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Is America Ready for Universal Healthcare

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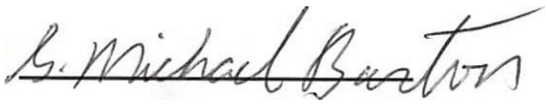
FIELD OF STUDY

PROJECT APPROVAL

I hereby recommend that the project prepared under my supervision by Heather Early Entitled be Is America Ready for Universal Healthcare accepted in partial fulfillment of the requirements for the degree of Bachelor of Integrated Studies.



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Abstract

The American healthcare system noted by politicians, medical professions, American citizens, and health care insurance companies is very complicated. With medical professions complaining of not receiving payment for provided procedures from either patient are insurance companies. American citizens were complaining they cannot afford health insurance or pay for procedures, making citizens not go to medical providers for care.

Furthermore, insurance companies do not get payments for insurance policies from citizens and payout payments to medical providers at a high procedure rate. Politicians have tried to fix the issues by mandating all American citizens have health insurance; they are employer-provided or self-insured.

The politicians created the affordable care act to help citizens afford Health insurance and raised the income gap for Medicaid for low-income citizens. Nevertheless, the problem is still there; let us look at the political evaluations of Universal Healthcare in America.

I. Views of the United States Healthcare System

A. Political Views of United States Healthcare System

Through the political history of the United States, from President Roosevelt through Obama politicians have introduced, proposed, and succeeded to have passed through congress several Health Care reforms in America. and shows that America has reviewed Universal Health Insurance several times for all citizens for several years.

America's growth to get where we are today has been mass improvements for the changes in each period's healthcare. The growth is shown below as we take a walk through the political path of the past.

a. Franklin D Roosevelt 1933 - 1945 Administration - The political awareness of Health Care reform started with President Roosevelt, with a proposal to be sent to Congress after World War II ended, but his death in April in 1945 discontinued the proposal (Morone, 2010).

b. Harry S Truman Administration - The actual first proposal for universal health insurance to be seen by Congress was by present Truman and paid by a national Insurance Board. The opponents of this proposal and the American Medical Association said it was "socialized medicine" with that congress let the proposal die. President Truman tried again in 1948 with the second proposal but was pushed aside due to the outbreak of the Korean War. However, these effects did not go without notice because the increase of Hospitals in the United States and the passing of the Hill-Burton Act was passed in 1946, which brought forth grants, and the issues of rapid unregulated health facility growth led to future legislation that would arise during the Ford administration (Morone, 2010).

c. Dwight D. Eisenhower 1953 - 1961 - Administration Due to the outbreak of the wars, the American citizen's Health reform, and the birth of the Military and Military dependent coverage in 1956 and the support of the For and Bill that provided health insurance for Social security beneficiaries had the support of the AFL-CIO but didn't gain much interest from Congress during the Eisenhower Administration (Morone, 2010).

d. John F Kennedy 1961 - 1963 Administration - The King-Anderson bill, which was for health coverage for citizens 65 years old or older and part of the social security benefit package, which is the start of the Medicare foundation we know today, was introduced by John F Kennedy. Frustrated by the efforts to deny the proposal, President Kennedy took it on the road with public events and speeches all over the United States. With his speech, President Kennedy foresaw the King-Anderson bill would pass Congress "this year, or as inevitably as the tide comes in next year." Unfortunately, President Kennedy passed away before the proposal was defeated by the AMA's opposes with the help of Democrat Wilbur Mills and the Chairman of the house ways and means committee (Morone, 2010).

e. Lyndon B. Johnson 1963 - 1969 Administration - a victory win for the Social Security amendments of 1965, even with the opposes from AMA and Conservative Republicans, legislation for the establishment of the Medicare and Medicaid Programs steamed rolled through Congress. Which brought forth the possibility of proposals of health coverage for those not eligible for Medicare or Medicaid would begin to surface (Morone, 2010).

f. Richard Nixon 1969 - 1794 Administration - proposed the "National Health Insurance Standard Act. The proposal called for

government-prescribed minimal insurance coverage levels mandated to be provided through employers and financed by employers and employees' payment of premiums. This plan would maintain competition between private insurance and expand coverage. The NHISA would provide government subsidies to pay premiums for employees. The NHISA did not pass; President Nixon successfully gained passage of the Health Maintenance Organization Act of 1973, which would affirm some of the groundwork for managed care (Morone, 2010).

g. Gerald Ford 1974 - 1977 Administration - "The National Health Planning and Resources Development Act of 1974 was an effort to control escalating healthcare costs. The goals of the HPRDA were to minimize and avoid duplication of healthcare facilities and services; it sought to do so by mandating certificate of need programs in the states. Although the CON mandate of the HPRDA expired in 1986, There are thirty-six states and the District of Columbia still operate CON programs today" (Morone, 2010).

h. Jimmy Carter 1977 - 1981 Administration – Campaigned for Universal Healthcare Insurance for Universal Coverage. Once in office, he immediately went to work to prepare a proposal with the support from the American Hospital Association endorsed the proposal and later found he had the support of the house and Senate committee responsible for healthcare legislation. The

proposal could have succeeded in passing if it were not for the abrupt withdrawal of Chairman Senator Edward M. Kennedy, who was running against Carter in 1980 Presidential election (Morone, 2010).

i. Ronald Reagan 1981 – 1989 Administration – There was no proposals for government-run or administered healthcare programs due to President Reagan declared, "In this current crisis, the government is not the solution to our problem. Government is the problem." However, news laws engaged in reducing the growth in federal spending on health care and improving efficiency. One way was the charging of Medicare reimbursement methodologies by reducing reimbursements to hospitals and physicians. There was also the expansion of the Medicare benefits: the Medicare catastrophic coverage Act of 1988, which expanded Medicare coverage for outpatient drugs, capped out-of-pocket co-pays for hospital and physician services and expanded long-term care payments. Funded by increasing premiums for Medicare beneficiaries and a surtax for wealthier beneficiaries based on income (Morone, 2010).

j. George H.W. Bush 1989 – 1993 Administration – For healthcare legislation, President Bush was more for measures to reduce fraud, health care spending and, abuse in Medicare and Medicaid. The most notable reform was a prohibition on physician "self-referrals," also known as Stark I (Morone, 2010).

k. Bill Clinton 1993 – 2001 Administration – President Clinton in 1993 sent to Congress the American Health Security Act, which provided affordable health insurance through a concept called "managed competition." Under this provision, health coverage would be provided under private insurers competing for customers in a highly regulated market, overseen by a regional health alliance established by each state. Employers had to provide insurance to employees and pay 80 percent of the premium. But by 1994, the proposal died, determined by the Senate Majority Leader George Mitchell. However, the Health Insurance Portability and Accountability Act was enacted, which is a portion of the Stark physician self-referral law "Stark II," and the State Children's Health Insurance Program (Morone, 2010).

l. George W Bush 2001 – 2009 Administration – With the tragedy of 9/11, President Bush's focus was the war on terrorism; Health reform took a step back. However, president bush has a legacy of the largest expansion of Medicare in history. The launch of the

Medicare Drug Improvement and Modernization Act of 2003, which made a massive change in the prescription drug coverage benefit, also known as Medicare part D (Morone,2010).

m. Barack Obama 2009 – 2017 Administration – President Obama's priority was health care reform. The ACA, also known as Patient Protection and Affordable Care Act, became effective on March 23, 2010. The ACA brought forth: Congress taxing power Medicaid expansion to all citizens with incomes up to 133 percent of the federal poverty level. Large employers to provide health insurance coverage to employees mandated all citizens to have health insurance coverage by an employer, government, individual Creation of health care exchanges federal finance subsidies for health care insurance for low-income individuals; all health plans provide a minimal level of essential benefits denial prevention for a pre-existing condition (Morone,2010).

Universal Health coverage must include everyone, as America is now just for Medicare, Medicaid, and the Military, three different Universal Health Coverage forms. However, the PPACA, a segmented law, is labeling Americans, and this is where Americans are receiving different care from providers. However, PPACA is a small step towards universal healthcare in America, but clear that Universal Healthcare's absence is a series of policy decisions. Demanding close attention (Béland, 2016).

With the expansions with Medicare, politicians see the characteristics of both the single-payer health service and the universal health coverage may increase high quality, equitable treatment. The expansion of Medicaid eligibility and the ACA coverage widening show Universal Healthcare Insurance's characteristic in America (Dalton, 2014). The research explores whether party control health insurance in the states with republicans are more effective than Democrats at expanding the health coverage and the Adoption of SCHIP, which raised the income level to qualify. Which is a positive towards Universal health reform. (Cummins, 2011).

Politically is America ready for Universal Healthcare with America already like Germany Universal health care now? The Germany model draws employer-based individual and small group plans and all the benefits of employee and employer taxations and individual state contributions (TUOHY, 2019).

Are politicians opposing Universal health insurance? Most are more concerned with and oppose that forty-five million citizens still today do not have health coverage. Along with the Heritage Foundation and Galen, institutes are urging a conversion of the current health insurance to a fixed, universal tax credit that anyone can access to pay for health coverage. America is close to universal healthcare insurance; the politicians have been heading there since 1933. With the health care system now, more and more facilities, American citizens, and providers are wanting the change and ready to accept Universal Healthcare Insurance. Finding the perfect model for the United States is where the politicians are disputing (Menzel, 2006).

In conclusion, American Politicians are ready for Universal Healthcare Insurance and the Healthcare System and American citizens. The problem of bringing forth Universal Health Care in America solely consists of Political views and Government views.

B. Government Views of the U.S. Healthcare System

In the American Healthcare System, the Federal Government is in charge of regulating the purchase of care, healthcare service by providers, education, training, research, and demonstration programs for healthcare professionals. Over the years, the governmental role has increased to achieve a better healthcare system for the American citizens (Straube, 2013, p. 40).

The high cost of healthcare in the United States has increased over the last three decades and consumed an increasing share of the U.S. Gross Domestic Product (GDP), which accounts for a more significant percentage than any other section U.S. economy. The Federal Government in 1965 established Medicare and Medicaid, which increased the number of citizens' access to quality health coverage. Also, from 1980 to the millennium, laws were created to protect citizens under employer-sponsored health insurance and increase federal healthcare programs (Straube, 2013, p. 40).

In 2008 under section 101 of the Medicare and Medicaid Improvements for Patients and Providers Act (MIPPA), by the authorization of Congress, the Secretary of DHHS added additional preventative services to Medicare's benefit

structure, which in turn, influenced the Medicaid and Children's Health Insurance Program (CHIP) (Straube, 2013, p. 40).

The most recent reform is the Affordable Care Act (ACA). This federal healthcare legislation allows the federal legislation to address the fallaciousness of federal healthcare efforts by promoting disease prevention and health as the foundation of healthcare reform by improving healthcare quality and reducing costs. The following describes the 10 Titles that define the ACA (Straube, 2013, p. 40):

"The Quality Affordable Health Care for All American is Title I"

All uninsured Americans' requirement to buy insurance or pay a tax penalty created federal funding for states that accepted the health insurance exchange. It allowed citizens to find assistance with qualifications for Medicaid or tax credits to use to find health insurance they could afford, and it required businesses of 50 or more employees to provide health insurance or pay $2000 per employee after the first 30 employees. Companies under 100 employees had access to use the exchange, and companies with less than 25 employees who provided health insurance qualified for a tax credit of fifty percent. Parents could cover their children and add children to their policies up to the age of 26. Insurance companies (Grogan, 2017, p. 993):

- cannot drop people due to illness

- cannot make lifetime coverages

- deny people coverage due to pre-existing conditions
- must cover wellness and pregnancy exams
- must spend 80 percent of premiums on medical services or give rebates back to the policyholder and submit rate increases to the state for approval

Title II: The Role of Public Programs

Extended Medicaid covers anyone with an income below 138 percent of the Federal Poverty Level and allows states to cover adults with no children. The Federal government paid 100 percent until 2017. After 2017 the federal government reduced assistance, and those states with expanded Medicaid received more assistance than the states that did not (Grogan, 2017, p. 993).

Title III: Improving the Standard and Efficiency of Healthcare

In Medicare part D, the ACA closes the gap in medicine coverages by giving Medicare beneficiaries a one-half discount for brand name pharmaceuticals, and in 2020 the discount increased to seventy-five percent and included free wellness and preventative care to ensure liberation to Medicare recipients (Grogan, 2017, p. 993).

Title IV: The Prevention of Chronic Disease and the Improvement Public Health

The Surgeon General supervises over the National Prevention, Health Promotion, and Public Health Council for the support of preventative health, which contained twelve federal agencies including seven priority areas (Grogan, 2017, p. 993):

- Tobacco-free living
- Preventing drug and abuse
- Healthy eating
- Active living
- Injury-and-Violence-free living
- Reproductive and Sexual Health
- Mental and Emotional Health.

Title V: Health Care Workforce

This title created scholarship funds and loans to increase the health care workforce and funded training in geriatric medicine, cultural competency, and dentistry (Grogan, 2017, p. 993).

Title VI: Transparency and Program Integrity

This title requires providers, medical device makers, and drug companies to reveal financial arrangements they have with doctors and to provide patients with alternative service providers. It created the manages the prescription drug portion of Medicare and state exchanges must report financial information they receive from pharmaceutical companies and provides training and background checks for nursing homes to reduce elder abuse (Grogan, 2017, p. 993)

"Improving Access to Innovative Medical Therapies, " Title IV

This title allowed drug discounts to hospitals and provided low-income patients with competitive pricing for vaccines and hormone therapies (Grogan, 2017, p. 993).

Title VIII: Community Living Assistance Service and Support Act

Disabled Americans received a $50 daily payment for assisted living expenses, and they pay five years of premiums if employed for three of those years. The amount was to help them reside in their own homes, assisted living facilities, nursing homes, or group homes. It would reduce $70.2 billion over ten years of the deficit and keep people working and out of nursing homes and hospitals. Unfortunately, on October 1, 2011, this title was canceled because of the competition with private sectors that offered better benefits (Grogan, 2017, p. 993).

Title IX: Revenue Provisions

For insurance companies selling plans with yearly premiums of $8,500 for single coverage and $23,000 for family coverage, the act leveled the excise tax of forty percent on health insurance, increased HAS tax distributions not being used for medical expense, and limited the FSA contributions (Grogan, 2017, p. 993).

Title X: Strengthening Quality, Affordable Care:

- Authorized the Indian Health Care Improvements Act
- Improved Medicare services and payments public health programs funding (Grogan, 2017, p. 993).

The Federal Government has been a significant game player in achieving better quality and value in health care. With healthcare being a significant segment of the U.S. economy, there are serious challenges that threaten its viability and output. The largest contributor to healthcare cost is Chronic disease, even the efforts of promotion and prevention, which plays a massive role in improving health outcomes. With the stimulation by the ACA of 2010 Federal leadership and other pieces of healthcare, legislations are providing powerful drives of healthcare quality. Though it is unknown if federal efforts will succeed, healthcare progress will be unlikely without the Federal efforts. (Straube, 2013, p. 40).

C. Citizen Views of the U.S. Healthcare System

The American Citizens should have a say on the Healthcare System because they are the ones using the system for the following five main processes of their quality of livelihood and Health (Bergman, 2011):

1. Keeping Healthy

- Physical fitness
- Bed Nets for malaria protection
- Healthy diet
- Clean Drinking Water
- smoking cessation

2. Detecting Health Problems

- Cancer Screenings
- Hypertension Screening
- Blood Sugar Screening
- Cholesterol Screening

3. Diagnosing Diseases

- Diagnoses are on a critical timetable: the quicker, the correct diagnosis, the quicker care can be delivered.

4. Treating disease

- The healthcare system currently has excellent treatment,

  Moreover, care for most diseases. However, patients self-manage.

  and work with healthcare providers to improve the process.

  of care.

5. Providing for a right end of life

- Treatment during the end of one's life is a difficult situation and can be time-consuming for patients, family, and the care provider. Medical specialists are divided by the deterioration of the human organ/symptom area. A specialist considered for the care of the symptom area may not be a good fit for the end-of-life process; therefore, hospice care is required; however, the current health care system does not have enough hospice care personnel.

The American citizen should have a voice in the healthcare system; there involvement would give a crucial perspective from quality to value of the healthcare system. With the citizen being an active partner in the operation and improvements of the healthcare system and not just the subjects to the system's production, patient care issues could improve tremendously (Bergman, 2011).

What Americans face today with the healthcare system consist of the following (Callahan, 2006):

- high premiums with high deductibles
- lack of quality of care, depending on what type of health insurance. a citizen has
- lack of providers who accept insurance policies.
- insurance policies' coverage for procedures
- difficulty understanding insurance policies.
- long waiting room times
- high procedure costs

American people who do not have insurance coverage for a procedure either borrow money to get the procedure done or avoid medical visits altogether. Most of America's debt is due to medical costs. Because of medical costs. Americans are filing bankruptcy, losing homes and employment. Today's healthcare is causing Americans to give up the standard American dream (Callahan, 2006).

D. Medical Professional Views of U.S. Healthcare System

Medical professionals struggle with healthcare reform and health insurance companies. However, the laws regarding race, gender, type of insurance, and insurance companies' payment methods stop physicians from providing the best possible care to patients. The following gives an example of one's general office visit (McCormick, 2009, p. 531):

- **Private Pay Insurance Patients**

    - The Healthcare administrator will process the claim and The insurance will pay 80 percent of the charges. The patient is responsible for 20 percent, and the office co-pay if the policy deductible is consistent. If a Health policy deductible is inconsistent: the patient pays the entire amount plus the co-pay until the deductible amount is covered. Usually, a wide range of providers accept private pay insurance (McCormick, 2009, p. 531).

- **Medicaid Patients**

    - These patients usually have a co-pay for office visits without a deductible and are not widely accepted by the medical provider. Most medical providers receive a tiny portion of the cost due to the state regulating the maximum amount a provider can charge for service. Usually, these patients receive medical care at health departments and low-cost clinics (McCormick, 2009, p. 531).

- **Medicare Patients**

    - Providers can charge a highly regulated Medicare fee, providers can charge and the patient have minimum coverage for vision and dental. The separate policies: Medicare Part A, Part B, Part C, and Part D, fall into play.

- **Patients have the choice to cover the cost with a** supplemental policy: however, these policies only cover the procedure if Medicare covers the procedure (McCormick, 2009, p.531).

Most insurance companies will not allow different genders and races to share a hospital room. Therefore, hospitals are mandated to have private rooms, which raises the hospital room's daily cost and lowers the hospital's bed capacity. A Medicare patient will prioritize all other insurance companies mainly because the patient is either disabled or elderly. Private insurance patients take the next priority, leaving Medicaid patients at the bottom of the list (McCormick, 2009, p. 531).

Furthermore, the administrator goes through many issues to code procedures correctly for the insurance to cover the cost. Most of the time, the claims are sent back for correction due to various potential mistakes (McCormick, 2009, p. 531).

II. Current Healthcare System in the United States

The United States currently has four different medical coverage versions offered to its citizens, extending from private pay to government-regulated medical coverage programs. However, U.S. citizens must have a medical insurance policy regardless of income level, but policy coverages and fees can be challenging to comprehend. Government-controlled insurance includes insurance for Military and veteran, Medicaid, and Medicare recipients.

The Department of Defense provides the program TRICARE for active-duty military personnel and dependents, veterans and retired active-duty personnel and dependents, and all uniformed Military, coast guard, and commissioned corps of public health service (Murray, 2018).

A. Military Policies and Veterans Health Insurance

Military personnel coverage is free, and their families receive coverage with a small premium fee with an allowance given to the military personnel to cover the cost of premiums and out-of-pocket expenses. However, if the conditional uses contracted Military Treatment Facilities, there is no out-of-pocket cost for the military member. If a non-Military Treatment Facility: then TRICARE fees are 60% of the care provided, and beneficiary fees are 40% (Murray, 2018).

Like active personnel, retired personnel and dependents, veterans and dependents, reserve active and inactive members, and dependents receive free

care at military medical treatment facilities. These groups pay 80% TRICARE fees and 20% beneficiary fees at non-medical treatment facilities (Murray, 2018).

Inactive military personnel: offered to continue the policy plan of their choice at the full premium price, but they cannot use military treatment facilities. If inactive military personnel do not accept the policy, then the member and dependents are covered for 60 days after discharge and are required to obtain health coverage for themselves and their dependents (Murray, 2018).

B. Medicare

Medicare is a government-administered program offered in the United States to elderly citizens 65 years old and over and some disabled citizens under the age of 65 years. It is the most extensive health insurance program the United States offers its citizens. Created in 1965 as part of the Security Act, it became effective in 1966. In 1973 the program was expanded to include citizens with kidney failure and those in need of dialysis or transplants, and Managed by the Health Care Financing Administration, a part of the Department of Health and Human Services. Similar to Social Security, Medicare is not based on financial need but by age and disability. Medicare remains constant throughout the United States, and the coverage is also worldwide for American Citizens. The benefits of Medicare have four types of policies (Browning, 2021):

- **Medicare Part A: Hospital Insurance with no premium cost**

  - **Coverage**

- Hospital Stays
- includes inpatient stays from the minimum of over two night to the maximum of 90 days.
- requires the patient to pay a deductible during the hospital stays.
- Post- Hospital nursing facilities
- Home Health Care for terminal patients
- Skilled nursing care the patients
- covers all costs for the first 20 days of stay, covers a portion the costs for days 21 to 100 and covers no costs after day 101 of stay.
- Meals
- a semi-private room
- physical and occupational therapy
- speech and language pathology services
- medical social services
- medications
- medical supplies and equipment used in a facility

- ambulance transportation
- dietary counseling
- hospice benefits to those with six months to live
- patients must select hospice care instead of assisted living.

- **Medicare Part B is medical insurance**: Enrollment in Part B is optional, and the beneficiaries pay a monthly premium, including an annual deductible (Browning,2021).

  - Coverage

  - Medical Visits
  - Laboratory Testing
  - Outpatient Medical Services
  - Medical equipment and supplies
  - Home Health Care and Physical Therapy when medically necessary

- **Medicare Part C, or Medicare Advantage Plans:** Congress passed the Balanced Budget Act during 1997, which allowed for those enrolled in the Original Medicare plans A and B to choose to enroll in Part C. Once the member pays the deductible and co-payment, the government will pay the

provider directly. The beneficiary will receive coverage from a private plane, which the government pays for the health plan to that particular private insurance company (Browning, 2021).

- Coverage

- Offers the Same coverage as the beneficiary who has Part and Part B Plans.
- Does not provide Hospice care
- Offers Health services through health maintenance Organization
- Private insurance companies decide policy premiums, deductibles, and services covered.
- Offers Prescription Drug Coverages, or beneficiary can Choose to use Medicare Part D

- **Medicare Part D Prescription Drug**

Congress in 2003 approved The Medicare Prescription Drug, Improvement, and Modernization, also known as MMA, and came into effect on January 1, 2006. Any beneficiary of Medicare can receive coverage under Part D but must enroll in a private company plan. They have the option to enroll in Part D stand-alone prescription drug plan or the Medicare Advantage Plan with

Prescription Drug Coverage. The cost for Part D varies depending on the policy the beneficiary selects, and individuals who make $85,000 or more a year have to pay an additional amount along with the premium, with the highest rates applying to those who make $214,000 or more a year (Browning, 2021). Congress passed the Patient Protection and Affordable Act (ACA) in 2010 to expand health care costs while controlling costs and improving healthcare delivery. This act helped more for Medicaid and did not affect Medicare beneficiaries. However, there are five provisions in the ACA related to Medicare (Browning, 2021):

1. No cost preventive Services
   - Colonoscopies
   - Mammograms
2. Brand name Prescription Drug discounts
3. Coordination with doctors
4. No change in Medicare Coverages
5. The Medicare Trust Fund extended to 2029

C. Medicaid

In 1965, The social security amendments founded Title XIX and provided most of Medicaid funding. Title XIX established the general guidelines for eligibility, services covered, and reimbursement rates for the joint state-federal program. The states provide the additional funding and have the program's administration's flexibility for eligibility levels, procedures, benefits, provider

payments, and care delivery. However, the states must follow actions, such as providing coverage for certain groups of individuals and specific services (Buchmueller et al., 2016, p. 26-136). The United States provides Medicaid as health insurance to low-income families, indigent seniors, and disabled adults. It is the most extensive health insurance program in the United States, providing coverage to over 68 million individuals and costing state and federal governments over $400 billion. Because Medicaid has several different types of services for other groups of beneficiaries, Medicaid is known as the four public insurance programs in one (Buchmueller et al., 2016, p.26-136). The following are the four sources, which provide:

- health insurance for low-income children and parents-a supplemental health insurance for low-income seniors who have Medicare as their primary health insurance.
- health insurance for low-income disabled individuals.
- the most extensive program that finances nursing home care.

In 2010, through passing the Patient Protection and Affordable Care Act, Congress expanded Medicaid eligibility to childless non-elderly, or non-disabled adult individuals with low income (Buchmueller et al., 2016, p.26-136).

Medicaid eligibility is available to individuals who are below 200 percent of the poverty rate in their state. Medicaid is an HMO insurance policy, meaning

that the benefit of coverage for an individual covers in-network providers that have applied for the insurance program. Out-of-network, the individual beneficiary is covered at 60 percent Medicaid and 40 percent beneficiary. Some in-network individuals are required to pay a small co-pay for sick office visits and prescriptions. For beneficiaries over 50, Medicaid 100% covers yearly wellness exams, including mammograms, pap smears, and colonoscopies at beneficiaries. All beneficiaries must visit their primary care physicians for referrals to specialists (Buchmueller et al., 2016, p.26-136)

Medicaid also provides vision and dental coverage for individuals over and under the beneficiary age of 18 (Buchmueller et al., 2016, p.26-136), including the following benefits:

- Dental for adults over eighteen -
- Yearly Dental Exam
- Cleaning one time a year
- Fillings
- Some minor repairs
- Extractions
- Dental for children under eighteen
- Two exams per year
- Two cleanings per year

- Fillings
- Repair
- Fluoride treatment (for a beneficiary under thirteen)
- Orthodontics
- Extractions
- Vision for all beneficiaries
- Yearly vision exam
- Glasses, contacts, or bifocal lenses one time a year
- Frames up to 59 dollars

D. Private Insurance

An American citizen has the right to purchases a health insurance policy from a health insurance company for a part or full calendar year to help with the expenses of health care procedures for themselves and their dependents (Berchick et al., 2019, p. 104).

American Citizens purchase private-pay health insurance by either employment-based insurance offered by employer or union, or by direct purchase, purchased from a private insurance company or through the marketplace (Berchick et al., 2019, p. 104).

In the United States, several different insurance companies offer several other policies. A policy label with one of the following titles (Berchick et al., 2019, p. 104):

- Primary Insurance: The central insurance policy for a beneficiary and their dependents.
- Secondary Insurance: An insurance policy that covers what primary insurance does not
- **Coverage.**
- Supplemental Policy: A policy covering the remainder of a procedure that Medicare Covers.
- Child Only Policies: Policies purchased by divorced parents to insure a child.

Health Insurance policies have several different forms of benefits of coverage and deductibles. All policies cover Preventative exams and procedures one time a year and require the member to visit their primary care physician one time a year at no cost to the member. Covered preventive services are (Berchick et al., 2019, p. 104):

- Yearly Preventative Exam
- Females of 21 years of age Pelvic and Cervical cancer testing

- Males of 35 years of age Prostate exam
- Yearly routine blood work
- Females 35 years or older Mammograms every year
- age 50 years colonoscopy
- Children birth: 1 year of age Wellness exams and vaccinations
- Children 2 years of age:4 wellness exams and vaccination
- Children 4 years of age: 12 years of age wellness exams and vaccination
- Children 12 years of age through 18 years of age: yearly wellness exam and vaccinations

For Sick office visits and medical procedures, the health insurance company covers per the policy, which there are several different coverages a beneficiary can choose. Insurance companies label them by 80/20/1000, 80/20/500, 60/40/1000, or 60/40/500, and the insurance company describes these as the first number is how much the insurance will cover, the second number is the percentage a beneficiary covers, the third number is the deductible amount that beneficiary must meet for the policy percentages to start and is also considered an out-of-pocket amount for the beneficiary. Some of the policies have co-pays paid to the provider at the time of service for any covered procedure that

is not a preventative medical service. These co-pays range from just a few dollars to $25.00 (Berchick et al., 2019, p. 104).

Insurance companies provide three different insurance plans; one is a PPO policy known as Preferred Provider Organization, HMO also known as Health Maintenance Organization, and POS, also known as Point of Service Plans (Berchick et al., 2019, p. 104).

- PPO is a managed care health insurance plan that provides maximum benefits to In-Network Providers and very little coverage for out of network providers
- HMO includes health insurance coverage for a monthly or annual fee, a network of providers that allow for lower premiums, require beneficiaries to receive care with primary care physicians. Beneficiaries must have a referral from primary care physician to receive care from a specialist.
- POS defines a plan in which a beneficiary pays less to use the policies of in-network doctors, facilities, and other healthcare providers, and a referral is required from a primary care physician to visit a specialist.

III. Universal Healthcare System

The universal health care system is like any health care system, the at least of basic health coverage to most of or all citizens of the country they reside. The coverage is not necessarily free; however, the coverage is affordable to even the poorest regardless of their health conditions or diseases or the need for long-term treatment. The sole purpose of universal health care is to provide health care services without causing the citizens to have health care debt due to the high cost of healthcare services today. The world today contains thirty-three nations, thirty-two of those nations have some universal healthcare coverage. The only nation that does not have universal health care is the United States. (Butticè, 2019b, p 12)

There are several ways to finance a healthcare system, such as taxation, government or non-government funding, private or national insurance, out-of-pocket payments, and donations. Most of the funding methods for the health systems are categorized into four models (Butticè, 2019b, p 12):

A. The Beveridge Model

The Beveridge model, named after William Henry Beveridge, a British economist and designed Britain's National Health Service, was appointed in 1942 by Prime Minister Winston Churchill during World War II to reform its welfare state. He presented the Social Insurance and Allied Service, which later became known as the Beveridge report. Beveridge identified the five "Giant Evils" which affected society:

Want, Ignorance, Idleness, Squalor, and Disease. The most critical disease identified the other four proposed creating the comprehensive social insurance system with the united healthcare coverage model (Butticè, 2019b, p 33-35).

The government owns and operates the Beveridge Model and acts as a single-payer model. All citizens are enrolled for a small fee or for free in the nations health care plan and the facilities are government-owned with government-employed doctors, medical professionals.

Citizens can choose a private medical provider for those who can afford to pay medical services fees. Private Providers can still see patients with government insurance, and the government pays them a fee or a co-payment (Butticè, 2019b, p 33-35). The Beveridge Model meets the definition of "socialized medicine," all the countries that use this model are capitalist democracies that focus on health care efficiency and equity instead of profit, except for Cuba. The countries that use this model are (Butticè, 2019b, p 33-35):

- United Kingdom
- Italy
- Spain
- Norway
- Denmark

- Finland
- Sweden
- Hong Kong
- New Zealand
- Cuba

B. Bismarck Model

The Bismarck Model, named after Prussian Chancellor Otto von Bismarck, created in Germany in 1883 and the first universal healthcare during the modern period and considered a social health insurance model. To fight poverty and build the welfare state, Bismarck, created sickness insurance instead of citizens paying for the social insurance offered by the trade unions and church-run labor federations. The industrial employers were to provide sickness and injury insurance for the employees that were low-wage earners.

Furthermore, required to hire wage-earning employees to fund the system with payroll deduction for sick funds and controlled by the employers. The countries with active Bismarck Model insurance require all citizens to join the sickness funds if they are low-wage earners, which covers all citizens' law must have health insurance. All citizens can still purchase private insurance plans or additional coverage: however, these policies are considered voluntary and constitute an additional expense only the wealthy citizens with no chronic illness

can pay the premiums of the policies. This model is found following wealthy countries but varies in variations, and financed by contributions according to income level and paid as a deduction from wages and salary (Butticè, 2019b, p 37-38):

- Germany: Sickness funds are private, nonprofit organizations that the government reimburses and required by law to provide set benefits of hospital, LTC, PCPs.' services, and preventative services.
- Netherlands: Citizens pay a yearly deductible of less than $500, and out-of-pocket the expense of 14.7% of healthcare spending.
- France: Medical students training, Prescription Drug fees, funds, budget and cost of procedures are all controlled by the Ministry of Health.
- Switzerland: Same as Germany
- Japan: More private doctors and hospitals than in the United States, however, the physicians receive a lower salary than other countries, and the hospitals pay their education tuition.

- Western European countries: Same as France

C. National Health Insurance

The National Health Insurance model contains some elements of the Bismarck Model. Citizens must have compulsory national insurance that the government runs instead of a profit or nonprofit organization. Citizen's payments as a deduction from their payroll tax or a revenue-based premium. Since this system is a public single-payer system, there is no marking, financial motive for claim denial, and minimal administrative expenses.

Therefore, the system is not for profit. The universal insurance program's cost is meager, with the power as single-payer insurance to negotiate for the lowest price. Patients do not participate in reimbursement; all payments occur between the provider and the government by negotiations for the physician and the hospital's global budget.

Limited medical services are due to cost control, responsible for long wait times for citizens' services. Also regulated by the government is the safety and efficiency of drugs. Moreover, medical devices, health research funds, and administers most of the health functions. The basic insurance coverage package is different between each region; however, many citizens purchase supplemental private insurance for the services not covered by public reimbursement or disease-

specific cash indemnity policies. The regions that use the National Health insurance Model are Canada, Turkey, Taiwan, Mexico, and South Korea (Butticè, 2019b, p 39).

D. Out of Pocket Model

Healthcare and services are covered solely by the expense of the patient. There is no monitoring of the expenses and collecting the money for payments of services provided to the patient. The out-of-pocket model is in the United States, rural parts of Africa, South East Asia, China, and some of the South American countries (Butticè, 2019b, p 39).

IV. Comparison of Universal Healthcare System to Current United States Healthcare System.

A. How the United States Current Health Care System Compares to The Beveridge Model

The United States military insurance TRICARE compares closely to the Beveridge Model with military facilities and physicians mostly being used to take care of the US military active duty, reserve, and veterans including their dependent family members. There is no fee for active-duty military and dependents to use medical facilities located on military bases.

However, there are small fees for the members to use nonmilitary facilities and physicians. The only difference between TRICARE and the Beveridge Model is TRICARE is for US military use only, where The Beveridge Model is for all citizens of the country who uses this model for healthcare (Butticè, 2019b, p 39).

B. United States Current Health Care System Compared to The Bismarck Model

The Medicaid insurance that the US provides for its low-income citizens compares to the Bismarck Model of sickness funds.

The US government chooses the income levels that qualify for Medicaid and is funded by both government and higher wage earners taxes and qualifies for the law of all citizens must have health insurance. With the Bismarck Model, citizens are seen by the same facilities as the higher wage-earning citizens. Intern in the US, Medicaid receipts are seen by providers who agree to accept the cost of services, the government will pay for which lowers the physicians and facilities who will accept this coverage due to service cost from the government are a meager price range (Butticè, 2019b, p 39).

C. United States Current Health Care System Compared to The National Health Insurance Model.

The National insurance model compares to the US Medicare program, they are both governments run, and payments are made directly to providers, services that providers can perform are also government regulated. Medicare patients do have to pay a small annual deductible and

most have a small monthly premium that has to be also made.

The only difference between Medicare and National Health Insurance Model is Medicare for disabled citizens and elderly citizens over the age of 65. The national health insurance model is for all citizens of a country who uses this healthcare model (Butticè, 2019b, p 39).

D. United States Current System Compared to The Out-of-Pocket Model

The out-of-pocket model compares to the US private insurance that is Either offered to employees through their employer or by a citizen purchasing the coverage privately. The citizens have a choice of policies and coverages with different monthly premiums and copayments, out of pocket, and deductible expenses for in-network providers and or out of network providers (Butticè, 2019b, p 39).

V. Pros and Cons of Universal Healthcare

A. PROS

1. All American Citizens would have health insurance to access Healthcare Services. The coverage would not change with age, employment, family status, income, or the state the citizens reside or relocate.

   The health insurance would be continuous (Blumberg & Holahan, 2019).

2. The health care coverage would be the same for all American citizens (Blumberg & Holahan, 2019).

3. The American citizens would have no premiums or out-of-pocket cost, and a wide range of medically necessary benefits covering preexisting conditions and terminal conditions. The medical cost would apply to all taxpaying citizens, which intern eliminates the financial burden to citizens with serious health problems (Blumberg & Holahan, 2019)
4. Access to quality health care would increase due to no premiums or out-of-pocket expense, especially for low and modest-income citizens. With benefits of dental, vision, long term care services would increase in Higher income citizens with access to services. The quality of health of the American citizens would improve and create a higher demand for health care providers (Blumberg & Holahan, 2019).
5. With Universal Healthcare provider payment methods and incentives that affect all providers servicing insured people are government-regulated (Blumberg & Holahan, 2019).
6. Universal health coverage would dismantle the employers and state government's administrative structure and save each state some money. Moreover, direct payments for health insurance coverage for employees and residents would stop. However, these changes would depend on the mechanisms financing the new program (Blumberg & Holahan, 2019).

7. American citizens would find that administrative interaction less complicated with not having premiums, provider networks. Pending the details of the program and its cost-containment Efforts (Blumberg & Holahan, 2019).
8. Much private health insurance administration cost such as: commissions, claims administration, premium determination, risk and profit, and other general administrative tasks could be lowered or eliminated. A software system developed to set the provider's payment rates and maintain quality of care and efficiency would increase the claims administrator's economies scale. The single-payer system would eliminate the administrative middleman: manager, agents, health insurance rebates (Blumberg & Holahan, 2019).
9. A single-payer insurance would minimize the administration's cost that every provider currently incurs in The United States. For example, Medicare currently
10. Currently, the health care system reimburses for public and private provide enrollees with either an exclusive or preferred network of healthcare providers and enrollees for these provider services. However, single payer

insurance would eliminate net-work providers, and all hospitals would be covered and offer patients a more considerable choice of providers (Blumberg & Holahan, 2019).

11. Under current health care laws, every provider decides independently which insurance providers to participate in, which created a significant problem in emergency care facilities that were patients do not have time to investigate providers acceptance, and problems with anesthesiologist, emergency room physicians that do not accept the same providers that the facility does. For example, Lourdes hospital is in-network for WellCare, but the emergency room physicians are independent physicians and do not except for WellCare, the patient has endured a large out-of-network health care expense. Single-payer insurance would eliminate the network providers and intern eliminate the surprise billing cost for patients (Blumberg & Holahan, 2019).

12. Universal healthcare ran by the federal government can be specific in disturbing raised revenues to fun, the American population's health care costs (Blumberg & Holahan, 2019).

B. Cons

1. Increase in federal government health care spending for a single-payer insurance system. With a possible decrease in household Furthermore, an employer's savings can offset most of the increase in taxes. Single-payer insurance would increase the federal deficit by increasing taxes, and federal spending (Blumberg & Holahan,2019).
2. A single-payer insurance could have a significant complication in revenue and physician incomes and payments reduced could cause an entailment in all healthcare sections. The health care system could also disrupt within the delivery system due to provider types, geographical location, decrease in payment rate to hospitals, physicians, medical device manufacturers,

prescription drug manufacturers (Blumberg & Holahan, 2019).

3. A new health care system to handle the price of health care services and medical supplies and would include monitoring and an evaluation system that would manage the benefits of the healthcare the system would have to be developed by the federal government. Which would be costly and time-consuming, but eventually even out over time (Blumberg & Holahan, 2019).
4. A single-payer insurance system would require an open enrollment period due to the risk would be created by the government and all citizens eligible, and Citizens would have to be slowly entered into the system in order for citizens to access providers and entered into the healthcare system (Blumberg & Holahan, 2019).
5. Under the management of care due to the delivery system could cause an increase in the cost of health service by

decreasing the cost of administration. Which would decrease the quality of care the patient receives (Blumberg & Holahan, 2019).

6. American citizens would not be able to choose a provider for their health insurance coverage. If a citizen is dissatisfied with the provider, the government has chosen, and the intern would pressure the government to meet all the citizen's needs (Blumberg & Holahan, 2019).

7. Countries that currently have universal health care insurance have seen a growth in the last two years in health care providers, services, technological advances, responses with manufacturers, sufficient incentives for ongoing research and development of new treatment costs. Furthermore, the United States has only seen an average growth with the current health care system (Blumberg & Holahan, 2019).

8. American citizens in the higher income brackets would likely pay-out-of-pocket for healthcare due to their care satisfaction. However, with a single-payer system, the restraint would be placed on the government system. Furthermore, the providers whom private-paying patients well support will most likely? not provide patient care under a single-payer system (Blumberg & Holahan, 2019).

VI. Is America Ready for Universal Health Care

Since President Roosevelt in 1933, the United States has been slowly increasing the plans of healthcare. The growth has been a complicated process with politicians and the government researching how to correct the health care situation. President Obama started the ground effect to end the conflict by mandating all us citizens obtain healthcare coverage and creating the Affordable Care Act, which corrected some of the issues and created a whole new world of issues.

Now, American citizens choose between paying for necessities such as food and electricity or paying their health insurance premiums. Most citizens have chosen to take the tax penalty for not having health coverage to keep their families provided, which was not the government's intent at all.

Several other countries are currently using Universal Healthcare in various models, and these countries are not struggling near as hard with health care, and citizens are not struggling financially. What correction in America needs to be corrected?

Politicians have stated that Universal Health Care would benefit the united states, However, the startup cost would be substantial, with new programs and medical services and salaries for medical providers and administrators. Do the politicians realize that the programs currently in use for the healthcare system have already addressed this issue! Medicare and Medicaid already have the cost of services priced, and Provider's and Administrator's salaries established in the program.

The United States Military already has providers enlisted as active duty and salaried by rank. The Military is already providing services for active and inactive citizens and Private. Health insurance is already offering supplemental policies to citizens with Medicare, Medicaid.

Medical Professionals are already struggling between all the different programs to process medical claims and offer medical services to citizens per medical insurance coverages. Furthermore, to provide the best quality of care to the patients.

All patients can think is insurance going to cover this procedure. The doctor says this medication or medical service is needed; Is it affordable even if insurance does not cover some of the cost. The actual question is When is America going to establish that using several different Universal Healthcare Models is the problem?

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