A Healthy Slice

With costs soaring and the economy struggling, more Americans are finding themselves doing without health coverage. Is there a way to make sure everyone gets a piece?

by Deborah Rudacille

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The scar is barely visible now. For a few weeks after the dermatologist burned off the white bump on my forehead last summer, I had a red dot there, like a slightly off-center bindi. But considering the diagnosis—basal cell carcinoma, a common and treatable but still malignant form of skin cancer—and the total cost of paying for my own lab tests and in-office surgery ($477), I figure I got off easy.

Like about 47 million other people who live in the United States—16 percent of adults, nationally, according to a June 2009 Gallup poll—I don't have health insurance. My excuse: I'm neither poor enough to qualify for medical assistance nor rich enough to easily afford a private plan. There are many people out there who fall into this gap, and, thanks to a struggling economy and stubbornly high unemployment rate, more are on the way. Many, like me, are self-employed; others work for companies that do not offer health insurance benefits, have been unable to pick up company-paid premiums after job loss, or just use youth and relative good health as an excuse to opt out of coverage—the so-called "young invincibles." We are "self-pay" all the way, which means that we typically only go to the doctor when family members start harassing us or we can't get out of bed in the morning.

As any doctor will tell you, such a strategy is a prescription for a potentially ruinous medical disaster. It took me more than six months, for example, to check out what was going on with that mysterious thing on my forehead. I was very lucky that it was not a malignant melanoma, which could have been busily seeding cancer cells through my body. Melanoma, which is responsible for three-quarters of all skin cancer deaths, is best treated with a swift surgical intervention.

As a science writer, I've often marveled at the brilliance of researchers striving to unlock the mysteries of disease and the skill of physicians translating research results into clinical practice. But as a citizen without health insurance, I'm baffled by the perverse logic of spending billions of tax dollars each year on cutting-edge research while failing to ensure that every American receives basic health care. That frustration, I've learned, is often shared by the people working within the system who struggle to deliver care within a framework that seems to discourage, rather than facilitate, the delivery of services to the sick. Amid the current polarized debate over how to improve American health coverage, it's worth noting that uninsured people like me are not the only ones anxiously awaiting reform; so too are doctors, nurses, hospital presidents, business owners, and just about everyone else who has to negotiate the labyrinthian complexities of insurance reimbursement. They just don't always agree on what that reform should look like.

According to a December 2008 study by the Robert Wood Johnson Foundation, for example, more than half of small business owners support health care reform, and a surprising 53 percent prefer some kind of "public

option"—the government-run health insurance plan famously favored by progressives. Since that's not the political ideology one generally associates with the business community, I meet up with Marie Gleason to discover why. Gleason, 58, is president of William J. Gleason & Sons, a construction equipment repair business founded by her father in 1951. She also works as director of administration for Days Cove Reclamation Co., a demolition debris landfill on the same site, and is responsible for purchasing and administering the health insurance plans for both companies. "Was I out sick the day I got stuck with this job?' she jokes
over a glass of lemonade at Barnes & Noble in Towson.

Although health insurance has always been a big expense for the company, premiums have skyrocketed in recent years as the company's workforce has aged, she says. Three of Gleason's twenty employees at Days Cove are now older than 60—one reason the company's premium jumped 18 percent this year alone. "We want to keep good people who are experienced, but they are going to get older, and insurers base everything on the age bracket," she points out. "Our insurance agent said, ‘Can't you hire a few 18-year-olds?'"

The company worked around the problem, she says, by choosing a high-deductible plan—$2,000 for individuals and $4,000 for families—and then paying employees' deductibles. "That brings the premiums down," she says. "Even if every one of our employees met their deductible, we would still pay less than we would for a lower-deductible policy." Gleason is also encouraging employees eligible for Medicare—the government-funded insurance program for citizens 65
and older—to come off the company policy "and we'll pay the supplement," she says. "That brought the premium increase downto 11 percent."

Most employees, Gleason adds, have no idea how much their health insurance actually costs. "It's only $10 out of each paycheck for individuals and $50 to $60 for families. They think that's their premium." Because their company-paid health insurance is so affordable, "people run to the doctor for every little thing," she says, "and doctors will order every last test. They have no idea how much it all costs until they leave and have to get COBRA [the federal program that permits former employees to continue insurance coverage after leaving their jobs]. Most can't afford it."

That's exactly the problem with employer-subsidized health care, says Bradley Herring, 38, an assistant professor of health economics and policy at the Johns Hopkins Bloomberg School of Public Health. "There is a pretty broad consensus among health economists that the system has led us as a nation to have coverage that covers too much and pays providers too much," he says. "If people have to pay, they make much smarter choices." It's certainly true that when you are paying for all your own medical care, you only buy what you really need; I use drug-store reading glasses rather than paying for a visit to the optometrist and prescription lenses.

But according to those in the health care trenches, excess coverage leading to too much choice is hardly the problem. In fact, they say, patients and doctors have too little say when it comes to deciding which treatments are needed and which facilities offer the best care. "A lot of people who have insurance don't really understand what their insurance provides until they use it," says nurse case manager Kathleen Saunders, who works in the critical care unit at a Baltimore-area hospital. "The networks determine where you will go and how much is covered. People are shocked to discover it doesn't cover everything."

Saunders, 51, has been a nurse for twenty-six years, but it wasn't until she began working as a case manager in 1999 that she had to start thinking about the ways that quality of care—and quality of life—are affected by what kind of insurance coverage patients have, or don't have. A person who is treated for stroke, for example, will need

some form of rehabilitation therapy. "Insurance plays a big role in where they go," Saunders says. "You have to go to the place covered by your insurance. That may not be the best place for stroke, or the place your doctor wants you to go."

Meanwhile, hospitals are under pressure to release the patient. "As soon as someone is ready to leave the hospital, we've got to get them out to a place that's covered," she says. "Sometimes that's easy and sometimes it's very hard." If the battle with the insurance company gets too ugly, she says, physicians themselves will wade into the conflict. "On paper you can fight or challenge the insurance company, but it is literally a full-time job, for doctors and families."

According to a 2003 study of 1999 data published in the *New England Journal of Medicine*, bureaucracy and administrative costs consume at least 31 percent of health care spending in the United States (versus 16 percent in Canada). Case managers like her, Saunders says, "are only necessary because the health insurance system is so damn complicated. You need people to oversee the whole spectrum of care and be sure that resources are being used appropriately."

The appropriate use of limited resources is, of course, at the heart of the health care reform debate—and different groups have different ideas about what constitutes fair use of resources. "The way that we in the U.S. have subsidized private health insurance is to exempt health insurance from taxes," says Hopkins' Herring. "For people with mid-to-high incomes, this is a generous subsidy. But for lower income people, the benefits are minimal. My choice would be to reverse that and make sure that lower income people get a much higher subsidy."

Herring, who worked as a health economist in the George W. Bush White House, is not a fan of the public option—a low-cost government health insurance plan that advocates say would force private insurers to offer more competitive rates. "Most progressive advocates suggest that a public plan is needed to increase competition, but my take is that it is possible to both increase competition and increase choice through a well-designed insurance exchange," he says—a nationwide or state-based pool of insurance providers that would improve access to coverage for individuals and employers by offering a wider choice of health plans.

The catch is that in order to function properly, the exchange would need to attract plenty of healthy young people to even out the risk pool for companies—and healthy young people are the least likely to purchase health insurance if they are not compelled to do so. A friend who works at a hair salon that recently began offering its employees an optional plan told me that most of the younger stylists dropped out after a few months. "They'd rather spend the money on other things," she says. Premiums for the older employees spiked as a result. The solution? The older employees pitched in to pay the premiums for the younger employees just to keep them in the program and keep their own premiums down.

A well-functioning exchange would have to eliminate insurers' ability to limit coverage or set premiums based on health status, Herring says—a reform that is unlikely to be instituted unless health insurance becomes mandatory for everyone. "The concern then becomes if you require coverage, that low-income people receive subsidies to cover some fraction of the plan." This is similar to the Massachusetts Health Care Reform law enacted in 2006 that provides fully subsidized health care for residents of the state earning up to 150 percent of the Federal Poverty Level (FPL) and partially subsidized health care for those earning less than 300 percent of the FPL.

Meanwhile, supporters of a public option point to an unofficial Congressional Budget Office estimate that a public plan based on Medicare rates—which are usually lower than private insurance rates—would save the federal

government $110 billion over ten years by pushing down premium prices, thus lowering the cost of subsidies to low-income people.

Maryland is now doing a pretty good job of making sure that low-income families and individuals are covered. Prior to 2008, the state had one of the most restrictive eligibility levels for medical assistance in the country, covering only families with incomes of less than $6,600 per year for a family of three. (See *Urbanite*, January '08.) The state's expansion of Medicaid under the Governor's Working Families and Small Business Health Coverage Act, effective July 1, 2008, raised the bar to 116 percent of the FPL, or approximately $21,200 for a family of three. The act also extended medical assistance to parents and other family members caring for kids covered under the Maryland Children's Health Program. More than 47,000 adults and 50,000 children are now covered because of the legislation. And, since June 2006, the Maryland Primary Adult Care Program has offered health services for adults with an income of less than $1,046 per month.

But those without employer plans who earn more than eligibility limits for medical assistance must navigate the Wild West of the private insurance market, where premiums for full coverage for midlife people like me usually range from $300 to $400 per month and premiums for families are well over $500 per month. During my extended bout of non-coverage, I spent weeks poring over booklets from Maryland insurers before finally tossing them in the recycling. The high cost explains why roughly 700,000 Marylanders—15 percent of the state's residents—remain uninsured.

Saunders sees the costs of this policy failure in the critical care unit every day. An uninsured person who shows up at the hospital with heart attack symptoms receives exactly the same quality care as an insured person, she says. "If you come into the ER with an acute, life-threatening problem, they will take care of it." But you won't get the necessary aftercare or pharmacy if you don't qualify for medical assistance, she says. "The hospital spends all this money to save someone's life, and then they are lost to follow-up."

My own "maybe it will go away if I ignore it" approach to a puzzling symptom is common among the uninsured, she points out, and winds up costing both the individual and the system more in the long run. "The really heartbreaking thing is when people come in with a cancer diagnosis that could have been picked up by screening but wasn't, so they come in with advanced disease," she says. "Then the health care system winds up spending lots of money to try and fix something when it's too late."

Every hospital in Maryland treats some number of uninsured or self-paying patients. At Howard County General Hospital, President and CEO Vic Broccolino says his number is far lower than at many other institutions. Broccolino, 67, has been in hospital administration since 1969, working as CFO/comptroller at Franklin Square and then Bon Secours Hospitals (where he became CEO) before moving to Howard County General in 1990. He oversaw that institution's merger with Johns Hopkins Medicine in 1998.

"Only 9 to 10 percent of our patients are self-pay or no insurance," he says. Even so, approximately 4 to 5 percent of the hospital's budget, or $8 to $11 million per year, goes toward bad debt (unpaid bills) or charity care, which is subsidized by the state. The hospital does not turn over charity care cases to collection agencies.

Still, "people wind up with huge bills they can't afford to pay," Saunders says—both the uninsured and the insured with high deductibles and copays. Despite its progressive policies, Maryland has the second highest rate in the nation of liens places on houses for medical debt. As the Baltimore Sun reported in a three-part series on hospital debt collection in December 2008, Maryland hospitals placed more than 8,000 liens on houses between January

2003 and June 2008 and won more than $100 million in judgments against former patients, some of them people whose medical expenses had previously been written off by the state.

Donna Smith, 54, is well aware of the dire consequences of unpaid hospital bills. She was diagnosed with uterine cancer around the same time her husband, Larry, was diagnosed with coronary artery disease. They had insurance, but copays and deductibles mounted to the point where they were forced to sell their home and move into their adult daughter's basement. Hospital, doctor, and pharmacy bills "wiped us out in a matter of months," Smith says.

For their troubles, the Smiths received roles as subjects in Michael Moore's 2007 documentary, Sicko, about the weaknesses of the American health care system. "Being in a Michael Moore film is not something you aspire to," Smith says dryly when we meet in the cafeteria at Howard County General Hospital, where her husband is currently being treated. He has aged into Medicare "and now he can go anywhere he wants" for medical care, she says. Four years after the couple was forced into medical bankruptcy, Smith is working for the California Nurses Association as an organizer. She lectures around the country on the need for health care reform—and insurance companies continue to provide her with great material for her talks.

In an unfortunate postscript to her Sicko story, Smith was hospitalized over Labor Day weekend with chest pains. After determining that she was not having a heart attack, physicians at Howard County General Hospital released her on the condition that she return after the holiday weekend for a series of tests. However, her current insurer refused to authorize either the prescription ordered by physicians to alleviate the pain or their orders for an upper-GI scope and cardiac stress test until a third-party administrator had reviewed the case. "I said, ‘You mean I have four Johns Hopkins doctors telling me I need this medication and these tests, and an insurance company bean-counter is going to overrule that?'" The answer, unfortunately, was yes. "My HR department said they found a provision in the policy that says if medication is considered an emergency, they have to cover them. I will probably get the tests eventually," she says, "but who knows where I will have them."

Patient choices are severely limited by the current system, Smith points out. "Even when you have insurance, you still fight. It's a defective product."

That sounds about right to me. As I was sitting on the table in my dermatologist's office, trying to absorb the unpleasant news he had just delivered, I said, "Well, I guess I'll never be able to get health insurance now." The doctor looked up from the chart he was scribbling on. "No, you can still get insurance," he said. "They'll just exclude skin cancer." ?

—Frequent contributor Deborah Rudacille wrote about Bethlehem Steel retirees who lost their health insurance after the company's bankruptcy in Roots of Steel: Boom and Bust in an American Mill Town*, which will be published by Pantheon Books in March 2010.*