A Healthy Distrust

Kelsey C. Cody

Writer's Comment: I was in the process of assembling a piece about universal healthcare for my column in The California Aggie when, about two days before my deadline, I realized I was 600 words over my 800-word limit and hadn't even mentioned HMOs. Reasoning it too difficult to cut and condense, I decided to shelve it and write about Scrabble instead. What eventually became "A Healthy Distrust" sat untouched for weeks until I was assigned the final paper in UWP 101 (Advanced Composition), at which point universal healthcare came back in full force. It was very important to me that I nail down the evidence and build a robust case from the ground up, so research consumed three-quarters of the time I spent on the piece. This strong foundation, along with ample help from Dr. Walker and a bit of wry wit to keep things interesting, is what made for my best writing to date.

—Kelsey C. Cody

Instructor's Comment: Kelsey Cody is a man of many devices, as I soon learned in UWP 101 last fall—columnist for the Aggie, captain of the cross-country and track team, a bio sci major headed for a graduate program in environmental policy, and a keen observer of national politics. In "A Lively Distrust," he presents a compelling case for national health insurance. Kelsey mobilizes the strategies of popular journalism—a first-person anecdotal lead, short sections with snappy headings, and a colloquial style that's sometimes funny, always engaging—to showcase the most striking details he uncovered in his wide-ranging research. (The secretly recorded conversation he cites between Richard Nixon and John Ehrlichman, which helped persuade Nixon to support the 1973 HMO Act, is a gem.) The piece is brilliantly structured to build consensus, step by step. Health care policy often makes for dull reading, but Kelsey's voice, his passion, and the resonant details he musters make this crucial issue come alive for the young readers he's addressing.

—Jayne Walker, University Writing Program

One Flu Over the Cuckoo's Nest

It was 3:30 a.m., and the doctors thought I was dying. I was lying on a hospital bed in the fetal position, holding my knees against my chest with an IV in each arm— one for saline, the other for medication. The small of my back was exposed, and a doctor was sterilizing the skin just above my fourth and fifth lumbar vertebrae with an iodine solution. Then, after administering a local anesthetic, the doctor inserted a needle into my spinal column and drained 20 cc of the fluid which insulates the nerve complexes in my spine and brain. I lay on my side with the needle inside my spine for ten minutes as the fluid drained into four different collection tubes. After the doctors had a large enough sample, the needle came out, a band-aid came on, and I was told to lie still on my back for two hours.

Over the course of those two hours I did what most people in my situation would—a lot of thinking. I thought about my friends, my girlfriend, and my family. I thought about how just a few hours ago I felt completely healthy, how bacterial meningitis, the disease I was being tested for, has killed people who felt the same in less than a day, as it does to 200 to 400 Americans each year. I thought about the four blood samples, the urine sample, the two throat cultures, and the MRI of my brain, and wondered if the spinal tap they just performed would finally tell them what they needed to know. Over the course of those two hours I thought about a lot of things. But there was one thing I didn't think about. The bill.

It was 6:30 a.m. when I was informed that I wasn't dying. After eight hours in the emergency room, I was instead diagnosed with a disease that kills over 36,000 people annually in the U.S.: the flu. It was rather anticlimactic, and, truth be told, I felt a bit cheated. I had just experienced the most bizarre and medically involved eight hours of my life, and all I had to show for it was my ER triage bracelet and some cough medicine.

Oh, and that bill I mentioned.

The Lucky Ones

Ten thousand dollars is a lot of money. It's a year of college at UC Berkeley. It's a year's worth of food for a family of four. It's more than a fifth of the annual income of 71 percent of Americans. And in my case, it's the cost of finding out you have the flu.

But I was lucky. Not only was I not dying, but I never had to pay one red cent of that ten thousand dollars. I was lucky, because I had insurance.

My insurance coverage is provided under my father's health plan. Like my mother, he is a high school teacher employed by the state and a member of the California Teachers Association, a union which represents over 340,000 educators statewide. This is important for two reasons. First, public sector employees, i.e. individuals employed by the government, are, as a group, the most well-covered sector of the workforce. As shown in a study released by The University of Texas at San Antonio, 100 percent of state governments and 99.5 percent of local governments offer health insurance to their employees. On the other hand, the same study reveals that only 62 percent of private companies offer health benefits. So it's clear that being a public employee in and of itself increases access to health insurance. Second, being a union member also increases the chance that an employee will obtain health care coverage. According to the federal Bureau of Labor Statistics, 80 percent of unionized workers in the private sector, i.e. individuals not employed by the government, are offered health coverage, compared with just 49 percent of their non-union counterparts.

So the fact that I have parents who are both union members and state employees means that my experiences with health insurance have been, on the whole, very good. I am not alone. The San Antonio study also found that 92 percent of public sector human resource departments report that employee satisfaction with their health plans ranges from "somewhat good" to "very good." In general, people are pretty happy when they don't have to pay $10,000 to find out they have the flu.

However, employers are not the only avenue for Americans to obtain health care coverage. The U.S. Census Bureau released data in 2006 showing that although 59.7 percent of Americans receive coverage in this way, 13.6 percent are covered by Medicare, 12.9 percent by Medicaid, 3.6 percent by the military, and 9.1 percent simply purchase insurance out of their own pocket. There is of course some overlap. For example, a senior citizen could be on Medicare and Medicaid simultaneously, or a worker could have coverage through his employer as well as through a direct purchase. When this overlap is taken into account, the Census Bureau numbers show that 84.2 percent of Americans have some kind of health insurance.

That number alone might lead us to believe that health insurance in America is a non-issue, that the vast majority of Americans have insurance and the system is functioning reasonably well. That number alone would lead us astray.

But I Thought I Had Insurance?

Being insured in America hardly means being secure. Sixty-nine percent of Americans get their health coverage from a private insurance company, which means that 69 percent of Americans have entrusted their health to a corporation which has only one purpose: to make money.

Now, I don't mean to single out the health insurance industry. After all, the only goal of any company is to make money. As Adam Smith said, "It is not from the benevolence of the butcher, the brewer, or the baker, that we expect our dinner, but from their regard to their own interest." In no way do the goods or services provided by a company reflect an interest on the company's behalf to serve the public good, although that does occur from time to time. Rather, what a company does reflects only what that company believes to be the best way for it to turn a profit; the actual goods or services are merely ancillary. For example, if General Motors wanted to serve the public, they wouldn't have bought up and dismantled California's trolley systems in the 1940s and early 1950s. If DOW Chemical wanted to serve the public, they wouldn't have repressed the negative health effects of Agent Orange during Vietnam. And if Blue Cross of California or Kaiser Permanente[1] wanted to serve the public, they wouldn't deny payment and cancel policies once people needed to use them. But if they wanted to make money, a lot of it, those actions make perfect sense.

I intentionally mention Blue Cross of California and Kaiser Permanente specifically. Kaiser Permanente was one of the first Health Management Organizations, and factored into President Nixon's decision to support the Health Maintenance Organization Act of 1973, which gave HMOs greater access to the employer-based insurance mar-

[1]The structure of the Kaiser family of organizations is highly complex. However, the basic synthesis is that Kaiser Foundation Health Plans operate as nonprofit umbrella organizations for the for-profit Permanente Medical Groups and Hospitals. So while Kaiser Permanente reports "margins" rather than "profit margins," it operates for all intents and purposes as a for-profit insurance company.

ket. Although originally skeptical, Nixon was persuaded in part by a conversation he had with John Ehrlichman, who, incidentally, would later spend a year and a half in jail for conspiracy, obstruction of justice, and perjury. Anyhow, thanks to President Nixon's foresight, their conversation, among others, was secretly recorded. The transcript reads:

> President Nixon: You know I'm not too keen on any of these damn medical programs.
>
> Ehrlichman: This—this is a—private enterprise one.
>
> President Nixon: Well, that appeals to me.
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> Ehrlichman: Edgar Kaiser is running his Permanente deal for profit. And the reason that he can—the reason he can do it—I had Edgar Kaiser come in—talk to me about this and I went into it in some depth. All the incentives are toward less medical care, because—the less care they give them, the more money they make.
>
> President Nixon: Fine.
>
> Ehrlichman: And the incentives run the right way.
>
> President Nixon: Not bad.

And thus the modern HMO was born, delivered from the loins of corruption and greed and into the homes of working American families.

Blue Cross of California deserves a special mention as well, because they've taken the spirit embodied in that conversation and turned it into a highly profitable business plan. Blue Cross of California, which has over 6.8 million members and is the insurance provider for all UC Davis students who are insured through the university, has a habit of telling their policy holders that a given procedure is covered under their plan, and then rescinding that coverage once the procedure has been performed. This foists the entire cost of the procedure, which was pre-approved in writing, onto the patient. The grounds for cancellation? That the policy holder had misrepresented their medical history when they signed on, and that the policy agreement was therefore void.

The Department of Managed Health Care in Sacramento got an unusual number of complaints about this sort of thing, and by 2006 the regulatory agency had decided to do some digging. In a random sample of 90 rescinded policies, the DMHC found that Blue Cross of California

had violated state law by not proving that the applicant had "misrepresented his or her medical history" in all 90 cases. I will repeat that. One hundred percent of the randomly selected policy cancellations were illegal, and 43 percent were found to be illegal on more than one count.

And what was the fine levied against the company whose parent corporation, WellPoint Inc., had $61.9 billion in revenue in 2006? One million dollars even. For those of us unfamiliar with such large sums of money, that's less than 0.0016 percent of WellPoint's income. You don't need an MBA to figure out that, even though they got caught, rescinding the policies was still an economically sound business practice. Ehrlichman was right, it certainly appears that the incentives run the right way.

The Economy Plan

Ultimately, even those with Blue Cross of California are better off than quite a few of their countrymen. In 2003, over fifteen and a half million of their fellow Americans were considered underinsured by the policy journal *Health Affairs*. Meaning that the insurance they did have was not enough to insulate them from "financially catastrophic health care expenses," even if their insurer didn't break any laws. Much of this shortcoming has to do with costs.

Declining union membership, which was once 35 percent of the workforce in the 1950s and now stands at just under 12 percent, and increasing deregulation, such as the Bush administration's decision to prevent the federal government from negotiating with pharmaceutical companies for reduced pricing, have combined to form a sort of perfect storm in health care costs. As people and governments lose the ability to collectively bargain for coverage and reduced prices, those prices have been increasing at an unprecedented rate. The aforementioned San Antonio study reports that the cost of health insurance increased by 73 percent between 2000 and 2005, which translates to the current average yearly premium of $11,500 for a family of four. To put that in perspective, the median amount of money that same family of four can expect to earn this year is $48,201. Were it not for the fact that employers offering health coverage pick up approximately three-quarters of the total premium, a striking majority of Americans would find themselves unable to afford even the most basic health insurance.

But the story doesn't end there. In the same time period that saw a nearly seventy-five percent increase in health insurance costs, *Health*

Affairs also found that the number of employers offering health plans dropped from just under 70 percent to just over 59 percent. Additionally, the increasingly weakened unions are being forced to settle for what are called "two-tier contracts." These contracts stipulate two different levels of benefits, almost always reducing them for employees making the least in wages and therefore most likely to suffer from the reduction. But even the plans that are offered often require significant copays and large deductibles, as well as limit the scope of care that's covered.

Take Wal-Mart, for example, the nation's largest employer. Wal-Mart is infamously and often illegally anti-union, and is currently the subject of dozens of criminal investigations across the country. According to the United Food and Commercial Workers, a union which represents over 1.3 million Americans, full-time employees that buy into Wal-Mart's health plans pay between 22 and 40 percent of their average annual income, which is just over $17,000, in deductibles and premiums to cover themselves and their families. But that's not all. The coverage provided by Wal-Mart's Value Plan, the most popular among hourly employees, does not count office visit copays, ER and ambulance deductibles, per event deductibles, or pharmacy copays towards the $3,000 family deductible. It's also important to note that benefits are limited to "in network" hospitals and doctors, and that full-time employees face a waiting period of 181 days before they become eligible for even this meager coverage. For part-time workers, the restrictions are even more severe.

This trend of decreasing employer benefits is clearly related to the trend of increasing costs. As insurance costs go up, it becomes less and less attractive to employers to provide robust health care benefits, and more and more working Americans are counting themselves among the growing ranks of America's uninsured.

American Roulette

It's tempting here to use the analogy of walking a tightrope without a net, but it wouldn't be entirely accurate; walking a tightrope implies the risk of falling, but the fall hasn't occurred yet. That's not the case for the uninsured. They've already fallen, and the only question is how far. A more apt analogy might be Russian roulette—except in this version of the game you don't ever pass the revolver, you just keep pulling the trigger.

What's so tragic about this analogy is that it rings so horribly true: 18,300 people die every year in the United States of America because they do not have health insurance. Let that sink in. It seems a terribly morbid and cruel form of extortion to force someone to forfeit either their financial solvency or their life, and yet the most affluent and technologically advanced nation on the planet does just that—allowing its citizens to perish simply because they don't have enough money, as though there was some kind of monetary benchmark that justified a person's existence.

When the Institute of Medicine reported that figure of 18,300 in 2003, there were just under 44 million uninsured Americans. Today, that number has risen to 47 million, and all trends indicate that by the end of 2008 America will be home to over 50 million uninsured individuals.

But that understates the problem. The phrase "the uninsured" implies a static group of people, living at the fringes of society, who are continuously without care, year after year after year. However, this loosely defined group is actually highly dynamic. A study published by The Commonwealth Fund in 2003 reported that from the beginning of 1996 through the end of 1999, 84.4 million Americans were classified as uninsured. The study states, "One out of three people had a lapse in coverage some time during the four years," and "More than two-thirds of the people . . . below 200 percent of the poverty level were uninsured at some point during the four years." So it's clear then that the incidence of noncoverage is much higher than a simple snapshot would indicate, and that those who need insurance the most are the least likely to get it.

On a psychological level, referring to people without insurance collectively as "the uninsured" can cause problems with public perception of the issue. Labeling persons without health insurance as "the uninsured" allows those of us with insurance to engage in what sociologists call "othering." Through this process we disassociate ourselves and those around us from the group in question, and thereby come to regard them as marginal and unimportant. This phenomenon causes those of us with insurance to be dismissive of the potential problems associated with a large uninsured population, because "they" aren't "us." But in reality, they are us; they're our neighbors, our coworkers, our friends, and members of our own families.

And what happens to those neighbors, coworkers, friends, and family members? Well, there's more at work than simply paying out of

pocket for a given medical service. According to the Kaiser Commission on Medicaid and the Uninsured, in a given year the average uninsured person spends $1,630 of their own money on health care, whereas the average insured person consumes $2,975 worth of care, of which they pay only a fraction. The Commission also points out that the uninsured, wary of the costs, rarely receive preventative care, such as mammograms and wellness checkups, or therapeutic care, such as chemotherapy and dialysis. What this means is that uninsured individuals forgo needed medical treatment, which ultimately results in far more advanced stages of disease, mortality rates 25 percent higher than the insured, and a higher imposed cost on society as a whole. And it's that cost, paid in lost productivity, higher taxes, overcrowded and bankrupt emergency rooms, and artificially inflated medical bills, that ultimately makes the case for single-payer, universal health care.

Hands Down

Policymakers constantly grapple with the uncertain economic consequences of their decisions, but this is one instance where grappling need not occur. The overall economic benefit of universal health care is unequivocal.

There are two basic reasons for this. The first reason is simple: sick people make lousy workers. The Institute of Medicine released another study in 2003,which documented the costs to society of maintaining such a large population of uninsured citizens. The report found that "the potential economic value to be gained in better health outcomes from continuous coverage for all Americans is estimated to be between $65 to $130 billion each year." Reenter the Kaiser Commission on Medicaid and the Uninsured. "Total spending for those who would gain coverage under a universal expansion would increase by $48 billion." In terms of cut and dry figures, it doesn't get any clearer than that. Even a limited plan to cover only those who are currently uninsured would produce a net economic benefit of $17 to $82 billion annually.

The second reason that universal coverage, and more specifically a single-payer plan, would be more economically sound may seem, if you listen to the conventional wisdom of the free market, completely antithetical. And yet, in no uncertain terms, the federal government is more efficient than the market at providing health care. As Paul Krugman, professor of Economics at Princeton University and columnist at *The*

New York Times, points out, "Medicare spends only about 2 percent of its funds on administration, for private insurers the figure is about 15 percent." Why? Insurance companies spend billions of dollars a year screening applicants in hopes of finding a reason to charge higher rates, denying claims in hopes of simply evading payment, hiring lawyers for when they break the law, and running ad campaigns trying to convince us they don't. They also award their executives lavishly. According to *BusinessWeek*, Larry Glasscock (no joke), the CEO of WellPoint Inc., was "compensated" with $46.2 million in 2005. That's more than the CEOs of Exxon Mobil, ChevronTexaco, and ConocoPhillips *combined*. Glasscock also has unexercised stock options valued at $55.9 million. As staggering as these numbers are, Glasscock is only the 11th most "compensated" CEO in the "Health Care Equipment and Services" industry. Medicare, on the other hand, has none of that. Ninety-eight cents of every dollar Medicare takes in goes directly to covering the health care costs of American citizens.

There is another reason to make the switch to universal health insurance: despite the fact that America spends more money on health care per capita than any other country on the planet, our current system simply fails to provide effective medical treatment. Per capita medical spending in the U.S. amounted to $7,600 in 2007, more than twice the spending of the next highest nation. On the other hand, Austria, France, and Italy, nations with nationalized health insurance, dished out $3,600, $3,160, and $2,610, respectively, in 2006. But rather than being an indicator of robust investment in America's health care infrastructure, this extra money actually has very little to do with its effectiveness.

The World Health Organization has ranked every nation in the world in terms of the overall performance of its health care system. The ranking considers such aspects as life expectancy, wait times, infant mortality, incidence of preventable diseases, and the quality, cost, and availability of care. The American health care system ranks a mediocre 37th in the world in overall performance, coming in just above Slovenia in the 38th position. To keep the benchmarks consistent, consider also that Austria was ranked 9th, Italy 2nd, and that France, the nation of wine, cigarettes, and casual sex, was ranked number one across the globe. What this means, then, is that industrialized nations with nationalized health care are able to simultaneously reduce costs (by no small margin, mind you) and provide higher quality care. It also means that sooner or later,

the American people are going to figure out they're being had. And it looks like that's exactly what's starting to happen.

By Popular Demand

A CBS/New York Times poll from March 2007 shows that 90 percent of Americans believe the health care system in the U.S. needs fundamental changes, with 36 percent of those saying the system needs to be completely rebuilt. Additionally, a Los Angeles Times/Bloomberg poll released in late October shows that 60 percent of Americans would be willing to repeal some of Bush's tax cuts to help pay for a government program that would insure all Americans. Repealing the tax cuts even garners support from 57 percent of Americans in households earning over $100,000 annually, 48 percent of whom say that they've benefited from those same cuts. Not only that, but 53 percent of Americans would support a "government-run, government-financed" health insurance program that would cover all Americans, while only 36 percent would oppose it. That bears repeating. A majority of Americans support single-payer, universal health care, and an even larger majority would be willing to accept higher taxes to pay for it.

Now I may be young, inexperienced, and wholly unqualified to make such a broad statement, but even I have been around long enough to know that when the American people are willing to pay higher taxes for something, it's a pretty big deal. I've also been around long enough to know that whether the American people have asked for wars in foreign lands through our apathetic silence, or for civil rights through our exasperated voice of dissent, we've generally gotten what we asked for. So my question to Americans is this: when it comes to our own health, our personal well-being and vitality, are we going to allow our silence to speak for us? Or are we going to rattle some cages, and make a little bit of noise in the process?

Davis, California
December 2007