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America's Love Affair With Markets: Is America an Outlier? Health Reform

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Although I am not a social scientist, it seems to me that in the twentieth century, what with fascism and communism, the idea of an “advanced Western democracy” became more sharply focused. Here in the U.S., we think of America as the prototype and natural leader, especially after World War II. Yet, in contrast to other developed Western economies, there is still no universal health insurance coverage here; moreover, the most strenuous efforts to arrange it continue to result in plans quite different from those in the rest of the West.

At some point, the failure to develop universal national health insurance, despite per capita health care costs far in excess of other OECD countries, has to raise the question, is there something fundamentally different about the U.S.? Do we believe in the free market as a means to an end, or an end in itself? Does capitalism resonate more deeply here? Are we not a paradigm, but an outlier? This is a question for us all to ponder. In this article, I shall supply some background.

Health Insurance Systems in the Rest of the Developed World

Today, in other OECD countries, all citizens have health insurance. In general, this insurance is comprehensive—it covers virtually all necessary health care expenses, although in some cases, for an additional voluntary payment one can access additional doctors, facilities, and perhaps some elective services. If there are co-pays, they are not onerous. Payments are from tax revenue, except in a few countries like Switzerland and the Netherlands, where citizens are required to pay premiums. Even there, however, premiums are regulated, those who can't afford the premiums are subsidized, and the basic benefit package is specified. Sick people cannot be charged more. Insurance intermediaries who process the claims are generally non-profit, or profits are limited.

Although in these countries the insurance cost is socialized, usually the health care providers—doctors, hospitals—remain private. (Britain is the big exception; its health care professionals work for the public National Health System.) Nevertheless, costs are tightly controlled, if not by the government directly, then by negotiations between the providers, the government and the insurance intermediaries. Western governments also negotiate the prices of drugs with pharmaceutical manufacturers.

Health Insurance in the U.S.

By contrast, in the U.S., apart from public health systems such as Medicare, Medicaid, the Veterans' Administration and the active duty military health care system (Tricare), there is currently no regulation of the cost of health insurance or the cost of health care. Private insurers, now mostly for-profit (although Blue Cross Blue Shield and other insurers structured along the same lines started out in the 1950's as non-profits) set premium prices at whatever level they wish, and structure complex benefit packages to attract the most desirable customers.

Insurers can hike prices for customers with pre-existing conditions or other undesirable attributes, or deny them insurance altogether. Insurers can require co-pays and set high deductibles: indeed, so-called "high deductible" or catastrophic policies, with low premiums but deductibles of up to \$11,000 per family per year, are the fastest growing category of insurance policies in the US today—no doubt because they are the cheapest. Many companies and individuals cannot afford better. If you get sick during the year, insurance companies can raise your premium for the following year, or drop your coverage altogether.

For many years now, many health insurance premiums in the U.S. have been going up faster than inflation, often much faster, and faster than health costs. Moreover, in America, insurers sort customers into different markets, based on customers' health and bargaining power. Employers with large, well-paid workforces, where beneficiaries are likely to be healthy, can negotiate decent plans—indeed insurers compete for this business, pushing benefits up and premiums down. Individuals and small businesses with little market power, on the other hand, have to accept higher premiums, deductibles, co-pays, and onerous conditions such as experience rating and pre-existing condition exclusions if there are risky individuals in the group.

Finally, prices for health care services in the U.S. are determined in closed-door negotiations between insurers and providers; the results depend on relative market strength. So an insurer that covers more than half the beneficiaries in a city with many hospitals can force the price for hospital services down. A pre-eminent hospital that people expect to be in any insurer's "network" can demand premium rates. The transaction costs of all these negotiations are enormous. Manufacturers that produce new specialized drugs, like cancer drugs—each insurer buys just a small quantity—can charge, and get, \$100,000 or more per year per patient for its products.

This system of negotiation means that in the U.S. everyone pays a different price for the same service, even in the same hospital. Services are marked up so that providers can "discount" them in negotiations. The only people who pay the sticker price are the uninsured.

So it should come as no surprise that Americans pay the highest prices in the world for health care. For all that, however, our health outcomes, compared to those of other OECD countries, are no better than middling. Our healthy life expectancy ranks only 29th in the world, behind Slovenia. Our infant mortality rate is 30th.

One reason, perhaps, is that fewer and fewer Americans can obtain or afford insurance, particularly if they have lost a job with insurance benefits and cannot find another. Only certain categories of people are eligible for Medicaid, insurance for the poor—generally families with young children and nursing home patients. In 2012, 17% of Americans, more than 49 million people, had no health insurance. Another 25 million were underinsured. Several years ago, Elizabeth Warren, a professor at Harvard Law School, found that 75% of personal bankruptcies were related to medical expenses.

Today, the U.S. spends 17% of its GDP on health care, more than 30% more than the next highest country. The Congressional Budget Office estimates that by 2020, that percentage will rise to 20%, and by 2050, if nothing is done, Medicare, Medicaid and Social Security will consume the entire domestic federal budget.

All Americans agree that the situation is intolerable, unsustainable. Something must be done, and quickly. In the information age, we all know that the rest of the developed world has road-tested a model that works much better and costs much less: publicly financed, tightly regulated, health insurance. At least two film makers—TR Reid in *Sick Around the World* and Michael Moore in *SICKO*—have laid it out for us in living color.

Health Insurance Reform in the U.S.: Romneycare and Obamacare

Yet after twenty years of *sturm und drang*, the U.S. political system has come up with something completely different: so-called “managed care, managed competition”. This novel, market-based concept, developed by American thinkers like economist Alain Enthoven of Stanford University and pediatric neurologist Dr. Paul Ellwood, assumes that the government can set up a marketplace where insurers will compete with one another for *all* customers (not just the healthy) on the basis of price and quality. The “managed competition” between them will drive down the price of insurance just like competition between GM and Toyota drives down the price of cars, or Walmart and Sears drive down the price of retail goods. In turn, the insurance companies will be forced to “manage” beneficiaries’ care so as to reduce health care costs, just as Toyota and Walmart drove down their suppliers’ prices.

The model for managed care has been Kaiser Permanente, a non-profit organization of hospitals and salaried doctors first established in California in 1945, which provided whatever care a beneficiary needed in exchange for a fixed yearly fee. Later, several

consumer-run co-ops, like Group Health Cooperative of Seattle, were formed to do the same thing. This arrangement was called “pre-paid health care.”

Managed competition, however, was a true unicorn, not seen until then-Governor Mitt Romney, together with a Democratic state legislature, put together a so-called “health insurance exchange” in Massachusetts in 2006. The state set up a regulated virtual marketplace for residents without employer-sponsored plans, and everyone whose income exceeded a certain level was required to carry health insurance or pay a penalty. Today, 97% of Massachusetts citizens are insured. The state bargained hard with insurers who sold plans to people whose premiums were subsidized by the state. Nevertheless, health care costs have remained high—there is little evidence that competition between insurers drove down premiums as hoped, or that insurers drove harder bargains with providers. Meanwhile, to Republican presidential candidate Romney’s chagrin, President Obama used the Massachusetts plan as a model for his own.

Some History

This divergence in systems started more than a century ago. According to Paul Starr’s Pulitzer Prize-winning account in *The Social Transformation of American Medicine* in 1982, public health insurance in Europe developed around the turn of the twentieth century as a response to social pressures. Professor Starr argues that Bismarck introduced health insurance for workers in 1883 (along with unemployment insurance and old age pensions) to avoid granting the wider political rights German Socialists were demanding, and to assure worker support for the monarchy; in England, already a parliamentary democracy, Lloyd George introduced social insurance to strengthen working class support for his Liberal Party.

In both countries the government built on ‘friendly societies’ or associations workers and craftsmen had put together themselves to insure one another in case of accident or illness. And Paul Starr observes:

Where liberalism had it greatest hold and where private interests were strong relative to the state, social insurance made the slowest headway. So, contrary to the modern view of the welfare state as a “liberal” reform (in the current American sense), social insurance was generally introduced first in authoritarian and paternalistic regimes, like Germany, and only later in the more liberal and democratic societies, like England, France, and the United States.*

* Starr, Paul. *The Social Transformation of American Democracy*. Basic Books Inc. (New York, 1982) p. 239.

The development of modern health insurance in the U.S. was entirely different: as medical costs began to rise, the first plans were organized by hospitals to be sure they would be paid. In 1929, Baylor University Hospital in Texas offered 21 days of hospital care a year to 1500 public school teachers for \$6 dollars per person. Similar plans developed elsewhere and eventually came together in a non-profit health insurance organization called Blue Cross. A similar organization, Blue Shield, developed to cover doctor visits. The two organizations eventually merged. A few years later, the commercial insurance industry developed competing products called “indemnity” plans, which insured customers for certain medical expenses up to a certain financial limit. The commercial insurers also introduced the practice of underwriting—charging more for subscribers at higher risk of accident or disease—which quickly spread to the Blues.

By the 1950’s in the U.S., most people were obtaining health insurance through their employers, as they do today. Historians attribute this arrangement to wage-and-price controls during World War II: the regulations did not limit health insurance benefits, which were deductible to employers and tax-free to employees. Employers used such benefits to attract scarce workers. However the employer sponsored model also worked well for insurers, who were able to negotiate with one entity to cover a large group of mostly healthy (they were working, after all) subscribers: this is why it has persisted.

The American private health insurance system worked well enough during the 1950’s and 1960’s, except for people at high risk outside the workforce, such as the elderly, and the poor. In 1965, pushed by President Lyndon Johnson, Congress passed Medicare, comprehensive insurance for the elderly, which resembles public insurance in OECD countries today. At the same time Congress set up Medicaid, a joint Federal/state program for selected groups of poor people. Medicare is probably the most popular government program in the U.S. today—Medicaid much less so.

But the U.S. system no longer works—medical expenses are out of control, health insurance policies cost more every year and cover less. Why? The American answer to this question is different from that of others, and I think it provides an important clue to peculiarly American thinking.

The Problem with Private Health Insurance in the 21st Century

Until the last few decades of the twentieth century, illness and accidents were like other adverse events the insurance industry had learned to cover—fires, floods, theft, funeral expenses, and death. These events were random, unpredictable as to the individual but predictable for the group, and rare. The maximum cost was known in advance, and the casualty was discrete—it ended the day it started.

In recent years, modern medicine has changed all that. We understand far more about illness than we did 60 years ago, and our treatments are much more effective. Illnesses like heart disease, cancer, even HIV, which we once thought of as *acute*—for which you

recovered or died—with treatment have become *chronic*: patients who used to die now live with their disease, and may continue treatment for decades or a lifetime. And they are often at significant risk of complications, from the disease, the treatment, or both. The cost of treatment, particularly but not exclusively in the U.S., is skyrocketing.

Most important, illness is not spread evenly through the population. Something like 5% of the population is responsible for 50% of health care costs. Today insurers can identify these people (they have pre-existing conditions) and either charge them the full price for their expected care, or avoid them altogether. One patient with severe congestive heart failure can ruin an insurer's day. Nor do healthy people want to participate in a pool with chronically ill patients. If one insurer's subscribers are riskier than another's, the first insurer will have to raise premiums to cover the additional cost, and the healthy, low risk people will transfer to the insurer with lower costs, so lower premiums. In the business, this process is known as the death spiral.

The market for health insurance is healthy people. The market for health care is sick people. In an unregulated system, these two markets will separate from one another: healthy people will get health care, while those who need it the most cannot get it.

The best way to avoid such a result, other democracies have found, is to put everyone in the same pool, to share the risks across the population, as in Medicare in the U.S.

America's Take on Health Reform: the Leadership

The American policy elite, on the other hand, doesn't worry about the death spiral. Republicans don't see it as a problem at all. Rather, they believe that the market result is by definition the correct result. For them, any problems with the health care system can be fixed by deregulating the market further. As for the sick that the insurers leave behind, occasionally Republicans suggest high risk pools, which could be subsidized by the states: indeed a few states have them now, and the Obama plan, the Affordable Care Act, provides some money for this purpose until 2014, when everyone without employer-sponsored insurance will be able to buy a policy in the state virtual marketplaces, the exchanges. Today's high risk pools, however, are very expensive even with subsidies.

Democrats would solve the death spiral problem by "risk adjustment"—a requirement that the insurers with the healthiest customers regularly compensate those with sicker beneficiaries. From countries that are trying this, such as Switzerland and the Netherlands, we learn that it is more difficult than it looks.

In fact, American leaders—Democrats and Republicans alike—believe the dysfunction in the U.S. health care has less to do with insurers than with the behavior of ordinary Americans. Policy makers are convinced there is tremendous waste in the American system: studies have shown that in some hospitals, patients receive far more care than in

others, but no corresponding improvement in outcomes. Analysts attribute this to perverse market incentives. Patients, they think, demand too many expensive medical services because, with insurance, those services are “free” at the point of care—so overutilization. By the same token, because doctors and hospitals profit from each service they provide (so-called fee-for-service), they provide too many services—so overproduction.

The American solution, therefore, is to realign market incentives.

First, as to patients: In general, the authors of the Affordable Care Act wanted to discourage generous insurance coverage; if patients have more “skin in the game”, the legislators believe, they will use services more prudently. So the ACA imposes a tax on so-called “Cadillac” insurance policies. High co-pays and deductibles are fine, and there are no limits in the ACA on premiums. If states wish to set limits, they can do so with state laws.

As to doctors and hospitals, policy makers would replace fee-for-service with a fixed fee for a bundle of services, say a hospitalization, or one year of care, as at Kaiser. If the provider can provide all the needed services for less, he can keep the difference; if the services cost more, he takes the hit.

Suspicion about such policies, to the extent they are known to the general public, may be one reason the ACA continues to be less popular than its authors expected.

More interesting however, is the contrast with Europeans. In general, OECD countries have comprehensive insurance plans with low deductibles and co-pays, if any. Yet they do not believe their citizens abuse the system, demanding wasteful services.

Indeed, at a Brookings Institution symposium held on November 9, 2011, Dr. Mark McClellan, head of the Engelberg Center for Health Care Reform at Brookings and a powerful advocate of the ACA, asked U.K. Secretary of State for Health Andrew Lansley point blank if overutilization was a major problem in Britain. No, the minister replied. How could that be? the American pressed on, incredulous. “Social solidarity”, the minister explained.

So that raises the question: are the Americans more selfish and wasteful? Studies have not shown a significant difference between the volume of services provided to Americans and to Europeans (although more services here involve advanced—and expensive—technology). So, then, do Europeans just trust one another not to take advantage, in a way that Americans do not? Do Europeans think of individuals less as rational economic actors than Americans do? These are important questions for social science. But there is more.

America's Take on Health Reform: the Citizens

Of course, a big part of the opposition to universal national health insurance has come from powerful economic interests that would be threatened: the insurance companies, doctors and hospitals, the pharmaceutical manufacturers, and so on.

But in recent years, it is no longer clear that a majority of ordinary Americans want comprehensive health insurance for everyone, if it means they would pay higher taxes to take care of other citizens—who might be fat, don't exercise, or don't fasten their seat belts. Of course everyone wants to be covered. But some healthy people clearly want to get the lower premiums their health would command in an unregulated insurance market. Healthy people with plenty of money like the idea of high deductibles, particularly if they come with tax advantages, even though that means less fortunate Americans pay more.

To someone who graduated from high school in 1965, after the New Deal, in the enthusiasm of the civil rights movement and President Johnson's Great Society, this feels different, and ominous.

True, these are tough economic times. Unemployment is stuck above 8%, higher among young people, even new college graduates. The median wage has stagnated over the last thirty years, while the cost of things middle class families need—housing, education for their children, has gone way up. Defined benefit pension plans are disappearing, and 401(k)s have swooned with the stock market. Inequality is worse than at any time since 1929.

The Cold War is over, and we have won. America no longer needs to prove that capitalism can provide workers with a better, more secure living than communism. The rich have no obligation to the rest of us. People living on the edge worry about keeping what they have—it is harder to be generous or tolerant when one is a paycheck or an illness away from disaster.

And there is far more money in American politics than there was then, even adjusting for inflation. In 1972, the two presidential candidates, George McGovern and Richard Nixon, spent a total of \$91.4 million (not counting cash in Nixon's brown bags). This year, it is estimated that President Obama and former Governor Mitt Romney will spend more than \$1.3 billion. The most idealistic candidate cannot raise that kind of money from small donations alone. And only a few wealthy individuals, and fewer large corporations, contribute to candidates who threaten their financial interests. So liberal politicians are afraid to speak out—and there is plenty of money to stoke whatever resentment against government programs is out there, say, in the Tea Party.

And the fact is, there is resentment, particularly among white working-class men, who have lost the most in the last thirty years. Many Americans believe that the Federal

government caused the terrible recession that we are still living through, not Wall Street. Justifiably, they resent the Federal bank bailouts; but they also oppose “entitlement spending,” even as they sign up for Social Security and Medicare, without which they would be forced out of the middle class. (Analysts say these people think “entitlements” refers only to programs for the poor, like food stamps and welfare.)

It may be that the backlash against the civil rights revolution in the 1960’s is still with us. And there is certainly resentment of the Democratic liberal elite, who talk the talk but don’t walk the walk, who eschew guns and fundamentalist religion, and who oppose U.S. wars of choice. These angry people believe liberals patronize them, and are hypocrites who don’t really care about them.

Or it may be that the diversity that America touts when times are good, shows a dark underside when times are hard: maybe we don’t have the kind of “social solidarity” a Tory minister finds in the British, because to some Americans, other Americans seem too “different” from themselves—even though, except for native Americans, we are all descended from immigrants. Demographers predict that before 2050, today’s minorities will make up the majority of the U.S. population.

Moreover, historians have shown that from the beginning, there has been an undercurrent of suspicion of government in the U.S., a sense that government—even though we elect it ourselves—is something alien and hostile. President Thomas Jefferson, the revered founder of the Democratic Party, believed in small government and low taxes. The American Revolution was sparked by a tax hike.

Yet in the twentieth century, Americans—Democrats, Progressives, and moderate Republicans—understood that only government is strong enough to protect ordinary people against exploitation by the giant corporations of modern capitalism. And Americans had no trouble identifying capitalist excess as the trigger for the Great Depression.

Today, big business, and the Republicans who represent it, have captured this resentment, both expressed and inchoate. And they have managed to redirect anger from Wall Street and big business, the most serious threats to the middle class today, to the government, the only institution that can save it. The states that went for the Democrat, William Jennings Bryan (“You shall not crucify mankind upon a cross of gold”) in 1896 were carried by John McCain in 2008. This is the tension we see in the battle over universal health insurance in America.

So is America a liberal democracy in the European tradition, or is it *sui generis*, a free market outlier? An important question for social scientists, indeed.