

Auerback, Marshall; Wray, L. Randall

**Research Report**

## Toward true health care reform: More care, less insurance

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Levy Economics Institute of Bard College

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# ***Public Policy Brief***

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No. 110, 2010

## **TOWARD TRUE HEALTH CARE REFORM: MORE CARE, LESS INSURANCE**

MARSHALL AUERBACK and L. RANDALL WRAY

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## Preface

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The United States has the most expensive health care system in the world, yet its system produces inferior outcomes relative to those in other countries. Moreover, it is the only country with a high per capita income that lacks universal health care coverage. Less than two-thirds of workers under age 65 have health insurance, while coverage varies greatly according to socioeconomic status.

Marshall Auerback and Senior Scholar L. Randall Wray examine the U.S. health care reform debate and argue that the fundamental structure of the health care system is unlikely to change. Both the House and Senate versions of the current health care bill entrench the centrality of private health insurance companies and contain no serious proposals to limit costs. “Reform” measures actually promote the status quo by pulling more people into an expensive health care system that is managed and funded by insurers. Since two-thirds of household bankruptcies are due to health care costs, forcing people to turn over an even larger portion of their income to insurance companies will further erode household finances and exacerbate the problem. Moreover, health care remains a function of employment, which preserves a significant cost disadvantage for U.S. corporations and is particularly unappealing during periods of double-digit unemployment.

The authors note that tying health insurance to employers was a historical accident that distorts the method of grouping individuals for the purposes of insurance. Since (private) insurance companies are in the business of maximizing profits, they attempt to reduce costs by denying coverage in consort with increasing exclusions. Prescreening and “denial management” costs are estimated to represent approximately 2 percent of GDP, while administrative overhead and profits represent almost one-third of health spending. And as health care costs have soared, legislators have backed off from enforcing mandates or financing new coverage for the poor.

According to the authors, the fundamental problem facing the U.S. health care system is the unhealthy lifestyle of many Americans. They would prefer to see a reduced role for private

insurers and an increased role for government funding, along with greater public discussion of environmental and lifestyle factors. Minimal competition between private insurers means that premiums based on behavior modifications that reduce health risk have not been adjusted downward. A campaign to promote healthy lifestyles would do more to improve outcomes and reduce costs than any of the proposed “health care reforms.”

Ideally, insurance premiums should be linked to individual risks, since 80 percent of health care costs are attributed to 20 percent of patients. Taxing current insurance holders and cutting Medicare to extend insurance to the uninsured should not be features of legislative reform.

In the authors’ view, insurance is best suited to cover unexpected losses. Furthermore, social policy dictates the losses that insurers must cover, and people need health care services on a routine basis. Since it is in the public interest to ensure that the entire population receives preventative and routine care, these services should not be subject to denial of coverage by the insurance companies.

The authors point out that Medicare is not really an insurance program but rather a universal-payer, pay-as-you-go system (there is no way to stockpile medical services for future use). An earlier version of the Senate’s proposed health care legislation featured a Medicare buy-in for people under 65—a feature that remains doable despite today’s political constraints. This “public option” provides more cost control (by competing with the private insurance companies), helps to solve the problem of denying treatment based on preexisting conditions, expands the risk pool of patients, and enhances the global competitiveness of U.S. corporations. Thus, a Medicare buy-in would bring the U.S. health care system closer to the “ideal” low-cost, universal (single-payer) insurance plan.

As always, I welcome your comments.

Dimitri B. Papadimitriou, *President*  
March 2010

## Toward True Health Care Reform

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This brief will examine the health care reform debate in the United States. We will make four points. First, the proposed legislation (both the House and Senate versions) will do little to improve provision of health care to currently underserved populations, and hence will have little impact on outcomes. Second, using insurance as the primary means of providing finance of health care delivery is costly — indeed, it is the main problem facing the nation. Third, in any event, relating coverage to employment is no longer viable. Fourth, the proposed reforms, rather than constraining exploding costs, will likely contribute to them.

### The U.S. Health Care System

Funding of our current health care system, like our retirement system, rests on a three-legged stool. The first leg is private insurance, almost all of which is provided through employment. The second leg is provided by the individuals receiving care, through out-of-pocket expenses, including copayments and paying for uncovered treatment or medicines. Finally, there is the government, which picks up the tab through a variety of programs at all levels of government. The biggest of these are Medicaid and Medicare.

As reported by Stephanie A. Kelton (2007), about 63 percent of the nonelderly population (those under age 65, who are not eligible for Medicare) rely on employer-provided insurance, while government pays for insurance for about 18 percent of the population and over 17 percent are uninsured. Also as reported by Kelton, there are several different types of plans offered by employers. By far the most important are HMOs and PPOs, which together provide 85 percent of employer-sponsored plans.

In 2000, approximately 67 percent of nonaged workers (again, excluding those over age 65, most of whom qualify for Medicare) had insurance, but this declined to less than 63 percent by 2005. Coverage varies greatly by socioeconomic status: in 2005 70 percent of whites had coverage, compared to only 50 percent of black workers and 41 percent of Hispanic workers (Kelton 2007). Fewer than half the workers in very small firms (fewer than 10 workers) were covered, while almost 80 percent of workers in the biggest firms (over 1,000 employees) had cover-

age. And less than one-third of workers who had dropped out of high school had coverage, while about 80 percent of those who had attended college received coverage.

Of course, the quantity and quality of coverage vary greatly, with some workers receiving what have been labeled “Cadillac” plans and others receiving only “catastrophic” coverage. Out-of-pocket expenses also vary widely by plan, as does the freedom to choose health care provision. Health care insurance is not the same as health care provision—there can be many a slip between cup and lip: insurance may not cover needed care, and insurance coverage does not guarantee access to needed care.

Relatively few individuals purchase individual health insurance plans, and those who do find it expensive. In 2007 about 14.5 million individuals (5 percent of the population) purchased insurance (Schiff 2009). Many were self-employed or worked in small companies; about a third were unemployed. Half were between the ages of 50 and 64. A survey found that about half of those who tried to purchase an individual plan found it difficult or impossible to buy insurance (*ibid.*). Further, premiums and deductibles are higher and coverage is less comprehensive for individual plans than for employer-provided coverage. Almost half of the individuals who acquired insurance paid at least \$6,000 a year for coverage, and a fifth paid at least \$8,000. The reform proposals would require more individuals to purchase insurance, albeit with subsidies.

It is no secret that the United States “enjoys” the most expensive health care system in the world—both absolutely and relative to GDP. In 2009 health care spending reached 17.4 percent of GDP, up from 16.2 percent in 2008 (Levey 2010). In 1960 health care consumed just 5 percent of GDP; by 2000, that figure had risen to 14 percent. Based on current projections, health care spending would reach one-fifth of GDP by 2020. Also based on current projections, the government’s share of health care spending will finally overtake the total spending by the other two “legs” (employers and individuals) by 2011 or 2012 (*ibid.*). In 1960 government accounted for just a quarter of total health care spending. Note that these projections are made exclusive of any possible health care “reform”—which would likely increase the government’s share.

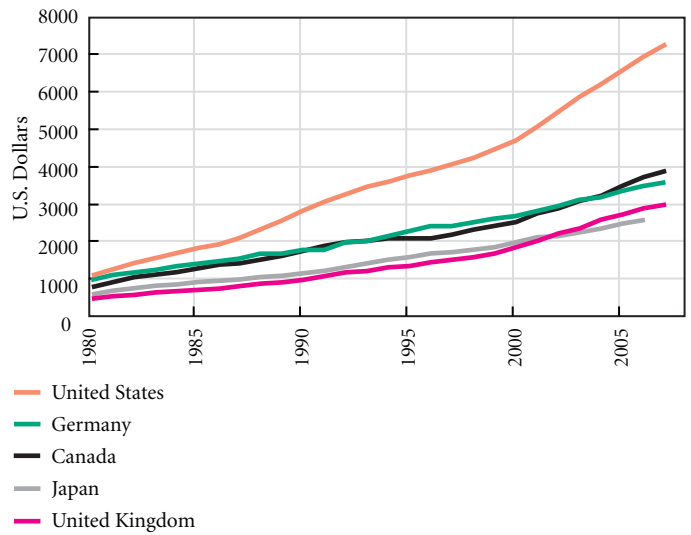
At the same time, in many respects the health outcomes fall short of those that are apparently delivered by much cheaper systems in both highly developed and less developed nations. Below we will explore some reasons for this. Here we only address the costs, and the composition of spending in comparison with other

nations. First, it is important to note how unusual the United States is—no other comparable nation (in terms of high per capita income) lacks universal health care coverage, and many nations that are much poorer provide universal access. And in most of the nations that are similar in other respects to the United States, government plays a much bigger role in health care delivery and in financing the system.

As reported by the New America Foundation (NAF; Damme 2009), the divergence of costs is growing rapidly. In 1980 the United States' per capita costs were approximately double those of the United Kingdom, which had the lowest cost of the largest OECD nations; by 2008, the United States' costs were triple those of the lowest-cost nation, Japan (Figure 1). As a percent of GDP, the United States devotes almost twice as much to health care as the average OECD nation (Figure 2).

The NAF study shows that even after accounting for the positive correlation between spending on health care and GDP (rich nations can afford to spend more, and do), the United States spends far more than would be expected. Yet, by several measures, U.S. outcomes are actually worse. For example, the United States has lower life expectancy and higher infant mortality than any other nation that has even remotely similar living standards, in spite of the much higher per capita expenditure on health care. Adult mortality rates in the United States are almost double those of Italy, Australia, Sweden, Japan, and other relatively wealthy

**Figure 1 Health Care Expenditures per Capita, 1980–2007 (in U.S. dollars\*)**

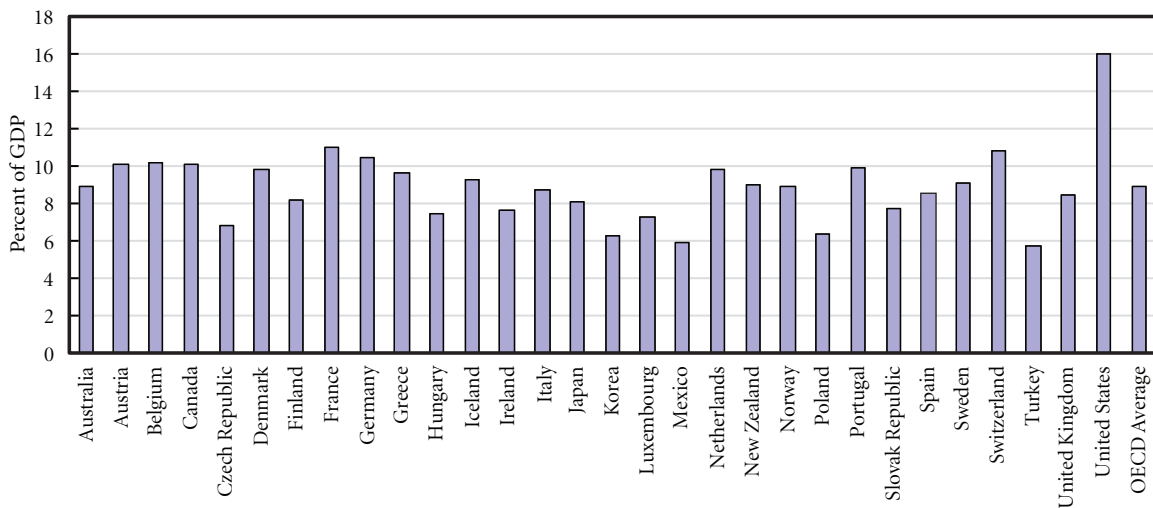


\* Purchasing power parity

Note: 1990 data for Germany is also used for 1991. No data is available for Japan for 2007.

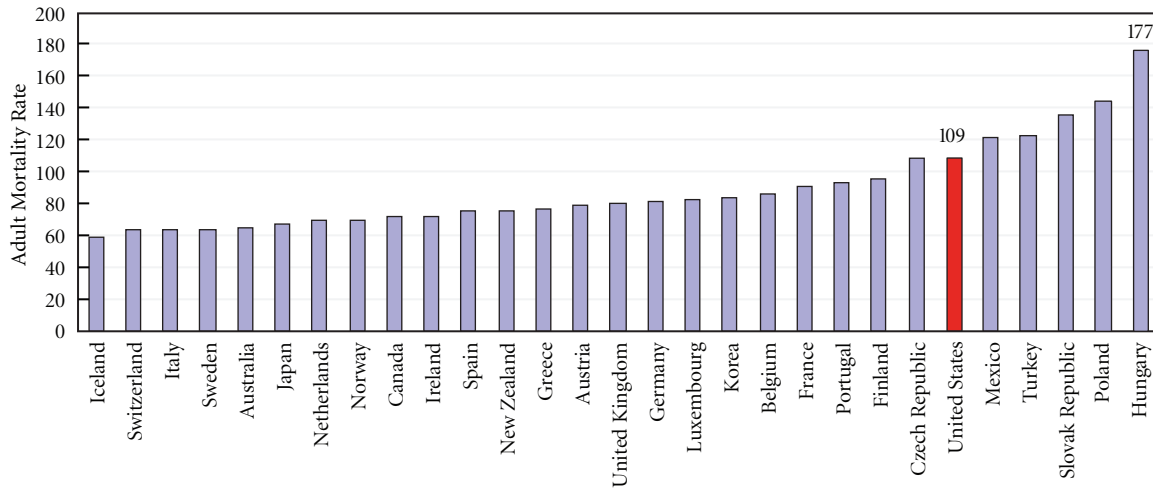
Source: OECD Stat Extracts

**Figure 2 OECD Health Care Expenditures, 2007 (in percent of GDP)**



Sources: OECD Stat Extracts; Damme 2009 for Japan, Luxembourg, Portugal, and Turkey

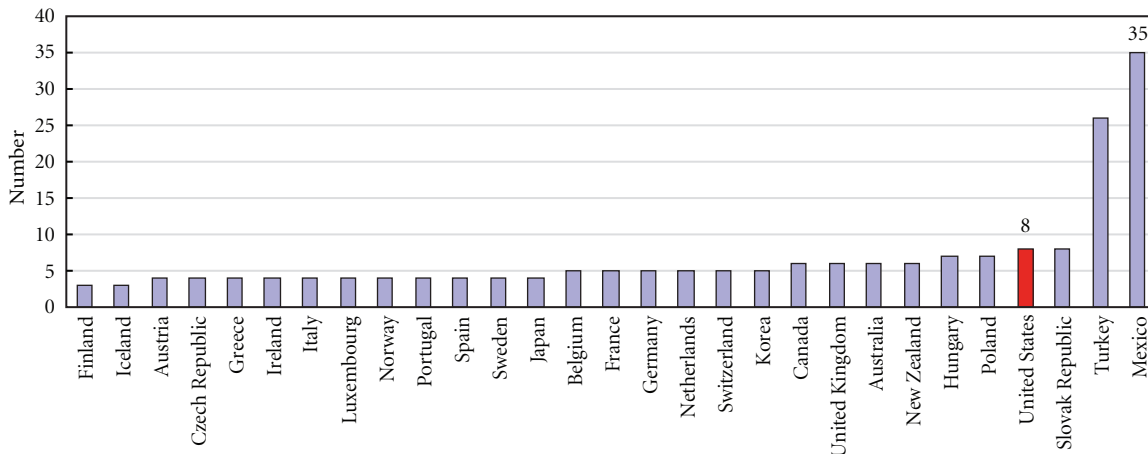
**Figure 3 Adult Mortality Rate\* per 1,000 Population, 2006**



\*Probability of dying between 15 and 60 years of age

Source: World Health Organization, Statistical Information Systems (WHOSIS)

**Figure 4 Infant Mortality Rate\* per 1,000 Live Births, 2006**



\*Probability of dying by age five

Source: WHOSIS

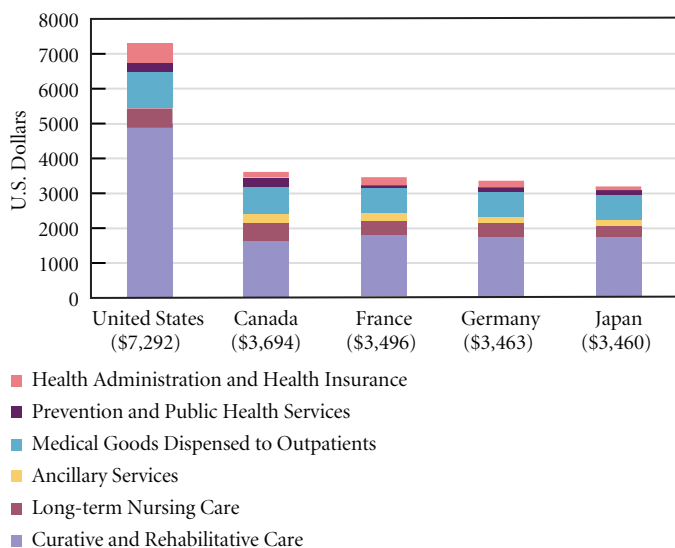
nations (Figure 3). Finally, infant mortality rates are far higher than those in comparable nations—similar to those in the Slovak Republic and double the rates in high-income nations (Figure 4).

To some extent, the higher costs and poorer outcomes could have something to do with the way we finance our care—through insurance—and with the choices we make over the kinds of care provided. The United States spends a lot more on curative-rehabilitative services, more on administration and insurance, and more on medical goods than the other nations

included in the study (Figure 5). The fastest-growing part of U.S. health care spending is outpatient care (included in the curative-rehabilitative category). The NAF study finds that the United States spends twice as much as would be expected on outpatient care, given per capita GDP, which now amounts to 40 percent of total health care spending. As we discuss below, this is related to a virtual explosion of costs in the caring for chronic health problems.

The study’s results are somewhat surprising because one would have expected that our higher costs would have more to

**Figure 5 Composition of Health Spending per Capita, 2007 (in U.S. dollars\*)**



\*Purchasing power parity

Note: Totals for Canada, France, and Germany do not include capital formation expenditures; Japan data is as of 2006.

Sources: OECD Stat Extracts for Canada, France, and Germany; Damme 2009 for the United States and Japan

do with administrative expenses of our more complex approach to health care—with a large number of insurers and lots of paperwork. However, even if we were able to reduce those costs toward OECD averages, the United States would still have much higher per capita expenditures. As we will argue, expanding insurance to the currently uncovered population is not likely to reduce the spending gap between the United States and our comparator nations. Some have argued that expanding coverage would lower emergency room treatment. While probably true, with outpatient care at 40 percent of the health care budget it is difficult to believe that more insurance will help reduce U.S. costs significantly.

### Overview of the Health Care Proposals

It now appears that President Obama’s hope for a grand, sweeping health care reform bill is unlikely to pass, given the unexpected election to the Senate of Republican Scott Brown. In response, there has been some discussion of a more incremental approach. But the whole episode has demonstrated one key fact: the fundamental structure of our health care system is unlikely

to change significantly, no matter what “reforms” are introduced, and however incrementally. Virtually all of the proposals put forth retain a dominant role for private health insurance companies: it is the Massachusetts model writ on a national scale.

Does the recent Massachusetts special election result have any implications in this regard? The loss of the Democrats’ supermajority is being used by many to call for a pause in reform. Yet Senate Democrats in particular should not obsess about the so-called supermajority number—60—required to end filibusters in the upper chamber of Congress. A 59–41 majority in the Senate still gives the Democrats ample opportunities to legislate significant improvements in our health care system, even if by means of a more piecemeal and incremental approach. Substantial reforms can, for example, be done via Senate reconciliation (a parliamentary maneuver that allows legislation in the upper chamber to pass with a simple majority vote). And it’s fundamentally more democratic: two or three senators should not be able to hold an entire piece of legislation hostage to their own narrow political interests, as Senators Joseph Lieberman and Ben Nelson, among others, were able to do with the previous reform bill.

In response to the “incrementalists,” Paul Krugman (2010) has argued that it is difficult to achieve significant health care reform via reconciliation, as this Senate procedure is basically limited to matters of taxing and spending, and therefore cannot be used to enact many important aspects of health care reform (such as the ban on preexisting conditions). What Krugman fails to recognize is that there exist major loopholes in the insurance “reforms” on exclusion for preexisting conditions and no cancellations on the grounds of sickness. The hard-fought “reforms,” in other words, are more apparent than real. Both the final Senate and House versions of the reform bill contain a significant loophole, whereby “intentional misrepresentation” or fraud can be used by insurance companies as a means of denying coverage on the basis of a preexisting condition. Not telling the insurer of a preexisting condition—even one the consumer does not know about—constitutes “fraud.” Both fraud and “intentional misrepresentation” are the main pretexts that insurers use today to deny coverage on the basis of preexisting conditions.



Other major loopholes, as noted by John Nichols (2009) of *The Nation* include:

Provisions permitting insurers and companies to more than double charges to employees who fail “wellness” programs because they have diabetes, high blood pressure, high cholesterol readings, or other medical conditions.

Insurers are permitted to sell policies “across state lines,” exempting patient protections passed in other states. Insurers will thus set up in the least regulated states in a race to the bottom threatening public protections won by consumers in various states.

The RN “superunion” National Nurses United, an organization with 150,000 members, opposed the Senate version of the health care bill for these very reasons (ibid.).

Loopholes aside, Krugman also embraces the principle flaw inherent in the whole health care reform effort. Both the House and Senate versions of the bill entrench the centrality of private health insurance companies. But as we seek to illustrate, insuring health care is not a service that should be provided by private companies.

Contrary to what the president suggested in the aftermath of the Massachusetts senate by-election, bad salesmanship was not the main problem here. There were lots of unattractive substantive elements in the bill, such as reductions in spending on Medicare in order to “pay” for the bill’s “reforms,” misconceived taxes on “Cadillac plans” as a means of “reducing” health care costs and “funding” reform, and a focus on costly end-of-life care (requiring “guidance” from an “independent group” outside of “normal political channels”). All of this occurred against the backdrop of vague, incomprehensible talk by the president and his budget director, Peter Orszag, about “game changers” and “curve-benders,” and arguments that “we’re going to have to change how doctors think about health care and how patients think about health care” (Obama 2009). These are the sorts of things that can be happily debated in a health care symposium but will hardly ease the fears of the average voter, whose main concerns are “Will I get coverage?” and “How much will it cost me personally?”

Remember the Alternative Minimum Tax (AMT) that was introduced almost as a footnote to President Reagan’s tax reform bill of 1986? At the time, it seemed like a relatively small item;

since the threshold for the AMT was set at a reasonably high level, it didn’t affect a lot of people initially. But as time went on and incomes rose, more and more of the middle class got trapped by it. The same thing almost certainly would have occurred in regard to the so-called “Cadillac tax” proposal, a tax on high-cost health care premiums in excess of \$8,900 for single plans or \$24,000 for family plans per annum (Mascaro 2010). Given that neither the House nor the Senate version of the bill contained any serious proposals for cost containment, health insurance premiums probably would have continued to skyrocket, which would virtually guarantee that an increasing number of health insurance customers would be hit by the tax as time went on. It is hard to see how pricing disclosure via national exchanges would significantly change that element, especially given the fact that the health insurance industry is an oligopoly dominated by a limited number of private companies, with no competition from the now-dead public option.

True, in the absence of any kind of health care reform, rising health insurance costs are still likely to remain an everyday reality. But that would be in a situation without the punitive taxation provisions contained in the current bill, which would simply add to the problems of the highly stressed, debt-laden American consumer.

It is important to note that none of the health care proposals ventured thus far remove the oligopoly structure of an inefficient, dysfunctional, fragmented, multipayer system dominated by five or six private health insurance plans (“too big to fail” insurance companies like AIG). Nearly all retain the structure of employer-based health insurance, preserving a significant cost disadvantage for U.S. corporations, which are forced to incorporate health care as a marginal cost of production. This means that not only will portability become virtually impossible but also that health care will remain a function of employment—hardly an appealing prospect at a time of double-digit (and still rising) unemployment.

As Julius Richmond and Rashi Fein describe in *The Health Care Mess* (2005), employer-based health insurance is largely a product of historical accident rather than conscious policy on the part of either employers or the government. It arose out of the labor shortages created during World War II, which, in the absence of controls, would have left employers in a position to bid aggressively against one another in order to attract workers. The government introduced controls that prevented a wage spiral but did not include health care benefits, a convenient loophole

exploited by employers as a means of competing for workers. Medical benefits proved to be an attractive form of compensation for workers to the extent that they protected them from risk; too, employers liked the fact that the benefits were not deemed to be part of workers' taxable income, thereby helping to moderate wage demands (Krugman and Wells 2006).

The intrinsic costs of providing insurance are relatively low, with one proviso: the entire population be offered insurance in the absence of screening, with the annual premium struck at a level that covers the average person's health care expenses and the insurance company's administrative costs (*ibid.*). Unfortunately, that is not what we have: many insurers (with a handful that dominate), many different kinds of plans, and many uncovered people. Hence, healthy people with low medical bills would find little incentive to join such a system, whereas unhealthy people would find the proposals to be very attractive. Insurers likewise prefer to select for healthy people, and to offer lower premiums to attract them. Premiums are thus higher for the unhealthy, who are more likely to go without coverage as a result. Uncovered individuals show up in emergency rooms, with the attendant high costs passed along to premium payers, hospital owners, and governments.

Harvard medical economists David Himmelstein and Steffie Woolhandler (2007) estimate the costs of prescreening and denial management to be approximately \$350 billion a year—just under 2 percent of GDP. (Woolhandler, in a 2007 interview, estimated that about 31 percent of health care spending in America goes to administrative overhead and profit.) They also point out that the common “reform” to mitigate this impact—employer mandates that seek to pool the risks more broadly and, in theory, reduce overall health insurance costs—has been singularly ineffective: “The ‘mandate model’ for reform rests on impeccable political logic: avoid challenging insurance firms’ stranglehold on health care. But it is economic nonsense. The reliance on private insurers makes universal coverage unaffordable” (*ibid.*).

To some extent, the move at the state level toward “universal health care” (in reality, mandated private health insurance) has increased coverage, notably in Massachusetts, where, according to state estimates, only 2.6 percent of residents remain uninsured. A report by John Holahan and Linda Blumberg (2009) indicates that the Massachusetts reform “has had positive impacts on insurance coverage and access to medical care. The number of uninsured has fallen by more than half—with no evi-

dence that subsidized coverage has ‘crowded out’ private insurance. Unmet needs for a range of medical services have dropped, as have financial burdens associated with health care.” But the program is not without its costs. The “reforms” introduced to great fanfare in Massachusetts mandate that people who do not want to buy insurance must buy it, and require insurers who do not want to extend insurance to them to provide it. This has led to frustration that might have been reflected in the recent electoral outcome in that state.

As the long-run costs of health care have soared, legislators have backed off from enforcing the mandates or from financing new coverage for the poor. Many people remain uninsured because they cannot afford the increasingly high costs of private health insurance. And forcing more people into the system does not address the cost issue:

The fundamental assumption is that the uninsured have enough money to buy insurance policies, that they can buy their way out of the predicament. If they had the money, they'd already have insurance! They don't have money in the first place. Someone my age, in their 50s, and making over \$29,400 a year, would get no subsidy. The cost of that premium would be \$4,200 a year, but along with that there's a \$2,000 deductible before any coverage begins, co-pays, and co-insurance after that first \$2,000.

That kind of coverage is worthless to a low-income person. They don't have money for the premium, and they can't pay the \$2,000 out of pocket. I don't call that insurance, I call it a hoax. You're not going to be able to cover everyone with those kinds of premiums. And expansion of Medicaid won't get us to universal coverage, either. We've had 10-plus years of experience with that. (Woolhandler 2007)

Deregulation and competition fail when consumers have no real choice, because the situation invariably leads to an abuse of pricing power. Rent-seeking monopolization is an inevitable outcome of any activity that becomes financialized. In Massachusetts, high costs have forced the state to trim benefits for legal immigrants and prompted one safety-net hospital to sue over a \$38 million shortfall. Strapped for cash, the state recently eliminated dental, hospice, and skilled nursing care for 30,000 legal immigrants. Cigarette taxes were raised to help pay

for the program. Coverage for workers in small businesses has lagged. And private health insurance premiums are expected to increase by about 10 percent next year, according to several estimates (see Holahan and Blumberg 2009). Minimal competition amongst the private insurers means that they have not reduced the premiums for those whose behavior modification has reduced risk.

### **Why Health Care Reform Proposals Will Not Reduce Costs or Improve Outcomes**

Too little exercise, too much smoking, and too much food—especially too much bad food—together account for a large part of the United States’ comparatively high health care costs and inferior outcomes. As Michael Pollan (2008) argues, unless we address these problems, we will not significantly improve our health no matter what we do with health care. According to Pollan, the cost to society of the American addiction to “fast food” is already \$250 billion per year in diet-related health care costs. One-third of Americans born in 2000 will develop diabetes in their lifetime; on average, diabetes subtracts 12 years from life expectancy, and raises annual medical costs from \$2,500, for a person without diabetes, to \$13,000. This in part explains the rapid growth in outpatient costs, which as noted above are very much higher than those of nations with comparable per capita income and wealth. A recent study finds that the medical costs related to obesity could have been as high as \$147 billion in 2008, amounting to 10 percent of all medical spending (Finkelstein et al. 2009). Annual medical costs are \$1,400 higher for an obese person than for a person of normal weight. Approximately two-thirds of adult Americans are overweight, and one-third are obese. Obesity and diabetes are correlated (being overweight is the biggest risk factor for developing diabetes), and obese diabetics are the most difficult to treat. Total spending on diabetes treatment is estimated at \$190 billion a year.

There are other factors that increase health care costs and worsen outcomes. Smoking causes more than 400,000 deaths yearly. Simply banning smoking from public places throughout our country could reduce this annual toll by 150,000 (Winslow 2009). We incarcerate a far higher percentage of our population than any other developed society on earth, and health care costs in prisons are exploding—for the obvious reason that prisons are not healthy environments. Our relatively high poverty rates, combined with a high percentage of the population that is left

outside the labor market (especially young adult males without a high school degree), contribute to very poor health outcomes.

For these reasons, we believe that more health insurance coverage would no more resolve our health care problems than would provision of car insurance to chronic drunk drivers solve our DUI problem. Instead, a campaign to increase exercise, reduce smoking, and otherwise promote healthy lifestyles would almost certainly do more to improve outcomes—and reduce costs—than do the so-called “health care reforms” now being considered in Washington.

While we are at it, we can reintroduce Americans to food. We don’t mean the corporate offerings that Pollan calls “food-like substances”—products derived from plants and animals but generated by breaking down the original foods into their most basic molecules and then reconstituting them in a manner that can be more profitably marketed. What we mean is real food, produced by farmers and consumed after as little processing as possible. Preferably, it will be local, and will consist mostly of vegetables, grains, and fruits. And let us provide decent jobs to anyone ready to work, as an alternative to having their labor skills eroded through the drudgery of long-term unemployment. Ban smoking from all public places and regulate tobacco like the highly addictive and dangerous drug that it is. Together, these policies will do far more to improve American health and to reduce health care costs than anything that the “reformers” are proposing.

To conclude this part of the analysis: the benefits of extending health insurance coverage are almost certainly overstated and are not likely to make a major dent in our two comparative gaps. We spend far more than any otherwise similar nation but do not obtain better outcomes, and in certain important areas we actually get worse results. Nations that adopt diets closer to ours begin to suffer similar afflictions: obesity, diabetes, heart disease, hypertension, diverticulitis, malformed dental arches and tooth decay, varicose veins, ulcers, hemorrhoids, and cancer (Pollan 2008, 91). In other words, the differentials in outcomes and costs probably have more to do with “lifestyle choices,” and the gaps might be lowered not by reducing U.S. spending and improving outcomes, but by rising spending and worsening outcomes among our comparator nations if and when they adopt the American lifestyle. We sincerely hope this will not be the case.

Even universal health insurance is not going to lower the costs of chronic afflictions that are largely due to the fact that we eat too much of the wrong kinds of food and get too little exercise. It makes more sense to attack the problem directly by increasing

exercise, reducing caloric intake, and minimizing consumption of corporate “food-like” substances that make us sick than to provide insurance so that those who suffer the consequences of an unhealthy lifestyle can afford costly care. Finally, the “reforms” mostly propose to simply do more of what we are already doing—that is, to get more people into an expensive health care system managed and funded by insurers. Insurers, in turn, will do what they can to shift costs by excluding individuals from coverage, restricting the coverage of those included, denying payment for care, and requiring copayments. It strains credulity to believe that this will result in a cheaper health care system.

### **Is Insurance a Reasonable Way to Provide Health Care?**

Americans rely on insurance—both private and public—to pay for most of the costs of health care. So let us ask a more fundamental question: is this a reasonable way for society to fund health care expenses?

We contend that health care is not a service that should be funded by insurance companies. An individual should insure against expensive and undesirable calamities: tornadoes, fires, auto accidents. These need to be insurable risks, or insurance will not be made available. This means the events need to be reasonably random and relatively rare, with calculable probabilities that do not change much over time. As discussed in Auerback and Wray 2009, we need to make sure that the existence of insurance does not increase the probability of insured losses. This is why we are not allowed to insure our neighbor’s house. Insurance works by using the premiums paid in by all of the insured to cover the losses that infrequently visit a small subset of them. Of course, insurance always turns out to be a bad deal for almost all of the insured—the return is hugely negative because most of the insured never collect benefits. The insurance company’s operating costs and profit margins are more or less equal to the net losses suffered by its policyholders.

Ideally, insurance premiums ought to be linked to individual risks; if this actually changed behavior so that risk fell, so much the better. That would reduce the costs to those policyholders who do not experience insured events, and would also increase the insurance companies’ profitability. Competition among insurers would then reduce the premiums for those whose behavior modifications had reduced risks.

In practice, people are put into classes—say, “over age 55 with no accidents or moving violations” in the case of auto insurance. Some people are uninsurable—the attendant risks are too high. For example, someone who repeatedly wrecks cars while driving drunk will not be able to purchase insurance. The government might help out by taking away the driver’s license, in which case the insurer could not sell insurance even if it were willing to take on the risk. Further, one cannot insure a burning house against fire because it is, well, already on fire. And even if insurance had already been purchased, the insurer could deny a claim if it determined that the policyholder was at fault.

The insured try to get into the low-risk, low-premium classes; the insurers try to sort people by risk and to narrow risk classes. To be sure, insurers do not want to avoid all risks—given a risk/return trade-off, higher-risk individuals will be charged higher premiums. Problems for the insurer arise if high-risk individuals are placed in low-risk classes and thus enjoy inappropriately low premiums. The problem for many individuals is that appropriately priced premiums will be unaffordable. At the extreme, if the probability of an insurable event approaches certainty, the premium that must be charged equals the expected loss, plus the insurance company’s operating costs and profits.

However, it is likely that high-risk individuals would refuse insurance long before premiums reached that level, since they will be better off paying out of pocket. With costs skewed toward the less healthy part of the population that bought this insurance, the insurance company would invariably seek to mitigate this impact on cost through a process of prescreening to identify those likely to require expensive treatment, and either rejecting their applications or charging significantly higher premiums to compensate. Again, this tends to guarantee that the uninsured pool is the most at risk. In any event, once an insurance policy is written, the insurer does its best to deny claims. It will look at the fine print and try to find exclusions and uncover preexisting conditions (say, faulty wiring) that would invalidate the claim. All of this is good business practice. However, regulators are needed to protect the insured from overly aggressive denials of claims, a responsibility largely of state government since most types of insurance are regulated at the state level.

Let us examine the goal of universal health insurance from this perspective. It should now be obvious that using health “insurance” as the primary payment mechanism for health care is terribly inappropriate. From the day of our birth, each of us is a little bundle of preexisting conditions—congenital abnormalities and

genetic predispositions to disease or, perhaps, risky behavior. Many of these conditions will only be discovered much later, probably in a doctor's office. The health insurer will likely remain in the dark until a bill is submitted for payment. It then must seek a way to deny the claim. The insurer will check the fine print and patient records for exclusions and preexisting conditions. Often, insurers automatically issue a denial, forcing patients to file an appeal. According to a recent study of claim denial by California's six largest HMOs, 21 percent of all claims submitted in the first half of 2009 were rejected (Ivory 2009). Of course, not all denials stand up—but appeals burden the insured and their care givers with mountains of paperwork. From the perspective of the insurer, this is just good business practice—exactly what one would expect from an insurance company, since those whose claims are denied must weigh the costs and benefits of trying to reverse the insurer's decision. Meanwhile, health care providers are stuck with unpaid bills and must decide whether to pursue collection.

From an efficiency standpoint, it would be best to match individual premiums to risk, but people are usually placed into groups, often (for the historical reasons discussed above) into employee groups. Insurers prefer youngish, urban, well-educated professionals—those with good habits and enough income to join an expensive gym with personal trainers and to consume a diet full of natural foods. The insurer wants to charge even these healthy people premiums that are higher than what the risks would justify, and to exclude from coverage the most expensive procedures. But their ability to do so will depend on their competitors, who will want to “skim the cream” by coopting the healthiest individuals.

Many individuals are not really insurable, a result of preexisting conditions or risky behavior. However, many of these will be covered by negotiated group insurance due to their employment status. The idea is that the risks are spread, and the healthier members of the group will subsidize the least healthy. This allows the insurer to escape the abnormally high risks of providing coverage to high-risk individuals. It is, of course, a bum deal for the healthy employees. To keep the premiums for the group down, it is critical to prevent the healthy employees from jumping to lower-risk pools. This probably explains at least part of Congress's reluctance to allow real competition in the provision of insurance: it could set off an oligopolistic premium-cutting war to recruit the healthiest beneficiaries, leaving pools of high-cost, high-premium individuals that no plan wants to cover.

This is not the place for a detailed examination of the wisdom of tying health insurance to one's employer. It is very difficult to believe that any justification can be made for it, so no one really tries to justify it (Kelton 2007; Semenova and Kelton 2008). It is simply accepted as a historical accident. It adds to the marginal cost of producing output, since employers usually pick up a share of the premiums. It depresses the number of employees while forcing more overtime (since health care costs are fixed per employee, not based on hours worked) as well as more part-time work (since insurance coverage usually requires a minimum number of hours worked). And it burdens “legacy firms” that offer lifetime work as well as health care for retirees. Finally, and fairly obviously, it leaves huge segments of the population uncovered because they are either unemployed, self-employed, or work in small firms that don't offer an insurance plan. In short, one probably could not design a worse way of grouping individuals for the purposes of insurance provision. Would anyone reasonably propose that the primary means of delivering drivers to auto insurers or homeowners to home insurers would be through their employers? Or that auto and house insurance premiums ought to be set by the insurable loss experience of one's coworkers? That is too ridiculous to contemplate—and so no one does—but it is what we do with regard to health insurance.

The only other major consumer expenditure that we tie to the place of employment is pensions. Pensions have their own disaster unfolding, as legacy firms convert defined-benefit plans to defined contributions, as the government's guarantor (the Pension Benefit Guaranty Corporation) moves toward insolvency and financialized pensions, caught in the global crisis, lose funds to the extent that their solvency is called into question. Two legs of the retirement stool (pensions and private savings) have already been knocked out from under households—only Social Security remains on secure footing. There are lessons to be learned from this experience that could be applied to the health care debates (see Nersisyan and Wray 2010).

Insuring a person with diabetes against the risk of developing diabetes is like insuring a burning house. An individual with diabetes does not need insurance. He needs quality health care, and he needs to follow good advice in order to increase his quality of life while reducing health care costs. Accompanying this health care with an insurance premium is not likely to have much effect on the health care outcome, because it probably won't change the insured's behavior beyond what could be accomplished through effective counseling. Indeed, charging higher premiums to those

with diabetes is only likely to postpone diagnosis among those whose condition has not yet been identified. Allowing diabetics into an insured pool increases costs for the pool's other members, so both they and the insurer have an interest in keeping high-risk individuals out of the pool. Adding individuals with diabetes to a pool increases the incentive for healthy members to defect. If we add to that higher premiums for those with diabetes, we are likely to increase total health care costs, since more individuals will go without coverage, opting instead for emergency-room care.

We are not picking on people with diabetes of course. We are just making a general point that the majority of the members of most employee groups have reason to fear the addition of high-cost individuals to their insurance pool. Experience shows that health care costs follow an 80/20 pattern: 80 percent of health care costs are incurred by 20 percent of patients (Woolhandler 2007). If only a fraction of those high-cost individuals could be excluded, costs to the insurer as well as to the insured in the pool could be cut dramatically.

We have nearly 50 million individuals without health insurance, and the number grows every day. The health "reform" proposals seek to insure many or most of these people—mostly by forcing them to buy insurance. All of them have preexisting conditions (we all do), many of which are precisely of the type that, if known, would make them uninsurable. While it is likely that only a fraction of those currently uninsured have been explicitly excluded from insurance coverage because of a preexisting condition (many more are excluded because they cannot afford the premiums), every one of them actually has numerous preexisting conditions. Yet one of the main goals of "reform" is to make it more difficult for insurers to exclude them.

So here is what the outcome of the current proposals could look like. Individuals will be forced to buy insurance against their will, often with premiums set unaffordably high. Government will provide a subsidy to insurance companies so that coverage (of a sort) can be provided to all. Insurance companies will impose high copayments as well as deductibles that the insured cannot possibly afford. In this way, they will minimize claims and the routine use of health care services by the nominally insured. When disaster strikes—putting a poorly covered individual into that 80/20 "high-cost patient" bracket—the insurer will find a way to dismiss the claim. The "insured" individual will then be faced with bills for uncovered costs that only bankruptcy can address.

Worse than that, as we noted above, the administration proposes taxing Cadillac plans—pushing costs onto those who already have insurance—and reducing Medicare expenditures to help "pay for" extended coverage. To try to keep plans below the "Cadillac" threshold, the quality of insurance could be reduced: less coverage, more exclusions, and higher out-of-pocket expenses. It turns out that the "tea partiers" were correct in their arguments that those who already had insurance would get taxed, and that Medicare would be cut, in order to extend insurance to the currently uninsured. This was something that was denied by the administration and by Congressional Democrats, but it is featured in the reform legislation. No wonder the voters of Massachusetts revolted and handed Ted Kennedy's seat over to the Republicans. This electoral outcome could be repeated all over the country as voter furor spreads.

At the same time, the health care reforms will add to the economic pressures on householders, who are already defaulting on debts and losing their homes. The higher health care costs that "reform" will impose on Americans will only increase their financial problems. This is not far-fetched. Currently, two-thirds of household bankruptcies are due to health care costs (Woolhandler 2007). Surprisingly, most of those who have been forced into bankruptcy had health insurance but either lost it after treatment began or simply could not afford the out-of-pocket expenses that the insurer refused to cover. In 2007 an individual in her fifties would have paid an insurance premium of \$4,200 per year, with a \$2,000 deductible (*ibid.*). Many of those currently without insurance would be unable to meet a deductible of this size, meaning that their "insurance" would not provide coverage even for routine care. Only an emergency or the development of a chronic condition would drive such a patient into the health care system; with exclusions and limitations on coverage, the patient could find that, even after meeting the deductible and copayments, bankruptcy would be the only way to deal with all of the uncovered expenses. Of course, that leaves care providers with the bill—which is more or less what is happening now without a universal insurance mandate.

By taxing Cadillac plans, the reforms will push more currently insured workers into precarious positions. Further, the costs of the reforms will be borne by taxpayers before the benefits accrue to those who will eventually be insured, because there is a delay in extending the coverage in order to build up a reserve or "sinking" fund—the exact method used to phase in Social Security after 1935. Since taxes began immediately but spending

was postponed, this reduced the fiscal stimulus that the New Deal was able to provide, throwing the U.S. economy back into depression in 1937. Will it be déjà vu all over again as the new health care taxes begin, before the uninsured get coverage?

In our view, insurance is a particularly bad way to cover the majority cost of health care. Insurance is best suited to covering unexpected losses that result from acts of God, accidents, and other unavoidable calamities. But except in the case of teenagers and young adult males, accidents are not a major source of health care costs. In other words, the costs to the insurer are not the equivalent of those caused by a tornado that randomly sets its sights on a trailer park. Rather, the costs of treating chronic illnesses, many of which are severe and often lead to death, are more significant. Insuring a patient with a chronic and ultimately fatal illness would be like insuring a house that is slowly but certainly sliding down a cliff into the sea. Neither of these is really an insurable risk; rather, each represents a certain cost with an actuarially sound premium that must exceed the loss (to cover the insurer's operating costs and profit margin). So if the policy were appropriately priced, no one would have an economic incentive to purchase it.

Another significant health care cost results from provision of what could be seen as public health services—vaccinations, mother and infant care, and so on. And a large part of that has nothing to do with calamity but rather with normal life processes: pregnancy, birth, well-child care, school physicals, and certification of death. Treating a pregnancy as an insurable loss seems silly—even if it is unplanned. We should not be financing the health care costs associated with pregnancy and birth in the same way that we finance the costs of repairing an auto after a wreck—that is, through an insurance claim. Many of these expenditures have “public good” aspects; while there are private benefits, if the health care cannot be covered through private insurance or out of pocket, the consequences can lead to huge social costs. For this reason, it does not make sense to try to fund all the private benefits of such care by charging the individuals who may—or may not—be able and willing to pay for them. Nor does it make sense to raise employee premiums in order to cover expected pregnancies as more young women join a firm.

There are additional ways in which health care is not similar to protecting a homeowner against losses due to natural disasters. The risks to the health insurer are greatly affected by the behavior of the covered individuals, as well as by social policy. For example, smoking trends have a huge impact on insurer

costs. Discovering cures and new treatments to diseases can greatly increase, or reduce, costs. To a large extent, this is outside the control of the insurer or the insured. If a new treatment becomes standard care, there will be pressures on insurers to cover it—even if it is extraordinarily expensive. Death might be the most cost-effective way to deal with certain cancers, but standard practice does not present that as a viable treatment—nor would public policy want it to do so. In other words, social policy dictates to a large degree the losses that insurers must (or can) cover. Neither standard practice nor acts of Congress are equivalent in their origins to acts of God—although their impacts on insurers are similar.

We currently pay most health care expenses through health insurance, both public and private. But people need health care services on a routine basis—and not simply for unexpected calamities. We have become so accustomed to health insurance that we cannot understand how strange it is to finance health care services in this manner. Our automobiles need routine maintenance, including oil changes. Imagine if we expected our auto insurer to cover such expected costs. We are all, of course, familiar with various “extended warranty” plans sold on practically all consumer items—from toasters to flat-screen TVs. But we recognize that these are little more than scams—a way to increase the purchase price and boost the retailer's revenue. Further, we tolerate these scams because we can “just say no”—caveat emptor and all that. But health care “reform” proposes forcing us to turn over a larger portion of our income to insurance companies—who will then do their best to guarantee that the most expensive health care services we need will not be covered by the plan we are compelled to buy. Unlike a broken toaster that can just be thrown out when the warranty fails to cover repairs, we do not, and do not want to, throw out people whose insurance coverage proves to be inadequate.

Above we noted that health care already absorbs more than 17 percent of GDP. It is worthwhile to step back and look at the costs of providing health care payments through insurers. According to Woolhandler (2007), 20 cents of every health care dollar goes to insurance companies. Another 11 cents goes to administrative overhead and profit of the health care providers. Much of that is due to the paperwork required to try to get the insurance companies to pay claims (there are 1,300 private insurers, with nearly as many different forms that health care providers must fill out to file a claim). It is estimated that \$350 billion a year could be saved on paperwork alone if the United

States adopted a single-payer system (Taibbi 2009). Hence, it is plausible that a full quarter of all U.S. health care spending results from the peculiar way that we finance our health care system—relying on insurance companies for a fundamentally uninsurable service. Getting insurance companies out of the loop might conceivably “pay for” provision of health care services to all of those who currently have inadequate access—including the underinsured. However, none of the reforms being seriously contemplated in Washington would do that; instead, they would actually strengthen the insurers’ hand by forcing more people to acquire (unaffordable) coverage.

Note that we are not recanting what we said above: getting rid of insurance would still leave America with a very expensive system because of our “lifestyle choices.” We see definancialization as a rationalization of and an improvement to our system that will also reduce costs. Still, we also believe that much must be done in the way of improving our lifestyles that would not only lower costs but also improve the quality of life. Indeed, we believe that is probably more important than funneling everyone into the insurance system, or removing them from the grasp of insurance companies. However, we are faced with health care “reform” that is focused on what we believe is the less important problem—insurance—and realize that there is little political will to undertake the more fundamental problem of our unhealthy lifestyles. Hence, for now we would like to see a reduced role for private insurers, a bigger role for government funding of health care, and—over the longer run—greater public discussion of the “real” problems, such as environmental and lifestyle factors, that help make ours by far the most expensive health care system in the world.

In sum, using insurers to provide funding is a complex, costly, and distorting method of financing health care. Imagine sending your weekly grocery bill to an insurance clerk for review and having the grocer reimbursed by the insurer to whom you have been paying “food insurance” premiums—with some of your purchases excluded from coverage at the whim of the insurer. Is there any plausible reason for putting an insurance agent between you and your grocer? No. Then why should an insurer stand between you and your health care provider?

### **Financialization and Health Care Reform**

Clearly, extending health care insurance to all is not desirable, nor will it reduce health care costs. But “insurance for all” also represents yet another unwelcome intrusion of finance into every

part of our economy and our lives. In other words, the envisioned “reforms” would simply complete the financialization of health care that is already diverting resources into the same financial sector that swallowed residential real estate. We have previously written about the financialization of houses and commodities (Wray 2008) and the plan to financialize death (Auerback and Wray 2009). (Michael Moore’s latest film, *Capitalism: A Love Story*, even details the use of “peasant insurance” as a means for employers to place bets on the death of employees.) In these cases, Wall Street packages assets (home mortgages, commodities futures, and life insurance policies) so that gamblers can speculate on outcomes. Health insurance works somewhat differently: the insurer sells you a policy and then denies your claim due to a preexisting condition, or simply because denial is more profitable and you probably don’t have sufficient funding to fight your way through the courts anyway. You then go bankrupt, and the FIRE sector (finance, insurance, and real estate) takes your assets and garnishes your wages.

So here is one rather extreme way of looking at health care “reform” proposals. There is a huge untapped market of nearly 50 million people who are not paying insurance premiums. Solution? “Reform” that requires everyone to turn over a portion of their pay to insurers. Can’t afford the premiums? That’s okay—Uncle Sam will kick in a few hundred billion to help out the insurers. Of course, do not expect much more health care or better health outcomes because these have little to do with “reform,” which is instead directed toward delivering more premium-paying customers to the FIRE sector. Viewed from this angle, “reform” is just another timely bailout of the financial system, because the tens of trillions of dollars already committed are not nearly enough to keep it afloat.

Yes, that does sound extreme. You might wonder about the connection between insurance and the financial sector. They are two peas in a pod. This is because we threw out the New Deal Glass-Steagall Act that separated commercial banking from investment banking and insurance and replaced it with the Gramm-Leach-Bliley Act of 1999, which allowed Wall Street to form bank holding companies to integrate the full range of “financial services”—the companies that sold toxic mortgage securities to your pension funds, created commodity futures indexes for university endowments to drive up the price of your petrol, and took bets on the deaths of firms, countries, and your loved ones.



Student loans, credit card debt, and auto leases? Financialized—packaged and sold to gamblers making bets on default. Even the weather and earthquakes can be financialized. We're not kidding: in the madaughts the U.N. World Food Programme (WFP) proposed issuing "catastrophe bonds" linked to low rainfall. The WFP would pay principal and interest when rainfall was sufficient; if there were no rainfall, the WFP would cease making payments on the bonds and would instead fund relief efforts (Das 2006, 32). This winter, the unexpectedly cold weather in December and January across much of the United States and Europe has undoubtedly led to large (but as yet unreported) losses on "weather insurance" purchased not only by farmers but also by resorts and retailers whose profits are impacted by bad weather. Earthquakes have also been financialized: Tokyo Disneyland has issued bonds that do not have to be repaid in the event of an earthquake. Traders talk about new frontiers "trading in rights to clean air, water and access to fishing grounds; basics of human life that I had always taken for granted" (ibid., 320). The next bubble will probably be in carbon trading—the financialization of pollution! This time, actual toxic waste will be packaged and sold to global savers.

### Is There a Policy Alternative?

Is there an alternative? Frankly, we don't know. Leaving aside the political problems—once the financial sector has got its hands on some aspect of our lives it is very difficult to wrest back control—health care is a very complex issue. It is clear that provision of routine care should not be left to insurance companies. Perhaps unforeseen and major expenses due to accidents might be insurable costs, with a "single payer" (that is, the federal government) left to provide basic coverage for all of life's normal health care needs and individuals purchasing additional coverage as desired. Basic coverage—for things like births, routine exams and screening, inoculations, hospice and elder care—can be de-insured.

However, a significant portion of health care expenses is due to chronic problems, some of which can be traced to birth. We argued above that these are not really insurable—they are the pre-existing conditions that insurers must exclude. Others can be traced to lifestyle choices. Some employers are already charging higher premiums to employees whose body mass index (BMI) exceeds a chosen limit—with rebates provided to those who manage to lose weight. While we are skeptical that a monetary incentive will be effective in changing behavior that is certainly quite

complex, this approach is probably better than excluding individuals from insurance simply because of an undesirable BMI.

Some observers have called for extending a Medicare-like program to all (Fonkalsrud and Intriligator 2009). Although sometimes called insurance, Medicare is not really an insurance program. Rather, it pays for qualifying health care of qualified individuals based on age and employment history. It is essentially a universal-payer, pay-go system. Its revenues come from taxes and "premiums" paid by covered individuals for a portion of the program. We will not go into the details here, but "pay-go" means it is not really advance funded. Many believe that Medicare's trust fund could be strengthened through the application of higher taxes now, so that more benefits could be paid later as America ages. Actually, Medicare spending today is covered by today's government spending—and tomorrow's Medicare spending will be covered by tomorrow's government spending. At the national level, it is not possible to transport today's tax revenue to tomorrow to "pay for" future Medicare spending (see Papadimitriou and Wray 1999).

This is a difficult concept. In real terms, however, it is simpler to understand: Medicare is pay-go because the health care services are provided today, to today's seniors; there is no way to stockpile medical services for future use (of course, some medical machinery and hospitals can be built now to be used later, but most medical services provided in the future will require allocation of real resources at the time the service is provided). And the true purpose of the Medicare taxes and premiums paid today is to reduce net personal income, so that resources can be diverted to the health care sector today. Many believe that sector already has too many dedicated resources. If so, the solution cannot be to raise taxes or premiums today in order to build a bigger trust fund that will offset financial burdens tomorrow. If we find that 25 years from now we need more resources in the health care sector, the best way to deal with that will be to spend more on health care *at that time*, and to tax incomes *at that time* to reduce consumption in other areas so that resources can be shifted to health care *at that time*.

Our problem today is that we need to allocate more of today's health care services to the currently underserved, which is comprised of two different sets of people: folks with no health insurance, and those with health insurance that is too limited in its coverage to provide the care they need. The reform legislation proposed would provide a subsidy to get private insurers to expand coverage. (According to Taibbi 2009, the subsidies provided in the

current House bill are projected to reach \$773 billion by 2019.) If we take the example above of a person with diabetes who is excluded because of his preexisting condition, the marginal subsidy required for this patient if he is unable to pay for insurance would have to equal the expected cost of care, plus a risk premium in case that estimate turns out to be too low, plus the insurer's costs of doing business, plus normal profits. If, however, diabetes care were directly covered by a federal government payment to health care providers, the risk premium, insurance business costs, and profits on the insurance business would not be necessary. In other words, using the insurance system to pay for the added costs of providing care to people with diabetes adds several layers of costs. This makes no sense.

Given today's political constraints, perhaps a full single-payer option might not be feasible, but one earlier variant of the Senate's proposed health care legislation did feature a Medicare buy-in. Congress could use Senate reconciliation and expand Medicare via the Senate's buy-in provisions (the House can approve this on the basis of a simple majority vote). The Congressional Budget Office has already signed off on this as a means of saving money ("budget savings" is in some respects a nonsensical concept, but it provides the necessary political cover to deploy what is essentially a budgetary procedure). More important, a Medicare buy-in would provide a genuine "public option" that, by competing against private insurance companies, would help control costs. It would also help solve the problem of preexisting conditions, since Medicare does not deny coverage on this basis. As James K. Galbraith notes in *The Predator State* (2008),

Public health insurance entities such as Medicare do not evaluate risk because they are universal. Therefore, they save the major cost associated with private health insurance. They pay their personnel at civil servant salary scales and are under no obligation to provide a return to shareholders via dividends or meet a target rate of return. Insurance in general is therefore intrinsically a service that the public sector can competently provide at lower cost than the private sector, and from the standpoint of the entire population, selective provision of private health insurance is invariably inferior to universal public provision. (158)

In other words, this brings us closer to the "ideal" low-cost universal insurance plan discussed by Krugman and analyzed

above. Allowing a Medicare buy-in to Americans under age 65 would give people a genuine alternative to private health insurance and thereby render the whole issue of denying coverage on the basis of preexisting conditions moot. And it would substantially enhance the global competitiveness of American corporations.

A Medicare buy-in would also have the added benefit of getting us closer to a single-payer system, which is a far more rational way to control health care costs, largely due to the administrative complexity associated with our current patchwork system and the corresponding inability to bargain with suppliers, especially drug companies, for lower prices. Residents of the United States notoriously pay much higher prices for prescription drugs than residents of other advanced countries, including Canada. This proposal would also give American health care consumers far more bang for their buck than the current legislation.

What is less appreciated is that both Medicaid and, to an even larger extent, the Department of Veterans Affairs get drug discounts from the pharmaceutical companies similar to or greater than those received by the Canadian health care system. Another little-known secret of the Obama health care proposals is that they would have placed considerable restrictions on the importation of generic drugs from other countries as part of the deal to get Big Pharma on board (Heavey 2009). This is a mistake.

## Conclusions

It will be clear by now that a magic bullet doesn't exist. We face three serious and complex issues that can be separately analyzed. First, we need a system that provides health care services. Our current health care system does a tolerably good job for most people, although a large portion of the population does not receive adequate preventative and routine care, and thus is forced to rely on expensive emergency treatment. The solution to that is fairly obvious and easy to implement—if we leave payment to the side: we need to guarantee that all Americans have access to preventative and routine care. The problem, clearly, is not that we do not have sufficient resources to do this. We might choose to use markets or increased public provision to ensure those resources are available where they are most needed. We must also recognize that a big part of America's health expenses is due to chronic and avoidable conditions that result from the corporatization of food—a more difficult problem to resolve, and one that surely requires more leadership from government.

Second, and conversely, our system might provide in the aggregate too many resources for the provision of health care (leaving other needs of our population unmet). Rational discussion, followed by rational allocation, can deal with that. We don't need "death panels" (which we already have—run by the insurance companies), but we do need rational allocation. We suppose that health care professionals could do a far better job than the FIRE sector would ever do in deciding how much care and what type of care should be provided. Individuals who would like more care than professionals decide to be in the public interest could always pay for it out of pocket, or they could purchase private insurance. Maybe the cost of Botox treatments is an insurable expense? Obviously, what is deemed to be necessary health care will evolve over time—it, like human rights, is "aspirational"—and someday might include nose jobs and tummy tucks for everyone. But meantime, it makes sense for government to play some role in promoting sensible discussion about the portion of our nation's total production that ought to be devoted to health care—and what kinds of health care uses of those resources ought to have top priority.

Third, we need a way to pay for health care services. For routine care and for preexisting conditions, the only logical conclusion is that the best risk pool is one that encompasses the population as a whole. It is in the public interest to see that the entire population receives routine care. It is also in the public interest to see that our little bundles of preexisting conditions—otherwise known as infants—get the care they need. We cannot see any obvious advantage to involving private insurance in the payment system for this kind of care. If we decided to have more than one insurer, we would have to be sure that each had the same risks so that the respective premiums would be comparable, which would allow the general population to choose between them; hence, the same sort of insured pool. It is conceivable that competition among private insurers could drive down premiums, but it is more likely that competition would instead take the form of excluding as many claims as possible. We'd thus get high premiums and lots of exclusions—exactly what we've got now.

We could instead have a single national private insurer pursuing the normal monopoly pricing and poor service strategy (remember those good old days when you could choose from among one single telephone service provider?), but in that case we would have to regulate the premiums as well as the rejection of claims. Regulation of premiums cannot be undertaken without the regulation of the health care costs that the insurer(s)

would have to cover. If we are going to go to all the trouble of regulating premiums, claim rejections, and health care prices, we might as well go whole hog and have the federal government pay the costs. Difficult and contentious, yes. Impossible? No—we can look to our fellow developed nations for examples, and to our own Medicare system.

Finally, there may still be a role for private insurers, albeit a substantially downsized one. Private insurance can be reserved for accidents, with individuals grouped according to similar risks: hang gliders, smokers, and texting drivers can all be sorted into risk classes for insurance purposes. If it is any consolation to the downsized insurers, we also need to downsize the role played by the whole financial sector. Finance won't like that, because it has become accustomed to its outsize role. In recent years it has been taking 40 percent of corporate profits. It takes most of its share off the top—fees and premiums that it receives before anyone else gets paid. Rather than playing an auxiliary role, helping to ensure that goods and services get produced and distributed to those who need them, the FIRE sector has come to see its role as primary, with all aspects of our economy run by the tail that wags the dog. As John Kenneth Galbraith's *The Great Crash* (1955) shows, that was exactly the situation our country faced in the late 1920s. It took the Great Depression to put finance back into its proper place. The question is whether we can get it into the backseat without the consequence of an equally deep and prolonged depression.

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## About the Authors

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MARSHALL AUERBACK is a global portfolio strategist for RAB Capital PLC, a UK-based fund management group. He also serves as an economic consultant to PIMCO, the bond fund management group; a fellow of Economists for Peace and Security; and a contributor to the Roosevelt Institute's New Deal 2.0 ([www.newdeal20.org](http://www.newdeal20.org)). He received his B.A. from Queen's University in Canada, and an M.A. from the University of Oxford.

Senior Scholar L. RANDALL WRAY is a professor of economics at the University of Missouri–Kansas City and director of research at the Center for Full Employment and Price Stability. He is currently working in the areas of monetary policy, employment, and social security. Wray has published widely in academic journals and is the author of *Money and Credit in Capitalist Economies: The Endogenous Money Approach* (Edward Elgar, 1990) and *Understanding Modern Money: The Key to Full Employment and Price Stability* (Edward Elgar, 1998). He is also the editor of *Credit and State Theories of Money: The Contributions of A. Mitchell Innes* (Edward Elgar, 2004) and coeditor (with M. Forstater) of *Keynes for the 21st Century: The Continuing Relevance of The General Theory* (Palgrave Macmillan, 2008). Wray holds a B.A. from the University of the Pacific and an M.A. and a Ph.D. from Washington University in St. Louis.