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Why Reforming Medical Insurance in the United States Is So Difficult[1]

Our limited national medical insurance programs, Medicare for seniors and Medicaid for low income households, represent a real challenge to achieving a sustainably balanced federal budget.

Medicare, the senior citizen health care programs, for instance, consumed about 8.5 percent of the federal budget in 1990, but its share of the federal budget had risen to almost double that, over 15 percent in 2010, and is projected to consume 20 percent or more of the federal budget by 2020. This is not primarily due to flaws in the design and operation of Medicare, although there are significant improvements that could be made there. The primary problem, as all of us know, is that health care costs across our mostly private health care system are skyrocketing. As a result, while other wealthy nations spend 9 percent of their GDP on health care, we spend almost twice that, 17.6 percent.

Despite all this spending, the United States, compared to the other wealthy nations of the world, gets inferior health outcomes and is the only one that does not provide universal access to health care to all of its citizens. Despite the efforts of American presidents over three-quarters of a century, from Franklin Roosevelt, Harry Truman, Bill Clinton, to Barak Obama, we are still trying to cobble together a rational

[1] For more extensive discussion of these issues see Paul Starr's book ***Remedy and Reaction: The Peculiar American Struggle over Health Care Reform*** Yale University Press, 2011. Also Paul Starr's "The Medicare Bind," in ***The American Prospect***, November 2011, 22(9): 24-35.

and affordable way of extending access to health care to everyone while keeping medical costs under control.

The obvious question is what in the twenty-first century is preventing the United States from doing what all the rest of the wealthy nations did relatively early in the twentieth century? A good part of the problem is the unusual, even peculiar, medical insurance programs we have adopted compared to other countries. For instance, the only "universal" program we have is Medicare that provides a mix of mandatory and voluntary health insurance for our senior citizens. No other country has an *elderly-only* national medical insurance program.

That focus in the United States on universal national health care only for the elderly has had both economic and political impacts. Focusing national health care insurance on just the elderly defeats much of the purpose of insurance in the sense that it isolates the part of the population that is most likely to have very high health care costs rather than pooling the young and low medical cost groups with the older and more costly groups.

Second, because all workers during their work lives are required to pay a payroll tax that funds Medicare Part A, the hospitalization insurance for seniors, they have the impression that they have paid for "their" Medicare all their working lives and have not been subsidized by anyone. To them, Medicare is not a government program. It is something they bought and paid for. Although this self-funding is not true of Medicare Parts B and D, seniors have a strong proprietary feeling about their rights to Medicare and tend to sneer at the medical programs for low income households, which they see as costly government handouts. Seniors also fiercely want to protect "their Medicare"

and see efforts to extend health insurance to all Americans as a threat to their current Medicare benefits and have strongly opposed extension of similar benefits to other Americans.

A similar illusion affects families who receive their insurance through the workplace. It was the expansion of unionized workers' pay packages to include medical insurance after World War II that undercut efforts to use the federal government to provide universal health insurance. If private companies were expanding access to health care, why should the government get involved?

Workers with employment-based health insurance see their health insurance as part of their pay packages that they earn on the job. The fact that the federal government subsidizes those health insurance programs by making their cost non-taxable income is largely ignored. Those nationwide, federal tax subsidies to workplace medical insurance cost the federal government more than does Medicaid health insurance for low income households. But the workplace health insurance subsidy, remains hidden, and allows workers who get health insurance at work to also sneer at "costly" federally subsidized low income programs or the extension of publicly subsidized health insurance to those who do not earn their health insurance as part of their pay at work.

The net result is that we have a very complex, costly, and often hidden hodgepodge of national health insurance subsidies that divide us as a people about the wisdom of expanding the role of the federal government to assure access to medical care for all citizens while also keeping medical costs down and positive health outcomes up.

This is not to suggest that we cannot rationalize our health insurance system to make it universal in its coverage while controlling costs. We, like all other wealthy nations, certainly can. It does mean, however, that our system will look different than other nations' health insurance systems. But, then, each nation has built its health insurance system on its own particular history, the balance of political power, and its underlying social values and political ideology to craft quite different universal health care systems. We are simply struggling to do the same.

At the start, however, we need some honesty and open discussion of who is currently subsidizing whom, how successful we actually have been in protecting our health, and our common interest in bringing health care costs under control while assuring all of our fellow citizens access to basic health care.