1. **Introduction**

   In 2014, 12.1% of the U.S. population was uninsured (Figure 1) and an estimated 1 in every 3 Americans reported difficulty paying/affording their medical bills, with medical bills being one of the largest causes of U.S. bankruptcies. What does this say about today’s healthcare system? Are there more smokers? More elderly? Is obesity on the rise? Not necessarily. If it isn’t from factors like increased obesity, smoking, or life expectancy, then what could be driving million of Americans into debt or deciding that they would rather be uninsured? The answer can be found within the Affordable Care Act’s Individual Mandate, that requires all U.S. citizens to have some kind of health insurance. With this requirement for all Americans to hold some type of health insurance, along with a competitive market for health insurance policies, it seems nearly impossible to find an affordable plan that offers above-average benefits. Since its appearance in 2010, the Affordable Care Act has resolved some of America’s biggest health problems, like no longer allowing insurance companies to reject an individual because of preexisting conditions. However, this act has also shined some light on problems that still either need to be addressed. Due to the high prices found within America’s current healthcare system, this implementation has been unsuccessful and continues to fail its main goal to provide each American with proper and actually affordable healthcare.

2. **Background**

   An estimated 1 in 3 Americans have reported having difficulty paying their medical bills. Medical debt can increase when people must pay out-of-pocket for care that is not covered by their health insurance policy or when they must pay high deductibles for the care they need. In 2012, National Health Interview Survey (NHIS) found that 20% of non-elderly adults reported difficulty paying medical bills in the previous year. In Figure 2, you can see that within the 20% of adults that reported having difficulty paying their medical bills, 54% received health insurance coverage from their employer. The leading contributor to medical debt among people interviewed was found to be cost-sharing for covered services received by in-network providers and facilities. Of the 23 people interviewed for this data, 17 reported high cost-sharing burdens. These “high cost-sharing burdens” can be measured objectively, but
affordability is dependant on an individual’s income and other expenses. Many people who do not qualify for Medicaid but still have low-incomes have difficulty paying premiums, let alone medical debt that could come along with it. According to a recent article published in *The New York Times*, health insurance companies around the country are seeking to raise rates by 20-40%, saying that their new customers under the Affordable Care Act turned out to be “sicker than expected.”⁹ Blue Cross and Blue Shield are seeking to raise rates as low as 20% higher in Illinois and as high as 54% in Minnesota.⁹ Is this truly fair for the healthy individuals that have insurance plans with Blue Cross and Blue Shield?

Since the implication of Affordable Care Act, health insurance companies are no longer allowed to reject an individual because of pre-existing conditions, but it seems that the insurance companies have found a loophole to still acquire the money which they are losing by being forced to accept individuals with pre-existing conditions. While the uninsured rates decreased by 2.9% in just one year (from 2013 to 2014), 48% of uninsured adults said that the main reason why they lacked coverage was because it was too expensive.⁷ But just because more Americans are becoming insured, this does not mean that the prices they pay correlate to the services that their insurance company will offer. In 2003, 12% of respondents for Commonwealth’s survey were underinsured because they spent more than 10% of their household income on out-of-pocket expenses. By 2012, the percentage of underinsured nearly doubled, to 20%, which has remained steady since 2014.⁸ These are only a few problems that still occur, if not have worsened, since the implementation of the Affordable Care Act. What could fix these problems? When faced with that question, many Americans wonder “What are other countries doing that seems to be working?”

Commonwealth Funds released a report that ranked 11 countries based on different health care aspects, including: quality care, access, efficiency, equity, healthy lives, and health expenditures/capita (Figure 3). The United States was ranked dead last, at 11th place. One of the most disturbing findings was that the United States was ranked last in cost-related problems under the access category. The United States also spends the most health expenditures/capita with $8,508; $2,512 more than the second highest (Norway). This means that out of the 11 developed countries surveyed, the United States has the highest healthcare costs (Figure 3). The United Kingdom was ranked top, overall. The United Kingdom also
ranked number 1 in 10 of the 12 aspects that were used in this study. What is the United Kingdom doing to shows these kinds of results? It’s simple and called universal health care. The National Health Service (NHS) has been the United Kingdom’s healthcare system of choice for 68 years. The NHS was “born out a long-held ideal that good healthcare should be available to all, regardless of wealth.” The NHS offers all services, with the exception of prescriptions, optical services, and dental services, free to all residents of the United Kingdom. The funding for universal health care doesn’t come cheap though. The NHS funds the money they need to provide health insurance to the United Kingdom through taxation.

3. Policy Options

What can the United States do to fix the problems which we face when discussing health insurance costs? The United States needs to implement a more universal form of healthcare. Take the United Kingdom for example, the government is in control of the the health care services provided to all citizens, which means that all hospitals and medical facilities are apart of their socialized program. This means that all residents go to the same facilities, which can cause long lines and waiting periods for procedures. But what if the United States could have the best of both worlds, to have the freedom of choosing what health insurance company one would like to enroll in, but also have the government strictly regulate the costs of healthcare, similar to that of universal healthcare?

The Netherlands seem to have that “best of both worlds” outlook. All residents of the Netherlands are required to purchase health insurance, which is provided by private health insurers that compete for business (similar to the United States). The difference between the United States and the Netherlands is that these insurers are tightly regulated by the federal government, and are required to accept every resident in their coverage area, regardless of preexisting conditions (something the the United States must now do). The government provides larger subsidies to insurers for consumers who are elderly or have preexisting conditions. They also give tax credits to low income patients so they too can purchase health insurance. The best part is that consumers under the age of 18 are automatically insured at no cost. Residents can choose whichever insurance company they want, but similar to the United States, they often get their insurance through their employer.
The Dutch government is legally required to give standard benefits to all citizens, which includes: general practitioners, hospitals, maternity care, lab tests, and medicines. Most people also purchase additional private health insurance to cover other services that aren’t originally covered by law. The way the Netherlands covers these “legally required” benefits is through a nationally defined, income-related contribution, a government grant for the insured under the age of 18, along with community-rated premiums set by each insurer (where everyone with the same insurer pays the same premium). As of 2014, the average annual community-rated premium for adults was $1,331 USD. Employers must reimburse employees for this contribution, and employees pay tax on the reimbursement. For deductibles and out-of-pocket spending, every insured person over the age of 18 must pay an annual deductible of $436 USD for healthcare costs. Patients are also required to share some of the costs of selected services, such as medical transportation, through copayments, coinsurance, or direct payments for services that are subsidized to a certain limit. Only 0.2% of the Dutch population were uninsured in 2013, and another 2% defaulted or failed to pay their premium for six months, which causes them to become uninsured. Therefore in 2013, a total of 2.2% of the Dutch population were uninsured. The same year in the United States, 16.9% of citizens were uninsured, creating a 14.7% difference in uninsured residents between the Netherlands and the United States.

4. Recommendations

I recommend that we either abolish the Affordable Care Act and start from scratch, or to set stricter guidelines on how insurance companies set their prices for all citizens. It seems quite clear that the Netherlands are onto something with their healthcare system, due to the 2.2% of their population being uninsured. Abolishing the Affordable Care Act would be pretty risky, but if it were abolished the federal government could “start on a clean canvas” to figure out what type of health care system would be most effective, and most importantly affordable, for all Americans. The universal healthcare system, also known as the single-payer system, does look promising; however, many Americans would not like being restricted from choosing who they can and cannot insure with. The Dutch version of health care would give Americans the freedom to choose whichever health insurance company looks most appealing, but
also have the low-cost annual deductibles that in return provide all citizens with legally required basic medical benefits.
Appendix

Figure 1

Uninsured Rate Among the Nonelderly Population, 2000-2013

Uninsured Rate

16.1% 16.5% 16.4% 17.0% 16.8% 17.5% 17.2% 16.7%
16.8% 16.5% 16.4% 16.6% 18.2% 16.9%

2007-2010 “Great Recession”


Figure 2

Characteristics of People with Difficulty Paying Medical Bills

In 2012, the majority of people with difficulty paying medical bills had employer-sponsored private insurance (ESI)

Source: Kaiser Family Foundation analysis of 2012 National Health Interview Survey (NHIS) data. Includes all people who reported problems affording medical bills within the past year, and/or slowly paying past bills over time, and/or having medical bills they could not afford to pay at all.

Appendix cont.
### Figure 3

**Country Rankings**

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Notes: * Includes tie. ** Expenditures shown in SIS PPP (purchasing power parity) Australian $. Data are from 2010.

Sources: Calculated by The Commonwealth Fund based on 2013 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2014; World Health Organization and Organization for Economic Cooperation and Development; OECD Health Data, 2013 (Paris: OECD, Nov. 2013).
Bibliography


