Health Financing Challenges and Proposed Action Steps in the USA

Introduction

The United States of America is a high-income country with a gross domestic income 20.937 trillion in 2020 which fell from its peak of 21.433 trillion in 2019 (World Bank Open Data, 2019, 2020), making it the wealthiest country in the world at the time in which Covid-19 strained health care systems around the world. The corresponding GDP per capita was 63,543.6 and 65,279.529, respectively. The total population was 329,484,123 in 2020, with 50.518% of the population being female and 49.482% of the population being male. Additionally, 64.997% of the population was reported to be of working age (ages 15-64), with 54,796,260 people above 65. In 2019, current health expenditures (CHE) accounted for 17% of GDP, and CHE per Capita in the US was $10,921 (WHO Global Health Expenditure Database, 2019).

In the early 1900s, the Progressive Party, headed by Teddy Roosevelt, supported health insurance as part of the party platform (Kaiser Family Foundation, 2010). The former president and party were aware that other countries such as Germany, France, and Britain had established programs to provide financial protection in cases of old age, illness, injury, and unemployment (NY Times). In the United States, employer-sponsored health insurance began in the 1920s and became increasingly popular after World War II "when the government-imposed wage controls and declared fringe benefits, such as health insurance, tax-exempt" (Tikkanen et al., 2020). Although President Truman attempted to establish a national health program, the Red Scare, along with fear of a federal role in health, may force desegregation in the South, resulting in the blockage of proposed legislation (Kaiser Family Foundation, 2010). The popularity of private insurance rose in the middle of the 20th century, and private insurance was able to set premiums, making it difficult for retired and disabled Americans to get coverage, which the Social Security Act of 1965 attempted to resolve. With President Johnson's signature in 1965, the Social Security Act established Medicare and Medicaid without cost controls or physician fee schedule regulations (Kaiser Family Foundation, 2010), which remains the most comprehensive health care reform legislation until the ACA in 2010.

Universal coverage in the United States would entail a system in which all Americans have access to affordable and quality health services without going into financial ruin, which has not been achieved in the USA. The current health system includes public and private for-profit and non-profit providers and insurers, although private insurance through employment is the

most common form of coverage. The government provides regulations while private, and public insurers control benefits packages and cost-sharing structures (Tikkanen et al., 2020). Federally funded programs include Medicare and Medicaid (and Children's Health Insurance Program), which state governments manage.

The United States federal government operates in three branches: legislative, executive, and judicial. For federal health legislation to be enacted, it must be passed by the legislative House of Representatives and the Senate. The political landscape of the United States makes health care legislation difficult to pass due to the partisan divide in ideology. For Medicaid, which is funded by states and the federal government, federal funding was commonly rejected in states under Republican control (Rocco, 2019).

Public Health Insurance

The Social Security Act of 1965 established Medicare and Medicaid and public health insurance for Americans. In addition to these two programs, the federal government funds the Indian Health Service, which provides health coverage to 2.6 million indigenous peoples in 37 states. Additionally, the federal taxes fund health care coverage for military personnel and their families through the Veteran's Health Administration and TRICARE.

Medicare provides health care to Americans over 65 and those with long-term disabilities and end-stage renal disease (adopted in 1972). It is a fee-for-service-based program divided into four parts. Part A provides hospital insurance, Part B provides medical insurance, Part C (1973) allows for coverage through Medicare Advantage, and Part D (2003) is prescription drug coverage through private carriers. Part C allows Medicare enrollees to receive care through a private health maintenance organization (HMO) or managed care organization. Those who choose to drop their Medicare coverage after being covered can not get it back until the following January and may have to pay a fee to reinstate coverage (US Department of Veteran Affairs, 2021).

Medicaid is administered at the state level but receives federal funding to provide health coverage to low-income families, the blind, and individuals with disabilities. Low-income families and individuals have eligibility determined on a state-by-state basis and are required to enroll annually via an application. It currently covers nearly 20% of Americans. In some states, CHIP operates as an extension of Medicaid and independently in others. The program serves families that cannot qualify for Medicaid but can not afford private insurance, covering about 9.6

million children. Because states are responsible for setting eligibility, patient-cost sharing, and benefits packages for Medicaid and CHIP, the programs differ between states.

Private Health Insurance

Most Americans (67% in 2018) use private health insurance as the primary means of coverage. Private insurance can be purchased individually, but most Americans using private insurance are on an employer-sponsored plan from non-profit or for-profit insurers. In the case of most Americans who use private coverage, benefits packages are contracted between employer and insurer, and employees are given the choice of different plans, with premiums funded by employers and employees. This means that in the case of most Americans, health insurance is linked with employment. There is no national standard in terms of benefit packages, and vision and dental may or may not be included.

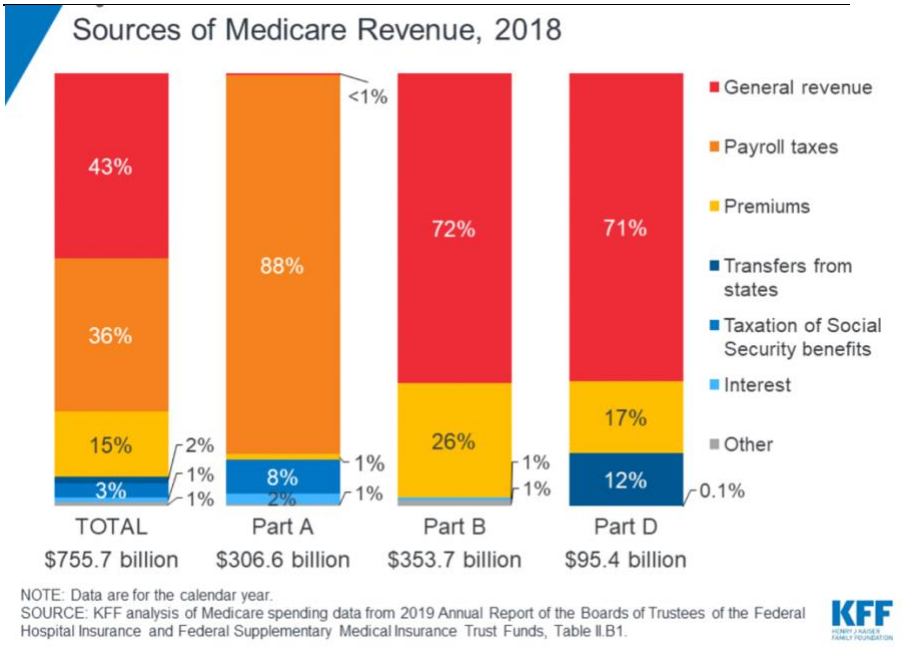
The ACA requires ten essential health services to be covered under the benefit package for private health insurance purchased individually. This does not include elective or non-essential treatment (Turbat, 2021).

Revenue collection, risk pooling, and purchasing

Since most Americans receive their health coverage through private insurance, revenue collection and risk pooling are done by private companies. Through employer-sponsored health plans, employers and employees contribute towards revenue collection in the form of a premium. Risk is then effectively pooled for all insured by the company (Understanding Health Insurance, 2021). For public insurance programs, the government (both federal and state) contributes to the revenue collection. In the case of Medicare, revenues are collected by general federal government revenues, payroll taxes, and beneficiary premiums. The sources of revenue depend on what Part (A, B, or D). In the case of Part C, which typically includes all three other parts, financing comes from the specified sources for each Part (Cubanski et al., 2019). Medicaid, which the federal and state governments finance, is sourced from state general fund appropriations, but states are given the flexibility to finance the program. Through the Federal Medical Assistance Percentage, the federal government matches state spending 1-to-1, and the ACA heightened match rates for the costs of newly eligible enrollees (Snyder & Rudowitz, 2015).

Figure 1

Sources of Medicare revenue, 2018.



Note. Sourced from Cubanski et al., 2019

Out of pocket spending (OOPS) as a percentage of current health expenditures was 11%, and OOPS per Capita was $1,235 in 2019 (WHO Global Health Expenditure Database, 2019). Of the approximately third of all US physicians that make up primary care, about half worked in physician-owned practices. Most purchasing (66%) was through fee-for-service payments but also included capitation for some private and public insurance programs (Tikkanen et al., 2020). In terms of hospitals, most accept Medicare/Medicaid, and services are purchased through diagnosis-related group rates (DRG), per diem, and cost-reimbursement. The most common form of hospital payment for private insurers is per diem (Tikkanen et al., 2020).

Administrative costs can consist of coding and billing staff in charge of coding the services provided and charging patients a copayment either at the time of service or afterward. Some insurance requires patients to pay and receive reimbursement for services afterward (Tikkanen et al., 2020). Since providers (ex: outpatient specialists) are free to choose what insurance they accept, some do not accept Medicaid/Medicare patients or occasionally any form of insurance (only accepting cash).

The WHO recommends strategic purchasing of health services to achieve universal health care goals and defines strategic purchasing as when

> *allocations are linked…to information on provider performance on health and the population they serve, with the aim of realizing efficiency gains, increasing equitable distribution of resources and managing expenditure growth (WHO, 2021).*

Strategic purchasing answers the questions of what, from whom, and how to buy health services to respond to the population's needs, deliver services effectively, and incentivize health outcomes through rates and contracts while monitoring compliance (WHO, 2021). The United States system of fee for service is not an example of strategic purchasing as providers are not incentivized to provide preventative care and per diem payments allow providers to make more money when patients have more extended hospital stays. Shifting towards and capitation system of payment would incentivize providers to take on a larger number of patients since the number of patients determines payment and incentivize providers to provide preventative and healing care.

Patient Protection and the Affordable Care Act

In the case of the Affordable Care Act, the Democratic Party held the House and Senate, in addition to the Oval Office. The partisan divide and resulting difficulty of passing health care legislation was seen in the 2010 midterm election when the Republican Party gained control of the House of Representatives and voted to repeal the ACA, only to fail due to the Democrat-controlled House (Levy, 2021). The judicial branch's role came into play during 2012, in which the Supreme Court ruled that the individual mandate, requiring all Americans to have health insurance, and Medicaid expansion if adopted by states, was constitutional (Levy, 2021). The party platforms, which are, in essence, the repealing and the expansion of the ACA, divide the country on future health care legislation at the federal level (JAMA Network).

The Affordable Care Act aimed to increase access to affordable and quality health insurance and reduce health care spending via consumer protections, regulations, subsidies, taxes, and insurance exchanges. Before the ACA, it was estimated that 20,000 to 44,000 Americans died annually from lack of health insurance, 38 million had inadequate health insurance, and 15% were uninsured (Turbat, 2021).

Table 1

Role of the government and ACA responsibilities.

Role of federal government	Affordable Care Act
Legislation and national strategy	Requirement of health insurance or payment of a penalty
Administration and funding for Medicare	Allowing young adults to remain on parents' private plans until the age of 26
Funding (in conjunction with states) and regulation Medicaid	Opening of health insurance marketplaces with subsidies
Funding (in conjunction with states) CHIP	Expansion of Medicaid eligibility with federal subsidies
Funding health insurance for federal employees, military (and military families)	Stopping insurance companies from denying coverage based on health status, dropping patients when sick, and unjustified rate hikes
Regulation pharmaceuticals	Preventing gender discrimination
Overseeing federal marketplaces for private health insurance	Right to rapid appeal of health insurance company decisions
Providing subsidies for private marketplace coverage	Establishing 10 essential benefits
	Requiring large companies to insure employees and giving tax breaks to small businesses

Note. Adapted from Tikkanen, et al., 2021 and Turbat, 2021

The ACA can be considered a necessary step toward UHC in the United States as it decreased the number of Americans who were uninsured from 15% in March 2014 to 13.4% in April 2014. The American people desired the ACA by the 8 million Americans who enrolled in a marketplace plan in 2014. In addition to subsidizing health plans for the 15% of uninsured Americans, it required businesses to insure employees and provided tax breaks to small businesses. It also made health insurance accessible to those with preexisting conditions. The legislation also prevented Americans from losing their insurance when sick or making an honest mistake on the application and stopped insurance companies from denying coverage based on health status. This reduced the number of Americans that could lose their existing health insurance. Regarding financial accessibility to health insurance, it banned insurance companies

from making unjustified rate hikes that would prevent individuals from continuing coverage. The ACA effectively made the responsibility for health insurance coverage a shared responsibility between the federal government, state governments, insurers, employers, and individuals, relieving the burden from just the individual and increasing the stakeholders in the goal to insure Americans.

To ensure the quality of care needed to achieve UHC, the ACA required ten essential health benefits offered at no dollar limit. These primary benefits provided that Americans with insurance would have access to care for necessary health services. This was important for the 38 million Americans who had inadequate health insurance before the ACA.

Table 2

ACA essential health benefits.

1	Ambulatory patient services	Outpatient care, home health services, hospice care
2	Emergency services	Care for conditions that may cause disability or death without treatment
3	Hospitalization	Inpatient care, nursing home care
4	Maternity and newborn care	During pregnancy, labor, delivery, post-delivery, newborn care
5	Mental health services and addiction treatment	Inpatient and outpatient, evaluate, diagnoses, treat mental health or substance abuse disorder
6	Prescription drugs	Medications prescribed by doctors
7	Rehabilitative services	Help recovering skills lost and developing skills (habilitative)
8	Laboratory services	Testing to help in the diagnosis
9	Preventative services	Wellness and chronic disease treatment
10	Pediatric services	Care for infants and children

Note. Turbat, 2021

The ACA is inadequate in achieving UHC in the USA because there are still Americans who do not have health insurance and job loss is the most significant factor to health insurance loss. This is especially prevalent as many Americans lost their jobs during Covid and effectively lost

their insurance coverage. In regard to future action to move towards UHC, poor working-class families should be the focus of legislation as they are the most likely to be uninsured.

Current State of Coverage

As of 2018, 8.5% of the population (27.5 million) remained without health insurance, a significant decrease from 2010 when 15% was uninsured (Commonwealth, Turbat). The drastic reduction in uninsured Americans shows the effectiveness of the ACA over the past decade, but millions remain without coverage. The leading causes of Americans losing health insurance are cost and job loss (Turbat, 2021). The danger associated with linking health coverage to employment is the fragility of the conditions of employment.

During the economic recession in the late 2010s, an estimated 3.9 million Americans lost health insurance (Stolberg, 2021). Additionally, health coverage became more unstable in 2009 than in years prior, especially in demographics that had previously enjoyed higher proportions of health coverage like full-time workers, non-Hispanic whites, and middle-class families (Park et al., 2009). In particular, the demographic with the fastest increase in uninsured rates was non-Hispanic whites. The linkage between health coverage and employment puts workers at risk and families who often rely on coverage from working members of the family. Additionally, the reliability of employer-sponsored employment was decreasing in 2008, with the proportion of full-time and part-time workers without health insurance rising (Park et al., 2009).

In the post-ACA era, Covid-19 also significantly strained the economy and resulted in a 6.2% drop in employment between March and September of 2021 (McDermott et al., 2020). In December 2020, the Kaiser Family Foundation estimated that despite the decline in employment, "enrollment in the fully-insured group market decreased by just 1.5%" (McDermott et al., 2020). The relative stability of health insurance coverage despite large job losses can be attributed to various factors. Primarily, employees in the main sectors affected by lay off during the pandemic were not covered. Additionally, the expansion of Medicaid allowed some to gain public health insurance, and some were permitted to retain health insurance temporarily after employment (McDermott et al., 2020).

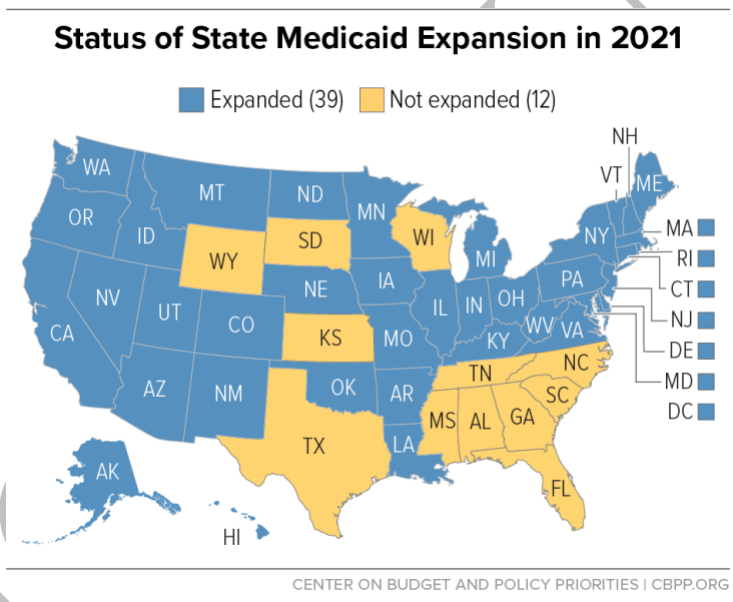
In the case of low-wage workers, the Americans who lost their jobs were not as likely to be covered by employers. Job losses were most significant in industries with low coverage rates, such as service and hospitality, meaning that employees never had health insurance in the first place (McDermott, 2020).

Part of the damage control in health insurance loss may be attributed to expanding Medicaid and government-subsidized health insurance through the ACA. For those who lost employment during the early months of the pandemic, nearly 80% qualified for Medicaid or government-subsidized plans. Still, the premiums' affordability and eligibility knowledge remains a challenge (Stolberg, 2021).

Because state governments oversee Medicaid, the 50 states created an interesting comparison between states that enacted Medicaid expansion and those that did not. In states like Texas (where 30% of the population is uninsured) that did not expand Medicaid, 43% of fired workers became uninsured compared to states which had expanded where 23% of works became uninsured (Stolberg, 2021).

This is not to minimize the individual trauma that millions who lost health insurance coverage experienced during a deadly public health emergency, but rather a warning to the future that without comprehensive health reform built upon the foundation of the ACA, the next pandemic will be just as bad, if not worse. It begs the question: could it have been better if the Trump administration had not cut outreach programs and expanded subsidized insurance?

Figure 1 *Status of state medical expansion in 2021*



Note. Sourced from *The Far-Reaching Benefits of Affordable Care Act's Medicaid Expansion*, 2020.

Racial and Ethnic Equity

A primary goal of universal health coverage should be to reduce inequities in health coverage to improve population health outcomes. In 2010 before the ACA, nonelderly Hispanic people and American Indian and Alaska Natives (mentioned below) had the lowest health coverage rates. Through the ACA experienced the highest increase in health coverage in the period between 2010 and 2016, but Americans of color were still underinsured compared to white Americans. After the change in presidential administrations, uninsured rates increased across racial Hispanic, white, and Black racial groups, with Hispanic people becoming uninsured at the highest rate. This is attributed to the federal government's decreased funding and resources for enrollment in coverage. In 2019, uninsured percentages most to least were American Indian/Alaska Native (22%), Hispanic (20%), Native Hawaiian/Other Pacific Islander (13%), Black (11%), White (8%), and Asian (7%) (Artiga et al., 2021).

In the United States, 573 federally recognized indigenous tribes can receive federally funded Indian health service services. Currently, the IHS provides health services to 2.56 indigenous peoples (out of 5.2 million) who predominantly live on or near reservations. Life expectancy at birth for American Indians and Alaska Natives is five years less than the overall US life expectancy at birth and, on average, dies at higher rates of chronic diseases. Given the health disparities, the goal of the service is to improve the physical, mental, social, and spiritual health of indigenous people through the federally funded program (Indian Health Services, 2019). The Indian Health Service is an example of a federally funded program working toward achieving universal health coverage in the US by providing health care to underserved communities.

The current presidential administration is taking action to reduce health coverage disparities through expanding subsidies for health insurance and increasing the reach of Medicaid to states who have not adopted the Medicaid expansion. Of the uninsured adults who would become eligible if all states adopted Medicaid, 60% are people of color and 70% are living in poverty. Additionally, the administration increased outreach that the previous administration had rolled back. These initiatives hope to reduce racial and ethnic disparities in health coverage and corresponding health outcomes, evidenced by research that supports Medicaid expansion correlating with reduced disparities (Ndugga and Artiga, 2021).

Conclusion

The World Health Organization states UHC entails "all people and communities receive health services…and of sufficient quality…while ensuring that the use of these services does not expose the user to financial hardship" (SDG Target 3.8, 2021). The ACA is inadequate in achieving UHC in the USA because there are still Americans who do not have health insurance and job loss is the most significant factor to health insurance loss. This is especially prevalent as many Americans lost their jobs during Covid and effectively lost their insurance coverage. Additionally, poor working-class families should focus on legislation as they are the most likely to be uninsured.

A proposed course of action is the expansion of Medicaid on the state level since twelve states have not expanded on Medicaid despite federal incentives. Texas, Florida, and North Carolina remain states of interest. Three of the five states contributed to nearly half of health care coverage losses during the pandemic (Stolberg, 2021).

Evidence for the expansion of Medicaid in states which chose to enact Medicaid expansion had lower mortality rates for near-elderly adults within the first year of policy enactment. The reduction, credited to a reduction in disease-related deaths, grew over time and showed evidence of the resulting health outcomes of Medicaid expansion on a state level (Miller). As mentioned previously, in the 37 states with expanded Medicaid programs, the rate of laid-off workers that became uninsured was nearly half that of states which did not expand Medicaid (Stolberg, 2021).

Political divides have become a significant predictor of state action or inaction in expanding Medicaid. The partisanship of the state is a strong predictor of the likelihood of either accepting or refusing federal funding for Medicaid expansion. Somewhat surprisingly, the partisanship of the state government does not matter as much as the competitiveness of elections in implementing the ACA. States that see competition in party control, like Nevada and Maryland, have implemented and not attempted to repeal the ACA than states like Alabama with one-party control (Rocco, 2019). The benefits of party competition echo the more significant party polarization seen on a national level on topics like health insurance.

In states that have not implemented Medicaid expansion, ballot box initiatives, in theory, give voters the ability to decide. Only four states without Medicaid expansion have presented the legislation to voters. As with other voting initiatives, institutional barriers posed challenges in getting initiatives on the ballot, passing, and allowing them to appear on the ballot again poses

significant challenges in the face of state governments opposed to Medicaid expansion. Even after approval by the voting box, as seen in the case of Maine, Medicaid expansion implementation can be refused by the governor (Rocco, 2019).

Rocco in colleagues (2019), attribute competitive elections as the most critical factor in Medicaid expansion on the state level. As the United States moves slowly through the second year of the Covid-19 pandemic, the partisan competition may be taking hold in states where Medicaid expansion is still lacking. With Stacey Abrams and Beto O'Rourke running for the governorship in Georgia and Texas respectably, the adoption of ACA Medicaid expansion may be taking hold across the US and continuing to shift American health financing to that provided by the government. If this could lead to better health outcomes or more Americans with health coverage is yet to be measured.

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