

# Universal Health Care Just Do It.

Lori Swanson, Attorney General

**Statistical Irony.** The Board of Directors of Minneapolis-based United Health Group awarded \$1,600,000,000 in stock options to its CEO--on top of his \$100 million per year salary--more compensation in a thousand seconds than a nurse makes in an entire year. At the same time, one-third of Americans under the age of 65 went without health coverage at some time over the past two years, and 75 percent of these people were uninsured for six months or more.

Starbucks pays more for group health insurance than it pays for coffee beans. General Motors pays more for group health insurance than it pays for steel for cars. The United States is the first and only nation in history to pay less for food than health care.

*"For my mother to die of cancer at the age of 53 and have to spend the last months of her life in the hospital room arguing with insurance companies because they're saying that this may be a pre-existing condition...there's something fundamentally wrong about that."*

President Barack Obama

Americans will spend \$2.5 trillion on health care this year--or \$8,160 per person--triple that of any other nation. Experts believe that one-third of that cost is unnecessary and unproductive. We will spend \$12,680 per year for the average family covered under employer-sponsored coverage—a figure expected to increase by 60 percent by the end of 2013. This cost dramatically reduces the capacity of businesses to invest in job-creating research, capital spending, and product development. We spend almost 17 percent of our gross domestic product (GDP) on health care--almost double that of other industrialized nations. This percentage is expected to increase to 20 percent of GDP by 2018. By that time the Medicare system is projected to be effectively insolvent, at least as applied to hospital coverage. More than energy, taxes, or raw commodities, the amount spent on health care is projected to be largest factor in the exportation of America jobs over the next ten years. At a disadvantage of \$1,500 per car, the CEOs of GM and Ford have said that the cost of health care alone means that new production plants will be built in Canada, Mexico, or Korea, where health care costs are not borne by the employer.

Over 50 percent of bankruptcies and 25 percent of housing defaults in America are related to medical debt. The proportion of working-age Americans who have problems with medical bills or are paying off medical debt climbed from 34 percent to 41 percent between 2005

and 2007, bringing the total to 72 million. One quarter of these adults were carrying \$4,000 or more in debt, with the average medical debt of those who file for bankruptcy being \$12,000. A full 70 percent of Americans with medical debt were insured when they had the health problem that put them in debt.

**Human Irony.** According to the Star Tribune, in 2004 Tab Jewett was a Hennepin County employee who worked with the mentally ill. She took home \$2,061 per month to support herself and three sons. By the time she paid for her family's basic needs such as rent, utilities, food and transportation, she had \$356 left. If she bought health coverage through the county, she would have to pay half the premium, or \$325, meaning she would only have \$31 left for clothing and other needs. Ms. Jewett could not afford health care from a system where she was employed.

**Doughnut Holes and Swiss Cheese.** Americans pay more than the citizens of any other nation for health insurance and get coverage riddled with holes:

- High deductibles (up to \$5,000 per policy)
- High co insurance (averaging 20 percent of the cost of health care)
- High co-pays (up to \$100 per visit)
- Much higher employee premiums (with employees paying on average 25 percent of the premium).

*"For those who have health insurance, women are more likely than men to have health coverage which has too many gaps and leaves them at great financial risk - 1 in 4 women says that she is unable to pay her medical bills."*

Marcia Greenberger,  
National Women's Law Center

Between 2000 and today, the employees' share of group insurance premiums has more than doubled. This has caused some families to look to the private market--although 90 percent of them don't buy this coverage because the premium is unaffordable or the policy broadly excludes coverage.

Ever-thinning coverage has resulted in the fastest growing sector in the healthcare debate: the underinsured. Uninsured and underinsured Americans eventually receive medical care, but they are three times as likely to postpone the care until the medical condition becomes more acute and more expensive to treat. Nearly half of all uninsured adults report having a chronic condition, such as diabetes, hypertension, arthritis, high cholesterol-

ol, asthma, or heart disease. Forty one percent of uninsured adults report being unable to see a doctor when needed in the past 12 months due to cost, compared with nine percent of adults who have health coverage. Over 40 percent of Americans report that they have problems paying for medical bills, and one-third describes the problem as “serious.”

The problem with Swiss cheese coverage (coverage that is full of holes) is also evidenced in the quality of health care. One-third of Americans who are underinsured experience one of three basic benchmarks of substandard care:

- Test results and medical records are not available at the time of their scheduled appointment
- Redundant and unnecessary tests
- Late or no notice of abnormal results on diagnostic tests.

**Comparative Statistics.** While U.S. spending per capita on health care exceeds spending in other industrialized countries by large margins, we statistically have poorer health outcomes than many countries. For instance, we are in the bottom quartile of hospital beds per capita. We have a lower per capita level of physicians. We rank 29th in life expectancy, between Slovenia and Portugal. Seven out of every 1,000 American babies die before age one, ranking the United States 23rd in the world in infant mortality. The average expenditure per hospital day in the U.S. is three times higher than in other industrial nations. The United States is below the median of western countries in physician visits per capita, acute care beds per capita, hospital admissions per capita, and acute care days per capita. We rank 15 out of 20 countries in deaths from illnesses that would not have been fatal with preventative treatment. The World Health Organization ranks the United States 37th in quality health care.

*“I’m proud to have paid the entire cost of “platinum” health coverage for my employees and their families. I considered it the right thing to do. However, when our insurance doubled in just two years, something had to change. With over twelve percent increase in gross income, 2002 was a stellar year for my business. We all deserved a raise. Instead, a fifty percent hike in the price of our coverage in that same year ate-up more than we made: No one got a raise.*

*I had to do three things to make up the difference: choose a lesser-priced policy, raise our rates, and lay-off one person for six months. This is about more than the money.”*

**David White – Small Business Owner**

**Public Health Coverage: Give me your aged, your disabled, your poor, your young, ...and your government employee...and your military personnel.**

**Medicare.** Prior to 1966, hospitals were generally charitable institutions supported by religious affiliations. In Minneapolis, Catholics supported St. Mary’s Hospi-

tal, Lutherans supported Fairview Hospital, Methodists supported Methodist Hospital, the Jewish population supported Mt. Sinai Hospital, Swedes supported Swedish Hospital, and the government operated Hennepin County Medical Center. Care for low-income senior citizens was largely supported by these hospitals through their religious and fraternal affiliations. The growth of the older population in the 1950s and 1960s, however, placed great economic stress on hospitals. In addition, better medical technology and treatment resulted in seniors living longer and receiving more expensive treatment. This was simply too much for a private charity system to support. The creation of Medicare in 1966 not only provided coverage to senior citizens but also enabled hospitals to continue to provide services to the general public.

Medicare was eventually expanded to cover those with disabilities on Social Security.

*“Financial ruin from medical bills is almost exclusively an American disease.”*

**Roul Turley**

**Medical Assistance.** The second initiative to provide expanded health care was directed to the poor. In 1966, President Lyndon Johnson also signed Medical Assistance into law, which provides health coverage to people who meet the federal poverty guidelines. While individual states may elect whether to operate a Medical Assistance program, all states currently participate because of the financial inducement to do so. In Minnesota, at least 50 percent of Medical Assistance is paid by the federal government. Medical Assistance now consumes almost 22 percent of state budgets.

**TEFRA, IDEA, Government Employees, the Military.** A third initiative for expanded health care was the establishment of federal programs to provide health care for children who are disabled due to a chronic health condition. For instance, the federal government created programs such as TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), which allows states to extend Medicaid coverage to certain children with disabilities. Another program targeted to children with disabilities is IDEA (Individuals with Disabilities Education Act). IDEA is supposed to provide health care to children who, due to their disability, have difficulties in completing an education. Similarly, in 1987, Congress created the State Children’s Health Insurance Program (SCHIP) to help extend coverage to uninsured children in low income families who made too much money to qualify for Medical Assistance.

*“Every American should have the same health care options as members of Congress.”*

**Senator Tom Daschle**

The government also pays for health care for its public employees. Nine million active duty service members and retired personnel receive benefits through the military at a cost of \$50 billion next year, with 70 percent

devoted to retiree coverage. In addition, most public employees at the federal, state, school district, and municipal level receive health coverage through the government. In cities like Duluth, Minnesota, an employee with only three years of service gets free family health care for life.

In summary, almost 60 percent of health care in the United States is provided through taxpayer-funded health programs. The following divides up the approximate sources for the American health care dollar:

Medicaid and SCHIP:	16%
Medicare:	19%
Veterans Affairs, Indian Health Services, the Department of Defense, Public Health Service	
Workers Compensation:	12%
Federal, state and local government employee:	10%
Out of Pocket:	11%
Private Insurance	27%
Other private (philanthropy)	5%

**State and Federal Initiatives.** In addition to the 60 percent direct funding of health care by the government, a variety of laws and regulations at both the federal and state level expand access, in some cases by shifting the cost of treatment from one citizen to the next. These shifts generally serve to transfer the cost of health care from the poor and the sick to those who can afford coverage. While the initiatives serve to extend coverage and provide access to some who would otherwise lack it, they generally do not tackle the overall high cost of health care.

For instance, in 1985 Congress enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA an insurance company and employer must offer departing employees the right to purchase health coverage for a period of 18 months at a premium equal to 102 percent of the group rate. This program is generally utilized by departing employees who cannot afford coverage in the private insurance market or with a succeeding employer, generally because the employee's age or medical condition imposes an additional surcharge. By utilizing COBRA, the cost of providing coverage to the departing employee is shifted onto the premium paid by the previous employer and employees.

*"It puts the provider in a situation of looking for ways to have someone else pick up a piece of the cost. As a result, every customer who has insurance ends up paying a 'hidden premium'. It simply adds to the health care cost burden."*

**Congressman David Obey**

Another cost-shifting initiative is the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA requires hospitals and ambulance services to provide care to anyone needing emergency treatment, regardless of ability to pay. Enacted to stop the inhumane practice of "patient dumping" by hospitals, EMTALA provides that patients in need of emergency treatment can be discharged only upon their own informed consent or when

their condition requires transfer to a hospital better equipped to administer the treatment. When the uninsured seek treatment in a hospital under EMTALA, the un-reimbursed cost is spread out on the financial statement of the hospital and eventually picked up by other patients and their insurers.

An example of a regulatory "cost shift" at the state level is the requirement that insurance policies continue to provide coverage to adult children between the ages of 18 and up to 25 years of age if they continue to be dependents of their parents. In some states, this mandate is limited to children who are enrolled full-time in school. The cost of extending this coverage is built into the group policy premium.

Another proposal--implemented in Minnesota and several other states--expands coverage through the creation of high-risk insurance pools for those with serious illness. For example, the Minnesota Comprehensive Health Association (MCHA), created in 1977, provides coverage to people who are denied coverage in the private marketplace due to a preexisting condition. Individuals covered by MCHA pay a premium that is 25 percent higher than the average health insurance premium in the state. Because the policyholders who purchase coverage from MCHA generally have serious medical conditions, MCHA runs a deficit each year. The deficit is funded by an assessment on insurance companies and HMOs that sell health coverage in Minnesota, which in turn is passed on in the form of higher premiums to other policyholders. The current problem for MCHA is that self-insured plans, generally utilized by employers with more than 100 employees, do not participate in the financing of MCHA due to federal preemption of state laws. As a result, a shrinking number of insured policyholders are left to pay the MCHA assessment.

*"I critique market-based medicine not because I haven't seen its heights but because I've seen its depths."*

**Paul Farmer, Educator**

**New Proposals to Extend Coverage.** Other proposals involve some form of publicly-facilitated insurance. Senator John Kerry proposed to allow employers to purchase coverage for sick employees from the federal employee health insurance program to assist them in controlling health care costs. Through this approach, more employers would arguably be able to buy health coverage regardless of whether they have a higher ratio of employees with serious medical conditions. Under this proposal, the cost of caring for the ailing population would be borne by the government insurance program, which in turn would be subsidized by the taxpayer. One problem with this approach is that too many small employers still would not be able to afford coverage for their employees.

A number of manufacturers have proposed a federal catastrophic insurance program, where employers could purchase reinsurance from the federal government to provide coverage for catastrophic costs associated with

serious illnesses. The aim of this proposal is to stabilize the premiums charged to employers so that more employers buy coverage. Under this proposal the program's deficit would result in a subsidy by the taxpayer and, in the end, too many small employers still would not be able to afford coverage.

Other proposals have been income-based, where the cost of a person's health coverage would vary according to their ability pay. Critics of these proposals assert that such a program could encourage employers to dump the health coverage they currently provide their employees.

**The Obama Proposal.** Our current health care system is unsustainable. It is far too expensive, and far too many people do not have access to it. We pay more per capita than any country in the world for health care. Medicaid and Medicare already account for one fifth of the federal budget. By 2014, Medicaid and Medicare will consume 50 percent of all health care spending. By 2018 Medicare is expected to be insolvent.

The Obama Administration is proposing a national health insurance policy that competes with but does not replace the private insurance system, with the goal of cutting the fat and redundancy on what many experts believe accounts for one-third of the \$2.5 trillion annually expended on health care in America. Although the insurance industry and some health provider groups strongly oppose the proposal, it would be the most significant change in our health care system in 45 years—since the passage of Medicare and Medicaid in 1966.

**Conclusion.** Some have criticized President Obama for trying to do “too much” in focusing on health care reform when our economy is in tatters and we face so many other problems. They are wrong. Our economy has been weakened in part because of our health care system. If there is any doubt about this, just look at the 50 percent of families who file for bankruptcy because of health care debt. Or who have to choose between paying their mortgage or paying their health care premiums. Or the employers who are making cuts or can't grow jobs because they are paying so much for health care insurance.

*“Fixing our healthcare system as a whole is our primary challenge, and to make it happen you need to get engaged – to pound the pavement, get your hands dirty, endure real sacrifice, take on antiquated thinking and help lead the public debate.”*

**Senator John Kerry**

We need a comprehensive approach to health care—and that takes the involvement of the federal government. We need universal health care that provides access to everyone. We need to control spiraling health care costs. And we need to do this now.

When FDR was President, there were approximately a dozen lobbyists in Washington, D.C. When President Reagan was inaugurated, there were fewer than 1,000 lobbyists. Today, there are over 37,000 lobbyists. For the most part, these lobbyists represent interests with clout. Indeed, for every member of Congress there are four lobbyists representing the health care industry. The pharmaceutical industry alone has spent \$1.2 billion in lobbying fees since 1999. The insurance industry is not further behind, having spent \$1 billion. There are few lobbyists for ordinary people.

Regardless of our individual differences on the best way to bring about health care reform, we need to stand behind the President if we are to finally get any reform of the health care system. If we pick away at our differences, or demand that a particular segment of the population be given priority, or reject this reform out of a belief that it does not go far enough, then the system will remain hostage to the interest groups that stymied President Clinton in 1994, and we will get no reform at all.

Winston Churchill once said that: “Americans can be counted upon to do the right thing—after they have exhausted all other alternatives.” We have exhausted all other alternatives when it comes to health care. We need reform, and we need it now.

Lori Swanson is Minnesota's Attorney General. Elected in 2006, she previously served the State as Solicitor General for four years and Deputy Attorney General for four years. In 2004 she was appointed to the Consumer Advisory Council to the Federal Reserve Board of Governors. She chaired the Council in 2006. Attorney General Swanson graduated magna cum laude from William Mitchell College of Law in St. Paul. As Attorney General, she has been an outspoken advocate for Minnesota consumers and citizens.

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