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TOWARD TRUE HEALTH CARE REFORM: MORE CARE, LESS INSURANCE

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Introduction

This brief examines the health care reform debate in the United States. We make four points: (1) 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; (2) using insurance as the primary means of financing health care delivery is costly and, indeed, a major problem facing the nation; (3) relating coverage to employment is no longer viable; and (4) the proposed reforms will likely contribute to rising costs.

The U.S. Health Care System

Funding of our current health care 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 through patients' out-of-pocket expenses, including copayments and paying for uncovered treatment or medicines. The third leg is the government, which picks up the tab through a variety of programs such as Medicaid and Medicare.

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As reported by Stephanie A. Kelton (2007), in 2005 about 63 percent of the nonelderly population relied on employer-provided insurance, while government paid for insurance for about 18 percent. Over 17 percent of the population was uninsured. Coverage varied greatly by socioeconomic status: 70 percent of whites were covered, but only 50 percent of black workers and 41 percent of Hispanic workers had insurance. Less than half the workers in firms with fewer than 10 workers were covered, while almost 80 percent of workers in the biggest firms (over 1,000 employees) had coverage. And less than one-third of workers who had dropped out of high school were insured, while about 80 percent of those who had attended college received coverage.

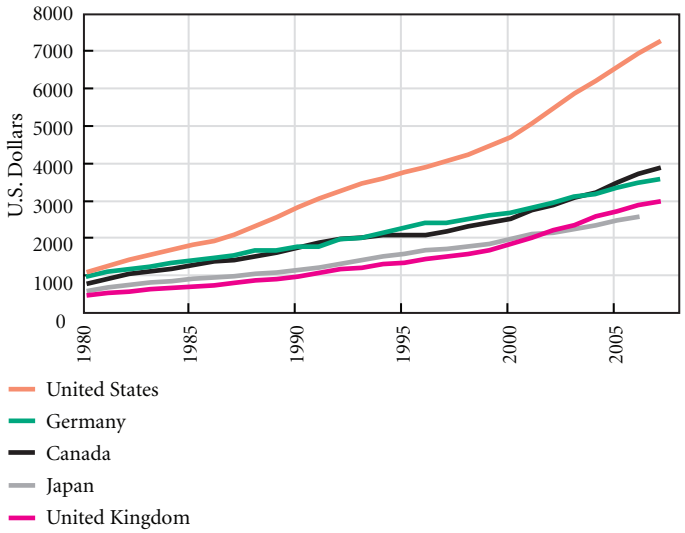
Of course, the quantity and quality of coverage vary greatly, as does the freedom to choose health care provision. Relatively few individuals purchase individual health insurance plans (5 percent of the population), and those who do find them expensive (at least $6,000 a year).

It is no secret that the United States has 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 (Levey 2010). Based on current projections (exclusive of any "reform"), health care spending will reach one-fifth of GDP by 2020 and the government's share will overtake the total spending by the other two "legs" by 2012.

It is important to note how unusual the United States is—no other comparable nation lacks universal health care coverage, and many nations that are much poorer provide universal access. Moreover, the U.S. government plays a much bigger role in health care delivery and in financing the system. And the divergence of costs is growing rapidly, according to a New America Foundation study (Damme 2009). By 2008, the United States' costs were triple those of the lowest-cost nation, Japan (Figure 1). Yet, by several measures, U.S. outcomes are actually worse, with lower life expectancy and higher infant and adult mortalities.

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 regarding 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 (Figure 2). It spends twice as much as would be expected on outpatient care, now amounting to 40 percent of total health care spending, and this is related to a virtual explosion in the cost of caring for chronic

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

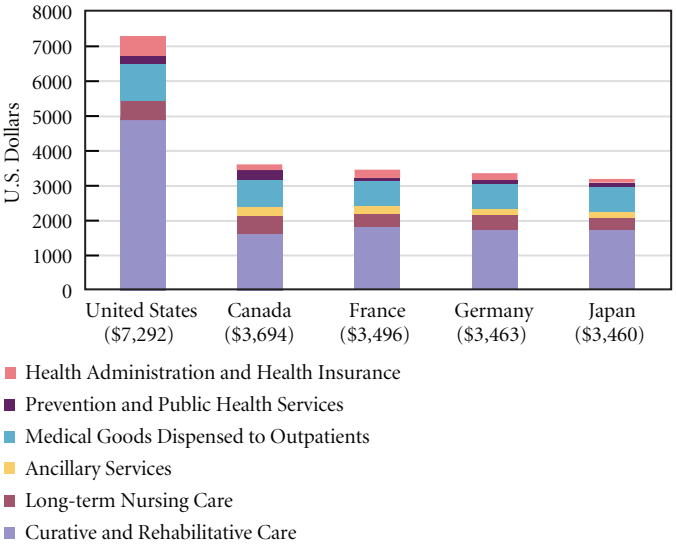


* Purchasing power parity

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

Source: OECD Stat Extracts

Figure 2 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

health problems, not administrative expenses. We argue that expanding insurance to the currently uncovered population is not likely to reduce the spending gap between the United States and comparable nations.

Overview of the Health Care Proposals

The unexpected election to the Senate of Republican Scott Brown 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.

Senate Democrats should not obsess about the so-called supermajority number (60), since a 59-to-41 majority still gives them ample opportunities to legislate significant improvements in our health care system, even if by means of a more incremental approach (e.g., via Senate reconciliation). There exist major loopholes in the insurance "reforms," such as exclusion for preexisting conditions, so the hard-fought "reforms" are more apparent than real. Other provisions permit insurers and companies to increase charges or to sell policies "across states lines," thus exempting patient protections passed in other states (Nichols 2009). Moreover, both the House *and* Senate versions of the bill entrench the centrality of private health insurance companies and include many unattractive elements, such as reducing spending on Medicare in order to pay for the reforms and taxing high-cost health care premiums ("Cadillac plans"). And given that neither the House nor the Senate bill contained any serious proposals for cost containment, health insurance premiums probably would have continued to skyrocket, virtually guaranteeing that an increasing number of health insurance customers would be hit by the tax as time went on. This would simply add to the problems of the 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 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 (in response to the labor shortage created during World War II) rather than conscience policy on the part of either employers or the government. The intrinsic costs of providing insurance are relatively low, with one proviso: so long as the entire population can be offered it 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. Unfortunately, that is not what we have, so premiums are 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.

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. And forcing more people into the system does not address the cost issue (see Woolhandler 2007). 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 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. Approximately two-thirds of adult Americans are overweight and one-third are obese, which correlates with diabetes. Moreover, there are other factors that increase health care costs and worsen outcomes (e.g., smoking, incarceration, poverty, and unemployment).

For these reasons, a campaign to promote healthy lifestyles would almost certainly do more to improve outcomes—and reduce costs—than the so-called "health care reforms" now being considered in Washington. While we are at it, we can

reintroduce Americans to real food, produced by (local) farmers and subjected to as little processing as possible. It makes more sense to attack the problem directly by increasing exercise, reducing caloric intake, and minimizing consumption of corporate "foodlike" substances that make us sick than to provide insurance so that those who suffer the consequences of an unhealthy lifestyle can afford costly care.

Is Insurance a Reasonable Way to Provide Health Care?

We contend that health care is not a service that should be funded by insurance companies. An individual should insure against unexpected losses that result from acts of God, accidents, and other unavoidable calamities. This means the events need to be reasonably random and relatively rare, with calculable probabilities that do not change much over time. Another significant health care cost results from the routine provision of public health services, a large part of which has nothing to do with calamity but rather with normal life processes such as pregnancy and child wellness care. Moreover, social policy dictates to a large degree the losses that insurers must (or can) cover.

Ideally, insurance premiums ought to be linked to individual risks. Competition among insurers would then reduce the premiums for those whose behavior modifications had reduced risks. 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. 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.

Once an insurance policy is written, the insurer does its best to deny claims, since its operating costs and profit margins are more or less equal to the net losses suffered by its policyholders. 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. It should now be obvious that using health "insurance" as the primary payment mechanism for health care is terribly inappropriate.

People are often placed into (employee) groups where insurers prefer youngish, urban, well-educated professionals—those with good habits and enough income to join an expensive gym with a personal trainer and to consume a diet full of natural foods. And many individuals are not really insurable, a result of preexisting conditions or risky behavior, but they 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.

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. To keep down the premiums for the group, 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.

There is no justification for tying health insurance to one's employer (see Kelton 2007; Semenova and Kelton 2008). It adds to the marginal cost of production and depresses the number of employees while forcing more overtime as well as more part-time work (since health care costs are fixed per employee). And it burdens "legacy firms" that offer lifetime work in addition to health care for retirees. 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.

The only other major consumer expenditure that we tie to the place of employment is pensions, which have their own disaster unfolding. Two legs of the retirement stool (pensions and private savings) have already been knocked out from under households—only Social Security remains on fairly secure footing. There are lessons to be learned from this experience that could be applied to the health care debate (see Nersisyan and Wray 2010).

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 (two-thirds of household bankruptcies are due to health care costs). And 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.

According to Steffie Woolhandler (2007), 20 cents of every health care dollar goes to insurance companies. Another 11 cents goes to the administrative overhead and profits of health care providers. It is estimated that $350 billion could be saved annually 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. Nevertheless, Washington would actually strengthen the insurers' hand by forcing more people to acquire (unaffordable) coverage.

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.

Financialization and Health Care Reform

"Insurance for all" represents yet another unwelcome intrusion of finance into every part of our economy and our lives. We have previously written about the financialization of houses and commodities (Wray 2008) and the plan to financialize death (Auerback and Wray 2009).

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. 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. Furthermore, insurance and the financial sector are two peas in a pod because Wall Street was allowed to form bank holding companies to integrate the full range of "financial services."

Is There a Policy Alternative?

Frankly, we don't know. Leaving aside the political problems, 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.

However, a significant portion of health care expenses is due to chronic problems, some of which can be traced to birth or to lifestyle "choices." 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 (not advanced-funded) system. Its revenues come from taxes and "premiums" paid by covered individuals for a portion of the program. 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). And there is no way to stockpile most medical services for future use. If we need more resources in the health care sector in the future, 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 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. If diabetes care, for example, 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.

One earlier variant of the Senate's proposed health care legislation did feature a Medicare buy-in, which provides 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 (see Galbraith 2008), and of lower costs, by expanding the patient risk pool. It would also substantially enhance the global competitiveness of American corporations. A Medicare buy-in would have the added benefit of getting us closer to a single-payer system and the ability to bargain with suppliers, especially drug companies, for lower prices.

What is less appreciated is that both Medicaid and the Department of Veterans Affairs get drug discounts from the pharmaceutical companies. Another little-known secret of the Obama health care proposals is that they would place 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.

Conclusion

We face three serious and complex issues. First, we need a system that provides health care services with a guarantee that all Americans have access to preventative and routine care. We must also recognize that a big part of America's health expenses is due to chronic and avoidable conditions that result from our diet.

Second, our system might provide in the aggregate too many resources for the provision of health care (leaving other needs of our population unmet). 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 (finance, insurance, and real estate) sector in deciding the type and level of care, and that individuals who would like more than the recommended care could always pay for it out of pocket or purchase private insurance. It makes sense for government to play some role in deciding what portion of our nation's total production ought to be devoted to health care and what kinds of health care 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. We cannot see any obvious advantage to involving private insurance in the payment system for this kind of care.

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. If it is any consolation to the downsized insurers, we also need to downsize the role played by the whole financial sector. 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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