A Healthcare Primer

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FOR MORE THAN 100 YEARS, healthcare has been an issue in American politics. Theodore Roosevelt emphasized it during his unsuccessful “Bull Moose” campaign for the presidency in 1912. Presidents from Truman to Nixon, Carter and Clinton attempted to address needs in the healthcare system or to promote some kind of national health insurance plan.

During the Johnson administration, in 1965, the nation enacted historic legislation establishing Medicare and Medicaid, and for a time these government programs were thought to create a kind of “health Utopia” for Americans. Working citizens and their families would receive coverage through their employers, Medicaid would provide coverage when workers retired, and Medicare would protect widows and widowers and those who were medically indigent. However, in large part because of steady increases in healthcare costs during the 1970s and ‘80s, this “Utopia” failed to materialize.

By 2008, according to a U.S. Census Bureau report, more than 36 million Americans — not counting those covered by Medicaid and Medicare — had no insurance coverage. And this number was (and is) growing, as were the costs of premiums, which rose at a rate faster than inflation. The Kaiser/HRET Survey of Employee Sponsored Health Benefits reported that the average premium contribution for an employee rose from $1,543 a year in 1999 to $3,515 in 2009. Over the same period average employer contributions rose from $5,791 to $13,375.

As a result, many workers, especially those at or near the minimum wage, were electing not to purchase health insurance because they couldn’t afford it.

More problems began to emerge. Some people could not obtain coverage because they worked for small companies that were unable to afford group plans, and the cost of individual policies was prohibitive. Part-time employees were generally not offered coverage, and most young adults were removed from family plans within a few months of graduation from high school or college because of private insurance guidelines.

Employees looking to move from one company to another also faced roadblocks. A new job would usually require them to change insurance carriers, and many found that they or a family member with a chronic, pre-existing condition, such as cancer, diabetes or asthma, would not be covered. So people became hesitant to change jobs. Moreover, if they lost a job, they might have trouble finding a new plan that would cover a pre-existing condition.

Others were dealing with catastrophic bills brought on by unexpected illnesses or accidents. Many families had no means to pay them, especially if they had no healthcare plan. Even for those with insurance, high deductibles for hospital coverage and high maximum out-of-pocket standards often led to massive bills. According to a 2009 report in the American Journal of Medicine, some studies estimated that healthcare costs had contributed to 60 percent of personal bankruptcies in recent years.

All of these factors provided the backdrop for what we now know as the Affordable Care Act — Obamacare, as many call it.
The ACA emerges
When Barack Obama began his quest for the presidency in 2008, healthcare was not, at first, a major tenet of his campaign. Hillary Rodham Clinton, his main rival for the Democratic nomination, actually led the call for healthcare reform during the early primaries. But as Obama's campaign gathered momentum and his support grew, he began to emphasize healthcare in an effort to draw support away from her.

After he was elected president, some advisors suggested he delay tackling healthcare reform and focus more on the economy. But others, like the now deceased Sen. Edward Kennedy of Massachusetts, a powerful politician and longtime advocate for healthcare reform, advised (and pressured) Obama to push ahead. Party leaders also felt that the new president could use his "honeymoon" to help encourage an overhaul of the system, despite Republican opposition.

Most of us are familiar with what followed. Obama launched his healthcare initiative, the Republicans resisted, the parties bickered ad nauseam, and the bipartisan "Gang of Six" failed to find common ground. In the end, the Democrats mustered the votes to pass the bill in both houses of Congress. While parts of the Affordable Care Act (ACA), signed into law by Obama in March of 2010, have already been phased in, its strongest impact will begin to be felt this October.

But do Americans fully know, or understand, what the ACA does, even after more than three years of discussion and publicity? The Huffington Post suggested otherwise in a March 20 story, citing a Kaiser Family Foundation report that the public is "uninformed and confused" about the law. While people say they approve of many of its provisions, such as tax credits for individuals and small businesses, better coverage for prescription drugs and coverage for pre-existing health conditions, many remain resistant to the "mandate" that they purchase some form of health insurance, and others believe that the ACA establishes "death panels" to ration care and designate who gets what kind of treatment — and who does not.
Reducing the occurrences of preventable diseases is the only way to truly cut costs. Until people begin taking preventive actions at earlier ages, little will change.

A look at the basics
The Affordable Care Act, with its many stipulations and requirements, is a complicated piece of legislation. Both of us have taught classes on the topic. The following “primer” is based on our research and course preparation. We do not attempt to judge the merits of the law but to provide a summary of some of its key elements, and to offer insight into how different groups might be affected.

Under the ACA, children and dependents under 26 cannot be refused coverage for pre-existing health conditions, nor can they lose coverage or have policies canceled — a practice known as rescission — because they are “too sick” or have reached a lifetime limit. If their family incomes are less than 133 percent (or gross income adjusted to 138 percent) of the U.S. poverty level, they will be covered under expanded Medicaid, assuming their state participates in the expansion. If their parents are covered under a private insurance plan, they can be included up to age 26.

Young healthy people with jobs but without healthcare coverage will be required to purchase a plan. If they choose not to, they will pay a penalty (some call it a tax) that will be a percentage of their gross income. The penalty would, in theory, cost them pretty close to the price of a basic annual insurance premium. This is the “individual mandate” recently tested in the Supreme Court. The government’s ability to enforce the individual mandate, however, is somewhat suspect; property cannot be seized or liens on property levied, and the Internal Revenue Service can withhold money only from those in line to receive a tax refund. An exemption is allowed for those who prove that they cannot afford a plan or that having a plan goes against their religious beliefs.

No changes are required for those with private insurance, although employers may elect to change their insurance coverage at any time. Interstate insurance exchanges mandated by the Affordable Care Act are designed to allow employers to seek better deals across state lines.

For the elderly, the so-called “doughnut holes” — gaps in Medicare prescription drug coverage that force many to pay the full cost of prescriptions for extended periods — will be closed. A federal advisory board, established to make recommendations designed to keep costs down, may rule that some routine procedures that are currently

### Healthcare spending per capita

<table>
<thead>
<tr>
<th>Country</th>
<th>Spending Per Capita</th>
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<tbody>
<tr>
<td>Australia</td>
<td>$3,685</td>
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<tr>
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<tr>
<td>United States</td>
<td>$6,233</td>
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</tbody>
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covered will be unnecessary for certain age groups or high-risk populations. (This is the so-called “death panel” concept derided by opponents of the law.)

Insurance companies that provide supplemental insurance for Medicare patients will be paid less. The insurance industry will also face limits on profits that will require companies to refund some premiums or reinvest in patient care. Preventive treatments such as screenings and vaccinations will be free (no co-pay). Lifetime limits on coverage have been eliminated.

Physicians will see cuts in Medicaid and Medicare payments, which will be based on outcomes rather than the number of tests or office visits. The idea is that more patients in the system will offset lower fees for services. Medical students who graduate and choose to work in underserved communities may have their school loans forgiven.

As an incentive to develop healthcare plans, small businesses with fewer than 25 employees who make less than $50,000 per year will receive a tax credit. For 2013-14 the credit will be 35 percent of the cost of insurance; afterward it will be 50 percent. Initially the plan also called for businesses with more than 50 employees to be required to provide health insurance, or to pay a penalty; the Obama administration has recently delayed implementation of this aspect of the ACA for a year.

How will we pay for the Affordable Care Act, with its estimated cost of $940 billion over the next 10 years? The Medicare tax will increase 2.35 percent on those making more than $200,000 per year, and 3.85 percent on couples making more than $250,000 per year.

There will be a 40 percent corporate tax on companies that provide so-called “Cadillac” insurance plans, high-end plans through which employers may gain tax advantages. And there will be a 10 percent tax on persons who use tanning beds. Because 30 million new customers will be required to buy health insurance, the assumption is that the revenue they generate will offset the costs of the other provisions.

**Let’s treat the causes**

Legislation and regulation may be necessary to treat the symptoms of the healthcare crisis in America, but what about the causes?

As health sciences professors, we are especially concerned with the impact of our society’s poor health choices — smoking, lack of exercise, high-fat diets — on the rise in healthcare costs. We believe that reducing the occurrences of preventable diseases is the only way to truly cut costs. Until people begin taking preventive actions at earlier ages, little will change.

We can begin by improving health and physical education classes in our elementary, middle and high schools. Just as we seek to hire the best math and language teachers, we need to hire dedicated, knowledgeable health and physical education teachers and to offer physical education classes several days per week, at the least. We need to teach our children healthy behaviors and offer them healthier food choices, because almost one-third of the nation’s children are now considered obese.

If we don’t start assuming more responsibility for our health behaviors, we will place a huge economic burden on current and future generations. The cost of treating chronic illnesses such as heart disease, lung disease and diabetes, to name just a few, rises into the billions each year. Many of the risk factors connected to these diseases can be addressed through simple lifestyle changes — 30 minutes of daily physical activity, decreasing our fat and sugar intake, and making better dining choices, such as fruits, vegetables and healthy grains.

And all of us need to become advocates for these changes. We’ll never find solutions if we don’t attack the root causes of the problems.

Tony Caterisano joined the Furman faculty in 1984; Si Pearman ’87 has taught at the university since 1990. Illustrations by iStockphotos.

Charts adapted from a July 17 talk at Furman by Hugh Greene, chief executive officer and president of Baptist Health in Jacksonville, Fla., as part of a summer lecture series on healthcare reform sponsored by the Riley Institute and the Osher Lifelong Learning Institute.