Cover Me
by Dan Jacoby

One of the promises Barack Obama made (sort of) when campaigning for President was to create a system where everyone could get decent healthcare at an affordable price. This promise is nothing new; President Truman tried to accomplish it sixty years ago, and we're still far from managing it.

One major problem lies in the complexity of the issue, and in the fact that the medical practice, for all of the science underlying it, is still far from being a complete science. Diagnosing ailments is often a matter of guesswork, or at least educated guesswork. Once a diagnosis is made, deciding on a treatment is often a judgment call, based as much on a doctor's (or patient's) hunch as on science.

Add to the mix the various special interest groups that spend a lot of money protecting the money involved in their particular special interests. Then top it off by the fact that most patients have no real training in medicine, or understanding of what is really going on inside their own bodies.

The fact that the result only occasionally approaches chaos is something of a miracle. Unfortunately, the chaos that frequently occurs makes finding a complete solution to the entire healthcare coverage system practically impossible.

Once we accept that a complete solution is impossible (for now), the next step is to cobble together a solution that works pretty well, and allows for enough flexibility to adapt not only to new ideas for improvement, but also to changing circumstances in the medical field. Right now, there seem to be two basic concepts, neither of which seems to work particularly well.

The first concept is private insurance, usually paid for by employers. The obvious drawbacks to this concept include the problems when employees change jobs, or lose their jobs, as well as how to include those people who have no jobs. For those people, there are a variety of methods available, including COBRA and other private groups that bargain for lower costs for individual members. Unfortunately, these options only provide a partial solution at best, often at a cost too high for most people who need it to afford. In addition, they fail to provide needed security in an increasingly insecure job market.

Another drawback is that private insurance companies are trying to make a profit. Following this ultimate goal, these companies will often refuse to pay for needed medical care, using whatever excuses they can invent. As a result, many people who believed their insurance providers would pay their medical costs are forced to pay for needed, though expensive, procedures. Other people who are aware that they will have to pay choose to forgo needed procedures and medicines because they don't have the money.

The final drawback is that it adds to the cost of labor, driving jobs overseas. If a business must provide healthcare coverage for their employees, the cost of adding an employee includes the cost of that employee's healthcare coverage. As a result, many businesses are either dropping healthcare coverage, or hiring overseas where healthcare coverage is either nationalized or nonexistent.

The second concept is government-funded medical coverage. There are some advantages to this concept, most notably that there is no need for a company to make a profit, and also the potential for far lower administrative costs, such as those currently borne by Medicare. Many people are pushing for some sort of “single-payer” system, where the federal government is the single payer. Most single-payer plans involve expanding Medicare to cover all Americans. This would initially eliminate huge sums spent on administrative costs for private insurers, as well as both private insurers’ advertising costs and the money that goes into the profits those companies make.

There is a view that a single-payer system would pay for itself by saving money in two areas. The first area is the administrative cost savings and the elimination of corporate profits. The second area involves the cost of many uninsured people who use emergency wards, either for minor ailments, or for minor problems that went untreated and became true emergencies. The belief is that those savings would pay to cover everyone who is currently uninsured.

There are, of course, problems with a single-payer system as well. For one thing, who decides how much is paid for various procedures? Different doctors charge different fees, based on a variety of circumstances; how are those fees kept to a “reasonable” level – and who decides what is reasonable? Who decides whether a hospital needs a new gadget, or should offer a certain new procedure?

There is also the problem that occurs when people who don’t have to bear any of the cost of tests and procedures demand those tests and procedures “just to be safe,” even when they are totally unnecessary. Medical professionals, and especially organizations formed to represent them, also tend to make recommendations based less on what kind of medical care is truly needed, and more on what will make more money for the organizations’ members. For example, the generally accepted concept of the annual checkup is now believed by many medical professionals to be unnecessary in many cases, but the AMA still blindly recommends it for everyone.

Meanwhile, although Medicare currently has low administrative costs, this is at least partially a result of having to compete with both public opinion and private insurers. If Medicare were the only option available, it is virtually certain that bureaucratic red tape would only increase over time, and those costs would soon overwhelm the system.

Finally, we have no idea what “the practice of medicine” will look like in a generation. What new procedures, diagnostic measures, treatments, and other breakthroughs are in store, and how will we deal with them?

We need a system that relieves the burden on employers, eliminates as much fraud and waste as possible, preserves low administrative costs, preserves some sense of marketplace-type competition, and maintains the flexibility to adapt to changes within the field of medical care. Following is one concept that just might work.

In every section of the country, the federal government should establish two or more competing, nonprofit organizations that offer healthcare coverage to everyone, regardless of existing health conditions or financial situation. These companies would compete in many areas, although the federal government would provide minimum standards for medical care and general guidelines for when procedures are needed, based on panels of medical experts, and nearly all of the funding. Additionally, local panels of medical experts would oversee each nonprofit to ensure that it provides sufficient medical care for its members.

Everyone would be required to choose from among the available nonprofits (which cost almost nothing), or select from a private, for-profit insurer that meets minimum standards of coverage. Private insurers would also be allowed to provide supplemental coverage for costs not covered by the nonprofit insurers; these costs would be in two areas.

The first area is that of unnecessary, elective procedures, including (but not limited to) age-masking procedures like facelifts, or procedures to “correct” various perceived physical imperfections that have no medical or societal consequences. The second area not covered by the government-funded nonprofit insurers is needs-based co-payments.

In order to minimize unnecessary procedures, people would be required to make a small co-payment for all doctor visits, surgeries, prescription drugs, etc. These co-payments would be based on two factors – the cost for such medical care and the patient’s ability to pay. As a result, nobody would be denied needed care based on their financial situation, but people would not seek, and doctors would not be pressured to provide, unnecessary medical coverage because it’s free.

Since the co-payments for wealthier people would be larger, and sometimes quite substantial, some wealthy people would want to insure themselves against having to make large co-payments. Private companies would certainly fill that demand.

Once the ultimate goal is set, the next step is to determine how to get there. Whatever system of universal healthcare coverage we select, it will not be implemented overnight; implementation will take years to complete.

Since various government programs, such as Medicare, Medicaid, the recently expanded SCHIP program, not to mention many other state and local programs, already cover millions of Americans, it stands to reason that they should be the first to be covered under the new system.

This first step has the political advantage of garnering right-wing support from those who have been accused in the past of trying to privatize Medicare, while being supported from the left because it is merely the first step on the road to universal healthcare coverage. It has the economic advantage of costing no more in tax dollars than the current systems, and may save money, as the massive Medicaid fraud and waste we’re constantly being told about would be eliminated.

Once the new nonprofits are already covering everyone who is already getting their healthcare coverage from the government, we can then expand them to cover everyone else, except those who choose to remain with profit-making insurance companies. We might even be able to move into this area before completing the first step.

Finally, there is the question of how to pay for this government program. Currently, the largest cost of healthcare coverage is borne by companies, so it stands to reason that they could most easily bear the cost of the new program. By raising corporate tax rates, or closing corporate tax loopholes, we can raise the additional money needed.

While business groups may object at first, they have little to complain about. Those companies that currently cover their employees, either completely or to a large extent, would actually save money under this plan, since they would no longer bear the direct cost of providing medical insurance. Only those companies that currently do not provide healthcare coverage for their employees would have to pay more. In other words, this plan levels the playing field between “responsible” and “irresponsible” companies.

In addition, no company can complain that they cannot afford the new cost, since the new corporate tax would only be levied on corporate profits. Under this system, only companies that make a profit would have to pay; those companies operating at a loss would be off the hook.

There are many details to be worked out. For instance, how are the new nonprofits set up, and who runs them (and how)? How are panels created to determine what medical procedures are covered? Who chooses the panels' members, and how often are the panels' members changed? How are the levels of government payments to the nonprofits determined, and how often do they change as various elements of the medical profession change and evolve?

And who pays for research? After all, without robust research and development, there will be little reason for the medical arts to advance.

There are other steps that should be taken, such as consolidating forms. If everyone used the same set of forms, it would reduce administrative costs and mistakes.

This is far from a complete plan. It is, however, a plan with the potential to solve many current economic and social problems. It can raise our level of medical coverage, save money, create new jobs, improve our health, raise our standard of living, and help America compete in the 21st century global economy.

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