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Patchwork Protections: How a Lack of Universal Coverage Contributes to and Exacerbates Health Disparities in the U.S.

I: Introduction

The United States remains the only developed nation in the world to not offer its citizens universal health care. Instead, the country has opted for a unique patchwork of private and public systems that leaves many without coverage, and those who are covered often suffer from high deductibles and co-pays. The high costs associated with accessing health care thus disproportionately disadvantage low-income individuals, leading to reduced health care utilization and thus worse health outcomes, as well as heavy financial burden. In response to these costs, recent calls for “single-payer” and “Medicare for All” platforms have gained considerable traction among progressives.

In order to fully understand the issues these reforms seek to address, this paper will explore the history of U.S. health insurance and previous reform efforts, followed by an examination of the areas in which the current health care system fails to address the needs of Americans. Finally, this paper will survey how Americans respond to and are impacted by the high costs of health care, revealing that the lack of universal health coverage in the United States

limits the utilization of health care resources, thus exacerbating health disparities and worsening overall health outcomes.

II: The Rise of Employer-Provided Health Insurance

Health insurance arose in the United States in the mid twentieth century in response to a rising demand for medical services. From 1940 to 1960, insurance rates in America grew rapidly from 9 to 70 percent (Morrisey 2014). While most European nations established national health insurance programs in which health care was provided by the state, the United States instead elected for an employer-provided health insurance system. In order to fully understand how this system contributes to health disparities, it is worthwhile to first understand how employer-provided health insurance became the norm in the United States and how previous reforms have attempted to broaden the scope of coverage.

The rise of employer-provided health insurance has been described by some as a "series of accidents" (Ternov and Akselsson 2005). During World War II, American companies competed for a scarce labor market by increasing salaries, and President Roosevelt, concerned over inflation, ordered a freeze on wages (1943). At the same time, the Labor Board ruled that employer-provided health insurance was not considered a wage. The unintended result was that companies began to entice workers by providing health insurance as a benefit. One year later in 1943, the Internal Revenue Service issued a ruling stating that employer-provided health insurance was exempt from federal taxation (M.K. 1943). With this new tax subsidy, health insurance as a benefit became the most affordable method of acquiring access to health care, and in fifteen years the majority of Americans received employer-provided health insurance.

However, this majority fell short from full coverage; the elderly, the disabled, and the unemployed still had little access to care. In an effort to address these gaps, Congress created Medicare and Medicaid in 1965, providing publically funded health care to the elderly and certain low income groups, respectively. The low-income individuals served by Medicaid were termed the "deserving poor" and were mostly limited to single mothers, children, and people with disabilities (Tanenbaum 1995). Furthermore, Medicaid, as a state run program, varied by state in eligibility requirements and the services provided. As such, many low-income individuals were still without access to care. Over the next several decades, health care costs continued to rise and millions of Americans remained without coverage. Major health care reform was not again successful until the 2010 passing of the Patient Protection and Affordable Care Act.

III: Health Insurance in America Post ACA

The Patient Protection and Affordable Care Act (ACA) ushered in sweeping changes to health insurance; two key provisions with regards to increasing access to coverage will be explored in depth here. First, the ACA attempts to make coverage more obtainable for lower and moderate income families by providing tax subsidies to reduce premiums and out-of-pocket costs. To qualify for a tax subsidy, individuals must purchase their private plan from a state health insurance exchange and must have a household income below 400 percent and above 133 percent of the Federal Poverty Level (FPL). In its second key provision, the ACA attempts to provide coverage for the lowest income group (below 133 percent of FPL) via the expansion of Medicaid (Kaiser Family Foundation 2018). However, following the 2012 Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, states may choose whether or not to

implement this expansion (Library of Congress 2012). As of 2019, 37 states (including DC) have chosen to expand the program. In the 14 remaining states, residents with incomes below 100 percent of the FPL and who do not qualify for their state's Medicaid eligibility requirements receive no assistance in obtaining health coverage, as they also do not qualify for tax subsidies through the health insurance Marketplaces. An estimated 2.2 million Americans fall into this coverage gap (Garfield, Damico, and Orgera 2018).

Nevertheless, the ACA has made considerable improvements in coverage. Nearly 20 million more Americans have health insurance today than in 2010, with substantial gains made in racial and ethnic minority groups. As a result of this expansion, the percentage of adults without a usual source of care and who forwent treatment due to costs decreased among all groups and led to a narrowing in health disparities between whites and members of minority groups (Zielsdorf et al. 2017). However, it is worth further exploring the exact form these new insurance plans take.

While the years since the passing of the ACA have seen the number of uninsured decrease, they have also seen an increase in the number of Americans who are underinsured. Underinsured individuals have health coverage, but through a combination of high premiums, deductibles, and/or co-pays they face out-of-pocket costs that are high relative to their income. As of 2018, 29 percent of U.S. adults – an estimated 42 million people – are currently underinsured, which is an increase of over 10 million people since 2010 (Commonwealth 2019). The increase in underinsurance is largest among employee-provided plans, and people who purchase individual plans through the health insurance exchanges are most likely to be underinsured.

Even with coverage expansions, the ACA still falls short of universal coverage. On top of the coverage gaps present in the states which did not expand Medicaid, the ACA also fails to address the health insurance needs of undocumented immigrants; both Medicaid and the health care exchanges are inaccessible to undocumented immigrants, who make up 25 percent of the uninsured population (Kaiser Family Foundation 2018). Furthermore, recent changes from the Trump administration may impact the ACA's scope of coverage gains. In 2017, Congress eliminated the individual mandate penalty, effectively negating the law's requirement that most people have insurance. With the removal of the penalty, young healthy people may abstain from purchasing plans, leaving the pool of the insured older and sicker. The Congressional Budget Office has estimated that removing the mandate will lead to a decrease in health insurance enrollment between 3 and 6 million between 2019 and 2021, as well as a 10 percent increase in the cost of premiums (Eibner and Nowak 2018). Additionally, the Trump administration has shortened the open-enrollment period and significantly rolled back funding for ACA advertising, potentially decreasing the number of Americans aware of or enrolled in a plan. The end result is as follows: in 2018, the uninsured rate increased to 13.7 percent, meaning an estimated 7 million people have lost coverage since 2016 (Collins et al. 2018). With the ACA's gains in coverage starting to reverse, as of today there are approximately 30 million Americans that are still without health insurance.

IV: Health Insurance & Health Disparities

For the 30 million uninsured and the 42 million underinsured, accessing health care continues to be prohibitively expensive. As a result, many Americans are forced to forgo care due to costs. According to NORC at the University of Chicago, approximately 40 percent of

Americans have chosen not to receive a recommended medical test or treatment due to high costs (2018). These decisions have real and measureable health impacts: people who have forgone medical care or medication due to costs exhibit worse health outcomes, lower quality-of-life, and greater risk of health decline, even when controlling for baseline health status and socioeconomic and demographic background (Chen et al. 2011; Heisler et al. 2004). Such impacts on health are especially prevalent among cancer survivors and the chronically ill.

Alec Raeshawn Smith, for example, was a Type 1 diabetic who passed away in 2017. At 26-years-old, Alex had aged out of his mother's insurance, but his annual salary as a restaurant manager left him unqualified for subsidies on the Minnesota health insurance exchange. When faced with insulin costs mounting $1,300 a month and insurance plans with deductibles upwards of $6,000, Alec elected to remain uninsured. He decided to ration his insulin supply until he could afford to buy more. In June, Alec passed away after falling into a diabetic coma (Sable-Smith 2018). Unfortunately, Alec's story is not unique. According to a study by the American Journal of Public Health, nearly 45,000 deaths occur annually due to lack of health insurance (2009). Millions more suffer health effects that fall short of mortality.

In addition to forgoing treatment and medication, the high costs of care for the uninsured and underinsured also leads to a decrease in the use of preventative services. Among the uninsured, preventative service utilization is low compared to the insured (Holden, Chen, and Dagher 2015). But for those insured by high deductible health plans, preventative service utilization is also low, especially for screenings (Mazruenko, Buntin, and Menachemi 2019). This reduction is occurring despite the ACA's elimination of cost-sharing for preventative services; it could be explained by patients not knowing such services are fully covered or by lower utilization of regular office visits, where they are most likely to be offered preventative

care. Regardless, preventative services are a key factor in reducing the prevalence of cancer, cardiovascular disease, and other chronic diseases, and their low utilization among the uninsured and underinsured could exacerbate existing health disparities. For example, cardiovascular disease is most common among low-income individuals and minorities, and these groups are also the least likely to be fully insured (Graham 2015; Artiga, Orgera, and Damico 2019).

When accessing medical care is non-optional, such as following an accident or cancer diagnosis, the uninsured and underinsured are besieged by high out-of-pocket costs. Many turn to crowd funding to help cover their bills. Nearly half of all fundraisers on GoFundMe are for medical costs; however, only 11 percent of healthcare fundraisers reach their goal (Helhoski and Simons 2016). As a result, 26 percent of U.S. adults under 65 have reported difficulty in paying their medical bills, and medical costs have now become the most common cause of bankruptcy in the U.S. (Hamel et al. 2016; Himmselstein et al. 2019). The high cost of health care and the inadequate protection offered by health insurance has crippled the American people with a financial burden they cannot afford to pay.

V: Conclusion: A Call for Change

The calls for universal coverage do not exist in a vacuum. They respond to the growing health care crisis in the United States, in which profits are prized above people and Americans cannot afford to pay their medical bills. Our patchwork of public and private systems is not able to properly protect our citizens, abandoning many within coverage gaps where they cannot afford access to care. These gaps have had serious consequences for the health of our country and have disproportionately hurt minorities and low-income individuals, exacerbating existing health and financial inequalities and prolonging inequity.

It is important to note that financial barriers to health care access are one of many obstacles to health equity; among others, differences in environment, resources, and other social determinants of health also play an important role. However, equalizing access among all Americans regardless of income is an excellent first step towards leveling the playing field. By replacing our current health insurance system in which the rich and poor receive different deals for different prices with a system of universal coverage in which all are treated equally, we can begin to equip the medical and public health communities with the tools they need to address health disparity concerns. Just as insulin should not have to be rationed, health care should not be rationed to only those who can afford it.

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