Health Care: Access and Coverage

Date: Thursday, November 29, 2012 5:30p.m.
Location: The Museum of Northern Arizona

Facilitated by: James Joiner and Dr. Jason Matteson

5:30 p.m.  Welcome and Introduction
Dr. Heidi Wayment, Director of NAU’s Compassion Project and Psychology Department Chair
Andrea Houchard, Director of Philosophy in the Public Interest

5:45:  James Joiner and Dr. Jason Matteson, NAU Philosophy Department
-What exactly is universal healthcare?
-How is the U.S. healthcare system characterized?
-How does the U.S. healthcare system compare to other countries’?
-What are the moral, legal, economic and political questions?

6:50:  Recap of discussion
Universal Healthcare

Universal health care is the systematic establishment of ensuring that all citizens have access to affordable, high-quality medical care. It takes many forms around the world. In structure and funding the unifying principle is governmental regulation, mandate, or legislation. The population provides funding for universal health care through compulsory health insurance, taxation, or some combination. The patient may pay some health care costs and the universal health insurance program may cover some health care costs. In some universal systems, the government may manage the health care system, but in many instances the health care system uses both public and private health care providers.

Pros

The appeal of universal healthcare is providing coverage and accessibility to those who may otherwise be ineligible or excluded. Many have argued that healthcare is a right, citing sections from the U.N.’s Universal Declaration of Human Rights, the Preamble of the U.S. Constitution, and even the Declaration of Independence. Others argue that universal healthcare would promote entrepreneurial and economic activity in America. Some have suggested that healthcare is a civil right, one that should be of equal opportunity. Another argument is that the financial burden of medical bills on the uninsured or uninsurable is too great to bear, and should be shared.

Cons

The burden of sharing the cost for universal healthcare is one that many oppose, and maintain that health care is a matter of individual responsibility. One view is that universal healthcare is incompatible with the free market, and perhaps represents a movement towards socialism. A further criticism suggests that it would exacerbate the government deficit and that the administration would fail to provide adequate health services. Universal healthcare in Canada is criticized for its long wait times, which cause those with serious ailments to receive insufficient care in time.

Healthcare in the U.S.

There are private and public funders and providers of healthcare in the U.S. Because of this it is difficult to pinpoint the nation, since there is not one national system. Additionally, in both the private and public sectors medical services are generally regarded as high quality. The Medicare and Medicaid programs make up the largest federal portion of the American healthcare system.

Medicare

In 1965, President Lyndon B. Johnson signed the Medicare and Medicaid amendments to the Social Security Act, and both have been expanded since. Eligibility for Medicare extends to Senior Citizens—that is, 65 and older—and certain people under 65 with a disability. Medicare is funded by two trust fund accounts held by the U.S. Treasury. In 2011, Medicare covered 48.7 million people and total expenditures were $549.1 billion. The Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) trust funds can only be used for Medicare, and the two partition the healthcare and administrative expenses. The HI trust fund is funded by payroll taxes paid by most employers, employees, and the self-employed as well as through income taxes paid on Social Security, and Medicare Part A premiums paid by those ineligible for premium-free Part A. Medicare Part A pertains to Hospital Insurance benefits which include home health care, hospice care, skilled nursing facility care, and inpatient hospital care. Both of these trust funds acquire interest earned from trust fund investments and both contribute to Medicare program administration including costs for paying benefits and for combating fraud and abuse. Unlike the HI trust fund, the SMI is funded by premiums from those enrolled in Medicare Part B (Medical Insurance) and Medicare Part D (Prescription Drug Coverage), as well as those funds authorized by Congress. As indicated, SMI funds are allocated to Medicare Part B, which encompasses medically necessary services and preventive services, in addition to Part D. The Medicare Advantage plan (Part C) is a type of plan with a private contract which contracts with Medicare to provide Part A, Part B, and sometimes Part C benefits. The ‘traditional Medicare’ plan is a single payer health care plan, which encompasses Parts A and B, while Part C embodies the network plan.

Medicaid

Medicaid provides healthcare to those with low income and few assets. This includes all Americans under 65 with incomes up to 133% of the federal poverty level. In 2009 the cost of Medicaid was over $366 billion, split between federal payments of $243 billion and state payments of $123 billion. States manage this revenue individually, and have a greater degree of leeway in designing their Medicaid programs. Accordingly, there is great variation across the country over who is eligible for Medicaid, what services are covered, and how much doctors and hospitals will be paid for treating Medicaid patients.

Medicaid recipients theoretically have access to a comprehensive package of health services and receive healthcare services through the same public and private hospitals that serve the general public. However, as is increasingly the case with Medicare, in reality their access to private physicians is often limited by Medicaid’s generally very low payment rates, thus making healthcare providers unwilling to take on Medicaid patients. States are likely to provide Medicaid through the private insurance market using managed care plans.

The Patient Protection and Affordable Care Act “Obamacare”

On March 23, 2010, President Barack Obama signed the Affordable Care Act, a bill to reform healthcare in the United States. The law was recently brought before the Supreme Court, which determined the act constitutional as Congress ratified it, and upheld the mandate as a tax. The ACA establishes that no insurance provider can deny coverage to citizens with pre-existing conditions as an extension of American Healthcare accessibility, while simultaneously establishing penalties for individuals who lack coverage. The ACA establishes much regulation to assess accessibility and ensure universal care for citizens and lawful residents. The expansion of Medicaid eligibility comes as a set of reforms, allowing dual eligibility for Medicaid and Medicare to be much more refined. Another facet of the act stipulates that insurance issuers must provide coverage for preventative health services. The act also establishes dependent coverage, in which children may be covered under their parent’s health plan until 26 years old, or married. The prohibition of discrimination based on salary section of the act ensures that higher-wage employees will not be favored over any lower-wage employees in any context. The act establishes several levels of transparency for the health care consumer and the chosen healthcare provider, as well as extending reinsurance to early-retirees, ages 55 – 64, who are not yet eligible for Medicare. The Affordable Care Act includes a multitude of explicit ‘improvements’ to the American healthcare systems of Medicare and Medicaid, typically aimed at ensuring transparency and accessibility for all citizens and lawful residents.

The Numbers: 2011 Statistics

Public/Private Coverage

The Census Bureau reported in 2011 that people with health insurance made up 84.3% of the population. In the same report, Medicaid covered an estimated 16.5%, and 15.2% were covered by Medicare. Those with private insurance made up 63.9%, which was statistically equivalent to the numbers acquired in 2010.

Coverage Distribution

The Centers for Disease Control and Prevention estimated that in 2011, approximately 15.7% of Americans were uninsured. At the same time uninsured rate was approximately 11.1% among non-Hispanic Whites, 19.5% among Blacks, 16.8% for Asians, and 30.1% among Hispanics. In 2010, 41% of American Indians and Alaska Natives had private health insurance coverage. 36.7% of AI/ANs relied on Medicaid coverage. 29.2% of AI/ANs had no health insurance coverage in 2010.

When the U.S. Supreme Court upheld the Affordable Care Act, Sarah Palin tweeted, ‘Obama lies, freedom dies.’ She’s referring, I guess, to the freedom to go without health care when you’re sick. —Richard Trumka

Obamacare comes to more than two thousand pages of rules, mandates, taxes, fees, and fines that have no place in a free country. —Paul Ryan

Hot Topics Café, Thursday, November 29, 2012
Canada: Single Payer

In an analysis done by the Institute for the Study of Civil Society, it was found that Canada often suffers from the problems associated with a single-payer (government) healthcare model. Accountability and transparency are poor and aggravated by the federal structure. Additionally, decision-making is politicized and single-payer government control leads to a lack of innovation. This adds up to a lack of responsiveness to patient needs or wants, and some overly aggressive cost cutting and delays in quality improvement. However, the single-payer and provincial management structure cuts administration costs because bills go straight to the provincial government rather than via the patient or insurance company. As a result Canada only spends 2.4% of its total health care costs on administration compared to 7% in the USA.

The Canadian Health Act of 1984 defined several important principles of Canadian Medicare, which includes the explanation of accessibility. It specified that there should be reasonable access to services, not impeded by user charges or extra billing. One of the criticisms of the Canadian healthcare system is the speed of access, A 2005 Healthcare in Canada survey by the public opinion research firm POLLARA shows that 49% of the public said they would be willing to make out-of-pocket payments to purchase faster access to health care.

In terms of coverage, Canadian healthcare is universal; 100% of provincial residents are entitled to the plan. As for prescription drug coverage, the Fraser Institute think-tank has been highly critical of the poor coverage of new drugs. Of all the new drugs approved by Health Canada between 2004 and 2009, the average coverage rate across provincial drug programs was less than 23%, which favored the 83% coverage under private drug plans in the same period. All things considered, Canada achieves universal coverage for less money than America spends on only a portion of its population.

Switzerland: Hybrid

The Swiss healthcare system aims at upholding both the principles of universality and equality by mandating people to purchase healthcare plans on the private market, and providing financial assistance to those with lower income. Additionally, the government regulates the insurance market in order to protect individuals with poor health.

The Swiss government requires people to purchase a “basic-package” determined by the Federal Office of Public Health or face a penalty. The basic-package defines the type of healthcare that all citizens can expect to receive, including emergency treatment, basic examinations, maternity costs, limited dental service, and abortion. Those covered only by the basic-package are have access to certain specified providers and facilities. They can only receive treatment in hospitals in their canton of residency and those accredited to receive reimbursement for basic packages. A basic-package should be medically and cost effective. Beyond the basic-package individuals are still allowed to purchase supplementary insurance to fund additional health care, but the same regulations do not apply with regards to open enrolment, for-profit status and premium variations.

This system is funded primarily (60%) by taxes. Individuals pay the balance of the premium. Those who cannot afford the deductible are permitted to apply for government assistance. Insurers are regulated in three ways: (1) the government requires that they adopt an “open-enrollment” policy (no person who applies can be turned away); (2) insurers cannot vary premiums based on the health of the customer; (3) insurers cannot profit from providing basic coverage (as determined by the basic-package). In other words, the cost of basic health-care cannot exceed the costs of carrying out the services as determined by individual residencies. So long as these requirements are met, insurers may vary their offerings in competitive markets.

Examples of Other Systems

Moral, Legal, Economic and Political Questions

Moral

Do people have a moral right to medical care regardless of citizenship or economic status?

Are there different moral obligations to different populations? Children? Young adults? The disabled? The elderly? The incarcerated? Veterans?

Should publically funded care be extended to medical problems that individuals might have avoided?

Political

Whose political interests are actually most influential in shaping medical care?

How does an adversarial political system affect choices about health care?

What roles should experts play in discussions of medical care? Which experts are the most relevant?

If medical access and coverage must be rationed, on what basis should limitations be justified?

I believe that free-market principles will solve our healthcare problems.  
—Rick Scott

Because of the president’s leadership, every American will have access to affordable, quality health care.  
—Rahm Emanuel

“IT is health that is real wealth and not pieces of gold and silver.”  
—Mahatma Gandhi

“If we could give every individual the right amount of nourishment and exercise, not too little and not too much, we would have found the safest way to health.”  
—Hippocrates

Attention to health is life’s greatest hindrance.  
—Plato

SOURCES

http://www.medicare.gov/  
http://www.whitehouse.gov/healthreform/healthcare-overview#access  
http://healthcare.procon.org/#pro_con
Hot Topics Café Community Committee

The “hot topics” in the Hot Topics Cafés are selected by NAU students that represent diverse constituencies and viewpoints. We thank our committee for their participation.

Flagstaff
*Allan Affeldt, Owner, La Posada; Founder, Winslow Arts Trust; Former Mayor, City of Winslow; Museum of Northern Arizona Board Member, Arizona Town Hall Board Member, Arizona Citizens for the Arts Board Member
Diana Arendt, County Chairwoman, Coconino County Republican Committee
*Scott Deasy, Deacon of Epiphany Episcopal Church, semi-retired OB/GYN
Coral Evans, Flagstaff City Council
Jean Friedland, Compassion Project, Northern Arizona University
*Patty Garcia, Coconino Community College District Governing Board, Nuestras Raices, Raymond Educational Foundation Board
Ken Lamm, Flagstaff Community Foundation
*Stephanie McKinney, Chair, Flagstaff 40
*Jerry Nabours, Flagstaff Mayor
*Wayne Ranney, Geologist, Author, Museum of Northern Arizona Board Member, Grand Canyon Historical Society, Flagstaff Festival of Science Board of Directors
Craig Van Slyke, Dean, NAU Franke College of Business
John Stark, General Manager, KNAU
*Michael Vincent, Dean, Northern Arizona University College of Arts and Letters
*Harriet Young, First Vice Chair of the Arizona Democratic Party, Arizona Town Hall Member, Member of the Museum of Northern Arizona, Member of the Arboretum at Flagstaff, President of American Association of University Women Flagstaff Branch, NAU Department of Politics and International Affairs since 1992

Sedona
Rob Adams, Mayor of Sedona
Carol Gandolfo, President, Verde Valley Republican Women
*Jane Hausner, Executive Director, Verde Valley Sanctuary
*Tom O’Halleran, Arizona Republican Senator 2007-2009; President, Keep Sedona Beautiful; Chair, Verde River Basin Partnership; Citizens Advisory Board, PBS
Alicia Magal, Rabbi of the Jewish Community of Sedona and the Verde Valley
John Neville, President, Sustainable Arizona, Lead, SEDI Sustainability in Education & Green Business Network
*Judy Reddington, Northern Arizona University College of Arts and Letters Advisory Council; Museum of Northern Arizona Board Member, Philosophy in the Public Interest Advisory Board, Sedona Community Plan, Sedona International Film Festival Board Member
Steve Williamson, President, Democrats of the Red Rocks

Ex officio
Robert Breunig, Museum of Northern Arizona
Kathy Farretta, Museum of Northern Arizona
Andrea Houchard, Philosophy in the Public Interest
Jerome Thailing, Osher Lifelong Learning Institute, Yavapai College
Julie Piering, Philosophy Department
Scott Sanicki, Sedona Public Library
John Tannous, Coconino Center for the Arts

*Voted to select “hot topics” for the Fall of 2012.

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Next Flagstaff Hot Topics Café
Is Freedom Threatened By Equality?
Facilitated by: Dr. Christopher Griffin, NAU Philosophy Department Chair
Date: Wednesday, December 5, 2012
Location: The Museum of Northern Arizona

You are also invited to attend Hot Topics Cafés at NAU’s Green Scene Café and in Sedona. Visit nau.edu/ppi for a schedule.

This informational handout was prepared by the Kyle Beloin and Coren Frankel, NAU Hot Topics Café Student Research Directors. Both Kyle and Coren have double majors in philosophy and political science at Northern Arizona University.
2011 Statistics—Public/Private Coverage

Source: The Census Bureau

- Medicaid: 16.5%
- Medicare: 15.2%
- Private insurance: 63.9%
- Uninsured: 15.7%
Source: The Centers for Disease Control and Prevention