Health maintenance organizations (HMOs) are the essence of what Americans know of as the backbone of the healthcare system. Unless one has a lot of cash in their pocket or such little cash that they qualify for government assistance, HMOs act as the gatekeeper for all health services in the U.S. In this paper, topics will be brought up of the murky history of HMOS, the issues HMOs have caused during the COVID-19 pandemic in the U.S., current solutions, and lastly policy and economic implications in potential solutions for the future. This is to try and find an explanation as to how the presence of HMOs has affected the U.S. and its residents during the COVID-19 pandemic and ask whether HMOs are the most socially and economically efficient form of national healthcare.

Private healthcare has been established in the U.S. for many years, but HMOs got their start in 1973 when former President Nixon passed the Health Maintenance Organization Act of 1973, which academics such as the Missouri Medical Journal dub as, “the primary cause of America’s problems with cost and quality in health care” (Gale). Nixon was not initially interested in the creation of these organizations. However, when talking with his aide, John D. Ehrlichman, they held a conversation about Edgar Kaiser of Kaiser Permanente which planned to run his healthcare company for profit. In a conversation recorded in February of 1971 on the Nixon Tapes, Ehrlichman is recorded saying, “All the incentives are toward less medical care, because…the less care they give them the more money they make” (Gale). Nixon was hesitant at first about establishing HMOs in the country, not out of concern for the well-being of American residents, but out of profit. Since Nixon’s acceptance of HMOs, costs of health spending in the United States has skyrocketed (OECD). Attempts have been made later to socialize healthcare to lower costs for the average American such as during the Clinton campaign. Former President Clinton assigned First Lady Hillary Clinton to chair the Presidential Task Force on National Health Reform. The bills proposed would give universal healthcare to American residents. This formation of the taskforce and the bills proposed caused an uproar in American politics. Ronald Reagan even produced and distributed vinyl records for people to listen to him speak about how socialized healthcare will slide into scary socialism. Overall, the attempt to defeat this bill costed the healthcare industry over $100 million – the attempt of which succeeded, and Clinton’s proposed universal healthcare was defeated (Moore). This defeat was very well funded and well thought out. It would not be in the interest of share holders and CEOs to allow a universal healthcare plan to exist where HMOs already had existed. The murky history behind politicians selling the health of American residents is dastardly yet unsurprising. While private healthcare had already been established before Kaiser’s time, it did not have the control that insurance agencies have today over the American residents. American residents have since had their insurance tied to their employment, known as employer-sponsored insurance (ESI). Public policy think tank AEI writes, “In health care, job-based health insurance is especially susceptible to disruption” (Capretta). ESI, in theory, is a great way to encourage hard-working and employed members of a national community for the interest of capital gain and productivity. However, this theory gets thrown out the window when a global pandemic strikes and millions lose their jobs, their insurance, and their livelihoods.

When one’s health insurance is tied to their job, it makes it imperative that they keep a job lest they be susceptible to outrageous out of pocket expenses and potential non-service from medical staff. So just how many people are at risk of being uninsured during the pandemic? Why are they uninsured? What does the future of the uninsured look like? According to The Congressional Budget office, the office estimates that around 31 million people, over 12% of the population, will be uninsured in 2020. This is an increase from around 30 million people recorded being uninsured in 2019 (CBO). Meanwhile, the Kaiser Family Foundation reports that between January and September of 2020, 6,012,287 had enrolled in Medicaid and/or CHIP (KFF). Medicaid and CHIP (Children’s Health Insurance Program) are alternative insurance options for those who qualify for government assistance due to low income, disabilities, or being elderly. According to the Center of Disease Control, the most common reason why individuals between the ages of 18-64 are uninsured is that coverage is not affordable to them (CDC #382). This is unsurprising as the maximum amount an individual can earn to qualify for Medicaid is $17,131 before taxes (benefits.gov) and the Bureau of Labor Statistics states that the Seattle average annual expenditures excluding healthcare is $24,094 and the national average annual expenditures excluding healthcare is $15,305 (Seattle Summary, bls). This would mean a less than $2,000 for wiggle room between average expenditures and Medicaid qualifications for national residents. It is only natural that 31 million individuals are going without any kind of health coverage – they are merely at the whim of chance that they might get hurt and go bankrupt from it. This issue is compounded as, “During a pandemic, with health risks elevated too, the fragility of job-based coverage looks like a flaw requiring a policy solution” and “Premiums for employer plans have grown steadily and in excess of wages for many years, as have the costs the plans’ enrollees pay” (Capretta). Both the World Bank and Organization for Economic Co-operation and Development state that the U.S. ranks highest in healthcare spending per capita on a global scale in both 2018 and 2019 (OECD, World Bank). “In 2019, health benefit costs for employers was 220% higher than they were in 2000. By contrast, wages in 2019 were only 68% above what they were in 2000” (Capretta). So, with costs rising and wages stagnating, it is no wonder that many American residents are faced with difficult decisions about what to do when they get hurt or sick. The Congressional Budget Office states that 57% of the non-elderly population gets their healthcare coverage through ESI in 2020. Considering this, millions will have to get coverage in other ways, which includes Medicaid/CHIP, uninsured and paying out of pocket, nongroup, Medicare, other, and basic health programs (CBO). The future of the newly unemployed who lose their ESI, statistically, is to be uninsured (CBO). When insurance is tied to employment, risk is inherent that when the job falls through so does one’s protection against outrageously expensive out of pocket expenses. During the COVID-19 pandemic, striking in 2020, unemployment peaked at 14.7% in April of 2020 (BLS). This puts millions of American residents without their ESI coverage during the height of a deadly and global pandemic, terrifying millions and killing hundreds of thousands.

The U.S. government is not inept, and help is offered – but just how much and how does one acquire it? “Access to medicines has become the test above all others by which the rich world will be judged in its dealings with the poor” (Davis). Kaiser Health Network writes a piece about a family out of Nashville, Tennessee and of the late Darius Settles who was between full time jobs, so he was uninsured. Darius tested positive for COVID-19 after going to the hospital once with COVID-19 symptoms. The symptoms improved and he left. The symptoms worsened and he worried about going to the hospital a second time saying, “I bet this hospital bill is going to be high” (Farmer). He reluctantly went again, and his symptoms fluctuated, improved a small amount and he was not admitted into the hospital and went home. He died not long later in his home with his wife and father as they prayed over him after he refused to go to the hospital a third time. What the hospital did not tell the family was that, as adhering to the FFCRA, PPPHCEA, CARES Act, and CRRSA under CFDA: 93.461, the Department of Health and Human Services reimburses these healthcare providers for testing uninsured patients for COVID-19 and treating uninsured COVID-19 patients (HRSA). The hospital later sent the family a costly bill for Darius’ stay, but when asked why, the spokesperson for the hospital said it was sent in error and does not have to be paid. Darius could have and should have been informed and admitted into the hospital, but he was not aware of the reimbursements. One of the major limitations of the CARES Act is that there is no legal requirement for physicians to tell uninsured patients with COVID-19 that their expenses will be covered. A researcher for state policy of the uninsured, Tolbert, says about this oversight, “This is obviously a great concern to most uninsured patients” (Farmer). Tolbert adds that doctors are not always familiar with how the program even works. Still, doctors are reluctant to bring it up even if they do know. An ER physician in Kentucky and board member of American College of Emergency Physicians, Dr. Stanton, says, “I don’t want to absolutely promise anything … There should not be a false sense that it will be an absolute smooth path when we’re dealing with government services and complexities of the health care system” (Farmer). These complications and complexities between government and private HMOs are nothing new as over the years, “local health departments have lost funding and crucial hospital surge capacity has been eroded in the wake of the HMO revolution” which leads to how “no state is fully prepared to respond to a major public-health threat” as written in a report by the Government Accounting Office in 2004 (Davis). While limited, help is still making its way through. On January 28, 2021 President Biden signed Executive Order 13997, which directed agencies to re-examine policies that undermine COVID-19 patients with pre-existing conditions, policies that complicate Medicaid and Affordable Care Act applications, and policies that undermine the insurance market affecting affordability (EO 13997). On February 2, 2021 President Biden announced a substantial increase of vaccine supply and expansion of reimbursement – even retroactively reimbursing from when the pandemic started in January of 2020 – of costs for PPE, emergency feeding stations, and emergency sheltering (White House). Often, the issue is found to be not that no help has come – rather, the help has come so late and the populace made unaware, that it has little use. Considering over half of one million American residents have died due to COVID-19 (CDC), the time for intensive policy re-examination of policies that make it more difficult to get care is far too late – but late is better than never.

 The future is as uncertain as the sun is bright and that most certainly is the case when concerning the future of healthcare in the United States. Clinton’s attempt at universal healthcare was the last major push to get every American resident healthcare, which failed. The latest attempt to improve and give healthcare to more American residents was made by former President Obama with the Affordable Care Act which made healthcare available for those near or at the federal poverty level, expanded Medicaid to cover all adults below 138% of the federal poverty level, and help to overall lower medical care costs (H.R.3590). Current President Biden makes promises to make even more changes to cover more American residents with health coverage. The best possible scenario for getting all American residents covered and to detangle this mess that HMOs have put American residents in would be to build a time machine and establish socialized healthcare like all other developed nations. Considering the improbability of this course, academics have suggested other courses of action. There are several issues in totally replacing HMOs and privatized healthcare with socialized healthcare such as what would to the current, privately owned hospitals? Many new pieces of legislation would need to be passed to control drug and care prices. Additionally, wages in the U.S. are contingent on benefits such as healthcare coverage – that, too would need to be addressed. So clearly, the switch cannot happen overnight. A proposal by AEI is a form of tax credit in the employer’s share of benefits’ costs of ESI (Capretta). This proposal has a baseline of a good idea and neoliberals would sure love it; however, there are some issues that can arise from this. Their proposal would cut costs in the employer’s sector with the assumption of the employer passing on the savings to the employee to create higher wages, covering the remaining expense for ESI while not addressing the healthcare industry at head. Reagonomics, the “trickle-down effect”, is fallacious and presumptuous in that there is no requirement of adherence for raising wages in the wake of a cheaper share of ESI costs to the employer, which is as AEI assumes. A better proposal would be to subsidize and standardize medical care costs through reimbursements and tax credits where the beneficiary is the individual. Clinton’s proposed healthcare bill would have given every American resident a kind of “pass” that could be used at healthcare clinics and hospitals where it essentially just billed the government. A better recommendation would be to take inspiration from that and if wiggle room is demanded, then lower the deal into tax subsidization or partial coverage for everyone. With how much the average American resident spends on healthcare, they deserve to feel safe and cared for – not nickel-and-dimed for their very life.

 The privatization of healthcare through HMOs is neither the socially nor economically efficient form of healthcare coverage for American residents. This paper has given information into the history of HMOs, issues of HMOs during the COVID-19 pandemic, current solutions, and the implications of other potential solutions. The U.S. needs to join the club of other developed nations and HMOs should be phased out and replaced by a single payer healthcare system paid for American taxpayers like these other developed nations. An intelligent society and government takes inspiration from other, better ideas and adopts a form of it as their own – much like the U.S. has done with its legal system from England. HMOs need to go, and American residents need the quality care they pay for.

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