Inequities in Insurance

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What's the Issue?

Marcia, a hardworking mother of two in Minneapolis, MN, never imagined she would have trouble with her children's healthcare bills. When they were in college, Marcia's uninsured, healthy son, underwent a tonsillectomy. A complication resulted in a second surgery and a hospital bill of $15,000. With Marcia making less than $45,000 a year, she could no longer afford her children's healthcare [1]. Marcia's son–while still in college– filed for bankruptcy. Marcia's family is just one example of the inequities of the American healthcare system still prevalent today. In the United States, healthcare is divided between employment-based and individual coverage; if a company has less than 50 workers, in California it is 100), it does not legally have to offer health insurance for its employees. Out of the 6.1 million employer firms, the ones with 100 or fewer employees accounted for 98.1%, employing 32.4% of the workplace [2]. In 2015, only 56% of Californians had employer-based insurance [3]. This leaves employees and the unemployed searching for coverage on the open market. With insurance companies wanting to maximize their profits, premiums are proportionately high, with the average premium for a self-insured plan being $35,000, making it the most expensive healthcare in the world [4].

What's the Background?

Insurance Companies

Revenue for insurance companies mostly stem from underwriting, a process where companies determine premium after considering a person's risks. A person with worse health would either be asked to pay a higher premium or not be taken on as a client. Insurance companies then pool all premiums. When one enrollee submits a claim for medical care, the insurance companies pay a proportion of it. Enrollees typically share the cost of healthcare with their insurance companies in the form of deductibles or copays. Any revenue left in the pool at the end of the fiscal year is reinvested, used for lobbying, and distributed to investors as profit [5]. This system incentivizes higher premiums so insurance companies can maximize their political power and profits. Consequently, while making a 3.8% profit margin, the health insurance industry netted $31 billion in profit in 2020 alone [6].

The Uninsured

As of 2020, there were an estimated 30 million uninsured people under the age of 65 in the United States. Though many factors contribute to accessing insurance, like employment status and location, Native Americans are currently the most uninsured demographic, with 28% lacking health insurance. Next are Hispanics and Latinos with 22% uninsured, followed by Black and African Americans at 12%, Native Hawaiian and Pacific Islanders are 9% uninsured, the same as White and Caucasians, with the most insured demographic group being Asians at 7%. Being uninsured also correlates with lower income, with those making an income less than $35,000 per year having an uninsured rate of 20%, $35,000-$49,999 at 16%, $50,000-&74,000 at 11%, and $75,000-$99,000 at 7%. The uninsured rate for those making over $100,000 was only 4% [7].

Outside of insurance, many factors like one's Social Determinants of Health (SDOH) and access to healthy foods affect people's access to healthcare. Social determinants of health are the conditions in which people are born, live, learn, work, play, and worship that affects a wide range of health, functioning, and quality-of-life outcomes and risks 8. Lower-income Americans, for example, are more likely to live in urban areas that can be considered food apartheids where their SDOH negatively impact their access to healthy options and health. As a result, people with lower income have poorer health and therefore extremely costly insurance plans. With low income and high premiums, many Americans face exorbitant healthcare costs that they cannot afford [9].

Distribution of Insurance

As an effort to combat some of the inequities, the Affordable Care Act (ACA), was signed into law by President Barack Obama in 2010 and becoming fully executed in 2014. The ACA sought to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising healthcare costs. The uninsured rate dropped from 16% in 2013 to 9% in 2015 [3]. Though the ACA improved access to care with 8 million Americans enrolling for health care and increased preventative care, many U.S. residents continued to avoid medical care and insurance because of the high costs and inadequate health services with 78% of workers in small businesses not insured, causing divisions across political lines now in how to further reform health care.

Though the ACA was a step towards dismantling the inequitable distribution of insurance, a range of legal and political battles diminished its efficacy, with many problems still existing today. With 31.6 million people uninsured, costs rising by 17.7%, and the average American family of four paying $22,221 a year, and a single person around $6000 in premiums.

What's the Debate?

Theoretical Debates

In a study done in North Carolina, about 66% of the participants reported being satisfied with their coverage but only 8.3% thought the company had their best interests. The study also found that 48.3% reported being very dissatisfied with their healthcare [10]. The majority of satisfaction sparks a debate about if healthcare reform is necessary at all. Pharmaceutical companies, insurance companies, and their supporters are against policy reforms in health care as they stand to profit from the inequities and state of the people, given by insurance companies netting 31 billion in 2019 alone. If there are reforms that subsidize the costs of health insurance, insurance companies might pool less money that could pay for a claim. The smaller amount of money pooled also leads to fewer profits. Any change to this profitable system introduces an inherent risk to the growth of successful insurance and pharmaceutical companies [11].

Additionally, another argument against reform deals with the fairness of the unhealthy having to pay more fees for their own healthcare. Essentially the argument is that the healthier should pay less and the unhealthy should pay more versus everyone should pay the same amount for healthcare. Paying a varying amount based on health is considered fair by some as each

person pays for themself based on their own needs. Others, however, disagree and think it is fairer for everyone to pay the same amount with funds from the healthier paying part of the claims for the less healthy. However, those for reform argue that policymakers must look at an individual's whole situation, paying closer attention to their SDOH than just unhealthy. "advancing urban health equity in the United States in an age of health care gentrification: a framework and research agenda" By looking at one's context, reformers argue that more urban communities are often trapped in tough financial situations, leading to limited opportunities to be healthy and higher insurance rates. This causes a cycle in which the poor become poorer in unhealthy contexts and insurance companies overcharge them when they might not be able to pay for them [12, 13]. The final theoretical debate is either subsidizing the claims for those from poor SDOHs as their care will be more expensive or everyone paying their own amount by themselves, regardless of their context.

Though this debate has been ongoing, the debate of healthcare being a right or a privilege still persists. Those who see healthcare as a privilege see America through a negative-rights framework where rights are restraints on actions rather than an obligation to act. In the case of the constitutional decree that people have the right to life, liberty, and the pursuit of happiness, a negative rights outlook would mean that you have no obligation to help another person to attain life, liberty, or happiness—but they do have a duty not to get in their way. In the case of healthcare, those who believe in a negative rights framework believe that people cannot have healthcare as a right because it places a positive obligation on others to provide access through the nonconsensual surrender of income to the state. From a negative rights perspective, the only duty or obligation people have to one another in regard to healthcare is not to threaten choice or bar access, but no one should be forced to contribute to the care of others. In this perspective, more public healthcare is based on voluntary efforts. The government's role in healthcare is to protect the individual's right to choose. Essentially, in a negative rights framework, healthcare can be available through the mechanisms of a free market system, but it is not a right. Alternatively, there is the positive rights perspective in which a duty is placed upon people to sustain the welfare of those in need. This would present itself through greater government involvement and responsibility in healthcare. From this point of view, marginalized populations who struggle to find or are unable to work should have a right to healthcare. In this framework, it is the government's duty to ensure that the conditions that mediate fundamental human rights are attainable, regardless of their wealth and SDOHs. Therefore, the government has a right to impose taxes that will help those in need [14].

Political Debate

The true nature of the political healthcare debate was on full display during discussions of implementing the ACA. Democrats, on average, believed that accessible, affordable, and quality healthcare should be a human right with no American having to face financial destitution if they fall ill. They also believed that insurance companies should not deny coverage to Americans with pre-existing medical conditions, cap or cancel coverage, or charge women more due simply to gender [15]. Republicans, on average, believed the ACA needed to be repealed, opposing the individual mandate that people are required to have healthcare and the role of government involvement in healthcare [16]. Once the ACA was passed, the debate continued, but now, Democrats believe in universal coverage of health care that should be publicly funded, privately

delivered, fiscally tractable, affordable, comprehensive, secure, high-quality, efficient, sustainable [17] while Republicans believe that healthcare needs to be more personalized and that premiums are too high with restrictive networks, poorly planned subsidies, and dysfunctioning exchange-based plans [18]. While the parties are divided in policy, a variety of nonprofits and lobbying groups are getting into the mix, influencing policy decisions. Conclusion: Today, healthcare reform remains one of the most contentious issues in the US, with 63% of voters in 2022 believing it's one of the most important issues in the US [19]. Since the 2000s, especially with the introduction of Obamacare and the ACA, changes in health care and health policies have become further and further divided by politics As the ACA was a part of Obamacare, Republicans, and the right previously argued for it and the rest of Obamacare to be repealed or replaced. Now, though they still oppose Obamacare, they mostly prioritize changing the ACA rather than repealing it. Similarly, the left and Democrats also want changes brought to the ACA, mainly to the states' exchange-based programs, which is ridden with poor coverage that doesn't adequately cover the sickest. A great point of contention between Republicans and Democrats is the amount given in subsidies. Democrats generally are in favor of ideas of more affordable and subsidized health care and even universal health care. While Democrats want more subsidies to make more premium and broader plans more affordable, conservatives argue for fewer subsidies where customers would get more options but for less value and expensive plans with fewer benefits and protections. Republicans also oppose shared responsibility and rather let businesses to give tax-preferred money to their workers to buy coverage on their own, not through their employers

What's Next?

Current Debates

As the 2022 congressional midterms brought in a Republican House, Congress is unlikely to support extensive policies. For example, though coverage under Medicaid expansion was effective in 2014, some states did not adopt the expansion either at all or until later years. More recently, Virginia and Maine adopted it in 2019; Idaho, Utah, and Nebraska in 2020; Oklahoma and Missouri in 2021; and South Dakota in 2023. This expansion allows for those making 138% above the poverty level to receive gives Medicaid through an enhanced federal matching rate [20].

However, bipartisan agreements in major health-related policies still prevail. For example, Congress passed the Inflation Reduction Act this year (2022), and states are expanding Medicaid access [21]. The Inflation Reduction Act will, among making a down payment on deficit reduction to fight inflation, invest in domestic energy, and reduce carbon emissions by 40%. It will also allow Medicare to negotiate prices of prescription drugs and extend enhanced credits for the ACA marketplaces for 3 more years [22]. The prices for prescriptions, through the Inflation Reduction Act, are capped at $2,000, lowering costs for 1.4 million people enrolled in Medicare. Additionally, the subsidies for those already eligible for the enhanced tax credits - amount of money given to offset taxes - were increased, and eligibility was increased for individuals making 400% over the federal poverty line. This ensures that no one purchasing a plan through the ACA marketplace will pay more than 8.5% of their income on premiums [23]. In the House of Representatives, the Inflation Reduction Act was close to being bipartisanly passed as 95% of

Democrats, 50% of Republicans and 75% of independents voted in favor of it. Republicans not in favor of the Act were concerned about increased spending from the government, which could lead to future unfair taxes on the poor and small businesses [24].

Covid-19 had also shaped the recent healthcare landscape and increased policies on mental health. Covid demonstrated that there was great disparity in the healthcare in minority populations, which led to a new focus on SDOHs and health inequity. Covid also opened the opportunity for more policies that finance and otherwise address social needs [25]. The isolation due to Covid had led to an overall worse mental state in most people with the CDC estimating that 40% of people were struggling with mental health or substance use and another 11% reporting that they considered suicide during the lockdown. This led to an increase in mental health awareness and policies that address them [26].

The Plan

Perhaps one way to improve health policy is by creating a system in which a law requires insurance companies to allocate a portion of their profits to subsidize specific customers. For example, those with known social determinants of health that would lead to downstream increased health costs and insurance premiums could benefit from an insurance company offsetting these higher future costs. This could involve a law that requires insurance companies to allocate 10% of their net profits to this subsidy fund. As profits for 2021 were $19 billion, even a modest 10% requirement would allow for a $1.9 billion subsidy [6].

To accomplish this plan, social determinants of health could be captured for each customer during the underwriting process. Risk stratification could be performed, with companies determining which social determinants lead to the highest future costs, working to help control bills for their consumers. While this allows for a system that is hypothetically more fair for those with poor SDOHs, it also comes with possible downsides. Most obviously, it directly decreases the profit margins for insurance companies, which could become a formidable lobbying force for defeating this potentially equitable change. It also does not consider those that are with pre-existing conditions, with and without SDOHs.

Additionally, the government could consider subsidizing healthy activities for those living along the poverty line. People up to 138% of the poverty line would qualify, aligning with the expansion of Medicaid. The government should, similar to stimulus checks, give checks to support the more expensive options of buying wholesome groceries, healthy foods, and gym memberships so that those in poorer situations may still be healthy, lowering the cost of their plans. The cost of eating healthy in 2013 was $550 more a year [27], which, adjusting for inflation, would be $700 a year. Additionally, a gym membership at planet fitness is $10 a month with a $49 annual fee [28], so the subsidy would be $760 a year. Insurance companies, though having to invest 10% of their income, would still benefit as the government is investing in these subsidies so that the customers are already healthier. As a result, insurance companies would pay less, not needing to pay out as many claims. However, this would cost the government to spend more money, which would upset people concerned about its reflection in taxes. People could also take advantage of this money and spend it ignorant of their health.

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