

HEALTH REFORM IN NORTH CAROLINA

Market Hazard, Moral Imperative: Why We Need Health Reform

Chris Fitzsimon

Despite the rancor about health care reform this summer, there is little disagreement about the problems with the current health care system in the United States. The US Census Bureau reports that the number of uninsured reached 46.3 million in 2008, with 1.5 million uninsured in North Carolina.¹

The majority of Americans still receive health care from their employers, and they lose the coverage if they lose their job. People with preexisting conditions are often denied coverage or only offered plans with exorbitant premiums and copayments they cannot afford. People with insurance can lose their coverage if they become sick and an insurer discovers a precondition, even if it is unrelated to their current illness.

The rising cost of health care is unsustainable. Premiums for family coverage rose 5% in 2009 and have risen 131% in the last 10 years.² US health care expenditures reached 16% of the gross domestic product (GDP) in 2007, significantly higher than any other industrialized democracy. However, the US ranks well below the average for industrial nations on life expectancy and other major health indicators.³

Many Americans with coverage still cannot afford their medical care when a major illness strikes. Sixty-two percent of personal bankruptcies are related to health care costs, and 75% of those filing for bankruptcy reported had health insurance coverage.⁴

The current health care system is clearly broken, but that is where the consensus ends. Proposals for reform vary widely but fall distinctly into philosophical approaches, based on the role of the public sector and degree of regulation of the private health care market.

Solutions suggested by those who identify themselves as free market conservatives include expansion of health savings accounts (HSAs), creation of broad personal health care tax credits, and further deregulation of the insurance industry by allowing companies to sell policies across state lines.

Each of those solutions is based on the assumption that a significant factor in health costs is that individuals with insurance are unaware of the total cost of their care and therefore seek treatment they may not need. The author Malcolm Gladwell explains this "moral hazard" argument by comparing the current health care system to an employer providing free Pepsi at the workplace, which leads to employees drinking more Pepsi. Gladwell says, "Making you responsible for a share of the costs, the argument runs, will reduce moral hazard: you'll no longer grab one of those free Pepsis when you aren't really thirsty."⁵

But health care is a much different commodity than soft drinks. Gladwell cites a Rand Corporation study in the late 1970s that found that people with higher copayments did cut back on care they might not have needed. But Gladwell points out the study also found that higher copays led people to forgo care that is important, like treating high blood pressure.⁵

Other proposed market solutions like health savings accounts are based on that flawed moral hazard argument, and that's not their only flaw. HSAs assume that even low-wage workers can save enough to pay for their medical care, including emergencies and major illnesses. The accounts are currently available to many employees now and are used primarily by wealthy families as a tax shelter, not by middle-class workers as a health care plan.⁶ The investment publication Kiplinger.com calls HSAs "just another tax-deferred way to save for retirement."

The argument for relaxing regulations of insurance companies to allow them to sell policies across state lines is also misguided. It assumes only the benefits of the market, not the negative consequences. The

proposal would encourage states to end virtually all regulation to attract insurance companies in a race to the bottom, removing most restrictions and safeguards for consumers, a scenario that has already occurred in the financial industry.

The only way interstate competition makes sense is if a public insurance plan is also an option for consumers. The public plan, modeled generally on Medicare with its lower administrative costs, would provide an incentive for private companies to reexamine their operations to look for savings. The companies would be allowed more flexibility in the plans they offer to compete with the public plan and other companies in the private sector.⁷ Estimates of the savings from a national health insurance exchange that includes a public option range from \$224 billion to \$400 billion over 10 years.⁸

The incentives in the current system encourage insurance companies to deny coverage and claims to maximize profits. Even most opponents of a public option support regulations that would prohibit insurance companies from denying coverage because of preexisting conditions, which contradicts their fundamental assumption that regulation is the problem. Much of what economist Paul Krugman calls the “health-care industrial complex” makes money based on the number of procedures they perform, which provides an incentive to perform more, or on the number of high-tech machines they sell, which then must be used to justify their cost.

The bottom line is that the delivery of health care doesn’t fit into the traditional understanding of the free market. There is no profit for insurance companies in providing care for the chronically ill. The profit comes from denying it.

The problems in our current system are costing us billions of dollars and endangering millions of lives. As distasteful as it may be to the conservatives’ free market doctrine, the public sector must step in and play a larger role.

All the other Western industrialized nations have recognized that this is the only way to provide basic coverage for all citizens. Everybody needs health care, and there is a strong argument to be made that to ensure the equal opportunity guaranteed in our Constitution, everybody deserves it.

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Chris Fitzsimon is the executive director of NC Policy Watch.