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AN AMERICAN CRISIS

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Sometime during 2006, the population of the United States surpassed 300 million.¹ Of that 300 million, it is estimated that approximately 16%, or 48 million, are uninsured.² Setting aside for the moment that some estimate that 8.7 million Americans are uninsured because they choose to be,³ many experts believe that the rising cost of health care coverage will be the number one problem facing Americans in the very near future.

In 2004, health care costs exceeded \$1.9 trillion, or \$6,280 per person.⁴ The total cost of health care has risen approximately 7.9% annually, which is three times the rate of inflation.⁵ Total health care spending represents approximately 16% of the gross domestic product.⁶ In 2006, employer health insurance premiums increased by 7.7 percent.⁷ Studies have shown that "premiums for employer-sponsored health insurance in the United States have been rising four times faster on average than workers' earnings since 2000."⁸ Moreover, there are additional costs to cover the uninsured population's health services. The United States spends "nearly \$100 billion per year to provide uninsured residents with health services."⁹ Health care spending by the national government is 4.3 times the amount spent on national defense.¹⁰ Also, hospitals provide about \$34 billion worth of uncompensated care a year.¹¹

Most Americans look to insurance to cover their medical expenses. Insurance coverage in the United States is provided through public and private sources. It is estimated that approximately 174.8 million Americans (59.5%) have health insurance through their place of employment.¹² Another 40.1 million (13.7%) are on Medicare.¹³ Still another 38.1 million (13%) are on Medicaid and 8.3 million (11.2%) are on children's health plans through State sponsored programs.¹⁴

Even so, a large segment of the population remains uninsured. Of that group, an increasing number are considered "uninsurable." These are individuals who, because of certain health conditions, are unable to obtain health insurance from the private market at any price. Additionally, they are not eligible for Medicare or Medicaid. If they are working, and many are, there is no health insurance provided through their place of employment or their spouse's. Because of their health condition, they cannot obtain insurance coverage in the individual market.

Unfortunately, Americans have come to see health care as an entitlement, or right. Inseparably connected with that entitlement or right is the fact that Americans want the absolute best health care, to be provided by the best doctors, they choose, and for the absolute minimum in cost. Americans have wrestled for decades with affordability, accessibility, and quality of care issues. They want complete freedom of choice to see any doctor for any type of procedure, which inevitably causes the cost to be higher. Additionally, Americans want every procedure and treatment to be covered. If steps are taken to reduce the cost, then accessibility to certain doctors may be eliminated, or the scope of coverage reduced, and the quality of care overall may suffer. Most Americans have not been able to come to grips with these issues; however, if they do not soon, the decision will be made for them.

In 2006, Americans spent approximately \$2 trillion on health care.¹⁵ If medical costs continue to rise at the same level of increase they have over the last decade, it is easy to see why some experts believe this is the number one problem Americans are facing. This problem is not new. In his 1979 State of the Union Address, President Carter stated: "We must act now to protect all Americans from health care costs that are rising \$1 million per hour, 24 hours a day, doubling every 5 years."¹⁶ The average cost of an employer-provided family

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health insurance plan has increased from \$6,000 per year in 1999 to around \$11,000 per year in 2005.¹⁷

As previously mentioned, the number of uninsurables has continued to grow, particularly as small employers drop health coverage for their employees. One way states have attempted to deal with the uninsurable problem is the creation of risk pools to provide coverage for those individuals who are unable to obtain health insurance in either the public or private sector. In general, applicants must demonstrate their eligibility to participate in the program. Once in, the premiums paid by these individuals are clearly insufficient to cover the cost of their medical expenses. The balance of the funds to pay for the claims incurred by these individuals is subsidized by the various states in a variety of fashions. Many of the pools have evolved over time, due to a number of factors. The Comprehensive Risk Pool in Utah, for example, was started in 1991. At that time, it not only covered eligible individuals who were unable to obtain insurance through either the public or private sector, but it also allowed small employers who were in danger of losing their coverage as a result of one or two employees who were bad health risks, to place those employees in the risk pool. The employers could require an employee with certain health conditions to apply for coverage with the risk pool in Utah, thereby allowing the other employees to keep their coverage and reduce the premiums for the remaining employees, or at least incur smaller increases in premiums for covered employees.

However, with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), states were required to provide a mechanism to cover the uninsurable population within their respective states. Several states, including Utah, had to modify their risk pools in order to comply with the conditions established by HIPAA. At that time, if an individual could obtain health insurance coverage through his or her place of employment or his or her spouse's place of employment, they were no longer eligible for risk pool coverage and had to be covered by the employer's health plan. Small employers could no longer "dump" unhealthy employees into a risk pool if they provided a health insurance plan for their employees.

Prior to the passage of HIPAA, some states, such as Kentucky, South Dakota, Washington, Utah, and others, passed guaranteed issue laws for individual health insurance policies. While it was assumed this would be a benefit for individuals attempting to obtain and maintain health insurance coverage, it actually resulted in health insurers leaving those markets, thereby reducing competition, which obviously decreased availability and increased the cost of the insurance for those who could find it.

Risk pools have helped to reduce this problem. Even though risk pools provide coverage for a relatively small portion of the U.S. population, they are an integral part of maintaining the viability of the current system. Because of the stability provided by risk pools, they give an incentive to health insurance companies to come back into the market. Through 2006, there were 33 risk pools.¹⁸ Tennessee is commencing operation this year. One of the major problems facing these pools is funding. The total claims for these risk pools in 2006 reached \$1.49 billion.¹⁹ Though enrollee premiums constitute a significant contribution toward the cost of the claims, they clearly are insufficient. Each year, those states with risk pools must find monies to make up the shortfall in the funding of the pools. For example, Utah's Comprehensive Health Insurance Pool (HIPUtah) is funded through enrollee premiums, the State's general fund, as well as interest and dividends earned from the fund's assets.²⁰ Since the risk pool's inception in 1991, the Utah State Legislature has appropriated \$68 million for operational funding, with a total of \$16.2 million contributed in 2006.²¹ However, claims and expenses from 1991 through 2006 have exceeded \$139,000,000.²² As enrollment continues to increase, funding becomes a more pressing issue. This is particularly true in lean budget years.

Several ideas or plans have been proposed in an attempt to solve the health care dilemma. In 1993, President Clinton announced the formation of the "President's Task Force on National Health Care Reform."²³ The task force was chaired by the First Lady, Hillary Clinton. In essence the plan "guaranteed health insurance for all Americans through the 'employer mandate,' a provision requiring that employers purchase insurance for their employees."²⁴ However, the plan lacked public support and never made it out of a congressional sub-committee.²⁵

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Recently, the State of Massachusetts implemented a plan in an attempt to cover all of its citizens. Its new law requires all residents to obtain a health insurance policy by July 1, 2007. Massachusetts was told by the federal government that it had to adopt measures to substantially reduce the uninsured population in its state, or risk losing \$385,000,000.00 in federal funds. Those funds, along with \$320,000,000.00 in assessments, which were being used to subsidize hospitals for uncompensated care, were used to help jump start the Massachusetts plan. In essence, employers with ten or more employees who make no contribution toward employee health coverage are required to make a contribution of approximately \$295.00 per year. Additionally, those employers are subject to a surcharge if their employees receive free care. The surcharge can be anywhere between 10% and 100% of the cost, subject to certain rules and regulations.

Under the Massachusetts law, the individual and small group health insurance markets are merged. A new entity will be developed called the "Connector." It will act as a clearinghouse for individuals and small groups to purchase coverage and to oversee subsidies which will be provided to those who are entitled. It is expected that funding will come from current assessments, the federal Medicaid grants that the State of Massachusetts was about to lose, the surcharges and assessments under the new law, additional federal safety net revenues, and money generated from the State general fund. Even so, many are concerned that the amount of money the plan has projected it will need for the program is inadequate.²⁶

More recently, in his January 2007 State of the Union address, President Bush further refined his health care plan. President Bush proposed a tax deduction for those who purchase health insurance on their own.²⁷ Because those who purchase health insurance on their own must do it with taxed dollars, President Bush's proposal would have a "flat, standard deduction for anybody who purchases any kind of health insurance, no matter how much the health insurance costs and no matter where they get it."²⁸ The deduction would be \$15,000.00 for a family policy or \$7,500.00 for a single policy.²⁹

Additionally, there are others who are espousing a single payor plan. One type of single payor plan would set up a governmental agency which would collect all health care fees and pay out all the health care costs.³⁰ Some argue this system would eliminate the vast amounts of administrative waste created by many different health care organizations and billing agencies.³¹ The plan would be federally funded and has been estimated to reduce overall health costs more than \$225 billion.³² The administrative savings could be passed on to patients.

Still, many want to use the approach found in countries with socialized programs. They point to Canada and Europe as having very successful socialized medicine plans. However, those plans are not without problems. They still must deal with the same issues; namely accessibility, affordability and quality of care. Reports vary as to the actual success of those programs. Because of the direction America appears to be headed, it may be spiraling towards this result, making it inevitable.

However, regardless of the approach that is eventually settled on, there are some actions which if taken can help to minimize the rising costs of health care. First, preventative health care must have a larger role in a health care plan. A system of check ups and exams can help ensure early detection of larger health problems. Healthier lifestyles, including exercise and eating habits, would greatly reduce health care needs and problems resulting in a reduction in cost for all Americans. It is estimated that more than 61% of Americans are overweight or obese.³³ In 1999, there were 300,000 U.S. deaths associated with obesity and being overweight, compared to 400,000 deaths that year associated with cigarette smoking.³⁴ From all of the medical journals, it is obvious that being overweight leads to numerous other health problems, thereby increasing medical costs which could be avoided.

Moreover, smoking continues to be responsible for 1 in 5 deaths in the United States.³⁵ Because smoking is an acquired behavior or choice, it is viewed as the most preventable cause of premature death.³⁶ Cigarettes cause more death in America than alcohol, car accidents, suicide, AIDS, homicide, and illegal drugs

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combined.³⁷ Smoking also accounts for an estimated 30% of all cancer deaths and accounts for 87% of lung cancer deaths.³⁸ Also, secondhand smoke continues to play a devastating role in our society. The 2006 U.S. Surgeon General's report reached many important conclusions such as: secondhand smoke causes premature death and disease, increases risk of SIDS for children and other respiratory problems, has adverse effects on the cardiovascular system, and increases the risk of coronary heart disease and lung cancer. The report further stated that proper ventilation and a separation of smokers and nonsmokers fails to eliminate exposure.³⁹ The increased health risks from smoking only increases the health care needs and cost. Continued legislative initiatives and personal awareness can help prevent many diseases caused by smoking.

Second, legislatures must stop mandating types of coverage. While most mandates in and of themselves may not be expensive, collectively, mandates are responsible for a substantial portion of the cost of health care. Each year, state legislatures and even Congress consider a variety of mandates, with many of them passing.

Third, drug companies should not be allowed to advertise on radio and television. Since the beginning of consumer-directed advertising in 1997, cost and usage of prescription drugs have risen dramatically.⁴⁰ Doctors seemed perfectly capable of prescribing medications prior to drug companies telling everyone what they absolutely need. Fourth, tort reform should be revisited. Finally, licensing enforcement must ensure better doctors and encourage better practices.

In conclusion, the problem of health care and its attendant cost should be the concern of everyone. Many believe these problems have already reached crisis stage. The health care debate should be on every political platform, both nationally and locally. Unfortunately, at the present time there are more questions than answers.

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