



Policy Note

2017 / 3

WHY THE COMPULSIVE SHIFT TO SINGLE PAYER? BECAUSE HEALTH-CARE IS NOT INSURABLE

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In recent weeks, the push for a universal single-payer healthcare program in the United States has gained momentum. In part, this is due to Republican plans to gut Obamacare. However, it is Obamacare's surprising successes *and* failures that have boosted support for a single-payer system. With heavy federal government subsidies of premiums for low-income people, private insurance became more affordable for millions, while an expansion of Medicaid further reduced the ranks of the uninsured.¹ Fearing a backlash in the next election, Republicans are having trouble making good on their promise to repeal Obamacare—or even to replace it with the mean-spirited Republican version that would kick tens of millions off insurance. But, as Stephanie Woolhandler laments, Obamacare itself

left 28 million Americans completely uninsured and tens of millions more with these unaffordable gaps in their coverage, like copayments and deductibles and uncovered services. And that's why the Affordable Care Act has been vulnerable to these Republican attacks, because people look at their own situation and say, "Even under Obamacare, under the Affordable Care Act, healthcare [is] still not affordable to me." (Woolhandler 2017)

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Even in the event that Obamacare survives Republican repeal efforts, if government subsidies and out-of-pocket spending continue to rise as insurers intensify efforts to deny submitted claims and/or withdraw from the “marketplaces,” a political reaction is inevitable. Obamacare is ultimately politically unsustainable because it relies too much on a private, for-profit insurance system to pay for healthcare. It is time to abandon this overly complex and expensive payments system and reconsider a single-payer system. For inspiration, we can look back to President Roosevelt’s New Deal.

Social Security remains among the most important achievements of the Roosevelt legacy. It was sold as an insurance program to provide old-age security—with “premiums” (in the form of payroll taxes) paid over working years to cover retirement income. In truth, it never conformed to usual insurance principles (it was set up as a “redistributive” scheme in favor of low-income workers and those with shorter work histories), and it moved ever-further away from an insurance model over time (as benefits were expanded to cover those with little work experience, such as people with disabilities, children, and surviving family members).

Still, part of its persistent popularity is attributed by many to the belief that workers “pay in” to the fund that will support them in their golden years—although increasingly poor “money’s-worth” returns to higher-wage workers as well as erroneous claims that the system faces insolvency some years down the road leave an opening for the program’s critics that might be used to “reform” the program by gutting it (see Galbraith, Wray, and Mosler 2009; Wray 2005). This weakness is entirely due to Roosevelt’s insistence on selling the program as insurance. In truth, Social Security is an intergenerational *assurance* program: today’s workers take care of today’s retirees and tomorrow’s workers will take care of tomorrow’s retirees. There is no alternative, because no matter how much we might save for our retirements, most of what we consume during our golden years will have to be produced by those still working after we retire (Wray 2006). Old age “insurance” does not change that—what matters is our “single-payer” Uncle Sam who will provide us with the income we will need for a decent retirement. The taxes he will impose on tomorrow’s workers are not really insurance premiums—payroll taxes simply assure us that workers will not purchase everything they produce, leaving something for retirees to buy. Social Security is a single-payer retirement system.

Some in the Roosevelt administration had planned to push for a national system of healthcare as part of Social Security, but backed off due to opposition by the American Medical Association (AMA)—which managed to prevent any significant advance until President Johnson succeeded in adding Medicare for the aged, prevailing this time over the AMA’s well-financed campaign that enlisted Ronald Reagan to try to convince the population that Medicare was a communist-inspired plot to destroy the American entrepreneurial spirit (Skidmore 1999). By this time, private insurance had a lock on the healthcare payments system for many workers through their employers. Medicaid—a federal-state partnership—was also added to provide payments for the poor.

This patchwork system left many gaps, including workers at small establishments that did not provide group coverage, the self-employed, those with too much income to qualify for Medicaid but too little to afford expensive coverage for individuals, and those living in states with inadequate Medicaid coverage. At the time of the passage of the Affordable Care Act in 2010, approximately 50 million individuals were without healthcare insurance.

US healthcare provision is far more expensive (as a percentage of GDP) than that of other developed capitalist countries, with no better outcomes—indeed, similar outcomes are obtained while spending as little as half as much. There is no single cause for our relatively high costs, although higher overhead, higher profits, greater reliance on emergency room visits, and higher spending on chronic diseases account for much of the difference.

Our peers use a wide variety of methods of provisioning and paying for healthcare, ranging from full-on “socialization” with government ownership of the hospitals to market-based private ownership of medical practices. Many use a single-payer system (whether provisioning of healthcare is nationalized or privatized), with government covering the costs, while some use private insurers. What is unique about the United States is that we rely so extensively on private *for-profit* insurers—in other countries that allow participation by private insurers, these are run more like heavily regulated, not-for-profit charities. Foreign health insurance plans largely exist to pay bills and improve health, not to make a profit (Reid 2010). Not coincidentally, the United States is also the only wealthy nation with such a large segment of its population still lacking adequate health coverage—even after Obamacare.

Alongside its expansion of Medicaid, Obamacare doubled down on the use of private insurers by requiring all individuals to purchase insurance, with rising tax penalties assessed on those who do not. In return, Obamacare offers two big “carrots”: government subsidies of premiums for lower-income people and some regulation of private insurers who choose to participate—most importantly, requirements for coverage of preexisting conditions. The success of Obamacare relies on providing insurers with a diversified pool of enrollees, including, most importantly, many young, healthy people. The idea is that insurers would overcharge the healthy in order to subsidize the unhealthy with preexisting conditions. Obamacare’s “stick” is the penalty on individuals who opt out—many of whom are those healthy, young people.

The problem facing insurers is that 80 percent of healthcare costs are incurred by 20 percent of the population. To keep premiums and government subsidies down, insurers need to spread the costs of the unhealthy fifth across the more healthy four-fifths of the population. However, if insurers operate on a for-profit basis in a competitive environment, they cannot offer competitive rates to relatively healthy people if they must overcharge them to cover the unhealthy members of the pool. For-profit insurance *requires* some combination of the following: exclusion of those with preexisting conditions, denial of payment for expensive claims, huge government subsidies, and large penalties on healthy people who would rationally opt out rather than pay high premiums to subsidize the unhealthy.

It is important to understand that insurance is supposed to be a bad deal—you pay for fire and auto insurance over most of your life and hope that you will never have to collect benefits. Insurance is a good deal only for the unlucky. The idea behind it is that you pay small premiums to cover rare but expensive calamitous events. Your premiums cover the insurance company’s payouts, plus their administrative costs and profits. Even for the covered pool as a whole—lucky and unlucky—insurance is a bad deal because the total of the premiums paid has to be greater than the total of the payouts. We accept that because the alternative would be even more expensive—if each of us individually tried to self-insure, we would face insurmountable obstacles.

Healthcare is much different from losses due to fire or automobile crashes. While we do face healthcare expenses due to accidents, this does not amount to much of our national healthcare spending. Most of our healthcare needs are either

routine (prenatal, birthing, and well-baby care; braces for the kids’ teeth; annual checkups and vaccinations) or due to chronic illness (including those present at birth as well as those that appear later in life). Routine healthcare is not analogous to an “act of god” that destroys your house: it is predictable, welcome, and life enhancing. It is also, increasingly, very expensive.

Chronic illness is not, in principle, insurable: it is like purchasing insurance on a house that has just caught fire. The premiums that should be charged to cover a preexisting condition would be equal to the expected cost of treatments plus the insurer’s operating costs and profits. Obviously, the patient would be better off simply paying for the healthcare costs out of pocket. This is why Obamacare insurers need subsidies from the government, as well as young and healthy subscribers who will overpay for coverage in order to subsidize the unhealthy members of the pool. As the young and healthy have an incentive to stay out, government subsidies must be higher or the insurers will choose not to participate. Their only other alternative is routine denial of coverage: collect the premiums but aggressively reject the bills submitted for payment.

The problems with the model could have been foreseen, and indeed were foreseen (see Wray 2009). Simple tweaking will not do. Social Security and Medicare provide a model for reform along single-payer lines. Social Security’s old-age retirement plan is nearly universal, with the federal government acting as the single payer; Medicare is universal for those over age 65 and the main part of it is single payer, with the federal government making the payments.

Both of these programs impose a payroll tax, ostensibly to fund the spending—with both building reserves to provide for an aging population. As discussed above, this is simultaneously a strength (“I paid in, so I deserve the benefits; it is not welfare”) and a weakness (intergenerational warriors continually foresee bankruptcy). But we can look at the taxes another way, from the perspective of the economy as a whole. Taxing today’s workers reduces their net income, which reduces their spending. This leaves resources that *can be* directed to caring for the needs of today’s elderly; government spending on retirement and healthcare ensure that some of the resources *are* directed to satisfying those needs. From the aggregate perspective, it would be better to broaden the tax base beyond payrolls—since wages today account for less than half of national income. We should also tax other income sources, such as profits, capital gains, rents, and interest.

What is the right balance between spending and taxes? Let us pose two extremes. In the first case, the economy has ample unemployed resources to provide healthcare for all. In this case, the single-payer government simply spends enough to provide adequate healthcare with no additional taxes required. In the second case, let us presume the economy is already at full employment of all resources. To move some of the employed resources into the healthcare sector, the government needs to impose taxes sufficient to reduce consumption and investment spending to free up resources for healthcare. It then spends to reemploy those resources in the healthcare sector. The more likely case is somewhere between those two extremes, so that a combination of increased taxes and spending by the single payer can free up and move resources to provide healthcare for all.

Of course, this is too simple, as the unemployed resources may not be appropriate for provision of healthcare services. It will take some time to train and retrain workers, and to invest in healthcare facilities and pharmaceuticals production. The nation will need to rely on a combination of market forces (responding to higher demand for healthcare) as well as government incentives (taxes to reduce spending elsewhere, subsidies to encourage investments in healthcare delivery, and spending on training and infrastructure) to prepare for the tide of baby boomers requiring more healthcare.

Single-payer systems are much cheaper, much more efficient, and simpler to understand and implement (Frank 2017). While it might seem to be counterintuitive, eliminating competition in the payments system actually reduces costs. Competition among for-profit insurers works to exclude those who need healthcare the most—simultaneously boosting paperwork and billing costs even as it leaves people undercovered.

If we do not allow insurers to exclude preexisting conditions, and if we could somehow block insurers' ability to deny payments for expensive and chronic illnesses, then each insurer needs young and healthy people in the pool to subsidize the unhealthy. The best way to ensure such diversification is to put the entire nation's population into a single pool. This is essentially what we do with our single-payer Social Security retirement system. Medicare does the same thing, albeit only for those over age 65. Medicare for all would provide the truly diversified pool needed to share the risks and distribute the costs across the entire population. If the "insured" pool includes all Americans, there is no possibility of shunting high-cost patients off to some other insurer. And total costs are much lower

because billing is simplified, administrative costs are reduced, and no profits are required for operating the payments system.

Medicare is a proven, highly cost-efficient payments system, and it is compatible with the more market-oriented system that Americans seem to prefer over a nationalized healthcare delivery system such as that enjoyed in the United Kingdom. A single-payer Medicare-style universal program is also compatible with the existence of private health insurance that can be voluntarily purchased to supplement the coverage offered by the single payer. Medicare itself already offers such supplemental coverage, and, of course, Americans have access to a plethora of private supplements to Social Security's retirement program.

Basic healthcare is not an insurable expense. All other rich nations provide universal basic healthcare. The United States stands out because, even with Obamacare, it has huge gaps in coverage all while facing the highest healthcare bill in the world (as a percentage of GDP)—by a long shot. Just a few months ago, few politicians aside from Senator Bernie Sanders were willing to stand up for single-payer healthcare. However, the debate over "repeal and replace" has made it clear that if we are serious about providing universal healthcare to Americans, the only sensible option is single payer.

Note

1. A subsequent Supreme Court decision allowing states to opt out of the Medicaid expansion has undermined this prong of Obamacare.

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