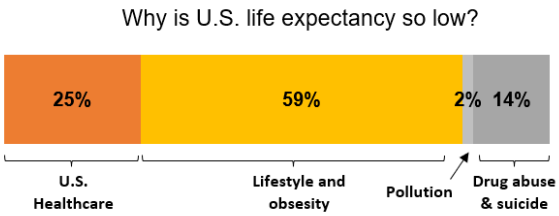
Amy Finkelstein

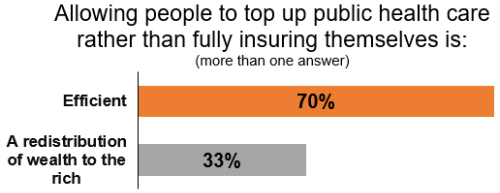
On Thursday, December 14, Amy Finkelstein joined Markus' Academy for a conversation on her book with Liran Einav: We've Got You Covered: Rebooting American Health Care. Amy Finkelstein is the John Jennie S. MacDonald Professor of Economics at MIT.

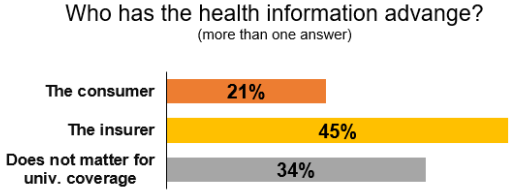
A few highlights from the discussion:

- **A summary in four bullets**
  - The goal of Finkelstein and Einav's book is to outline the tradeoffs around government health insurance and to answer the question: free from political constraints, what is the ideal healthcare system for the US?
  - They argue that the current system has three main problems: (1) too many are not insured, while even (2) the insured face uncertainty about their coverage in the immediate future. Further, (3) the coverage is not complete, with the insured facing a high degree of cost sharing.
  - To arrive at the solution, we must first be clear on what the goal of healthcare policy is. It is not to fix market failures, to reduce inequality, or to improve general health outcomes, it is to provide care for those in need. Healthcare is a part of the social contract.
  - With this in mind, the book argues for automatic, free, and basic universal healthcare. It would be closer to Medicaid for all (than Medicare for all), and would be supplemented with a private insurance market.

- **[00:00] Markus' introduction and poll questions**
  - As Angus Deaton highlighted in a recent Markus Academy episode, there has been a drastic decline in life expectancy in the US in recent years, especially among non-college graduates. Is the healthcare system to blame?
  - Adverse selection has been widely studied in health insurance markets. In the literature's models high risk types tend to be underinsured, but this is not what we see in reality. Einav and Finkelstein 2012 argue it is due to the correlation between being a high-risk type and being risk averse. With universal coverage, there is no adverse selection, but these come in as soon as top ups or supplemental opt-ins are introduced. In the emergence of AI insurance







companies invert and have a statistical information advantage. Hence, we will live in a world “inverse selection”.

- **[6:25] The three problems of the US healthcare system**
  - The goal of the book is to outline the tradeoffs around government health insurance and to answer the question: free from political constraints, what is the ideal healthcare system for the US?
  - It has 3 parts. The first identifies the problems with the current system. The second clarifies the objective of healthcare policy. The third makes a proposal for automatic, free, and basic universal healthcare (to be supplemented with a private insurance market, details below.)
  - Two of the main problems of our current system are highlighted by two facts: 1 in 10 Americans under 65 are uninsured, while over any 2 year period 1 in 4 Americans will be uninsured at some point. The first fact gets the most attention: the US is the only high income country that does not provide universal healthcare insurance.
  - However the second fact highlights the uncertainty that even the insured face: for example, half of those who lose their insurance will remain uninsured for 6 months or longer. For economists the point of health insurance is to provide economic security and to smooth consumption across states of the world. It is perverse, then, that while health insurance is supposed to be a stabilizer it is uncertain and insecure.
  - The Affordable Care Act barely moved the needle in this. Instead, it continued the patchwork approach of expanding different pathways to qualify for health insurance. The problem with this is that some people will fall under the cracks. But further, due to the complexity, many will not claim healthcare even if they are eligible, with estimates showing that of the uninsured, 6 in 10 are eligible for free or heavily subsidized health insurance.
  - The third main problem is that for the insured coverage is incomplete, with high degrees of consumer cost sharing. Research has shown that collection agencies hold more medical debt than all other kinds of consumer debt put together, while approximately 3/5th of this debt is owed by the insured.

- **[21:23] Function before form**
  - Many arguments have been given to motivate government healthcare: solving market failures, redistributing income, and improving the population’s health.
  - However, history makes clear that in reality governments seek to provide healthcare because society cannot stand idly when the sick do not get the care they need. As Charles Rosenberg (whose book outlined how hospitals in the US originated as charitable organizations) put it: “Fellow creatures could not be allowed to die in the streets.”
  - Across the political spectrum there is agreement that access to essential medical care is a part of our social contract. Charles Murray from the American Enterprise Institute, when arguing for replacing the welfare system with direct checks to individuals, made an exception for healthcare. His

reasoning was that, even if you've given people sufficient income and they don't spend it on insurance, if they become sick society will still help them.
    - Indeed, studies show that in a sense no one is actually uninsured in the US. As the Oregon Health Experiment showed, the uninsured are still receiving 80% of the care they would receive if they were insured. They are only paying for 20% of that cost, with the bulk of the money coming from community health centers, public hospitals, or other programs like subsidies to non profit hospitals.
    - Government health insurance is not the solution to all our problems. In general there is no compelling evidence that providing it will reduce costs. Further, the experience of Nordic countries and the literature (Fuchs 1974 or Chetty et al 2016) show that providing healthcare only marginally improves health outcomes: the social determinants of health are much more important.

- **[38:59] Writing the Unwritten Contract**
    - The book's proposal can be neatly summarized: universal coverage that is (1) automatic, (2) free, and (3) basic, allowing for market-based supplemental coverage for those who want and can afford it
    - If you agree that healthcare is a part of the social contract, the need for automaticity is clear, and government healthcare is the only way to achieve it. As the ACA showed, simply mandating universal coverage will not make it so.
    - The key tension on whether healthcare should be free is about moral hazard: should there be some cost sharing so that patients have skin in the game when seeking care? The competing proposals for universal healthcare from Nixon and Ted Kennedy in the 1970s exemplified this debate. In the end Nixon may have been right: as the literature shows (Aron-Dine et al. 2013 or Einav and Finkelstein 2018), when people have to pay for healthcare they use less of it.
    - However, in countries that introduced cost sharing we see that in conjunction they always implement numerous exceptions, to the point that for example in the UK 90% of prescriptions are exempt from cost sharing. There will always be people that can't pay the copays, so if there is a commitment to guaranteeing access to healthcare, cost sharing will just lead to complexity in the system, and it will not reduce costs.
    - Lastly, this universal coverage would provide the essential care, but not the high-end experience. It would not cover the non-medical amenities which healthcare often comes with (like an individual hospital room), as they are not a part of the social contract. Wait times for non-urgent care would be longer than under private health insurance or Medicare, and would be more similar to those in Medicaid. There would also be less choice over doctors, while unlike in Medicare there should be a careful assessment about the cost effectiveness of treatments.
    - Under the book's proposal an estimated 70% of people would opt for supplemental coverage. If needed, they would get a voucher equal to the expected savings to the government from not having to insure them. The key is that individuals opting for private insurance should not have to pay for

privately being covered for the basic care provided by the government. Otherwise we would just impose an enormous tax on those who want coverage beyond the basic. This would be a transfer in favor of the 70% of people who would get the supplement, but inequality is about taxes and transfer, not distorting choices in any particular market.
    - Can we afford it? Yes, without raising new taxes. Without addressing the problem of waste (which requires more research), the key is that, under our current system, we have chosen to allocate the government's 9% of GDP of healthcare spending to a more expansive program for the elderly, which has no budget constraint and no considerations for the cost effectiveness of technologies. The question is: Should we subsidize comprehensive insurance for the elderly, or the barebones essentials for everyone?

- **[59:14] Q&A**
    - Is the US subsidizing healthcare innovation for the rest of the world? Probably. However the question should always be whether the marginal value of this innovation for the US is higher than the marginal cost.
    - Would supplemental insurance be provided through employers? No; it distorts labor market decisions, while the tax exclusion for employer provided insurance is highly regressive: the wealthy tend to work more in jobs that provide insurance, and are able to avoid their high marginal tax rates. As Finkelstein et al. 2023 employer based health insurance has a similar impact on labor market inequality than more typically explained trends like the decline of unions, automation, and trade.
    - The Congressional Budget Office has recently projected that healthcare spending will slow down in the medium term. Why is this? We only see the slowdown in medicare spending. There is some evidence this is a mechanism effect from payment reforms, but much of the slowdown is not well understood. It is worth noting that there are only 2 time periods in recent history when we have seen this slowdown. The first was around Clinton's proposal for universal coverage in 1994, the second around the ACA in 2009-2010. It is possible that the threat of radical healthcare reform can somehow affect provider behavior.

Timestamps:
[00:00] Markus' introduction and poll questions
[6:25] The three problems of the US healthcare system
[21:23] Function before form
[38:59] Writing the Unwritten Contract
[59:14] Q&A