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Beyond the Spin, New Health Law and the Affordable Care Act (ACA)

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"We have not changed the fundamental problem with the health care system in the US...health care is treated as a commodity to be bought rather than as a good that all people need", writes Margaret Flowers

On the first day that the new health insurance exchanges went into effect as part of the new health law, the Affordable Care Act (ACA), I was caught off guard by a question asked by Bruce Dixon of the Black Agenda Report. I was prepared to detail the complexities of the ACA, but Dixon's only question was: "What would it be like if this was the first day of a single-payer health system?" Most media outlets in the US are solely focused on the ACA – either promoting it as a positive step or calling for its repeal. This limited debate misses the facts that a single payer health system, also called Medicare for all, would both resolve the fundamental failings of our current system and is the solution favored by most Americans.

What we are hearing in the US is fear-mongering from extreme right-wing groups, who have gone so far as to shut down our government in their attempt to remove funding for the health law, and deceptions from Democrats and their front groups about the virtues of the ACA. This is what happens when a basic issue such as health care is determined by politics instead of policy. In fact, the ACA was born in a right-wing think tank, the Heritage Foundation, and is only supported by "progressives" because it was passed by a Democratic president.

I suspect this manufactured confusion may sort itself out over time as more people discover that having health insurance in the US doesn't guarantee access to necessary care. In the meantime, I will try to cut through the spin and hyperbole to explain why the ACA is not a step in the right direction and what health care would look like if we implemented a publicly-financed "Medicare for All".

Here are the top three facts that need to be addressed:

- The rise of health care costs are slowing, but not because of the ACA.
- More people will have health insurance but that doesn't mean they will have access to health care.
- The ACA further privatises our health care system, which is the opposite of single payer.

White House spokesperson Jay Carney stated numerous times recently that the slowing of the rise of health care spending in the United States is a result of the Affordable Care Act. In fact, the slowing of total health care spending actually began after the economic crisis of 2008, which was prior to the ACA being signed into law in 2010. As I wrote earlier this year,

the slowing of health care spending was due to self-rationing. As more of the cost of health care is shifted onto the individual, we see less utilisation of health services.

For example, a recent report found that low-income workers with health plans that required high out-of-pocket payments in Massachusetts did not go to the emergency department for serious medical conditions because of the costs. They had 25 to 30 percent fewer visits, whereas high income workers with similar plans did not reduce their visits. A health survey from 2012 found significant increases in the number of people who did not get care because of the cost (80 million total), who had difficulty paying medical bills (75 million) and who went into bankruptcy as a result (4 million over 2 years).

It is not likely that the ACA will have a positive effect on health care spending, by which I mean making health care more affordable. As economist Dean Baker writes, we will continue to pay high prices for medications, medical devices and physicians. Although there are proven methods to control health care costs such as simplified administration, global budgets and negotiating bulk prices, none of them were included in the ACA. In fact, the ACA increases our already enormous administrative costs by adding new levels of administration to our health system.

While it is true that because of the ACA more people will have health insurance in the US, what is not discussed is that tens of millions of people will still be without health insurance of any kind. There are 48 million people without insurance and that number is expected to fall to 31 million in 2019. Although historically in the US, estimates of new coverage are always overblown. At the state level, similar new programs that were predicted to lead to universal coverage fell far short of their goals and ultimately failed completely. Even though, because of the ACA, young adults up to the age of 26 can stay on their parent's health plans, this has had only a tepid effect. The percentage of 19 to 26 year olds without insurance has fallen from 48 to 41.

Health insurance does not equate to healthcare

In the US, having health insurance does not guarantee access to necessary health care. The ACA will increase the number of people who have inadequate insurance which requires high out-of-pocket costs and does not cover all necessary services. This trend towards underinsurance has been growing steadily over the past decade so that currently about one-third of employer-based health insurance and half of individual plans are high-deductible plans. It is expected that in 2014, 44 percent of major US companies will only offer high-deductible health plans.

The ACA has significantly lowered the bar for what is considered to be adequate health insurance coverage. On the new health insurance exchanges, plans are offered based on four tiers. The Platinum plans will pay for 90 percent of covered care and Bronze plans, the lowest tier, will pay for 60 percent of covered services. It is important to distinguish that these levels are only for covered services because people don't usually understand that they will have to pay for uncovered services and out-of-network services. Unfortunately, the use of out-of-network services is often involuntary and occurs without being known at the time of care, especially in emergency situations.

Subsidies are being offered to help people purchase insurance. These exist on a sliding scale for people who earn 133 to 400 percent of the Federal Poverty Level (FPL). If an uninsured

person earns below 133 percent of the FPL and lives in one of the 26 states that did not expand their Medicaid programs, that person is likely to be out of luck. And the subsidies only apply to the Silver plans, which cover 70 percent, or to higher level plans. Because the subsidies are believed to be inadequate, it is expected that many people will choose the least expensive Silver or Bronze plans.

Subsidies can only be used to purchase plans in the state or federal exchanges. Employees will not qualify for subsidies to purchase insurance offered by their employer; but if what their employer offers costs above a certain percentage of their income, they can purchase insurance on the exchange and possibly receive a subsidy. Some employers will stop offering insurance and will instead provide what is called premium support, or funds that can be used for buying insurance. And some employers will decrease their employee's hours below the 30-hour per week threshold that relieves them from the mandate to provide insurance or pay a penalty. These actions will push more people into the exchanges.

Pre-existing caveats

Insurance companies have a long history in the US of skirting regulations that interfere with profits. So, while insurers can't exclude sick people, they can avoid areas where there are sick people. For example, several of the large insurance companies are selling plans on only a small number of exchanges, preferring to sell plans mostly to businesses instead. And companies that sell plans on the exchanges are restricting their networks. They avoid hospitals that care for complicated patients and keep the number of doctors in their plans low, making it more likely that people will have to go out of network and pay more of the costs of care.

And while companies can't charge more to people with health problems as individuals, they can charge up to three times more based on age and can charge more in geographic areas where the population has more health problems or the costs of care are higher. It is expected that if a company finds they can't make enough profit in a particular area, they can just pull their plans from that area. These are some of the most obvious ways that insurers will game the system. The largest insurance companies assisted with writing the law and then with the regulations that accompanied it, so we will see what other tactics they employ as time goes on.

The new health system is complex by design because that inhibits transparency and accountability. Imagine what we would be seeing right now if instead of the ACA, we had passed HR 676, also known as Expanded and Improved Medicare for All. This would have created a single publicly funded non-profit universal and comprehensive national health insurance. Overnight, everyone living in the US would be eligible for care without financial barriers. Any person who showed up to a health facility for care would be admitted because they would be automatically enrolled. Every person would have the right to receive the care they need rather than the care they can afford.

Some people believe that the ACA is a step towards a Medicare for all health system, but it actually takes us towards greater privatisation of our health system which is the opposite direction. Over a trillion dollars of public funds will go directly to private insurance companies to subsidise the purchase of inadequate health plans. Nothing was done to stem the tide of large health corporations that are acquiring and consolidating health facilities. And since the ACA was passed in 2010, our public insurances, Medicaid and Medicare, have become more privatised. Private Managed Care organisations are taking over Medicaid

plans. And Medicare Advantage plans, private insurance plans that are more expensive than traditional Medicare, were supposed to be curtailed by the ACA but have actually grown by more than 30 percent.

We have not changed the fundamental problem with the health care system in the US: that health care is treated as a commodity to be bought on the market rather than as a good that all people need. In fact, the dominant message in the mass media is that the ACA has created a health insurance marketplace as if this is a good thing for patients. The United States is the only industrialised nation that uses a market-based health system and it has clearly failed. The US spends the most by far on health care and has low life expectancies and poor health outcomes to show for it. I often say that if our health system was a medical experiment, it would have to be stopped for ethical reasons.

Perhaps television comedian Jon Stewart summed it up the best when he recently said, "I don't understand the idea of staying with a market-based solution for a problem where people can't be smart consumers. There are too many externalities in health care that I honestly don't understand, why businesses would jump at the chance to decouple health insurance from their responsibility, and why the government wouldn't jump at the chance to create a single-payer that simplifies this whole gobbledegook and creates the program that I think America deserves."

Only a single payer, Medicare for all health system will begin to correct the many problems with the health care system in the United States. Grassroots groups across the country continue to organise support for Medicare for all. And just as similar groups did in Canada and Mexico, we believe that one day we will succeed as well. We aspire to join the ranks of civilised countries who understand that a healthy population makes a better society and is best achieved through national health insurance.

Margaret Flowers, MD, served as Congressional Fellow for Physicians for a National Health Programand is on the board of Healthcare-Now. She is co-director of It's Our Economy and co-host of Clearing the FOG Radio Show.

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