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Health insurance for the 21st Century

Upgrading To National Health Insurance (Medicare 2.0)

The Case For Eliminating Private Health Insurance

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Private health insurance was an idea that worked during part of the last century; it will not succeed through the 21st Century. With jobs increasingly service-based and short-term, the large employment-based risk pools that made this insurance system possible no longer exist. Medical care has become more effective and more essential to the ordinary person, but also more costly and capital-intensive. The multiple private insurance carriers that emerged during the last century can no longer provide a sound basis for financing our modern health care system.

Alone among the nations of the world, the U.S. has relied upon private insurance to cover the majority of its population. In the mid-20th Century, when medical care accounted for barely 1% of our gross national product, medical technology was limited, and jobs lasted for a lifetime, health care could be financed through such employment-based, premium-financed health insurance. But the time for private insurance has passed.

Health care has now become a major part of our national expenditures. The premium for an individual now averages more than \$4,000 per year, while a good family policy averages more than \$10,000 per year, comparable to the minimum wage and nearly one-fourth of the median family income. As a consequence, though the US spends far more on health care than any other nation, we leave millions of our people without any coverage at all. And those who do have coverage increasingly find that their plans are inadequate, exposing them to financial hardship and even bankruptcy when illness strikes.

If we believe that everyone should have health care coverage, and that financial barriers should not prevent us from accessing health care when we need it, then it has become clear that the private health insurance system cannot meet our needs. Health care has simply become too expensive to be financed through private insurance premiums.

Supporters of insurance companies claim that they create efficiency through competition. However, the truth is that insurance industry is increasingly concentrated, with three national firms, United Health, Wellpoint, and Aetna, dominating the industry. And the high and rising cost of health care shows that whatever competition there was in the past has not worked to hold down costs.

Supporters of private insurance also claim that it expands consumer choice. However, the choice of plans that these companies offer is not what consumers want; it is the choice of their physician and hospital, exactly the choice that private insurance plans, in the guise of managed care, increasingly deny us.

What has been the response of the health insurance industry to this situation? To protect their markets and

try to make premiums affordable, they have reduced the protection afforded by insurance by shifting more of the cost to patients, especially through high-deductible plans. They have also targeted their marketing more narrowly to the healthy portion of the population, so as to avoid covering individuals with known needs for health care. Yet premiums continue to rise each year, increasing by nearly 70% above inflation in just the last six years.

The so-called “universal health care” proposals being put forward by mainstream politicians would simply expand the current system without addressing any of its problems. They would simply mandate that either our employers provide us with coverage or we, as individuals, purchase our own coverage in the private insurance market. These plans cannot work in the face of the high cost of premium-based coverage for even the average person. (Some proposals would offer the option of buying a competing public plan, under the theory that the public program would be more efficient and effective. The flaw here is that the public plan would attract those who are unable to afford private coverage or who are paying high premiums or have no insurance because of pre-existing conditions. Placing these high-cost individuals in a separate government pool would make it unaffordable for most other people. This “death spiral” would cause the public plan to fail.)

The main impetus for renewed interest in health care reform has been the rapid rise in costs over the last few years. Yet, while most of these proposals give lip service to the need to control costs, none actually addresses the problem in a serious way. (The introduction of health information technology and “disease management”, which some of them urge, are mere placebos; they may make politicians feel better, but studies have shown they will do little to reduce costs and may actually increase them.)

Everyone acknowledges that coverage for low-income individuals must be subsidized. But what about the average-income individual and family? If they must now be subsidized as well, we might as well throw in the towel and recognize that a more efficient, more equitable financing system has to be adopted if it has any chance of providing coverage while being affordable to the society. An individual mandate to purchase private insurance cannot provide good coverage while remaining affordable, while employer-provided coverage also can no longer be sustained as the premium costs to the employer become increasingly unaffordable.

The private insurance industry spends about 20 percent of its revenue on administration, marketing, and profits. Further, this industry imposes on physicians and hospitals an administrative burden in billing and insurance-related functions that consumes another 12 percent of insurance premiums. Thus, about one-third of private insurance premiums are absorbed in administrative services that could be drastically reduced if we were to finance health care through a single non-profit or public fund. Indeed, studies have shown that replacing the multiplicity of public and private payers with a single national health insurance program would eliminate \$350 billion in wasteful expenditures, enough to pay for the care that the uninsured and the underinsured are not currently receiving.

Such a single payer plan would make possible a set of mechanisms, including public budgeting and investment planning, that would allow us to address the real sources of cost increases and allow us to rationalize our health care investments. The drivers of high cost such as administrative waste, deterioration of our primary care infrastructure, excessive prices, and use of non-beneficial or detrimental high-tech services and products could all be addressed within such a rationalized system.

In sum, we will not be able to control health care costs until we reform our method of financing health care. We simply have to give up the fantasy that the private insurance industry can provide us with comprehensive coverage when this requires premiums that average-income individuals cannot afford. Instead, the U.S. already has a successful program that covers more than forty million people, gives free choice of doctors and hospitals, and has only three percent administrative expense. It is Medicare, and an

expanded and improved Medicare for All (Medicare 2.0) program would cover everyone comprehensively within our current expenditures and eliminate the need for private insurance. This is the direction we must go.

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