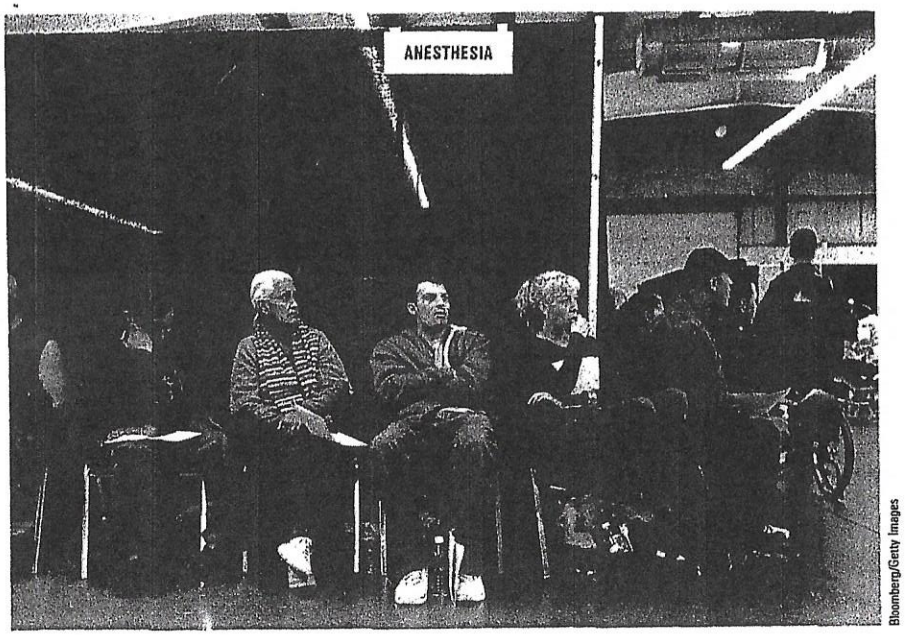
CHAPTER

8

Provides story of woman who dies of breast cancer because (ch 4) doesn't want to pay hosp. cost

Health Care in the United States



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LEARNING OBJECTIVES

After reading this chapter, students should be able to:

- Discuss the history of health insurance in the United States.
- Understand the basic elements of the Affordable Care Act and its likely impact.
- Explain why health care in the United States is so costly.
- Describe the gaps in US health insurance coverage and the consequences of those gaps.

In March 2010, Congress passed the Patient Protection and Affordable Care Act, followed a few days later by the Health Care and Education Reconciliation Act of 2010. These acts are commonly referred to jointly as *Obamacare* or, more neutrally, as the **Affordable Care Act (ACA)**. Supporters argued that the acts would significantly reform the US health care system. Yet that system remains in crisis, as Peter Drier's story illustrates:

> *Before his three-hour neck surgery for herniated disks in December, Peter Drier, 37, signed a pile of consent forms. A bank technology manager who had researched his insurance coverage, Mr. Drier was prepared when the bills started arriving: $56,000 from Lenox Hill Hospital in Manhattan, $4,300 from the anesthesiologist and even $133,000 from his orthopedist, who he knew would accept a fraction of that fee.*
>
> *He was blindsided, though, by a bill of about $117,000 from an "assistant surgeon," a Queens-based neurosurgeon whom Mr. Drier did not recall meeting.... In Mr. Drier's case, the primary surgeon, Dr. Nathaniel L. Tindal, had said he would accept a negotiated fee determined through Mr. Drier's insurance company, which ended up being about $6,200. (Mr. Drier had to pay $3,000 of that to meet his deductible [the amount his insurance requires him to pay out of pocket].) But the assistant, Dr. Harrison T. Mu, was out of network and sent the $117,000 bill.*
>
> *"I thought I understood the risks," Mr. Drier, who lives in New York City, said later. "But this was just so wrong—I had no choice and no negotiating power" (Rosenthal, 2014a).*

The most basic element in any nation's health care system is how it provides and pays for health care. As Peter's story illustrates, however, the United States is the only **more developed nation** that does not guarantee affordable health care to its citizens. Nor, despite this chapter's title, does it really have a health care system. Instead, an agglomeration of public and private health care insurers (such as

Medicaid and Aetna), health care providers (such as doctors and physical therapists), and health care settings (such as hospitals and nursing homes) function autonomously in myriad and often-competing ways.

In this chapter, we first look at the origins of the US health insurance system. We then analyze two current crises in US health care: rising costs and lack of access. Finally, we explore the nature and the impact of the health care reforms passed in 2010.

A HISTORY OF US HEALTH INSURANCE

For most of US history, most Americans paid for their health care out of pocket. The upper class could buy any health care they wanted, the middle class could afford most needed health care, the poor mostly went without, and few questioned the system. But during the Great Depression of the 1930s, millions of Americans lost their jobs, savings, and the ability to pay for medical care. This financial crisis led to growing calls to adopt a national health care system such as those that had recently emerged in Western Europe.

Unlike in Europe, however, proposals for a national health system were stymied by **stakeholder mobilization**: organized political opposition by groups with vested interest in the outcome (Quadagno, 2005; Hoffman, 2012). This opposition came from numerous sources. For example, labor unions opposed national health care because it would eliminate one of the major benefits they offered: the ability to press employers to offer affordable health insurance to workers. Meanwhile, national health care also was opposed by politicians who considered it socialistic or who feared it would force racial integration in health care facilities.

The Birth of US Health Insurance

The most important source of opposition, however, was the American Medical Association (AMA), which feared that any sort of national health system would reduce doctors' incomes or autonomy. At the same time, however, the AMA knew that doctors' incomes were plunging because so many Americans could no longer afford to purchase health care. Consequently, the AMA and (for similar reasons) the American Hospital Association founded the nation's first major insurance programs: **Blue Shield** to cover medical bills and **Blue Cross** to cover hospital bills (Hoffman, 2012). These two plans (collectively known as "the Blues") continue to play an important role in the US health care system, currently insuring about one-third of all Americans (Blue Cross Blue Shield Association, 2014). Because these plans freed most middle-class Americans from worrying about paying their health care bills, they significantly cut popular support for any national health system (Quadagno, 2005; Rothman, 1997).

Given that the primary purpose of the Blues was to protect hospitals' and doctors' incomes, the plans had little incentive to control what kinds of care were given, to whom, or at what costs. Under Blue Cross/Blue Shield, doctors and hospitals were free to provide whatever treatments they thought were needed, at whatever price they thought was reasonable. Patients paid their bills up front, and then requested reimbursement from the Blues. Because patients were billed a fee for each office visit, test, or other service received, these plans were and are called **fee-for-service** insurance.

But although the primary goal of the Blues was protecting doctors' and hospitals' income, these plans still had to restrain costs in some way to stay financially solvent. To do so, the Blues sold their insurance only to people likely to be healthy (such as workers at major businesses) and covered members' expenses only until preset yearly or lifetime limits were reached. They also relied on **community rating**. Under community rating, each individual pays a "group rate" **insurance premium** (yearly fee) based on the average risk level of his or her community as a whole. Even if one individual in a community racked up high bills, those bills would be covered by the insurance premiums paid by the many healthy members of the same community.

The 1930s also saw the rise of a very different type of health insurance program, **health maintenance organizations (HMOs)**. Unlike the Blues, the early HMOs, such as Kaiser Permanente and the Group Health Cooperative of Puget Sound, were founded not to protect the incomes of doctors or hospitals, but to provide affordable health care. These plans also used community rating. But unlike the Blues, which reduced their costs by seeking only healthy individuals to enroll as members, HMOs reduced costs by keeping members healthy through preventive care, monitoring doctors' decisions to avoid unnecessary care, and requiring HMO members to use only salaried doctors who worked for HMOs rather than independent doctors paid fee-for-service.

The Government Steps In

Although the Blues, HMOs, and other insurance plans enabled most Americans to pay for health care, by the 1960s, many poor Americans, as well as many middle-class retirees, were finding it difficult to do so. Reflecting in part the rise of the civil rights movement and of the belief that government should use its power to improve Americans' lives, Congress in 1965 authorized two new health insurance programs: **Medicaid** to insure the poorest Americans and **Medicare** to insure Americans who were permanently disabled or over age 65 (Hoffman, 2012).

Importantly, *Medicaid* is funded jointly by state and federal governments, and is typically framed by politicians and citizens as a form of charity. Eligibility, coverage, and payments to providers vary considerably across the states, depending in part on how willing state residents are to offer such "charity." In contrast, *Medicare* is funded and organized by the federal government. Because most recipients are over age 65, the program is typically framed as an "entitlement" earned through a lifetime of working and paying taxes.

Both Medicaid and Medicare were established as fee-for-service insurance. Almost from the start, however, Medicaid offered relatively low reimbursement to health care providers, leading many to reject Medicaid patients. Medicare, however, broadened access to health care while allowing providers to set their own fees, at least initially. As a result, the incomes of doctors, hospitals, and others working in the health care field skyrocketed.

The Rise of Commercial Insurance

Recognition of the profits to be made in health care led commercial insurance companies to enter the field in large numbers. Whereas the early insurance programs were mostly nonprofits, **commercial insurance** programs by definition are organized on a for-profit basis and so must focus on earning a profit for their investors. To do so, they use **actuarial risk rating** rather than community rating. Under actuarial risk rating, insurers maximize their profits by doing whatever they can to avoid signing up individuals who are likely to have expensive medical bills. For example, until recently commercial insurers charged higher premiums to those who had back strain, kidney stones, or ulcers, and typically denied coverage to those who had diabetes or ulcerative colitis or who worked as airline pilots or in construction. (The ACA has changed this at least partly, as we will see later in this chapter.) Similarly, commercial insurers charged especially low rates to low-risk individuals. As a result, these insurers lured many low-risk individuals away from nonprofit insurers, leaving the nonprofits with a sicker clientele overall. To avoid having to raise their rates for all members to cover the bills of their sicker members, many nonprofit insurers have switched to actuarial risk rating or even become for-profit corporations.

The Rise (and Partial Fall) of Managed Care

By the 1980s, the amounts spent by government and insurers on health care had soared. This led to the explosive growth in **managed care** (Hoffman, 2012). Managed care refers to any system that controls costs through closely monitoring and controlling the decisions of health care providers; HMOs are one form of managed care organization (MCO). Most commonly, MCOs control costs in three ways. First, MCOs may negotiate prices with doctors and require consumers to use only doctors who accept their price schedule. Second, MCOs may offer bonuses to doctors who keep costs down and may require doctors to obtain approval before hospitalizing a patient, performing surgery, ordering an expensive diagnostic test, or referring to a specialist outside the MCO's "network." This system is known as **utilization review**. Finally, MCOs may rely on expert opinion to create lists (known as **formularies**) of the most cost-effective drugs for treating specific conditions. Doctors who work for an MCO must get permission before prescribing any drugs not on the MCO's formulary. Most insured Americans now belong to some form of managed care plan.

Despite evidence suggesting that managed care makes little difference in access to care, quality of care, or patient satisfaction, there has been a substantial backlash against the managed care revolution (Hoffman, 2012; Mechanic, 2004; Miller and Luft, 1997). A string of legislative and legal moves—often framed as "Patients' Bills of Rights"—have pressed insurers to drop some of the less popular aspects of managed care. For example, legislators have opposed the early release of women from hospitals soon after giving birth (labeled "drive-by deliveries" by the media), even though early release typically is safer because it reduces women's chances of contracting infections in the hospital. Similarly, legislators have fought to get patients access to experimental treatments, although patients are more likely to be harmed than helped by these treatments. In addition, even in the absence of legislative pressure, the need to keep both consumers and doctors happy has led insurers to scale back the use of formularies and utilization review and to increase consumers' access to doctors outside of the MCO's network (Bodenheimer, 1999; Hoffman, 2012).

Why has this backlash been so effective? Two important reasons can be found in American culture (Mechanic, 2004). First, a central theme in American culture is an emphasis on individual autonomy and independence. By its very nature, managed care reduces individual choices for both consumers and health care providers, which left it vulnerable to political attack. Second, Americans typically believe that more health care is always a good thing. Yet overtreatment can be both dangerous and costly. For example, mortality rates are *higher* in geographic regions where Americans receive more extensive medical care, apparently because the extra medical treatment often is more dangerous than helpful (Fisher et al., 2003; Wennberg, 2010). Because of this cultural belief in treatment, however, Americans less commonly fear the pressure to overtreat built into a fee-for-service system than the pressure to undertreat built into managed care. These cultural factors made managed care an easy target.

The Attempt at "Health Care Security"

Pressures for reform began simmering again in the early 1990s as more and more Americans found themselves uninsured or otherwise unable to pay their health care bills. These problems led US President William J. Clinton to propose his Health Care Security Act (HCSA) in 1993. The HCSA represented a liberal approach to health care reform. If adopted, the act would have broadened access to care without seriously threatening the basically entrepreneurial nature of the US health care system or the power of the "big players" in health care. Under the HCSA, Americans still would have received health insurance from many different insurers, retaining the complexity and costs of the current system. Wealthier Americans would have retained the right to purchase health care options unavailable to others, so health care would have remained a two-class system. And the proposal included no oversight mechanisms to restrain the costs (and profits) of hospital, drug, or medical care.

Nevertheless, opposition to the plan was fierce, especially from the insurance industry, which poured millions into fighting the bill (Quadagno, 2005; Hoffman, 2012). Moreover, the sheer complexity of the bill made it easier for opponents to raise fears among the American public, which since the 1980s had

increasingly distrusted "big government" (Rothman, 1997; Skocpol, 1996). In the end, Congress rejected the bill. However, Congress did approve passage of the State Children's Health Insurance Program (SCHIP). That program has extended coverage (primarily through Medicaid) to many children under age 18 whose families earned too much to qualify for Medicaid but too little to pay for health care on their own. Still, millions of Americans were left without access to health care.

THE 2010 PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

By 2008, with the election of US President Barack Obama, the time for larger-scale health care reform seemed to have arrived. The economy was spiraling into a recession, the costs of health care kept rising, and the ranks of the uninsured were growing rapidly, increasing public support for reform. Moreover, as the cost of insurance soared, many major employers who traditionally had paid most of their employees' insurance costs concluded that they could not compete in the global market unless those costs fell. As a result, the business community increasingly came to support health reform as well. Taken together, these factors led to passage in 2010 of the Patient Protection and Affordable Care Act.

Passing the Affordable Care Act

Stakeholder mobilization against the ACA, however, was strong among anti-tax and anti-government conservatives, older Americans who feared it would reduce their Medicare benefits, and parts of the health care industry. As a result, in designing the ACA, the Obama administration emphasized working within the existing health care system (Jacobs and Skocpol, 2010; Miller, 2010; Oberlander, 2010). To earn the support of hospitals, doctors, and insurance companies, the ACA included many millions in government subsidies for health care, all of which would eventually be paid to the health care industry. To assuage voters who opposed new taxes, the ACA would instead be funded by requiring individuals and employers to bear the costs of expanding coverage. To earn the vote of those who feared "creeping socialism," the government abandoned the idea of a government-run insurance system (such as an expanded version of Medicare). Finally, to earn the support of the major pharmaceutical manufacturers, the government promised new regulations that would reduce competition from foreign manufacturers and manufacturers of generic drugs (Jacobs and Skocpol, 2010; Miller, 2010; Oberlander, 2010). Thus, the Obama administration chose, in essence, health *insurance* reform over health *care* reform (Leonhardt, 2010). Nevertheless, opposition to the ACA remains strong. Numerous bills to alter or end it have been proposed in Congress, and numerous court challenges against it have been filed at the state and federal levels.

Understanding the Affordable Care Act

The ACA reflects the neoliberal premises underlying the US health care system. **Neoliberalism** is an economic and social philosophy that encourages free trade and private enterprise; disapproves of government involvement in education, health care, or other social services; and promotes the idea that each individual has both the freedom and the *responsibility* to make wise consumer choices in health care, as in all areas of life (Fisher, 2007; Fisher and Ronald, 2008). Although the government continues to play a role in health care under the ACA (especially in services for the poor), the law requires many individuals to obtain for-profit insurance coverage to purchase goods and services from for-profit pharmaceutical companies, hospitals, and doctors' offices. Moreover, the ACA holds individuals responsible for any bills not covered by their insurance.

The central goal of the ACA was to increase access to health care *within* the existing health care framework and *without* increasing costs. Creating universal access to health care was never stated as a goal (Hoffman, 2012). As a result, rather than requiring the *government* to provide health insurance or care to all citizens (as many nations do), the ACA established an **individual mandate**: that is, the requirement that each US citizen and legal resident obtain health insurance. To make that insurance affordable, the ACA proposed establishing both state-level "health exchanges" and a federal exchange through which individuals and small businesses could purchase coverage (helped by subsidies and tax credits for middle- and working-class individuals). In theory, the individual mandate would force healthy as well as unhealthy Americans to join, thus reducing the cost of insurance for each individual by spreading the bills across a large and mostly healthy population.

In addition, the ACA established an **employer mandate**: a legal requirement that employers with more than 50 employees are required to subsidize (for-profit) health insurance for their employees. (Small businesses will receive tax credits to encourage them to do the same.) The employer mandate was supposed to begin in 2014, but the date has been pushed back to at least 2016 in response to political pressure.

The ACA also called for Medicaid to be expanded to include all poor and near-poor Americans under age 65. This change was to play a major role in reducing the under-insured and uninsured population. However, in a landmark decision, the Supreme Court decided that the federal government could not require states to expand their Medicaid programs. As a result, about half of the states have decided against doing so, even though the federal government would have paid almost all the costs and about 8 million people would have gained insurance coverage (Dickman et al., 2014).

Finally, the ACA established various new restrictions on insurance companies. Among other things, companies are now prohibited from capping annual or lifetime benefits, refusing to cover those with preexisting health problems, or charging higher premiums to such individuals. Insurers also are now forbidden from charging more than $6,000 per individual per year (or $12,000 per family per year) for out-of-pocket expenses such as **deductibles** (required minimum

amounts individuals must pay out of pocket before their insurance coverage kicks in) and **copayments** (unreimbursable fees paid out of pocket each time one sees a doctor). Insurers also must cover at least 60 percent of average medical costs and must allow young people to remain on their parents' insurance policies until they turn 26.

It will be some time, however, before the full impact of the ACA becomes known. Opposition to it remains fierce, and court battles over the laws will likely continue for years. Similarly, Congress will need to approve budgets annually for various aspects of the ACA's provisions, and these battles will likely be bloody. Finally, hundreds of new regulations will have to be written to implement the highly complex ACA, and this process, too, is likely to become a battlefront (Jacobs and Skocpol, 2010).

THE CONTINUING CRISIS IN HEALTH CARE COSTS

Unfortunately, even with adoption of the ACA, the cost of health care in the United States is perilously high. For example, in 1980, Americans spent on average about $1,000 per person (in current dollars) for medical care, drugs, supplies, and insurance. Those costs increased to more than $8,000 per person in 2014 and are expected to pass $12,000 per year by 2022, even with implementation of the ACA (Centers for Medicare & Medicaid Services, 2014).

Moreover, although costs have also risen in other nations, they remain by far the highest in the United States. Yet despite these costs, researchers consistently rank the US health care system below that of other more developed nations (Muennig and Glied, 2010; Schoen et al., 2010). Not surprisingly, compared to citizens in those other nations, Americans are considerably less likely to be able to afford needed health care and to believe their health care system works well (see Table 8.1).

The Myths of Health Care Costs

What accounts for the rising and unusually high costs of health care in the United States? If you ask the typical American—or member of Congress—he

TABLE 8.1 Citizens' Views on and Experiences with Health Care

Country	Percent Believing Their Country's Health Care System Works Well	Percent Who Could Not Visit Doctor or Afford Recommended Treatment in 2013
Canada	42%	13%
Germany	42	15
United Kingdom	63	4
United States	25	37

SOURCE: Commonwealth Fund (2014).

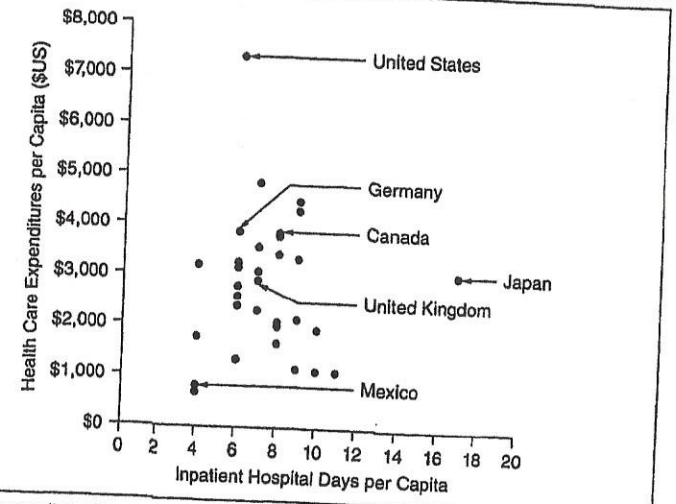
or she is likely to respond with one of four popular "myths" about US health care (Starr, 1994).

The first myth is that Americans receive more and better care than do citizens of other nations. Yet on average, the reverse is true. For example, despite our high health costs, Americans receive *fewer* days of inpatient hospital care and *fewer* doctor visits per capita, as Figures 8.1 and 8.2 show. And as Figure 8.3 shows, those higher health costs do not produce higher life expectancies.

The second myth attributes our high health care costs to our unique propensity for filing malpractice suits. Malpractice suits can raise prices both because doctors have to pay malpractice insurance premiums and because they may engage in **defensive medicine**—performing tests and procedures primarily to protect themselves against lawsuits. Federal researchers estimate, however, that defensive medicine accounts for no more than 2 percent of total US health care costs (Beider and Hagen, 2004). Moreover, their data suggest that changing the malpractice system would not significantly reduce the number of unnecessary tests and procedures.

The third myth attributes our rising health care costs to our aging population. Yet the population of the United States is no older than that of any of the other wealthy nations, and at any rate, economists have found no relationship

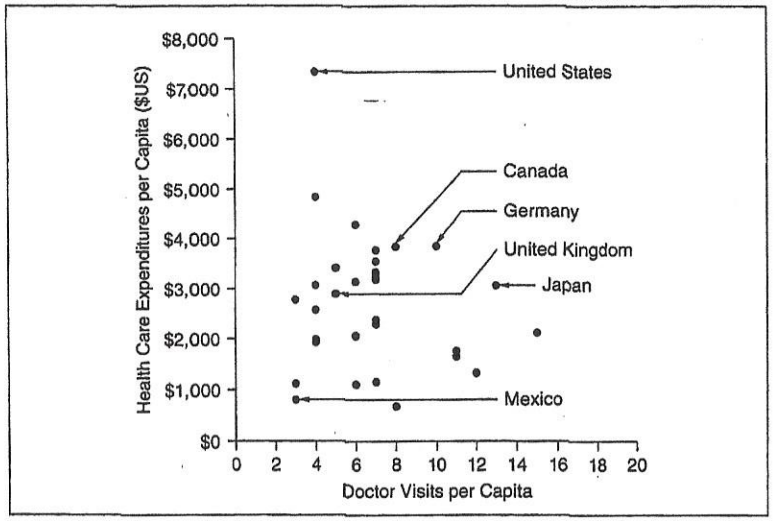
FIGURE 8.1 Health Expenses and Inpatient Days in Acute Care Hospitals in 30 Nations*



*Dollar amounts adjusted for purchasing power parity. This strategy controls for differences over time and across countries in the worth of a nation's currency by factoring in the number of units of a nation's currency required to buy the same amount of goods and services that $1 would buy in the United States.

SOURCE: Organization for Economic Cooperation and Development (OECD) (2014).

FIGURE 8.2 Health Expenses and Number of Doctor Visits in 30 Nations*



*Dollar amounts adjusted for purchasing power parity. This strategy controls for differences over time and across countries in the worth of a nation's currency by factoring in the number of units of a nation's currency required to buy the same amount of goods and services that $1 would buy in the United States.

SOURCE: OECD (2014).

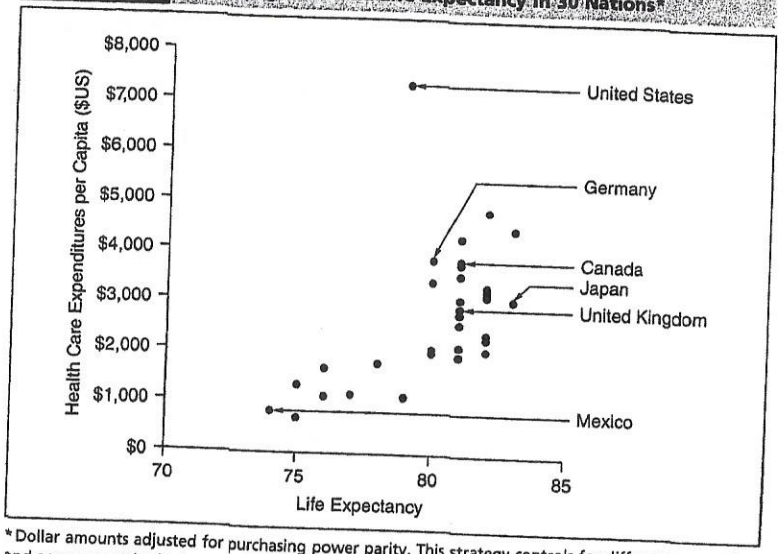
between the age of a nation's population and its health care costs (Bodenheimer, 2005a).

The fourth myth is that health care costs are so high in the United States because of our advanced technologies. Although these technologies certainly play a role in health care costs, technologies (other than pharmaceutical drugs) account for only a small fraction of all health care costs. Moreover, the same technologies exist in the other wealthy nations without producing equally high health care costs. Thus, the mere existence of technology can't explain these costs.

Understanding Health Care Costs

If patient demand, malpractice costs, the aging population, and advanced technology don't explain the rising costs of health care, what does? Research points to three underlying factors: a fragmented system that multiplies administrative costs, the great power that health care providers (doctors, hospitals, pharmaceutical companies, etc.) hold relative to health care consumers (whether individuals, the government, or insurers), and the for-profit basis of the US health care system (Bodenheim, 2005a, 2005b, 2005c; Reinhardt, Hussey, and Anderson, 2004; Davis et al., 2014).

FIGURE 8.3 Health Expenses and Life Expectancy in 30 Nations*



*Dollar amounts adjusted for purchasing power parity. This strategy controls for differences over time and across countries in the worth of a nation's currency by factoring in the number of units of a nation's currency required to buy the same amount of goods and services that $1 would buy in the United States.

SOURCE: OECD (2014).

Because Canadian society is probably the most similar to US society, comparing these two countries helps to illustrate why costs are so high in the United States. In the next chapter, we examine the Canadian health care system in detail. At this point, we need only note a few major points. Most important, Canadians receive their health insurance from a single payer: the government. For this reason, the Canadian system is referred to as a **single-payer system**. Similarly, hospitals receive an annual sum from the government to cover their costs. Those costs are restrained because, unlike in the United States, Canadian hospitals don't need an expensive administrative system to track patient expenses and to submit bills to multiple insurers. As a result, hospital costs per capita in Canada are almost 50 percent lower than in the United States (Himmelstein et al., 2014).

In Canada, costs are also restrained by government oversight on major capital development: If a Canadian hospital wants to add new beds or purchase new advanced technologies, it must first convince the government that such services are needed (Bodenheimer, 2005b). As a result, hospital costs are considerably lower in Canada than in the United States, even though admission rates are about equal and average stays are longer.

A unified rather than fragmented system also helps restrain Canada's medical and drug costs. Like hospitals, doctors must submit their bills only to the national insurance system rather than filing myriad different forms with different insurers.

Meanwhile, no one need spend money on advertising or selling insurance, trying to collect unpaid bills, or covering the costs of unpaid bills. Drug costs are limited because provincial health administrators develop formularies of the most cost-effective drugs and negotiate with pharmaceutical companies to buy those drugs at discount prices. Similarly, Canada's national health care system has the economic "muscle" to control the prices it pays doctors, technology companies, and other health care providers.

In addition to the fragmented nature of the US health care system, the fact that health care providers hold more power than health care consumers in the United States has also kept costs high. This results from the fact that profit-making—by doctors, hospitals, insurers, pharmaceutical companies, and others—lies at the heart of the US health care system.

As the next section discusses further, in the United States, pharmaceutical companies largely control which drugs come to market, how they are advertised, and at what prices, with few constraints imposed by any national consumer or government forces. Similarly, US hospitals are free of the governmental oversight that constrains costs in Canada *and* are forced to compete for patients to pay their bills (and perhaps earn a profit). As a result, hospitals must create demand by adding beds, specialized units (such as heart transplant units), and expensive technologies (such as kidney dialysis machines), and then encouraging doctors and patients to use those services.

Similarly, because no national health care system controls the number or distribution of doctors in the United States, most of the country (other than poor and rural areas) has far too many doctors, especially specialists. To protect their incomes in the face of this competition, doctors may increase either the number of services they recommend to patients or their fees for those services (Aizenman, 2010; Bodenheimer, 2005c). This largely explains why US doctors are exceptionally likely to adopt new, expensive, and often unproven technologies, such as full-body scans and bone marrow transplants (Bodenheimer, 2005b). In addition, US doctors increasingly are trying to raise their incomes by purchasing surgical centers, CT scan machines, and other expensive technologies—actions that would likely not be permitted in a single-payer health care system. Not surprisingly, doctors who do so are considerably more likely to recommend those services to their patients (Ruggieri, 2014). For all these reasons, Americans living in areas with many doctors per capita receive more medical tests, surgeries, and other procedures; pay more for those services; and have *worse* health outcomes than those living in areas with fewer doctors (Bodenheimer, 2005b; Center for the Evaluative Clinical Sciences, 1996; Wennberg, 2010).

Finally, the for-profit basis of the US health care system, combined with its fragmented nature and the power it gives to health care providers, has made it difficult for reform efforts to succeed. For example, since the 1980s the US has tried to reduce Medicaid and Medicare costs through a system of **diagnosis-related groups (DRGs)**. Under this system, the government calculates the average cost of inpatient treatment for each possible DRG, and then reimburses hospitals for treatment based on those averages rather than on the actual costs per patient. If the hospital spends less than this amount, it earns money; if it spends more, it loses money. Theoretically, then, the DRG system should have limited the costs of providing care under Medicaid and Medicare. Instead, hospitals developed sophisticated computer software to identify the most remunerative, but still plausible, diagnosis for a given patient—a process known as "DRG creep." In addition, hospitals increasingly shifted services to outpatient units, where the DRG system does not apply. As a result, the DRG system only marginally reduced government costs for hospital care. Similarly, when the government restricted the fees it would pay health care providers for treating Medicare and, especially, Medicaid patients, many providers either stopped accepting such patients or increased the fees they charged patients who had other forms of insurance.

Health Care Costs and the ACA

Given the reasons why US health care costs are so high, it seems unlikely that the ACA can cut costs significantly. First, the ACA continues the nation's reliance on a vast web of insurers, thus guaranteeing huge administrative costs and inefficiencies. Second, health care providers (especially insurers) continue to have considerable control over the system. Most importantly, to appease health industry opponents, most proposals to incorporate well-established cost control mechanisms into the ACA were dropped from the bill before it was passed.

At the individual level, and as the story that opened this chapter illustrated, even insured Americans may continue to risk bankruptcy because of copayments, deductibles, and other services not covered by their insurance. In 2014, those who purchased the least expensive insurance plans available through state health exchanges were responsible for insurance deductibles averaging about $5,000 for individuals and $10,000 for families (Goodnough and Pear, 2014). In addition, individuals remain responsible for many costs not covered by their insurance, such as drugs not approved by their plans or emergency care at hospitals not included in their plan's network.

Finally, the ACA preserves the for-profit nature of our health care system. Within such a system, doctors, hospitals, and other health care providers will be pressured to find ways to generate profits, through their decisions regarding admissions, diagnoses, tests, treatment, and so on. For example, two-thirds of for-profit hospices for the dying will not accept patients whose pain needs to be managed through chemotherapy or other expensive forms of care (Rao and Hellander, 2014). And as we've seen, even those working in nonprofit environments will be pressured to do the same in order to survive. Similarly, we can expect that for-profit insurers will continue to seek ways to enroll members who are relatively healthy and to avoid potential members who might generate high medical bills. This will leave nonprofits and state health exchanges with a disproportionate number of members who have high medical bills, raising the cost of such plans in the end.

For all these reasons, the Centers for Medicaid and Medicare Services (2010a), a nonpartisan federal bureau that advises Congress and the president, estimates that the ACA will cost the federal government an additional $251 billion between 2010 and 2019. Those costs may make it impossible for the government to offer the insurance subsidies for poor and middle-class Americans that

constitute the core of the ACA. If those subsidies are reduced, many will likely drop their insurance.

Health Care Costs and "Big Pharma"

Because the pharmaceutical industry, or "Big Pharma" as it is often known, has so quickly emerged as a major source of health care costs, it is worth exploring in more depth. This section looks at how the pharmaceutical industry affects doctors' and patients' ideas about illnesses and treatments and, as a result, affects health care costs.

Big Pharma Comes of Age The pharmaceutical industry is an enormous—and enormously profitable—enterprise. Indeed, it has been the most profitable industry in the United States since the early 1980s (Angell, 2004). Although the pharmaceutical industry routinely argues that their high profits merely reflect the high cost of researching and developing new drugs, such work accounts for only 14 percent of their budgets. In contrast, marketing accounts for about 50 percent (Angell, 2004). Largely because of this marketing, American citizens now spend a total of about $272 billion per year on prescription drugs, *not* including drugs purchased by doctors, nursing homes, hospitals, and other institutions (Centers for Medicare and Medicaid Services, 2014). Americans are buying *more* drugs, buying more *expensive* drugs, and seeing the *prices* of popular drugs rise more often than ever before. (The price of the popular antihistamine Claritin, for example, rose 13 times in five years.)

The pharmaceutical industry has not always been this profitable. Profits only began soaring in the early 1980s after a series of legal changes reflecting both the increasingly "business-friendly" atmosphere in the federal government and the increased influence of the pharmaceutical industry lobby—now the biggest spending lobby in Washington. First, new laws allowed researchers funded by federal agencies (including university professors and researchers working for small biotech companies) to patent their discoveries and then license those patents to pharmaceutical companies. This change dramatically reduced pharmaceutical companies' research costs—while giving these researchers a vested interest in emphasizing the benefits of new drugs.

Second, new laws doubled the life of drug patents. As long as a drug is under patent, only the company that owns the patent can sell the drug, allowing it to set its price as high as the market will bear. In addition, companies can now extend their patents by developing "me-too" drugs, which differ only slightly from existing drugs. For example, when the patent expired for Prilosec, a widely used treatment for common stomach troubles, its manufacturer released Nexium, an essentially identical new drug. Nexium now sells for $6 per pill and Prilosec for $1, whereas the chemically identical generic version, omeprazole, sells for 45 cents. Yet sales are highest for Nexium (Brawley, 2011).

Third, the pharmaceutical industry won the right to market drugs directly to consumers. Direct-to-consumer advertising has proven highly effective. According to a nationally representative survey conducted in 2008 for the nonprofit

due to successful advertising

Kaiser Family Foundation, almost one-third of American adults have asked their doctors about drugs they've seen advertised, and *82 percent* of those who asked for a prescription received one (Appleby, 2008).

Developing New Drugs Much of the recent rise in health care costs in the United States comes from the shift to new drugs. Whenever a new drug is developed, the crucial question for health care providers and patients is whether its benefits outweigh its dangers. For this reason, it is crucial that any new drug be extensively tested to determine whether it works better than already available drugs (which almost certainly are cheaper), whether it works differently in different populations, what dosages are appropriate, and what side effects are likely. But because pharmaceutical companies earn their profits by selling drugs, they have a vested interest in overstating benefits and understating dangers. And increasingly, these companies are both willing and able to manipulate the data available to outside researchers, doctors, federal regulators, and consumers (Abramson, 2004; Angell, 2004). For example, because scientific testing is typically designed to be accurate 95 percent of the time, manufacturers know that if they test a drug enough times, they will eventually hit the other 5 percent and obtain data that inaccurately suggest a drug works in some population. *Contemporary Issues: Race-Specific Medicine* describes one outcome of this process. . .

CONTEMPORARY ISSUES

Race-Specific Medicine

Is medicine a black or white matter? Increasingly, pharmaceutical manufacturers are acting as if it is. At least 30 drugs now on the market are claimed by manufacturers to be safer or more effective for African Americans than for whites (Epstein, 2007). Most commonly, these are drugs that proved ineffective in rigorous testing but that (perhaps accidentally) appeared to work in small studies of African Americans—some of which didn't even compare African Americans with whites. Yet as Chapter 3 discussed, there are no meaningful genetic differences between "races," so there are no biological explanations for these supposed differences in drug safety or efficacy. Indeed, one major review concluded that manufacturer's claims for "race-specific" drugs are "universally controversial" (Tate and Goldstein, 2004).

In addition to increasing drug costs as patients are shifted from older, less expensive drugs to newer and perhaps ineffective drugs, the rise of race-specific medicine reinforces the idea that racial differences are real and important (Epstein, 2007). Moreover, when drug companies focus on seeking racial differences, they may unintentionally hide more important causes of illness: Poor African Americans living in polluted neighborhoods in Mississippi, for example, may be no more susceptible to disease than their white neighbors, but this may be overlooked if researchers divide their subjects only by race and not by social class or living conditions. Similarly, the concept of race-specific medicine may lead doctors to quickly assign diagnoses and treatments based on race rather than on a holistic assessment of their patients as individuals. In fact, more than 80 percent of doctors responding in a national survey agreed that race should be used as a basis for diagnosis and treatment (Williams et al., 2010).

In the past, university-based drug researchers provided at least a partial check on the drug research process by bringing a more objective eye to their research. Since 1980, however, pharmaceutical industry funding for research by university-based scientists has skyrocketed (Lemmens, 2004). That funding comes in many forms, from research grants to stock options to all-expenses-paid conferences in Hawaii. Moreover, as other federal funding for universities declined over the past quarter century, university administrators came to expect their faculty to seek pharmaceutical funding. Importantly, when the pharmaceutical industry funds university-based research, it often retains the rights to the research results and so can keep university researchers from publishing any data suggesting that a particular drug is ineffective or dangerous (Angell, 2004; Lemmens, 2004).

At the same time that the pharmaceutical industry has increased its funding to university-based researchers, it has even more dramatically increased funding to *commercial* research organizations (Lemmens, 2004). These organizations are paid not only to conduct research but also to promote it. To keep on the good side of the companies that fund them, these research organizations must make drugs look as effective and safe as possible by, for example, selecting research subjects who are least likely to experience side effects, studying drugs' effects only briefly before side effects can appear, underestimating the severity of any side effects that do appear, and choosing not to publish any studies suggesting that a drug harms or doesn't help.

Doctors, medical researchers, sociologists, and others have raised concerns about the impact of bias on research publications (Bodenheimer, 2000). Researchers have found that medical journal articles written by individuals who received pharmaceutical industry funding are four to five times more likely to recommend the tested drug than are articles written by those without such funding (Abramson, 2004:97). Similarly, researchers have found that research studies suggesting a drug is effective are several times more likely to be submitted and accepted for publication than are those that suggest it is ineffective (Hadler, 2008; Turner et al., 2008). Concern about such biases led the *New England Journal of Medicine* (one of the top two medical journals in the United States) to forbid authors from publishing articles on drugs in which they had financial interests. The policy, however, was dropped quickly because it proved virtually impossible to find authors who did *not* have financial conflicts (Lemmens, 2004).

Even more astonishing than pharmaceutical industry funding of university-based researchers is the growing practice of paying such researchers to sign their names to articles written by industry employees (Elliott, 2004). For example, between 1988 and 2000, 96 articles were published in medical journals on the popular antidepressant Zoloft. Just over half of these were written by pharmaceutical industry employees but published under the names of university-based researchers. Moreover, these ghostwritten articles were *more* likely than other articles to be published in prestigious medical journals (Elliott, 2004).

Regulating Drugs In the United States, ensuring the safety of pharmaceutical drugs falls to the Food and Drug Administration (FDA). But during the same time period that the profits and power of the pharmaceutical industry grew, the FDA's power and funding declined as part of a broader public and political movement

away from "big government." These two changes are not unrelated: The pharmaceutical industry now routinely provides funding of various sorts to staff members at government advisory agencies, doctors who serve on FDA advisory panels, and legislators who support reducing the FDA's powers (Lemmens, 2004).

Under current regulations, the FDA must make its decisions based primarily on data reported to it by the pharmaceutical industry. Yet the industry is required to report only a small fraction of the research it conducts. For example, the company that produced the antidepressant Paxil had considerable data indicating that among teenagers Paxil did *not* reduce depression but *could* lead to suicide. To avoid making this information public, the company submitted to the FDA only its data from studies on adults (Lemmens, 2004). Similarly, drug companies need only demonstrate that new drugs work better than **placebos**, not that they work better than existing (cheaper) drugs. For example, because of intensive marketing campaigns, new antipsychotic drugs such as Zyprexa have largely replaced older, cheaper drugs, even though the new drugs work little better than placebos and carry life-threatening risks (Wilson, 2010b).

Marketing Drugs Once the pharmaceutical industry develops a drug and gets FDA approval, the next step is to market the drug. One of the most important limitations to the FDA's power is that, once it approves a drug for a single use in a single population, doctors legally can prescribe it for *any* purpose to *any* population. For example, doctors increasingly are prescribing Botox injections to treat migraines even though the FDA has not approved its use for that purpose.

Drug marketing has two major audiences, doctors and the public. Marketing to doctors begins during medical school as students quickly learn that pharmaceutical companies provide a ready source not only of drug samples and information but also of pens, notepads, lunches, and all-expense-paid "educational" conferences at major resorts. After graduation, the pharmaceutical industry continues to serve as doctors' main source of information about drugs. The *Physicians' Desk Reference* (or *PDR*), the main reference doctors turn to for drug information, is solely composed of drug descriptions written by drug manufacturers. In addition, the pharmaceutical industry spends $6,000 to $11,000 (depending on medical specialty) per doctor per year to send salespeople to doctors' offices on top of the money it spends advertising drugs to doctors in other ways. Most doctors meet with pharmaceutical salespeople at least four times per month and believe their behavior is unaffected by these salespeople. Yet doctors who meet with drug salespeople prescribe promoted drugs more often than do other doctors, even when the promoted drugs are more costly and less effective than the alternatives (Angell, 2004; D. Shapiro, 2004). In addition, the pharmaceutical companies now surreptitiously provide much of the "continuing education courses" doctors must take each year by paying for-profit firms to teach the courses and to arrange with universities to accredit the courses (Angell, 2004).

In recent years, and as noted earlier, marketing directly to consumers has become as important as marketing to doctors. To the companies, such advertising is simply an extension of normal business practices, no different from any other form of advertising. Moreover, they argue, advertising to consumers is a public service

because it can encourage consumers to seek medical care for problems they otherwise might have ignored. Finally, companies have argued that these advertisements pose no health risks because consumers still must get prescriptions before they can purchase drugs, thus leaving the final decisions in doctors' hands. Those who oppose such advertisements, on the other hand, argue that the advertisements are frequently misleading, encourage consumers to pressure their doctors into prescribing the drugs, and encourage both doctors and patients to treat normal human conditions (such as baldness) with pharmaceutical drugs (Angell, 2004; Hadler, 2008).

Marketing Diseases As this suggests, the pharmaceutical industry sells not only drugs but also diseases to doctors and the public alike. In some cases, drug companies have encouraged doctors and the public to define disease *risks* (such as high blood pressure) as *diseases* (such as hypertensive disease). In other cases (as Chapter 5 described), drug companies have defined symptoms into new diseases.

One example of this is the disease known as *pseudobulbar affect*, or PBA. PBA refers to uncontrollable laughing or crying unrelated to individuals' emotional state and can be caused by various disabling neurological conditions (such as head trauma, stroke, and Lou Gehrig's disease). The concept of PBA was developed by Avanir Pharmaceuticals, which markets the drug Neurodex as a treatment for it (Pollack, 2005). Although Neurodex seems to help some patients, its side effects are serious enough that at least one-quarter of users—all of whom already have serious health problems and must take numerous other medications—soon stop taking it.

To convince doctors that uncontrollable laughing and crying is a disease in itself, Avanir has advertised in medical journals and sponsored continuing education courses, conferences, and a PBA newsletter. Avanir also has marketed the concept of PBA directly to consumers through its PBA website and through educational grants it has given to advocacy groups for those living with stroke, multiple sclerosis, and other diseases (Pollack, 2005).

THE CONTINUING CRISIS IN HEALTH CARE ACCESS

The passage in 2010 of the Patient Protection and Affordable Care Act (ACA) reflected the growing consensus that health care in the United States is in crisis. But although the ACA has made a difference, shockingly high numbers of Americans nonetheless remain uninsured, underinsured, or precariously insured.

Uninsured Americans

According to the US Congressional Budget Office (2014), which provides nonpartisan analyses to Congress, 54 million Americans were uninsured in the months before the ACA began. The Office estimates that without the ACA, that number would have *risen* by 3 million over the next decade. In contrast, it estimates that the ACA will *reduce* the number of uninsured Americans by 26 million in its first three years alone. In fact, more than 8 million (most of them uninsured) purchased insurance through the ACA exchanges in the first months of the program (Kaiser Commission on Medicaid and the Uninsured, 2014), and many others gained insurance through expanded Medicaid coverage. This still leaves millions of Americans uninsured, however.

Young, childless adults—the population least likely to believe they might fall ill and least likely to be covered by government health care programs—are especially likely to be uninsured, as are African Americans, Hispanics, and poorer persons (Kaiser Commission on Medicaid and the Uninsured, 2014). Insurance coverage increased for all of these groups in the first months of the ACA. However, in part because most of the southern states opted out of the Medicaid expansion, southerners will remain especially likely to lack insurance (Garfield et al., 2014).

Surprisingly, given that insurance in the United States is typically linked to employment, most uninsured Americans live in families with one or more full-time workers (Kaiser Commission on Medicaid and the Uninsured, 2014). This reflects sharp reductions over the last two decades in the benefits employers offer their workers and sharp increases in the number of workers hired without benefits on a part-time or temporary basis. Ironically, because the ACA requires large employers to subsidize health insurance for employees who work 40 or more hours, many employers have cut workers' hours below that level (Rao and Hellander, 2014).

Finally, disabled and ill Americans remain disproportionately likely to be uninsured. In the past, most states allowed insurers to reject applicants for individual health insurance who showed any indications of health problems. The ACA now prohibits this practice, but experience suggests that insurers will continue to find ways to avoid enrolling individuals who seem likely to generate high medical bills.

Underinsured Americans

In addition to those who are *uninsured*, as of late 2014 more than 20 percent of all insured adults under age 65 are *underinsured* (Collins et al., 2014a). In other words, they have insurance but still can't afford to pay all their medical bills. Underinsurance is most common among poorer people and among those with chronic health problems (Collins et al., 2014a).

Underinsurance occurs when individuals can't afford to pay required insurance premiums, deductibles, or copayments. It can also occur when insurers either cap reimbursements per treatment or don't cover certain treatments, such as drugs or nursing home care. Since 2006, both the number of Americans who have to pay deductibles and copayments and the dollar amount of those payments have risen (Collins et al., 2014a). As a result, underinsured and uninsured individuals are equally likely to skip needed medical care (Collins et al., 2014a).

The ACA is expected to reduce underinsurance for those who buy insurance through the health exchanges or become eligible for Medicaid. However, the vast majority of Americans receive insurance through employers, and the ACA will not reduce underinsurance within this group (Collins et al., 2014b).

The Consequences of Underinsurance and Lack of Insurance

Uninsured and underinsured persons are considerably less likely than others to receive needed health care (Kaiser Commission on Medicaid and the Uninsured, 2010). As a result, they are also significantly more likely to suffer health problems and to die of potentially treatable conditions (Institute of Medicine, 2002).

This does not mean, however, that uninsured and underinsured persons have no access to health care. Federal, state, and some local governments provide clinics and public hospitals that offer low-cost or free care to such individuals. In addition, governments sometimes provide low-cost or free vaccination, cancer screening, and "well-child" programs. These facilities and programs, however, are not always geographically accessible to those who need them. In addition, these facilities are continually underfunded, so individuals may have to wait hours for emergency care and weeks or months for nonemergency care.

Uninsured and underinsured persons also sometimes can obtain health care through the private sector. First, some individuals can find private doctors who will reduce or waive their fees, and some live in communities where nonprofit hospitals offer inexpensive outpatient clinics. Second, uninsured persons can obtain care for both acute and chronic, emergency and nonemergency health problems from hospital emergency departments; although emergency departments legally can refuse care to anyone who is medically stable, many provide at least basic treatment to all who present themselves. Afterward, however, individuals can face stratospheric bills. Finally, uninsured persons increasingly have volunteered for experimental trials of new drugs to obtain at least sporadic treatment (Fisher, 2009). Yet in such experiments, some patients receive placebos, some receive drugs that prove ineffective, and some receive drugs that prove harmful. Moreover, even if the drugs work well, patients receive only temporary benefit because the drugs become unavailable after the experiments end.

THE PROSPECTS FOR STATE-LEVEL REFORM

Although the ACA mandates many elements of health care for the states, it also gives leeway for states to begin or continue their own reform efforts, some of which in the end may become models for national reform. So far, Vermont is the only state to have declared health care a right, and to have seriously considered adopting a single-payer system, operated under the ACA. Those plans are currently on hold, however. Vermont, though, is an unusual state, which leans heavily Democratic, and so few expect other states to follow its lead.

Hawaii's model is more likely to be adopted by other states. In 1974, Hawaii's legislators passed the Prepaid Health Care Act. Unlike the ACA, which is based on an individual mandate, Hawaii's program is based on an **employer mandate**—that is, on the requirement that employers offer health insurance to their workers and pay a specified percentage of the costs. Hawaii requires employers to pay at least 50 percent of the cost for any employees who work at least 20 hours per week for four consecutive weeks (Harris, 2009).

In addition, most employers voluntarily insure employees' families and pay more than their required 50 percent of costs.

The willingness of Hawaiian employers to care for their employees may reflect unusual aspects of Hawaii's history, geography, and culture. The state's geographic isolation makes it difficult or impossible for employers to move elsewhere, and decades of paternalistic control by pineapple plantation owners had established the idea that employers had some responsibilities to their employees. In addition, Hawaii's employers seem to share with many other Hawaiians the belief that all residents of these isolated islands should be treated like members of a family (Harris, 2009).

As in other states, elderly persons and very poor persons receive their health insurance from Medicaid or Medicare. Unemployed persons and part-time workers who earn too much to receive Medicaid but too little to purchase insurance on their own instead receive insurance through Hawaii's State Health Insurance Program (Harris, 2009). As a result, 90 percent of Hawaii residents are insured. Because such a high proportion of the state's population is insured, insurers can use community ratings rather than risk ratings—keeping rates affordable for all purchasers—and still remain financially viable. In fact, both insurance premiums and costs per Medicare enrollee are among the lowest in the nation (Harris, 2009).

In addition to ensuring a high level of coverage, the new system enabled Hawaii to achieve unusual success in restraining health care costs. First, because almost everyone has health insurance, residents can seek care early for illnesses and accidents. As a result, the system is protected from the tremendous medical costs that can accrue when illness or accidents are left untreated. Second, Hawaii benefited from the unintended development of monopolistic, nonprofit insurance plans. About 70 percent of Hawaiians receive their insurance from one of two nonprofit insurers, the Hawaii Medical Service Association or Kaiser Permanente. Because these two insurers control such a large share of the market, they can exert considerable control over medical costs. Doctors who refuse to accept their reimbursement schedules or salaries can attempt to seek patients elsewhere but will find few patients who don't belong to these plans. Finally, Hawaii restrained costs through reducing hospital use and costs. Unlike most US insurers, Hawaii's two major insurers pay only for hospital stays in multibed wards, not in semiprivate rooms. Meanwhile, Hawaii implemented a strict system for prospectively reviewing any hospital capital expenses. Hospitals can't purchase major equipment or construct new facilities unless they can demonstrate need for those services. Therefore, consumers need not pay the costs of maintaining unused hospital beds or duplicative technologies.

Conversely, the continued existence of Medicare and Medicaid has hampered Hawaii's ability to restrain health care costs. Because these plans don't reimburse hospitals at rates high enough to cover the actual costs of providing care, hospitals have shifted costs to patients with private health insurance. At the same time, Medicaid's and Medicare's low reimbursement schedules have hampered access to health care because many doctors won't accept patients who belong to these plans. These problems have been exacerbated by rising unemployment and by the (nationwide) shift toward replacing full-time workers

with part-time workers, which means that more Hawaiians must turn to the state rather than employers for their insurance. As a result, costs have increased, and the state has had to reduce the benefits available through its insurance program. In addition, the costs of meeting various ACA requirements also have placed pressures on Hawaii's health insurance program.

In sum, the Hawaii experiment demonstrates both the advantages of moving toward a single-payer, nonprofit system with strong centralized control and the problems when multiple payers—in this case, public and private insurers—continue to function in the same economic sphere. It also demonstrates the benefits available from a reasonably unified managed care system and the difficulties of sustaining a strong system in the face of external economic pressures.

IMPLICATIONS

As we have seen, Americans obtain their health care through a wide range of funding mechanisms, from publicly subsidized health care programs to private fee-for-service insurance to nonprofit HMOs. Even with passage of the ACA, some Americans will continue to have nearly unlimited access to health care—including unneeded and potentially dangerous care—and others will lack access to even the most basic health care. Although millions will now gain insurance, millions will still face bankruptcy because of the limitations built into that insurance. Thus, the United States will continue to face economic and health problems caused by both overuse and underuse of health care services. Moreover, the ACA reforms won't change the underlying structure of the system and so may not reduce the nation's health care costs or other problems over the long run.

The failure to pass—or even seriously consider—any proposals for more dramatically changing the health care system reflects the political and cultural realities of the contemporary United States. American culture has always contained both liberal and conservative tendencies. The freedoms established in the Bill of Rights, the commitment to public education, and the establishment of programs such as Social Security reflect the widespread (liberal) belief that the government has a responsibility to protect and value all its citizens. At the same time, US culture has long linked belief in individual freedom with belief in individual responsibility: If the idea of an "American dream" suggests that anyone can succeed, it also suggests (as conservatives often emphasize) that those who do *not* succeed so have only themselves to blame. It remains to be seen whether changing US demographics, politics, or economic realities will shift the balance between these two tendencies and thus push either toward or away from further health care reform.

SUMMARY

1. The United States does not have a health care system. Rather, it has an agglomeration of public and private providers functioning autonomously in often-competing ways.

2. Stakeholder mobilization—organized political opposition by groups with vested interest in the outcome—has stood in the way of any true reform of the system.
3. The Blue Cross and Blue Shield insurance plans were established to protect the incomes of hospitals and doctors. Both plans were nonprofit, offered fee-for-service insurance (in which consumers are reimbursed for their medical and hospital bills), and were initially based on community rating (in which all members pay the same insurance premium based on the average risk level of their community as a whole).
4. HMOs also used community rating but were established to provide health care to all. HMOs reduced costs by encouraging preventive care, monitoring doctors' behavior to make sure it was cost effective, paying doctors on salary, and requiring HMO members to use only HMO doctors.
5. Medicare and Medicaid are government insurance programs that provide health care coverage to poor, disabled, and elderly persons. Because they initially were a form of fee-for-service insurance with the government paying all health care bills for members, these programs dramatically increased the profits available in health care.
6. Commercial insurers rely on actuarial risk rating in which insurance premiums are based on individual's health risks. Competition from commercial insurers has led Blue Cross, Blue Shield, HMOs, and other nonprofit insurers to begin operating more like each other and more like commercial insurers.
7. Managed care refers to any system that controls costs by monitoring and controlling health care providers' actions. Most US insurers now use managed care, but public backlash has substantially reduced its impact.
8. The ACA, passed in 2010, aims to reduce the number of uninsured Americans primarily through expanding Medicaid, requiring large employers to offer insurance and requiring other individuals to purchase health insurance (with the assistance of government subsidies and tax credits). The ACA includes only minimal efforts to control the costs of care and won't change the underlying structure of the health care system.
9. The cost of health care in the United States is perilously high for three reasons. First, a fragmented system multiplies administrative costs. Second, health care providers have considerably more power than health care consumers (whether individuals, the government, or insurers). Third, the for-profit basis of the US health care system makes it difficult to control costs.
10. Pharmaceutical companies are an important factor in rising health care costs because they largely control which drugs come to market, how they are advertised, and at what prices. Pharmaceutical companies market new diseases as well as new drugs.
11. Although the ACA has made a difference, shockingly high numbers of Americans nonetheless remain uninsured. Those who lack good insurance are significantly more likely than others to experience illness, disability, or death.

REVIEW QUESTIONS

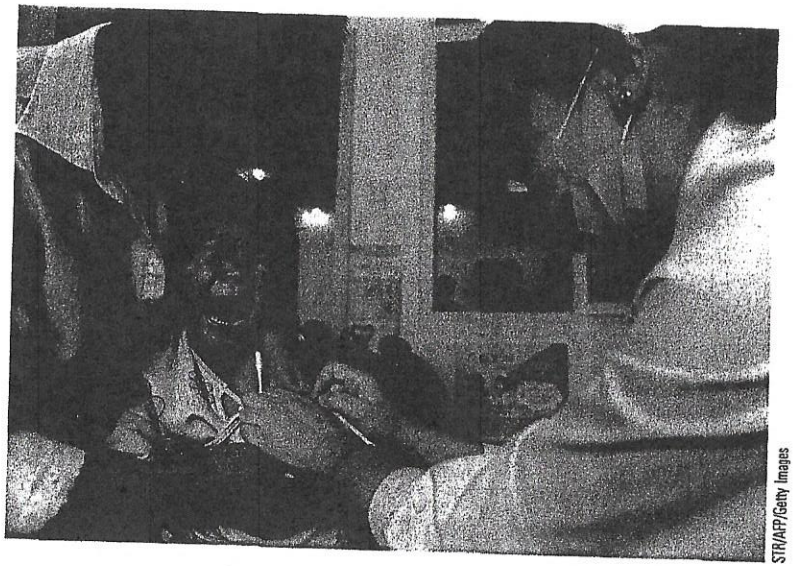
1. How and why does commercial insurance differ from insurance offered on a nonprofit basis?
2. What is managed care? How can it restrain health care costs, and how can it harm individuals' health?
3. What are Medicaid and Medicare?
4. Why have health care costs in the United States risen?
5. Who are the uninsured?
6. Why do individuals who have health insurance still sometimes face financial difficulties in paying their health care bills?
7. How does underinsurance or the lack of insurance affect individuals' health and health care?
8. What are the benefits and limitations of the ACA?

CRITICAL THINKING QUESTIONS

1. Researchers believe they have identified a gene that increases women's risk of breast cancer. You are the chief administrator of a health insurance plan. One of your board members, whose mother died from breast cancer, argues that your plan should offer this test for free as a routine preventive procedure.
   a. Explain to the board member what information you would want before you could make this decision and why you would want that information. Be sure to think about the consequences for the plan as a whole as well as for individual patients.
   b. Would you want different information and reach a different decision if you were a doctor in private practice? If you were a patient?
2. How do we ration health care in our present system? What are the financial costs of this rationing? What are the social costs?
3. How are the costs of care distributed among US residents now? Be sure to think about not only costs paid out of pocket but also costs paid through taxes for government-provided care. How would those costs be distributed under a single-payer national health plan?

CHAPTER 9

Health Care around the Globe



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