EconoFact Chats: Rebooting American Health Care

Amy Finkelstein, Massachusetts Institute of Technology

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Michael Klein
I'm Michael Klein, executive editor of EconoFact, a non-partisan, web-based publication of the Fletcher School at Tufts University. At EconoFact, we bring key facts and incisive analysis to the national debate on economic and social policies, publishing work from leading economists across the country. You can learn more about us and see our work at www.econofact.org.

Michael Klein
In their new book, *We've Got You Covered: Rebooting American Health Care*, Liran Einav and Amy Finkelstein write, "The health care sector is almost one-fifth of the U.S. economy. But it punches below its weight. It delivers far less than it could for that price tag." Many of us are familiar with stories of the shortcomings and expense of the healthcare system in the United States, and some of us may have first-hand experience with this. Amy and Liran draw on these stories, as well as their pathbreaking research, to report on the state of health care in the United States and, importantly, on their recommendations for how to fix the system.

Amy, who is my guest today on EconoFact Chats, is particularly well-placed to do this. She is the John and Jennie S. MacDonald Professor of Economics at M.I.T.. She has won many awards for her research, perhaps most notably the John Bates Clark Medal from the American Economic Association, which is given every other year to the economist under the age of 40 who has made the biggest contribution to economics. Amy, thanks for joining me today on EconoFact Chats.

Amy Finkelstein
Thanks for having me, Michael.

Michael Klein
Amy, congratulations on the publication of *We've Got You Covered*. I thought it was a really engaging and enlightening book.

Amy Finkelstein
Thank you so much.

Michael Klein
So let's start out with the state of play. What did you mean when you wrote "the United States health care system delivers far less than it could given that it represents one-fifth of spending in the United States?"

Amy Finkelstein
Yeah, so our book focuses particularly on the problems of health insurance coverage, and we emphasize three problems. The first is the one that I think everyone knows about, because it gets

a lot of attention, which is the fact that one in ten Americans under 65 still lack health insurance coverage. But the two that get much less attention that we also think are really important is that even for the 90 percent of Americans who are fortunate enough to have health insurance, that health insurance is both highly uncertain and highly incomplete. So just to give you a sense, one in four Americans under 65 will spend some substantial period, over a two-year period, without health insurance.

In other words, health insurance, whose purpose is to provide some measure of economic certainty and security in an insecure world, is itself highly insecure and uncertain, because you can lose your coverage if you change your job, or if you're qualified for a government program, but then your age changes or your income changes or your health changes. And then the final problem is that even for people who are fortunate enough not only to have coverage but to maintain that coverage, they can still face enormous out-of-pocket medical expenses for their supposedly covered care. So not only is the amount of medical debt in the United States just astounding – $140 billion in unpaid medical debt held by collection agencies is the current estimate, but even more striking, Liran and I estimate that three-fifths of that debt is incurred by households that have insurance when they're incurring that debt. And yet, because of high deductibles or unlimited cost-sharing, they end up still facing unaffordable bills.

Michael Klein
I thought it was very clever and useful in your book to begin your analysis of what's wrong with the health care system and what needs to be done by asking the question, ‘what is it that the U.S. health insurance policy is trying to accomplish?’ You wrote that no one was asking this central question.

Amy Finkelstein
Yeah, it's kind of striking to me, especially as an economist, where we're trained to define the objective and then figure out how to achieve it, that in policy debates in general, and particularly we've seen this in health insurance policy, people start throwing around slogans and buzzwords, single-payer, Medicare for all, pick your favorite one, without ever articulating what is the goal, what is the purpose of this policy. What are we trying to accomplish. And it seems to us you can't even begin to discuss the solution until you agree on the purpose. We spend a lot of time on this in the book, and I won't go into all the details, but I'll say that while there are many potential good reasons for the government to get involved in health insurance policy; to improve population health, to fix market failures, the list goes on and on, and we've worked and written on many of these – what became clear to us when we studied both our history of health policy, incremental reforms and patches over the last half century or more, as well as our current policy, is that actually they reveal a somewhat surprising but very real social commitment, a social contract, if you will, to try to make sure that everyone has access to essential medical care, regardless of resources. Now, it's not clear we've succeeded, but it's very clear as we discuss in the book that that's what we've been trying to do.

Michael Klein
Yeah, you’re right. Your mention of slogans reminds me of a bumper sticker that I put on my car a few years ago that I created. It said: “ideas, not slogans” as a bumper sticker.

Amy Finkelstein
I like it.

Michael Klein
So you said that there have been efforts to address the problems of the health care system, but they're patches, and as you and Liran write, they have all been incremental. So what did you mean by that, and why is this not the way to go?

Amy Finkelstein
So we're trying to describe what an ideal system would look like. These patches were created in the real world with political constraints and realities, and people were trying to accomplish the most they could. But what we've seen over the history of the last half century or more is that a particular policy window were open, a particular problem of a particular group will become salient, and health insurance coverage will be extended to a particular body of people based on often their health conditions. So we have separate programs for people who have kidney failure, for people who have breast cancer, for people who have tuberculosis, endless patches on top of patches. And the problem is that whenever there are multiple paths to coverage, there are always going to be people who don't find their path or who, you know, slip between the seams of the patches. So, you know, we give many examples in the book, but just to give one with all this disease specific coverage–so there's a famous program that covers people with end-stage renal disease, end-stage kidney failure. It was basically created because there was a new technology that was potentially lifesaving dialysis and artificial kidney, and yet people were not able to afford it. So we had a public outcry and we had this program. What's the problem? Well, people who have chronic kidney failure can't get covered until they reach the end stage. They can't get the preventive care that might help them from not get there. And then if they do get coverage and they're fortunate enough to get a kidney transplant, well, now they have a functioning kidney. They're no longer at the end stage and they lose their coverage, even though they face tens of thousands of dollars of immunosuppressant drugs for the rest of their life. So we discuss a lot of these examples in the book.

Michael Klein
One of the examples is this young girl, Katie Beckett, right?

Amy Finkelstein
Exactly.

Michael Klein
And that illustrates how sort of politically something that tugs at your heartstrings can lead to a big change in policy, but it's not done in sort of necessarily a rational way.

Amy Finkelstein
Yeah. It's particularly amazing that the heartstrings that were pulled at were President Ronald Reagan, who had been inaugurated the year before with a speech saying government is not the solution. And yet he was taken by the plight of this disabled little girl who couldn't leave a nursing home or a hospital because if she did, she'd lose her health insurance coverage. So, you know, he got the rules changed, but it only applied to kids and medical technology progressed

and she fortunately was able to live into adulthood. But of course, once she was no longer a child, the patch that had been created for her no longer applied.

Michael Klein
One of the things that really struck me in the book is that you kind of overturn a lot of conventional wisdom. For example, you write that no one is uninsured. And at first I didn't know what you meant by that, but after reading I saw, oh, that makes a lot of sense. So can you explain what you meant by that statement?

Amy Finkelstein
Yeah, it's a very important point. What does it mean to actually be uninsured? So obviously there are, as we said, one in 10 Americans who lack formal health insurance, but to actually be uninsured would mean that any medical care you receive, you pay for yourself. And that's just not what happens. If we look at work that I've done from the Oregon Health insurance experiment and other people's work, it's very clear that the uninsured get about four fifths of the medical care they would get if they're insured. And even more strikingly, they pay for only about 20 to 30% of that care. If they were actually uninsured, they'd have to pay for all of it. Why is that important? It's important because it's part of the evidence we suggest in the book of this actual social contract, this commitment to try to provide access to essential medical care, regardless of resources, because the rest of that care is paid for not out of private charity, but by a series of public programs that are designed and funded to cover care when people can't afford it, and are uninsured.

Michael Klein
So, Amy, you've used the term social contract a few times already, and implicitly there is a social contract in the United States having to do with the health of the population, and talking about the people who are seemingly uninsured, but in fact are not, is part of it. So can you be a little bit more explicit? What is the social contract that we have in this country towards people and their health?

Amy Finkelstein
What it appears to be, and you can look to the very origins of our republic and the growth of hospitals in the 19th century as primarily charitable institutions, even when they couldn't do much medically, it appears to be a strong commitment to, you know, put it quite crudely and to use words that the historian of medicine Charles Rosenberg used in describing the origins of the hospital system “to not let people die in the streets.” Or as we try and put it in the book, to try to provide access to essential medical care even if you lack the resources. That was why dialysis for end-stage renal disease patients got covered. That was why Katie Beckett, you know, got a program that allowed her and other disabled children to get cared for at home. So, you know, and we talk in the book about some of the psychological and philosophical motivations or impulses behind that contract. We're not here to defend it as, you know, the only or the right normative contract, but it's just very clear, and we're not the first to say this, this is an idea that has been supported for centuries and across the political spectrum, that once we recognize that fundamentally we are not going to let people die in the streets, that we are going to try in some ad hoc and probably inefficient way to do something once people are sufficiently ill and don't

have the resources, that we might as well formalize and fund that commitment up front through universal coverage.

Michael Klein
So, we don't let people die in the streets. There's not some kind of Dickensian dystopia, but there are huge disparities in health outcomes across income groups, across race and ethnicity, and you discuss this in the book. But again, I was surprised when you wrote that universal health insurance is not, as you put it, the policy lever to lean on in order to reduce these disparities. Why not?

Amy Finkelstein
That's a terrific question, and you know, I said early on that it's really important to define the goals of health policy or any policy before you talk about the solution. I think it's also important to be clear and realistic about what's out of scope, and as we discuss in the book, these disparities are real and they're very disturbing, and they are potentially amenable to public policy, but not, in fact, as a large body of research suggests, policies that affect medical care or access to medical care through health insurance. And I think one of the most striking pieces of evidence of this comes from work that economists have done documenting that even in countries like Sweden and Norway, which not only have universal health insurance but have, you know, a cradle-to-grave social safety net that's much more extensive than ours, even there you see shocking disparities in health outcomes across the income distribution that are on par with what we see in the United States. And this, and a whole other body of evidence that we discuss in the book, really suggests that the fundamental drivers of health disparities are not about the medical care you can access, but about, you know, the air you breathe, the cigarettes you do or don't smoke, the exercise you do or don't get, the food you eat. Pollution regulation, cigarette taxes, those are all amenable to policy. It's just not about medical care and health insurance.

Michael Klein
Yeah, along these lines, we have a really interesting podcast with Arline Geronimus in which she describes how those under chronic stress, especially people in the black community, suffer from what she calls weathering, resulting in much worse health outcomes. And the solution to these problems are not rooted solely in the health care system and would not be resolved with more widespread coverage.

Amy Finkelstein
Exactly. I mean, I think that her work is one of the many examples of the kinds of phenomenon we're talking about.

Michael Klein
So given all of this, what would you advocate as the health insurance and health care landscape? And again, what I really appreciated in your book is you didn't just lay out the problems, you laid out a set of solutions as well.

Amy Finkelstein
Yeah, it comes more naturally to me as an academic economist to point out the problems. So we did work hard on the solution as well. So I'm glad you appreciate that.

Michael Klein
Well, I really liked that at the beginning of the book, you motivated the book by having –was it your uncle ask you, what can we do – and you tried to quickly sort of point him towards the Thanksgiving turkey or something instead.

Amy Finkelstein
Yeah, no, I think it's easier to analyze current policies and say what's wrong with them or how they could be improved than to say what should we do? But we thought it was important. And that's why we took time to think about it and to write the book. It turns out that if you buy our argument, and I hope you do, and if not buy our book, and then maybe you will, the view of what's wrong with the health insurance system, these patches that allow people to slip through the crack and lose their coverage, even if they had it at one point, and the goal, which is to provide access to essential medical care, regardless of resources, then the solution actually becomes very straightforward. It's two-tiered. First, automatic, basic, universal coverage, that's completely free for everyone. And second, the ability to supplement that with additional coverage if you want to and can afford it in a well-designed market.

Michael Klein
So another thing that was striking in the book, and I guess you yourself change your mind about this, is you said the basic coverage was free to everyone, and economists think that the price system should be there to do things. But then on a little reflection, I'm not going to want another colonoscopy because it's free. And even a less extreme example, it takes time to go to the doctor. So it might be free in terms of charging me out of pocket, but not free in terms of other things that I value like my time. So on a little reflection, that made a lot more sense to me.

Amy Finkelstein
Yeah, that's the part of the book where I think we come as close as you can to committing professional heresy. As economists, we've done research, we've written on, we've lectured generations of students on this idea that if people have to pay something for their medical care, if they have a little bit of financial skin in the game, they'll be more judicious in making their healthcare choices. And the evidence on that is very clear that when you make people pay something for their medical care, they do use less of it. The reason we come out against any of these cost sharing, co-pays, deductibles and basic coverage is not because the evidence is wrong, but because the implications we drew from it were wrong, at least when it comes to universal basic coverage. And you can see that by looking at what other countries have done when they followed the advice of economists and introduced co-pays, they then introduced layer upon layer of exemptions, exempting 90% plus of the population if they were old or sick or poor or a student or a veteran. So basically, if you have a contract that you're going to provide essential medical care to everyone, regardless of resources, there's always going to be someone who can't afford the $5 co-pay or the $20 co-pay, and they end up creating the kind of patchwork mess we have in the U.S. just on the specifics of co-pays. And once we realized that in country after country, we said, better to just skip it entirely than create it and then create a bunch of workarounds to get rid of it.

Michael Klein
So you've already warned us against simplistic sloganeering, but there is the slogan "medicare for all." Is what you're describing a little bit like basic Medicare and Medicare Advantage?

Amy Finkelstein
In some ways, yes. Certainly, the Medicare Advantage is one natural way to do the supplemental market as we discuss. I would say that basic Medicare is both more generous and less generous than what we're proposing. It's less generous because basic Medicare still has the patient paying a lot out of pocket. They have to pay one in five of their physician bills with no cap in sight. So if you're unfortunate enough to say have large medical bills from oncology treatment, you can face tens of thousands, or hundreds of thousands of dollars in medical bills you owe. We think that's not what should be included in basic coverage. On the other hand, Medicare is more generous than what we would have in the basic coverage in the sense that it covers basically everything with no restrictions on what doctors can do. Medicare is prohibited by law from considering costs in approving new technologies. Physicians face no requirements or authorization requirements before they order a test or a treatment. Our basic system would be more like Medicaid for all. So longer wait times, perhaps more gatekeeping before you can get to see, get a specialist or a special test, but no copays, no deductibles, and automatically [inaudible], and then the ability to supplement in the private market.

Michael Klein
So let's talk about the supplementing then. You know, one of the things is that not everybody has the same access to housing, right? So there's some, like by the analogy, there's some basic housing that's afforded, but then if you want a nicer house, you have to pay for it. And you kind of make that analogy in the book, but is healthcare different than housing in that way or different from other things where, you know, because you're poor, you shouldn't be denied whatever would be covered under supplemental that is not covered under basic.

Amy Finkelstein
Yeah, this is something that we struggled a lot with and thought a lot about. There's an intuition that, you know, health is somehow different from other things like food and housing, that it holds, you know, a special place in our moral firmament, and that inequality in health is more disturbing than in other things. And I guess to that we have several answers. One, as we've already talked about, we don't actually think health insurance and health insurance policy is going to be the major lever to close those health inequality gaps. The second is more practical, which is this is how we do everything in the United States, whether it's security, we fund, you know, local law enforcement, but people buy private security cameras and home alarm systems. We fund universal public education, but people are allowed to, you know, supplement it with parochial or private school. And the third answer, which we talk a little bit about in the book, is that if you go to the political philosophers, people like Norman Daniels and John Rawls, they say that actually health and education actually are different from other goods precisely because they're related to equality of opportunity. But even they come down on the side of that means we have to provide a standard of adequacy, not one of equality.

Michael Klein
So, Amy, I'd like to close with something that I really don't understand very well. Maybe you understand it better, but it's the political side of it. So we're economists. We're not political scientists or politicians. And as we all know, the fight over Obamacare was incredibly intense and you and Liran are proposing a much more widespread overhaul of the system. What's your sense of the political viability of what you're proposing?

Amy Finkelstein
Well, first of all, let me say that I think that's the right place to end this discussion, as we also do in the book, rather than to begin it. I think too often policy discussions begin with let's consider what's feasible. And I think what's feasible is very hard to predict, or I at least missed that day in graduate school where they handed out those crystal balls. So we view our role as academics and academic economists as not to craft a plan that we think is the best we can do given the current political constraints. That's the job of the hardworking people trying to enact policy in the state houses across the United States and in Washington – but rather to articulate what we think is the ideal—constrained only by economics. We do have economic constraints in our book, but not politics so that when in the future a policy window opens up, people are ready and hopefully agree with our ideas to find a way to implement it.

I don't want to be overly simplistic and overly naive. There are certainly major political hurdles, but as we discuss in the book, our reading of the history of near misses in the United States at universal coverage, and we discussed some of them, including I think most saliently in the early 70s when both parties had competing proposals for universal coverage on the floor of Congress, as well as the incredibly bitter fights that occurred in other countries that did enact universal coverage, Britain and Canada being two examples we talk about, is that it's not obvious that it's our destiny to remain the only country without universal health insurance. And so our hope is that by putting the ideas out there, they'll be ready for when people who read our book, listen to this podcast and are persuaded by the ideas can figure out the right opportunity to introduce it at either the state or the federal level.

Michael Klein
Well, my hope is that when the policy window does open, they do in fact read very carefully the book by you and Liran, *We've Got You Covered*, and that they take into account the very good arguments that you've put forward. So, Amy, thank you very much for joining me today and good luck and congratulations on *We've Got You Covered: Rebooting American Health Care*.

Amy Finkelstein
Thank you so much. It's been wonderful talking with you.

Michael Klein
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