Demonstration for health care in front of the Hale Boggs Federal Building, Poydras Street, New Orleans. 23 Sept. 2009. Infrogmation of New Orleans, CC BY-SA 2.0 , via Wikimedia Commons. Accessed 11 Apr. 2020.

Sarah L. Berry // If you're a voter under 65, you vote yes for the highest cost of healthcare per person in the world. That's because no presidential candidate has advanced past the primaries to overhaul the expensive and inefficient multi-payer system in the U.S., a system for which expanded Medicare may be the antidote.

Election years bring big talk, and in 2020, the cost of healthcare has been a hot debate anchoring the presidential primaries. Candidates offered a range of promises for reforming one of the U.S.'s most lucrative industries: healthcare.[i] One by one, the most ardent proponents of Medicare for All dropped out. Just as all but two proponents—a moderate (Joe Biden) and a progressive (Bernie Sanders)—were left in the ring, a pandemic turned theoretical plans into urgent problems for patients and communities, especially in New York City where the infection rate rose at ten times the rate of other cities.

In Medicare for All debates, dollar amounts are used on all sides—billions and trillions—as figures to scare or to win voters, but what do they really mean for taxpayers, patients, and national fiscal health? And what do they mean during a pandemic where everyone is unequally insured but

equally a potential patient at the same time? This essay traces the idea of universal, affordable healthcare from its early days as "catastrophic care insurance" to the creation of Medicare during the Civil Rights movement to the present moment of COVID-19. The economic realities of the U.S. healthcare industry, this history shows, have always been obscured by an X-factor: American psychology. The 2020 public health emergency could be the tipping point toward a clear vision of the economic necessity and moral imperative of universal healthcare.

Medicare provides medical care to all Americans aged 65 years and over without exception. It comprises 15% of the federal budget, but has been so popular since it was enacted in 1965 that no president has altered it. In 2020, 64 million Americans are enrolled; by 2030, enrollment is projected at 80 million.[ii] The total US population is about 330 million. The program has a single payer, the federal government, which collects a dedicated tax on workers' pay into a type of trust fund, and pays for medical care (routine and urgent) at a few percent over cost (roughly half of what private insurers pay providers). Its central administration and its non-negotiable, low-margin pricing keeps costs down, saving about $750 billion a year (Brill para. 25).

If you're under 65 and receive a paycheck, you may have noticed the Medicare tax at each pay period. If you have insurance through your employer, there is a line item for the regular deduction from your pay. In addition, you may pay thousands more out of pocket for medical services until you meet a deductible, along with co-pays for each office visit and payment on bill balances not covered by your plan. This is the employer-based insurance system experience that has remained in place since World War II. By contrast, paying Medicare tax for forty or fifty years of working life, which is currently a single, 2.9% tax on each paycheck, garners you guaranteed healthcare services with little or no additional cost at point of care—but only when you turn 65. This alternative is probably very attractive to most people under 65. But most Americans don't know what they are missing. That is, until the 2020 primaries.

What is the question?

When politicians and pundits debate Medicare for All, what are they really asking?

Are they asking whether or not all people in the U.S. should have healthcare? This is called the moral imperative. If not all people in the U.S. should have healthcare, who should be included and excluded? Who will decide? Or are they asking who should pay—employers, patients, or taxpayers? The question tends to sidestep why healthcare is so expensive in the U.S., and goes immediately to trillion-dollar figures for the projected implementation costs. The kinds of questions that are debated raise important issues but also shift attention away from other problems, such as the question of who needs healthcare but cannot access it because of cost—a question that, during the pandemic, is becoming visible not only to experts in health disparities, but also to the public.[iii]

Essentially, then, the U.S. asks two questions: who deserves healthcare, and who should pay for it? Neither question exists in other nations that are equivalent in terms of per capita income and infrastructure. Other nations, from Canada to Spain, from Sweden to the U.K., have maintained healthy national economies since World War II with the philosophy put into practice that everyone

deserves access to healthcare. Other nations show a variety of structures: Great Britain's National Health Service is administered to all citizens by a single-payer government, while in Germany, insurance is issued by businesses even for retirees (Reid 12). In peer nations, payment is not the fundamental question. Additionally, the moral imperative of providing healthcare to every citizen consolidated in other capitalist democracies around the end of World War II. In peer nations, payment has been worked out; efficiency, access, and peoples' needs are the questions asked and researched and solved; in the U.S., aversion to "foreign" systems during the Cold War ran high, and government-run healthcare was presented as "socialized" medicine. American psychology tends to be exceptionalist and individualist. A look at the longer history of how Americans have paid for healthcare shows the effects of these persistent attitudes on our present system.

Double ~~In~~Demnity

Double Indemnity, a 1944 film noir starring Barbara Stanwyck and Fred MacMurray, dramatized a fraud scheme aimed at collecting double payment of life insurance in the event of an accidental death. The present state of healthcare insurance shows an equally dramatic inverse: those who are poorest pay more for care because insurance markets control the costs of care, drugs, and medical devices, and those who are underinsured or uninsured do not "benefit" from insurance-negotiated pricing with individual healthcare providers. Instead, they are charged full prices. But patients *with* full-coverage insurance also pay much more for their own care annually than Medicare beneficiaries. Why? Employer-based private insurance has the corner on the market. Over the past 120 years, this has led to a policy trap, according to historian and advisor to the Clinton administration Paul Starr, "that has satisfied enough of the public and so enriched the health-care industry as to make change extraordinarily difficult" (2). Yet, as economist T.R. Reid points out, the U.S. already has an affordable, universal healthcare payment program—two, actually: Veterans Affairs and Medicare (12).

A History of the Present Dysfunction

Around the turn of the twentieth century, health insurance began on a small scale as indemnity insurance (a premium paid out for living expenses if a worker was ill or injured). A form of workers' compensation, this plan was borrowed from European nations and American union models (Rosenthal 14; Starr 29), and it operated like the current AFLAC product does. Around the same time, hospitals, run by charitable organizations, were helping to keep their doors open by offering "catastrophic care insurance," which covered a 21-day hospital stay (costing $105) for the price of the premium ($6/year). At this time, three weeks of hospitalization would have cost $525, and would have bankrupted many workers (Rosenthal 15).

The catastrophic care insurance model caught on quickly and became the not-for-profit Blue Cross plan. Public health insurance was proposed by Progressive-era advocates but was voted down in a tide of anti-German (anti-socialist) sentiment following WWI. In the period leading up to WWII, proposals for national health insurance were actively opposed by the American Medical Association (Starr 38) and by hospitals, which were beginning to be run like businesses (Smith 20-

21). The Depression made unemployment relief a greater priority than universal healthcare, and advocates for such a system were undermined by the ever-increasing popularity of the Blue Cross plan. Harry Truman became the first president to call for national health insurance modeled on Social Security—federally-administered, compulsory, and available to almost every American—but capitalist and AMA interests vigorously defeated what they branded "socialized medicine," buoyed once more by post-war xenophobia. As a result, the U.S. raised the level of capital investment in health care before extending insurance (in reverse of European countries rebuilding after the war by providing all citizens with medical coverage) (Starr 40-41).

Health as a Civil Right

Widespread social reform beginning in the postwar years flourished in the 1960s, a decade of extremely rapid changes. In 1961, a young Ronald Reagan was using his star power to help the AMA instill Cold War paranoia about the new Medicare bill as "socialized medicine;" after the inauguration of Lyndon Johnson, the bill was expanded and passed in 1965[iv] (Starr 46-47). Medicare gained political security and at the same time helped cement the costly multi-payer system by airing the notion that retired people over 65 have earned the right to free or low-cost healthcare (Starr 47). This, along with a massive rise in competitive, for-profit insurance growth enabled by federal policy in the 1970s and 1980s, reinforced the sentiment that workers earn healthcare, and that healthcare is a valuable perk of work rather than a basic social necessity like housing. Even though the company career model has phased into the gig economy, favor for the employer-based, for-profit insurance model still prevails; the Affordable Care Act made some important improvements leading to a dramatic increase in coverage for millions of Americans by virtue of its federal reach, but it has been under siege and is coming up for a Supreme Court trial in fall 2020.[v]

Who pays? Who benefits?

Seven years before the 2020 primaries, Steven Brill pointed out that "When we debate healthcare policy, we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: Why exactly are the bills so high?" There are many reasons, but two major ones are industry-controlled pricing and high administrative costs, since each provider and insurance plan is a self-contained system of constantly-changing price negotiations. This arrangement also requires more administration to track individuals among systems. If you've ever changed jobs or moved to a new location, or even if you've had to see a specialist in a different network within the same town, you have no doubt experienced this disruption and confusion in your care and billing. Or perhaps you have an umbrella plan, where one insurance company covers hospitalization and another covers medical services outside the hospital.

Businesses and employers have responded to the insurance industry-controlled healthcare pricing in the U.S., which perversely rises as technologies age (Rosenthal 8) and drives up premiums, by cutting worker hours to 35 hours a week, the maximum before health insurance is required by law, and by purchasing cheaper policies for employees with high deductibles and co-pays that are

unaffordable to some workers. That is, the economy and political campaigns prior to 2020 have remained faithful to a system of work-based healthcare access while failing to require businesses to provide affordable plans to its workers.

There are more ways that the for-profit system costs the greater society more than a centralized system would. People who are poor tend to be sicker because of basic necessity deprivation and because of lack of regular healthcare access. When they do access health services, the costs of care are higher. The hospitals that began in the 1950s to govern themselves and set standards of healthcare without government intervention actively excluded poor patients and people of color.[vi] This created and increased the divide between private and public hospitals.[vii]

The Affordable Care Act (ACA) placed a cap on salaries for healthcare executives and required insurance to spend 80 to 85% of every premium dollar on patient care (Rosenthal 19-20), but most hospitals, including private ones, claim charity status through a tax loophole and net massive profits while not paying income taxes (Brill para. 55).

Efficiency May Save Us All

Medicare saves money on routine care, hospitalization, and outpatient services by centralizing administration (2% of its budget is on administration while 98% pays for patient care [Rosenthal 20]) and by paying for services at a target of 1% above cost (Rosenthal 351). Medicare pays a fixed rate tied to diagnosis; therefore, for patients with Medicare, healthcare providers make more money on efficient procedures with good patient outcomes and are not rewarded for unnecessary billable services or longer recovery times. Profit margins remain low while quality of care is assured. Dr. Atul Gawande has found that even people with conservative outlooks deem the Medicare system—pay in a little and receive coverage when needed—more fair than a free market system designed to exclude millions of citizens who cannot acquire employer-based insurance plans.[viii]

Maintaining the current patchwork dominated by for-profit healthcare corporations and private, employer-centered private insurance is, according to Dr. Gawande, “increasingly difficult, expensive, and self-defeating.”[ix] Then, with the rapid spread of COVID-19 in the U.S. in March 2020, Medicare for All suddenly became an emergency plan in action, especially in the hardest hit area, New York City.

Universal Health Threat, Universal Coverage

In spring 2020, Covid-19 started to break down the complex, expensive, inefficient multi-payer system.

New York City provides a case study of the complex and costly nationwide system that could be streamlined and more cost-effective with universal healthcare.[x] The public health crisis led to state-mandated combination of three hospital systems. Governor Andrew Cuomo declared, “We need to have a new mentality, a new culture, of hospitals working together. Private hospitals have

to help public hospitals."[xi] He also called for siloed local healthcare systems to share resources, and added federal resources including the USS Comfort, a Navy hospital ship staffed and administered by the federal government, and field hospitals installed by the Army Corps of Engineers, in tents and expo centers. The immediate medical necessity is treatment of acute patients and prevention via testing and public health messaging about preventing spread. Private insurers have been required to "waive" testing and treatment fees, begging the question of what the value of employer- and employee-shared premiums was supposed to be for if not for medical care. Medical billing, in this new context of volunteering, resource-sharing, and temporary facilities, will be extremely complicated—and costly in its own right.

In addition, the record numbers of people filing for unemployment carries with it an equally record-breaking wave of uninsured people, which has prompted the state to re-open the application period for its Affordable Care Act medical insurance program. At the same time, federal funding will cover a small fraction of the cost for New York and other states; in NY, however, this aid is offset by making one-third of Medicaid clients ineligible for medical coverage.[xii] Meanwhile, regular Medicare enrollment has experienced accelerated need and heightened barriers during the pandemic: accelerated need because older Americans delayed enrollment while continuing work, but have been laid off during quarantine, and heightened barriers due to paperwork and agency processes, which are now closed. A universal healthcare system would obviate these barriers to enrollment.

The costs and inefficiency of this multi-payer system are painfully apparent during this pandemic, when demands on healthcare are immediate and overwhelming, but the financial burden of a profit-centric system is yet to come. In the current system, employees, employers, the under- and unemployed, insurance corporations, healthcare corporations, and taxpayers are all responsible for the bill, and it's likely that New York State will be recovering from the costs for decades. A study from the Kaiser Family Foundation estimates that up to 2 million uninsured people nationwide will require hospitalization during the pandemic, costing up to $40 billion.[xiii] In anticipation, the federal government has stated it will reimburse hospitals, but, tellingly, at the Medicare rate (insurance rates would be nearly $80 billion for the same services).

Some of the most effective reforms in U.S. history have stemmed from activism that disrupts business as usual, such as strikes and sit-ins in business districts. In 2020, a virus is disrupting medical business as usual. It is showing voters what a for-profit, multi-payer system costs us all—and has been costing us, without proper attention, all along. Jarring but underplayed health disparities aggravated by radically unequal access to care during COVID-19 are front-page news and late-night monologue content. The pandemic has also foregrounded the moral imperative to promote collective health—concrete evidence that individual actions impacts other peoples' health and survival. All this begs the question: will this glimpse of efforts toward universal healthcare survive the public health crisis?

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[i] Dentistry, medicine, and outpatient healthcare services are among the top 11 industries with the highest profit margin. *Forbes*.com https://www.forbes.com/pictures/feki45efjgh/the-15-most-profitable-i/#153e4cd07a39. Accessed 11 Apr. 2020

[ii] All information in this paragraph is from Bunis, Dena. “Medicare and the Elections.” *AARP Bulletin*. Apr. 2020. Page 8.

[iii] Mays, Jeffrey C. and Andrew Newman. “Virus Is Twice as Deadly for Black and Latino People than for Whites in NYC.” *New York Times* 4 Apr. 2020. https://www.nytimes.com/2020/04/08/nyregion/coronavirus-race-deaths.html

[iv] Medicare is often confused with Medicaid, which also passed into law in 1965. Medicaid eligibility is dependent on income and is not federal but rather administered on a state-by-state basis. States contract with the federal government, and the Affordable Care Act followed this model in 2010.

[v] The case is based on a charge of unconstitutionality in the individual mandate (i.e., the federal law that uninsured individuals purchase health insurance), led by a small minority of states that have resisted ACA implementation.

[vi] See Smith's excellent book *The Power to Heal* for a detailed explanation of how the self-interested hospital system and Jim Crow segregation powered Medicare reform, and legacy in the healthcare industry up to the present.

[vii] A small portion of hospitals are designated, in problematic language, Disproportionate Share Hospitals; these centers receive federal funding for patients who cannot pay. But in the vast majority of community and private hospitals, costs for patients who cannot pay and who are not turned away (100% legal for private hospitals) are absorbed by paying patients and recouped by insurance companies by driving up premiums.

[viii] Gawande, Atul. "Is Healthcare a Right?" *The New Yorker*. 2 Oct. 2017.

[ix] Ibid.

[x] Other states and municipalities are enacting similar measures. New York State is discussed here because Gov. Andrew Cuomo's daily public addresses have made clear and consistent public statements about healthcare policy and resource leverage for a discrete population, making it a good case study and forming the backbone of information in this section of the post.

[XI] "GOVERNOR CUOMO DELIVERS UPDATE ON CORONAVIRUS IN NEW YORK STATE 3/29/20 -ASL." YOUTUBE. ACCESSED 29 MAR. 2020.

[XII] "GOVERNOR CUOMO HOLDS BRIEFING ON COVID-19 RESPONSE – ASL." YOUTUBE. ACCESSED 4 APR. 2020.

[xiii] Levitt, Larry, Karyn Schwartz, and Eric Lopez. "Estimated Cost of Treating the Uninsured Hospitalized with COVID-19." Kaiser Family Foundation. https://www.kff.org/uninsured/issue-brief/estimated-cost-of-treating-the-uninsured-hospitalized-with-covid-19/ Accessed 7 Apr. 2020