health care coverage and (2) the necessary facilities infrastructure. On the downside of this approach, health care access in the first part of the 20th century ranged from non-existent for many Americans to luxurious for few Americans.

The United States unlike then-peer countries such as Germany, France, and England has never developed a government blueprint that provided universal health care coverage despite many proposals dating back to Teddy Roosevelt. In 1912, he unsuccessfully supported a National Health Insurance (NHI) system. In 1916, the American Association for Labor Legislation (AALL) proposed compulsory medical care and sickness benefits insurance, but the United States entry into World War I squashed those attempts.

It is remarkable that the world’s first enacted NHI program was created not by a democratic government but by a conservative constitutional monarchy in the Kingdom of Prussia in the 1880s under the leadership of Otto von Bismarck. This first national program (1) provided cash support for sickness and accidental injury and (2) was financed by both employees (who paid two thirds of the premiums) and employers (who paid one third of the premiums). By the 1920s, most of the Western European industrialized countries, as well as Japan, had established some kind of NHI system which eventually progressed to national health care systems that were both comprehensive and compulsory.

The United States has remained the only major industrialized country in the world without some kind of NHI system. Aside from access to health care for members of the military and their families, as well as veterans, for whom the federal government had incrementally built a military healthcare system since 1811, the private sector slowly developed an employer-sponsored/based health insurance (ESI) system, but for the employed only. The U.S. system of health insurance developed in the 1910s from “prepaid” group practices which required plan members to pay a monthly premium to receive a wide range of medical services through an exclusive group of providers. These prepaid group practices were early forerunners of modern-day health insurance plans. In 1929, Blue Cross plans were established to provide “prepaid” hospital care at Baylor University Hospital to teachers in the Dallas public school system. In the 1940s, the leading employer-sponsored health insurance plans were Blue Cross and Blue Shield (founded in 1939) which acted as non-profit, charitable companies, and served 24 million members with 81 hospital plans and 44 medical plans.

At the same time, the fight for an NHI system continued with another Roosevelt. In the 1930s and '40s, it was Franklin Delano Roosevelt who failed because his priority was the 1935 passage of the Social Security Act, a cornerstone of the New Deal which may not have passed with an NHI proposal on the same agenda. Subsequent U.S. Senate NHI bills died as well. Next, it was on Harry Truman to propose NHI legislation. He also failed because in those politically turbulent times, the plan was touted "socialized medicine" by his opponents. Although the plan was withdrawn in 1951, Truman concurrently started the campaign to provide government health insurance for senior citizens that eventually led to passage of Medicare in 1965 under the Lyndon Johnson administration.

Notably, the AMA played for decades a major, yet dubious, role in fighting and defeating all attempts to create some form of an NHI-system. Since the 1920s, it basically had opposed all types of compulsory contributory insurance by any state or the Federal government because of potentially financial detriment to physicians. It was not until 1990 when the AMA dropped the noncompulsory principle.

By the mid-20th century, it had become obvious that inconsistent access to health care was a problem that needed attention mainly for two reasons: (1) health care had grown more and more expensive due to the development of more refined diagnostic and treatment modalities; and (2) lack of health insurance for the unemployed and poor. Consequently, Congress passed legislation between 1965 and 1997 for three non-employer-sponsored groups. These legislative acts included three landmark programs that fundamentally changed American healthcare from the public sector perspective: (1) Medicare for people 65 and older; (2) Medicaid for uninsured, low-income people; and (3) the Children's Health Insurance Program (CHIP) for uninsured, moderate-income families. As a result, many uninsured Americans suddenly received coverage through the public sector insurance (Medicare, Medicaid) which began to co-exist alongside the traditional private sector (employer-sponsored) insurance.

Additional public sector insurance coverage was enacted in 1986 when the Emergency Medical Treatment and Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA) passed legislation. EMTALA, for example, prohibited "dumping" of uninsured patients by Medicare-participating hospitals with active emergency rooms. HIPAA implemented several significant improvements by, for example, (1) mandating continuity or "portability" of coverage in the private health insurance markets; (2) creating national privacy standards related to personal health information; (3) establishing that data

within the medical record belongs to the patient and the patient has the right to ensure accurate information; and (4) constraining discrimination because of poor health status.

The second half of the 20th century was marked by growing demand for, and affordability of, healthcare services. In 1980, healthcare spending had increased to 4.1% of the GDP. Other important changes took place as well. Solo physician practices and single hospitals, the original backbones of the early U.S. healthcare system, were becoming obsolete. To further maximize profits in the rapidly changing healthcare system, capitation and managed care (e.g., health maintenance organizations [HMOs], managed care organizations [MCOs]) as well as multi-unit hospital systems and integrated health systems were introduced by the private sector and quickly expanded. These developments also resulted in a steep increase in the number of for-profit health care organizations. Even the "Blues", in 1994, permitted its affiliates to switch to for-profit status.

In essence, the fabric of U.S. healthcare had significantly changed during the 20th century from solo physician practice financed primarily by indemnity insurance to group practices financed primarily by capitation. Not only did horizontal integration of physician practices take foothold, but also horizontal consolidation of hospitals (mergers) and eventually vertical consolidation (fully integrated systems). This all occurred under purported improvements in efficiency, cost containment, and superior quality of care. However, it is undeniable that in the later part of the 20th century profit-making had become a crucial element in healthcare. Consequently, reduced competition and greater bargaining power of the medical and pharmaceutical industries resulted in ever higher prices and premiums. Hence, accessible and affordable health care for all Americans remained at the center of ethical and political controversies.

The final attempt in the 20th century to create a comprehensive, NHI-like healthcare system was the Health Security Act of 1993 by the Clinton administration. But despite influential proponents including all former U.S. presidents, this far-reaching legislation did not pass notwithstanding important and widely accepted key features such as private insurance for everyone while preserving Medicare, guarantee of health benefits through the work sites, elimination of unfair insurance practices, and choice of physician and health plan. Angst over purported government regulation and care rationing as well as concerns over limitations on profit-making was crucial conjectures in its defeat. However, high premiums, use of ever more expensive pharmaceuticals and procedures, lack of access and affordability, inequity and inequality, insufficient emphasis on health promotion and disease prevention remained simmering and unresolved

issues.

Current Developments in the 21st century

The lack of health insurance for millions of Americans with its associated costs had become a pressing issue at the end of the 20th century. In 2000, health care expenditures had significantly increased to 13.3% of the GDP and in 2009 to 17.3%.

The early 21st century saw the hard-fought 2010 passage of the landmark U.S. federal statute called Patient Protection and Affordable Care Act (PPACA, short ACA) or “Obamacare”. Under the original ACA, the “individual mandate” requires that most citizens and legal residents have health insurance.

Notably, the ACA did not create an NHI system but rather represented a compromise that maintained the complex mix of public and private stakeholders in the existing healthcare system. The ACA was a huge step forward in addressing many unresolved or conveniently suppressed shortcomings of the existing healthcare system. The new ACA members represented the uninsured population: (1) unemployed individuals who could not afford ESI and did not qualify for Medicaid; (2) employed individuals without ESI and who could not afford it on their own; (3) employed individuals who chose not take ESI that was available to them; and (4) individuals with means who chose not to be insured. Existing government health insurance plans (Medicare, Medicaid, CHIP, health insurance for veterans and the military) were retained under ACA.

Beyond the Medicaid expansion, “the ACA sought to increase the number of Americans with health insurance by providing new premium tax credits for the purchase of private health insurance” [5].

At the heart of the ACA, changes to the private health insurance market were made that aimed at important coverage issues such as access, affordability, and equity. The key components of the ACA mandated that private insurance plans (1) must meet minimum standards with guaranteed renewability, (2) cannot discriminate against people with preexisting conditions, (3) cannot impose lifetime and annual dollar limits on coverage, (4) must extend dependent coverage to age 26. In addition, ACA provided subsidies for low- and moderate-income individuals and investments in prevention and public health [6,7].

Despite certain deficiencies and shortcomings, the ACA enactment was highly successful. According to the U.S. Department of Health and Human Services, as of early 2023, more than 40 million people have enrolled in ACA coverage through Medicaid expansion, Marketplace coverage, and the Basic Health Program in participating states [8]. ACA was financed through new federal taxes (about \$1 trillion)

including on health insurance premiums, prescription drugs, and medical devices, as well as increased medical deductions and spending cuts in Medicare.

On the downside, lack of affordability has been an issue. About 4.7 million (mostly unsubsidized) Americans lost their insurance plans, average premiums and deductibles increased substantially, lower reimbursement rates for physicians resulted in many physicians refusing to treat Medicaid patients, and Medicaid potentially “crowding out” private health insurers. Furthermore, an increasing number of insurers exited the exchanges.

Notwithstanding heavy political opposition primarily from the Republican Party and about 40% of the American public having an unfavorable opinion of the ACA [9], all “repeal and replace” efforts were unsuccessful, and the U.S. Supreme Court upheld its constitutionality in 2012. However, some actions such as the removal of the individual mandate, Medicaid expansion being an option rather than a requirement (individual states could opt out), subsidy reduction, and reduced Medicaid eligibility have cut into the original legislation. Another consequence of the ACA has been the shift toward a more public (vs. private) initiative.

Despite the legislative passage of the ACA, according to the Centers for Disease Control and Prevention, 8.4% or 27.6 million Americans of all ages including 4.2% or 3 million children did not have health insurance in 2022. The question then is (1) who is opposing Universal Health Coverage and (2) what can be done to overcome the resistance to it.

PATHWAYS TO UNIVERSAL HEALTH COVERAGE IN THE UNITED STATES

The complex mix of private and public sector involvement in funding and financing of the historically grown, current health system as well as most for-profit stakeholders are the greatest objectors and preventers of Universal Health Coverage. Hence, it is both impractical and unrealistic to completely overturn and dismantle the existing health system in pursuit of Universal Health Coverage. Rather, incremental changes and modifications must be integrated and added to the existing system without bringing it to a collapse. The second reason why Universal Health Coverage has not been attained is its high cost. Proposals such as Bernie Sander’s “Medicare for All” which would implement a 7.5% payroll tax plus a 4% income tax on all Americans (with higher-income citizens subjected to higher taxes), higher estate and property taxes, special or one-time only taxes/fees (on large financial institutions and corporations) and/or establishing a “wealth” tax are politically hardly feasible and viable [10].

Moreover, his proposed Medicare-for-all single-payer health care system would in fact completely dismantle the current system with its private insurance component and immediately obviate present insurers. This is unrealistic given the fact that in 2021, private health insurance coverage was more prevalent than public coverage at 66.0% and 34%, respectively [11]. There were 174 million Americans enrolled in employer-sponsored health insurance [12] for whom this system works.

Implementation of Universal Health Coverage within the existing U.S. healthcare framework is an extremely complex undertaking that must be politically acceptable, morally responsible and economically affordable. Moreover, it requires broad societal buy-in and support.

The question then is: what are pragmatic pathways to Universal Health Coverage in the United States?

From the author's perspective, there are at least two possible scenarios without dismantling the current coverage structure that works for the majority of Americans:

First, Medicare (not Medicaid)-expansion. The reason for federal vs. state financing is as simple as unfortunate. Although the U.S. Supreme Court upheld the ACA's constitutionality in 2012, it allowed individual states to opt out and forego the Medicaid expansion which, as of September 2023, 10 states did. Without full compliance by all states for an additional Medicaid-expansion and in the absence of federal laws mandating it, Universal Health Coverage cannot be accomplished under the joint federal-state Medicaid program. Thus, federal Medicare-expansion is the only option for the public sector.

What about finance ability? If the presumed 27 million uninsured Americans would be enrolled in this proposed Medicare-expansion program at an annual cost of \$7,000 per enrollee (comparable to adult per capita ACA Medicaid expansion [13]) total expenditures would amount to almost 0.19 trillion, a staggering number-that would have increased FY 2022 U.S. discretionary spending from 1.7. to 1.9 trillion.

Funding/financing of Medicare-expansion for Universal Health Coverage will be provided through the following mechanisms: (1) a \$30-50 billion (2.5%) cut in U.S. household discretionary funds; (2) a small(!) increase in federal taxes (each 0.25% increase generates about \$12 billion in revenue); (3) increase in the pharmaceutical industry's contribution (\$20-30 billion) through savings from the Biden administration's- Medicare drug negotiations program and higher corporate taxation; (4) close monitoring of medical services by Medicare case managers (each 5%-decrease of the proposed adult per capita Medicare-expansion cost saves about \$20 billion); and (5) creation of a workforce (re-) integration program which would save Medicare-expansion

per each 100,000 formerly uninsured \$0.7 billion.

Second, creation of a national, 2-tier healthcare system with mandatory enrollment. This is a more complex pathway than the Medicare-expansion model because it does not retain some components of the current health system. However, it does retain all existing government programs with their federal (Medicare, Veterans Health Administration, Military Health System, Indian Health Service) and joint federal-state (Medicaid and CHIP) components.

The 2-tier system as outlined herein is different from the traditional 2-tier system in that every American has the choice between either full government and full private health insurance coverage. The argument against has always been that in a traditional 2-tier system patients with private insurance enjoy faster healthcare access and better quality of care. Hence, the 2-tier system is considered by some as a system that discerns the "the haves and have nots" because it supposedly discriminates against the poor. However, in this proposal, the vast majority of Americans (80%+) will (to save additional premiums) or will have to (due to lack of funds) be insured through Medicare. Access to care and treatment options based on medical necessity are the same for the two insurance choices.

If the public (Medicare) option is chosen, employers will continue to pay about 70% (for employees with families) and 80% (for single employees). If the private option is chosen, employers will pay their share of the standard Medicare-expansion premium and the employee the difference or remaining balance for the private insurance premium (which, of course, will be higher than the standard employee Medicare-expansion premium). In addition to all access and medical services provided by the Medicare-expansion program, additional "perks" of private insurance for an "extra-premium" include, for example, choice of physicians and hospitals, single hospital room accommodation, and treatment options not dictated by medical necessity (e.g., cosmetic surgery). Private health insurers must comply with ACA requirements such as inclusion of preexisting conditions, guaranteed renewability, and absence of lifetime and annual dollar limits. This proposed 2-tier Universal Health Coverage system will render the current and opaque system of HMOs, PPOs, POSs, and EPOs etc. superfluous in favor of traditional private insurance coverage. In contrast, supplementary health care services such as rehabilitation centers as well as nursing homes and assisted living or residential facilities (i.e., post-acute care systems) will be retained.

What about finance ability? Funding/financing of this 2-tier Universal Health Coverage system will be provided through the following mechanisms: (1) financing of the existing government programs with their federal (Medicare, Veterans

Health Administration, Military Health System, and Indian Health Service) and joint federal-state (Medicaid and CHIP) components will remain the same. Existing ACA funding will also be retained; (2) funding for the Medicare-expansion of the 27 million uninsured Americans will be provided as described above; (3) mandatory health insurance for employed Americans is paid directly to Medicare or the private insurer; employed Americans who opt for private insurance coverage may have to pay an additional premium that cannot exceed the Medicare premium by 200%; private insurance companies must disclose premiums and services on standardized forms for transparency, comparability, and auditing; since hospital and physician providers may receive higher reimbursements for their services from private insurance payers (vs. Medicare), they may be taxed at a higher rate to disincentivize them from exclusively treating privately insured patients.

CONCLUSIONS

Universal Health Coverage does not exist in the United States for two reasons: (1) concern over dismantling the historically grown and unique framework of the undoubtedly most complex mix of public and private sector health coverage system and (2) cost. The first apprehension can be abated by establishing a Universal Health Coverage system which retains many or most of the grown health infrastructure. The two proposed pathways comprise a leveled solution through Medicare-expansion for the uninsured only and a more complex solution through a national, 2-tier healthcare system for all Americans. Both pathways are based on solid financing without major tax increases by using existing and yet untapped funding sources. For the sake of forming a more perfect union as stated in our Constitution, Universal Health Coverage in the United States must no longer be an illusion that continues to haunt our society in the 21st century.

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