Marshall here. Welcome back to The Realignment.
When it comes to the post-2016 Democratic Party and the rise of Bernie Sanders,
debates over the future of America's healthcare system are near the center,
especially during the 2020 Democratic primary.
For a bunch of political reasons, however, mainly the lack of a strong Democratic Senate majority,
and a Republican Party still smarting from the failed Obamacare repeal effort in 2017,
healthcare just is not at the center of the American political agenda at the moment.
That said, the system remains fundamentally broken,
and I'm excited to speak with one of the authors of a new book,
arguing that it's time to just tear down the entire system,
rather than continuing to apply Band-Aids to paper over big problems,
namely, one, the lack of insurance for more than 30 million Americans,
and two, the spiraling cost of healthcare ever upwards.
My guest today is Amy Finkelstein.
She's a professor at MIT's Economics Department and a MacArthur Genius Grant winner.
She's written, We've Got You Covered, Rebooting American Healthcare, out today.
As I said, this is really not the hot issue at the moment,
but I guarantee you we'll be coming back to this at some point in the near future.
So always good to both check up on these topics and learn a bit along the way.
Huge thank you to the Foundation for American Innovation for doing podcast work.
Hope you all enjoy this conversation.
Amy Finkelstein, welcome to the Realignment.
Thanks for having me here, Marshall.
Yeah, I am really pumped to chat with you about the American healthcare system.
As you point out in the book, this is an incredibly complicated space
with incredibly complicated answers, but I think we will do our best in an hour
to kind of have a useful frame here.
So here's what I want you to do for this episode.
Pretend that I, we're going to age me up a tiny bit.
I'm like 40-something, Marshall.
I'm running for Senate.
I want to do something about healthcare.
So I'm just going to sit down with you for an expert for, you know,
50 minutes or so and ask you all the obvious questions that would come to mind.
So here is my first question.
You're coming to the healthcare policy space as an economist, as an academic.
You're not coming into this from a political perspective,
but I'd like to understand from your understanding,
what is the difference between your expert policy understanding
of the state of American healthcare and the political side of things,
the debates over Medicare for all, the debates about whether or not
Republicans want to even touch healthcare again after the 2017 debacle,
not actually getting rid of Obamacare.

Like what's just your understanding of the balancing act between those two factors?
It's very poor, I'd say.
As you said, I'm an economist.
I don't claim any expertise in politics.
And I'll say a couple of things.
First, we see the key point of our book is you started out by saying
it's a really complicated issue.
We actually think on the question of health insurance reform,
it turns out to be startlingly simple.
And so we'd like to articulate what the solution is,
so that if and when the politics align or people who are more skilled than I
at the politics realize there's a policy window of opportunity,
we at least know what we're aiming for.
That's the first.
The second thing I'd say-
And quick pause before you get to the second thing then.
What is the difference in your framing between me saying health care is complicated
and you zooming in on health insurance reform?
That's a great question.
There are two major problems with the U.S. health care system.
One is the problems with the insurance system.
And in fact, those problems are not just limited to the 30 million Americans
who lack health insurance, as we discussed in the book.
They're also the people who are fortunate enough to have insurance,
the other 90% of Americans, but risk losing it at any moment if they
lose their job or their income increases or they get older
or in some cases they get healthier.
So there's one major problem with health insurance is that it's ridiculously
uncertain for a product that's supposed to be about security.
And the second major problem with health insurance for those who have insurance
is even if they're lucky to hold on to it,
they still can face catastrophic expenses that they have to pay out of pocket.
So a startling fact is not only that there's a gargantuan amount of
unpaid medical debt, about $140 billion held by collection agencies,
but that three-fifths of that is held by households with health insurance.
So the first problem is the problems of insurance.
It's a very big problem, and that's the one that we are ready to shout from
the rooftops. Actually, there really is a simple answer.
The second major problem with the health care system in the U.S.
is just how darn expensive it is, right?
That we spend twice as much as a share of our economy on health care.
We have pretty poor health outcomes. These facts are widely known.
Most health policy debates try to combine those.

You know, think the Clinton health care reform, think the failed reform,
think the Obama care reform, they try to say,
we're going to extend coverage and make health care delivery more efficient
than the cost curve, as it were. That second problem is actually really hard.
We don't know the answer to it. I don't think anyone does.
Don't believe what they tell you on TV as we talk about in the book.
It's a really, really hard problem.
But one of our key insights is that those problems are separable.
We can solve our insurance problems without solving the still much harder
problem of how to rein in health care costs or get more bang for our health care buck.
Great. Okay. So, so many questions to follow up with.
So, number one question. We're not pretending I'm just 31 years old against.
We're going to mix the metaphors and make this very confusing for people who aren't taking notes.
So, when you brought up 30 million Americans without health insurance,
you bring me back to 2008, 2009.
I was a junior in high school then and that was when health care was a big issue
in the Democratic primary between then candidate Obama and then Senator,
well, both of senators, Senator Hillary Clinton.
Then you go into Obama care of 2009, 2010.
And the big talking point was 40 million Americans did not have access to health care.
There's a 10 million person difference between what I recall was the figure used
during the Obamacare debate and the one you just issued.
How should we understand how the past 10 to 12 years of Obamacare
has shifted the number of folks who are uninsured in the first place?
It's a great question. We actually wrote a recent paper on this that we discuss in the book,
which is, let's be clear, Obamacare was a major success when it comes to reducing the share
of people who lack health insurance at a point in time.
It basically have that number.
So from about 20% of Americans under 65 not having health insurance to about 10%.
But here's what it didn't do.
What we find is it didn't move the needle on the share of people who risk losing health insurance coverage.
So we calculate that although about 1 in 10 Americans under 65 are uninsured at any given moment in time
and that number is a lot lower now thanks to Obamacare,
yet a much higher share of Americans, 1 in 4 Americans under 65 will be uninsured
at some point over a two year period.
So this issue of insurance insecurity, this risk of losing coverage,
Obamacare didn't move the needle on it and it didn't move the needle on it
precisely because it was yet another incremental reform,
another patch to try and fix one particular problem.
And as we discuss in the book, this patchwork approach,
which is what we've taken over the last 70 years in the US is destined to punch below its weight.

Whenever you have patches, you're going to have gaps at the seam.
So to give you an example, one sobering fact is that if you take those people who are currently uninsured
at any given moment in time, the estimates suggest that 6 in 10 of them are actually eligible for either free or heavily, heavily discounted health insurance coverage.
But they don't have that coverage.
Why not?
The evidence is clear.
There's a lack of information.
They don't realize what programs they're eligible for because it's this patchwork
or they are unable to get together the requisite documentation
and fill out all the forms needed to demonstrate that they're eligible for it
or they manage to do that.
But whenever there's a program with eligibility requirements,
the program has to check every year or so to make sure you still meet the requirements.
If it's a program for the young, are you still young?
If it's a program for the poor, are you still poor?
If it's one of the many programs we have that get you health insurance,
if you have a particular disease, so there's a particular program, for example,
for low income women with breast cancer or for people with end stage renal disease
or for people with tuberculosis, the list goes on and on.
Well, then if you're cured, congrats, that's great for your health,
but then you lose that coverage because it's disease specific.
And so many people lose their coverage even if they don't lose their eligibility
because they fail to realize that they had to recertify.
They miss the form that comes in the mail that says,
tell us what your income is now or whether your cancer is in remission.
And so that's why we feel we need to tear down the current system
and start all over that this series of patches that is the approach we've pursued
since Medicare and Medicaid in 1965 is just never going to get us to where we need to be,
which is having security about your insurance,
knowing not just that you're covered at this moment,
but that you will be covered in the future as well.
Yeah, and I appreciate it because I want to make this point clear
because I kind of didn't frame it properly.
I was discussing the 30 million Americans.
The point, and correct me if this isn't correct,
but the point is not that there's this specific class or category of Americans
who permanently just do not have health care.
It's that over time, over this once again two year period,
a person A doesn't have health care for six months.
Therefore, he or she is part of that 30 million uninsured
and then six months later they may have health care again

and it's just constantly a constantly shifting percentage.
So me kind of saying, well, you know, 10 years ago we had 40 million
and now we have 30 million, that kind of like missed the point
in that this isn't just like a set group of people, correct?
Totally correct, but you're totally excused from,
as you put it, missing the point in the sense that I think we never talk about it.
The debate is always about the number of uninsured
and to be honest, in our own research and academic work,
I don't think we had focused on it until we really set out to try to write this book
and understand what the problems are in order to come up with the solution.
And once you realize that even if everyone is eligible for coverage,
if there are all these different pathways to eligibility,
we're going to always have people who don't have coverage,
then it becomes, I think, quite clear that the only solution is automatic universal coverage.
Because otherwise there's always going to be someone who doesn't know
which program they're eligible for or hasn't filled out the requisite documentation
to get on the program or to stay on the program.
And the history of what's happened in this country has made that abundantly clear.
You know, you've got this great, the book really specializes in using helpful anecdotes
to tell stories.
So that's just me being a quasi-reviewer praise.
But you've got this great anecdote you give about how in 2019,
you're asked the obvious question because Bernie Sanders is in the Democratic primary.
What do you think about Medicare for All?
And your answer is, well, that's a slogan.
It's not a specific policy proposal.
And obviously, there were bills in the Senate in the House.
But when people are asking you the question, they're not...
No, I would just bet a hefty amount of money.
No one was actually bringing HR-12 and saying, what do you think?
So all of that said, to bring up that anecdote, it seems like on the face of it,
Medicare for All is a response to the concerns you just raised.
In the sense that there's always different programs and it's so complicated
and who's eligible for what, what, and what.
If it was as simple from a starting point framing of, look, in this country,
if you want healthcare, there is this program, it's basically called Medicare.
And obviously, there's the conversation about, like, is there still supplemental insurance?
Is there private insurance?
Let's just put that aside.
What do you think about the strong rhetorical case that Medicare for All proponents would make
that their program simplicity and straightforwardness would kind of help push back
against the clutch together patchworkness that you're critiquing here?
That's a great question, Marshall.

And it's completely right on one dimension, but unfortunately, completely wrong on a different dimension.
So you're completely right from what we've been talking about, about the risk of losing coverage.
Nobody on Medicare risks losing coverage because eligibility is if you're over 65
and no matter how good your health insurance is, no one's getting younger, right?
So if you make Medicare for All, right, then everyone is covered
and there's no risk of losing insurance.
So that solves one of the two problems we've been talking about, but it doesn't solve the second, which is I don't think that most of the people who think they support Medicare for All
realize that Medicare for Some, which is what we now have, is in fact highly inadequate insurance.
So to give you a sense of that, if you have Medicare, you have to pay 20% of your doctor bills yourself with no cap
so that if you have an expensive illness like cancer or something,
you can end up with hundreds of thousands of dollars of medical payments that you have to make.
That is not insurance functioning as it should.
Health insurance is supposed to protect you economically, financially in the event of illness, right?
It's a bit of a misnomer when we call it health insurance because it's not actually ensuring your health.
That would be wonderful, but we're all mortal.
What it is doing is protecting you or what it should be doing, I should say,
is protecting you economically in the event of high medical expenses due to poor health.
And Medicare is currently structured, just doesn't do that.
There's some statistic we have in the book.
I'm forgetting it at the moment.
If you want, I can look it up.
It's something like a quarter of the elderly on Medicare pay more than a quarter of their income in medical expenses.
So that's not what good health insurance should be doing.
It should be protecting you against the economic costs of poor health.
So then why don't we just lower the percent that the recipients have to pay?
So that's a great question.
So now we're almost at our proposal.
So now you're saying Medicare for all in the sense of no insurance uncertainty.
Let's not have anybody pay anything out of pocket so there's no risk of large out-of-pocket medical debts.
Well, there's a third piece, which is the economics of it or the budget, right?
If you did that, you'd get enormous healthcare spending.
So our proposal is automatic universal basic coverage with no cost sharing.
And the basic part is the important part.
That's where we stop being the popular guy at the party who's just handing out puppies to everyone, right?
So in order to have this be affordable to the taxpayer, this automatic universal coverage has to be different from Medicare.

It has to be effective in covering all the copays and deductibles, but it has to be basic, limited to essential medical care.
So what does that mean if you say currently had Medicare?
It means probably longer wait times for non-urgent care, such as more like the wait times in Medicaid, which is more similar to what other countries has.
It means not coverage for things that aren't necessarily medically essential, such as, you know, some forms of plastic surgery, for example, or other high-end care.
And it means being quite basic or stingy, as it were, on the non-medical amenities that are part and parcel of healthcare,
such as, you know, having a private or a semi-private hospital room or, you know, nice waiting rooms or good food.
And this is how most other high-income countries organize their health insurance.
If you take Singapore, for example, they have an automatic basic coverage that provides essential medical care for everyone,
and they offer supplemental plans, and the main thing that people can buy and the main thing those supplemental plans pay for is shorter lines and a better overall quality of experience.
One of my favorite examples, they describe it, so Singapore is notoriously hot and humid, and they explain that under the basic plan, you'll be, if you're in the hospital,
you'll be in a 10-person hospital ward with what they euphemistically refer to as natural ventilation.
However, if you buy the A-plus supplemental coverage, you can have a private room with a private bath, high-speed internet, and air conditioning, as well as much better food.
So the key is that we provide the essential basic medical care to everyone, but the way we keep this affordable to the taxpayer is to not include many of the things we'd all love to have,
but that are not strictly essential from the point of view of maintaining health and functioning.
And since you said you liked analogies, an analogy we give in the book that may be useful is to give the analogy to airline travel.
So if we argue in the book that we have a clear, revealed social contract, social commitment to try to provide essential medical care when people are ill and can't afford it.
So we can discuss that if you want, but if you take that as given.
Can I pause you there?
Yeah.
Because this is actually, I listened to your Capitalism out of UChicago podcast, and this is a very important point that I think people across the political spectrum should just understand.
We can have all these big ideological, moral, practical debates about, like, what should healthcare look like?
Should you have this coverage, that coverage, death panels, et cetera, et cetera, et cetera.
But your point is, there is a consensus already, which is that if you have a catastrophic event or something happen, we will take care of you in this country.
And that any debate we're going to have should emerge from that shared reality, because I don't think that's acknowledged enough.
I think that's the awkward thing.
Thank you for backing me up to that.
It is not acknowledged.

And just to be clear, our argument in the book is not a normative argument of what we think our social contract should be.
We can have that discussion.
That's a separate one.
But we're just saying, empirically, if you look at what we do as a society and what our healthcare policy has been trying to do, we have an enormous number of government-funded, government-regulated programs to try, emphasis on the word try.
I don't think we've succeeded yet, and that's where we come in.
But to try to ensure that when people are critically ill and in need of essential medical care, they can get it regardless of resources.
Now, most people immediately think about the emergency room and the requirement that people who come to the emergency room have to be stabilized regardless of their ability to pay.
And that is, as we talk about in the book itself, not only its own failed patch, because you have to stabilize them, not actually treat them, and you can bill them afterwards for that care they can't pay for.
But it's just the tip of the iceberg when it comes to the layers of public policy patches we've put in place to try to provide health insurance to people in particular circumstances, particular diseases, particular ages,
such as veterans or prisoners or hostages. The list goes on and on.
And to fund hospitals and community health centers to provide medical care for non-emergency situations when people are uninsured and ill.
Now, we're not doing a good job of it, and that's why we think we need to tear it down and start over.
But all that clutch work, that Rube Goldberg machine, if you will, of contraptions put together to try to solve this problem, not only makes it clear that it's never going to work, we need to tear it down and build a coherent policy from the beginning,
but also why we need that policy, because those patches reveal this commitment, as you said, to try to make sure that no one is denied access to essential medical care because they can't afford it.
Yeah, sorry, go on. You were making an actual point before I interrupt you.
No, no, it was a great point. Your point was a great one, but I was going to say, if you take that argument to the airline analogy, imagine you had a social contract that was, I mean, this is a little ridiculous, of course, but that people should be able to fly from point A to point B.
That's the analog of nobody should be denied essential medical care because they can't pay. Okay, but there are many ways to get from point A to point B, and our analogy for our basic automatic basic universal coverage would be like the budget airlines that have taken over in Europe.
Anyone who's written on them knows that they're not a great experience, cramped leg room, limited or no checked bags, probably have to pay for the internet or for any food, but they do get you safely from point A to point B.
So in our proposal, universal basic coverage would do the same, and people who want to upgrade can allow business class pay extra for shorter wait times for non-urgent care, greater choice and flexibility of doctor, better amenities, etc.
Okay, so this is where I want to, because I'm not taking that rigorous note, but I want to make sure I understand this. So what is the difference between the basic care you're describing and I think

something we probably have anecdotally heard of catastrophic care?
Because I get the sense that these are different things from each other.
It's a good point. Catastrophic coverage is what, as economists, we were taught to love and worship, and for a long time I did, in the sense of go back to the fact that health insurance is an economic product designed to protect you financially.
Well, the real problem is not, you know, if you're reasonably affluent, the real problem is not, you know, a $50 doctor bill. The real concern is you end up really sick with tens of thousands of dollars of medical care.
And so the economist ideal, which we've, you know, I've written about and lectured generations of students on is to have so-called catastrophic coverage, which means, you know, for the first, say, $3,000 of medical care, you have to pay yourself, you the patient.
So the idea is you have, you know, skin in the game, as it were, you're not going to just rush to the doctor every time you sneeze or demand a CAT scan every time you have a headache, but that if you get actually really, really ill and your expenses become catastrophic, as it were, then insurance kicks in with the protection.
We take that back. This is the moment in the book where we commit professional heresy or perhaps we'll see professional suicide. And we say the problem with that is that some amount of healthcare expenses are catastrophic for someone. In other words, there's always going to be people who can't afford even a $5 copay for a prescription drug or a $20 copay for the doctor.
And what we've seen, and this is a practical argument, not a theoretical one, what we've seen in countries around the world that have universal automatic coverage, but have over the last several decades followed economists' advice and introduced or increased the copays and the cost sharing in these plans.
It's extraordinary. They've introduced or increased these copays with the one hand and immediately created all the exceptions and exclusions and alternative policies with the other hand. So take Britain, for example, they introduced copays in their prescription drug policy following the advice of economists.
And then they created exceptions for the poor, for the old, for the young, for people with cancer, for veterans. The list goes on and on. It's the US patchwork experience for health insurance writ large on the microcosm of copays.
And the end result is that 90% of prescriptions in the UK are actually exempted from those copays. So they just don't accomplish anything because, again, if we believe that we have this social contract to provide essential medical care, regardless of resources, we're going to inevitably have to create exceptions for any cost sharing.
And so we'll end up not accomplishing anything with it. So I think we said, let's go basic, not on the financial dimension, but on the flexibility, wait time and amenities dimension.
So, and this is where the metaphor of the airline is helpful. Obviously, like if you're, you know, I was flying American Airlines this week, and business class and economy and economy plus are all under the same company.
But in this metaphor with pretend that planes are a little bigger and you have like, you know, the United section in the American section, the spirit airline section on this giant jumbo jumbo jumbo jet.
To your point, under this basic system, I can still purchase private insurance, correct?

You can produce. Yes, exactly. Additional coverage. But the key is that you get, you'd still get the coverage under the basic system without having to pay anything additional. So in other words, all you're paying for is the, you know, as it were, additional leg room, not the original trip itself.
So to try and explain that a little more, that's how they do it in, say, Singapore or Australia, but it's not how they do it in the UK. So in the UK system, if you want to go outside of the National Health Service and say,
let's take cataract surgery, for example, the National Health Service will pay for cataract surgery, they'll pay for the surgeon and the hospital, either hospital stay or outpatient, usually outpatient, actually.
So they'll pay for the surgeon and everything else and they'll pay for the standard lens that you need. But there are some newer, fancier, arguably preferable lenses that are double the price and that they don't cover.
In the UK system, if you want that better lens, you have to go completely outside the National Health System and pay for the surgeon that the National Health Service would have otherwise paid for, and the full cost of that fancier lens, rather than just the additional or incremental cost to go from the basic lens to the fancier lens.
And our proposal is much more an upgrade approach, such as Singapore or Australia have, where if the basic plan as it were, we're already going to pay to fly you from point A to point B, you don't have to buy a whole new ticket, you just need to pay a little more for the additional leg room.
So, I guess the useful for me then is, it's, even when I asked the question when I said, you know, private insurance, it's more that there's supplement, it's not even about private versus public, there's supplemental insurance that you that you purchase.
Okay, so another question I have here then is, and this is where this does get political.
I just forced, quote unquote, you to make a couple commitments in those answers, you said, it's supplemental, we're not getting rid of private, you know, like there's still like privately sold insurance, etc, etc, etc.
This brings just to mind to me, you know, President Obama is like if you want your doctor, you can you can keep your doctor that kind of like early 2010s Obama care debacle.
How do you as a health policy economist scholar, think through the implications of promises and expectations in this category.
Because I'm just thinking if I'm adopting your plank here and I'm saying, well, listen, we've, you know, we run the numbers, you get this, this, this isn't that.
I would just be worried as a politician about promising aspects of this, given the doctor promise thing.
So I guess, but I guess, I guess to your point, though, this is different, this we're talking about health insurance, we're not necessarily talking about doctors.
So I guess, just thinking out loud here, like what is the difference between health insurance coverage and how you as a patient would interact with the health care system because that feels like when they when those get confused, that's where you get into the if you keep you keep your doctor problem.
Exactly. So again, let me reiterate that, you know, politics and political forecasting is not my forte. I think we I missed the day in graduate school where they handed out the crystal balls.
Part of it as a point is to articulate the ideal so that others who are more politically savvy can look

for the right window and the right message and part of it is just to say, well, okay, maybe in the real world, compromises will be needed.
But let's let's at least know what the ideal is so we know which compromises are more consequential than others and which, you know, we can make more or less comfortably.
But I will say the following.
My limited understanding of politics is that, yes, well, anything can be turned into a tagline that sounds wonderful or awful, or at least other people can do that.
I can't that a lot of, you know, when you think about do I support this policy comes down to you, is it better or worse for me.
And so that's what in the book we talk about for different types of Americans does our proposal for automatic universal basic coverage with absolutely no co pays or cost sharing, but really basic and then you have to buy additional insurance if you want something beyond the basic.
Who wins who loses so for the uninsured, it's a clear, you know, the people who are uninsured at any given moment in time, it's a clear win for the one fifth of Americans who have medicaid the public health insurance for low income individuals.
It's roughly a wash, except they'd be better off under our plan because they'd be allowed to supplement whereas Medicaid legally does not allow supplementation for people with private health insurance.
It's better in some very important respects, in particular, no risk of losing that coverage, you know, if you lose your job or change jobs to one without insurance, and no risk of these high out of pocket medical expenses for your so called covered care that we talked about.
On the other hand, it's more basic, right. So, but you know, you can again buy extra. And then finally, for the, you know, about one fifth of Americans on Medicare, which we talked about Medicare for all, we already said that, you know, it's going to be much better because there's not this risk of catastrophic medical expenses, but it's going to be more basic. So no one is strictly worse off, several groups are better off and for several I think it's a it's a wash but a wash worth worth having because again, let's remember the purpose of insurance.
It's about not it's not actually about can I choose my doctor or can I have a nice hospital room. It's about economic security in the face of illness. And if you are risking that you may lose your coverage at any moment, or that if you get sick and you maintain your coverage you may still face catastrophic medical expenses.
Health insurance is not doing its job.
And this is where I just want to push you a bit because I get you I fully understand your point about the limits of your political understanding and just you know frankly speaking to a lot of authors and scholars I think most folks would do well to start with that that premise.
But that said, you have throughout this episode and in the book critiqued the patch working versus system systemic reform approach and you know my defense of the political class is like that's an ultimately political decision.
Because the reason why we found ourselves patch working is well guess what there's like no consensus therefore the best I can do as you know representative and you know the house from Austin is proposed this like little fix to this this this or that thing you know President George W Bush you know he can't you
know change social security but he can do Medicare part you know D. That's why you have like the

patch working system. So I guess I would just be interested in understanding.
You're telling starting in the 1940s like after we get employer based insurance effect the World War two period. I was your understanding of how we got into the patch working system.
Why we stopped doing more overarching changes after you know Medicare Medicaid and then kind of the Obamacare quick period. What's just your understanding of how we got there then got here that yet.
Let me first say I think your point is entirely fair. So just to be clear. We don't mean we especially as as academics who have never let's be clear tried to actually get anything done in our lives.
We mean to sit here and at all critique the extremely hardworking and dedicated politicians and policy people who are out there trying to accomplish something and therefore you know not letting the perfect be the enemy of the good and make doing incremental reform when they
go. Obviously that that's better than nothing if you're usually it's better than nothing. Our goal is to just explain why you know it's worth keeping in mind that that's never going to get us to where we want to go.
It may be the best we can do in the moment but we also need to keep we're never if we're not going to solve this one brick and you know at a time there.
Before we started this book that was our instinct. Okay there are a few problems. What are the patches we need to fix it. It's only in realizing how how deep seated this this sort of contraption and the rot in it that we've created over the last 70
years that we realize ultimately a full solution is going to involve automatic universal coverage. But I just want to be clear. I don't mean at all to denigrate people who are working with the art of you know the possible at any given moment in time.
I do think it's important to articulate this this goal this North Star as it were because you know as as the economist Milton Friedman said you know you put the ideas out there and then you wait until the impossible becomes inevitable
and we've seen that happen many times over our history. But now let me go back to your question about how did we get to where we are and you said starting with you know the fundamental reforms of Medicare and Medicaid in the in
65 and after that it's just been a series of patches. We actually argue in the book that while of course Medicare and Medicaid were by far the biggest watershed moments in our health policy history. They were themselves even at the
time very clear clearly inadequate patches. It was only one or two years after the enactment of Medicare that bills were being introduced to try to add prescription drug coverage to Medicare. It didn't happen till 2006 but that was incomplete.
And with Medicaid there was a real concern you know that a lot of children were not covered that pregnant women weren't covered those got added in the 80s. Then the problem is you lose your coverage when you give birth or 60 days after you give birth.
So from the beginning I think the patchwork system has never quite worked. I think the reason you know what's happened is we discuss in the book is that you know at various moments in time certain issues become politically salient and there's enough of a
political consensus to pass a reform that will extend coverage to people with end stage renal disease or pregnant women in the example I just gave or a new program to cover disabled children so that they can be at home rather than an institution.

But each of those patches then sort of reveals their own inadequacy. So for example that the program that was passed by none other than Ronald Reagan the so-called proponent of limited government to make sure that disabled children could continue to receive Medicaid but be cared for at home.
The problem was when this when these the so-called Katie Beckett waiver was passed many of the very critically ill children that it was serving were unfortunately had very short lives they were going to you know die as adolescents.
There was then substantial medical progress which is wonderful but it meant that these children could now live much longer lives in fact Katie Beckett for whom the program was named ended up living till 34.
But guess what when she's no longer a child she then loses her coverage. That's just one example of many of how these patches can fail to fully solve the problem even the narrow problem that they were being designed to address.
Let me also say without without coming off hopefully is as hopelessly naive about the world I understand that politics is is brutal especially today but one thing that gives well two things that give me hope for our proposal.
One is that this is not a liberal or a conservative proposal that universal coverage is truly a nonpartisan issue. It's been embraced both in the intellectual community and in the public policy community by people across the political spectrum.
So you know on you know I think it's it's more obvious to see that on the progressive side people like former Supreme Court Justice Ruth Bader Ginsburg and talking about the constitutionality of the Obamacare mandate referred to our you know obligations to always help people in essential need.
But even conservatives such as Republican Governor Mitt Romney of Massachusetts who actually put in a mandate for health insurance in Massachusetts prior to the Obamacare mandate argued for it on exactly these grounds.
Charles Murray the famous libertarian at the American Enterprise Institute who has proposed a universal basic income basically as a way of getting the government out of people's lives and out of their wallets just give everyone $13,000 a year in cash.
Get rid of all that those government bureaucracies in Washington, even he has one and only one exception to where he'd have public policy come in except through providing cash, and that's to take $3,000 of his $13,000 universal basic income and use it for mandatory health insurance coverage.
Why, because he recognizes as does Mitt Romney as does many others that if we don't do that, that if people spend their money, even if we give them an adequate basic income and then end up sick, we are inevitably going to step in to do something so we need to recognize that and require it and fund it up front.
So for the last third of the show this is where things get really, really, really complicated. So it seems to me a huge and difficult aspect of the Obamacare push wasn't just the argument that we're making these reforms.
It's the argument, and this is key to the passage key to the intellectual framework that these reforms will reduce costs overall because that's like the bigger right greater problem.
You know, the cheaper healthcare costs would be the easier be to ensure people so it's not just that Obamacare wants to say hey like we're going to have an insurance mandate and we're going to provide for those 40 million it's that ultimately these different reforms that are attached to this

broader project are going to lower the cost overall but obviously,
at this point in the game has not happened so two things one and I want you to answer the first one.
Does everything we've just spent the past 30 minutes discussing at all affect the overall cost.
So the overall cost of the program is a political decision that depends on just how basic or less than basic or more than basic I guess as it were we want to make basic coverage.
The key thing we point out in the book is that we can fulfill our commit or revealed commitments without raising taxes now that doesn't mean if this plan were adopted that taxes wouldn't be raised if we decided to do things more generously.
But the reason we know we can do this without raising taxes is if you look at every other high income country may spend on average about 9% of their economy and healthcare and that's essentially all taxpayer financed in the US.
In the US we spent twice as much of our economy and healthcare about 18% but only half of that is taxpayer financed so half of 18% you know you don't need to be an MIT trained economist to realize that's also 9%.
In other words our taxpayer dollars which are financing Medicare, Medicaid, employer provided health insurance through a tax subsidy our taxes are already paying for universal coverage.
It's just that's not what we're getting with our tax dollars so we can afford universal basic coverage without raising taxes.
I should better clarify and actually that's a very helpful answer that I'm sure folks are thinking of I was more getting at just the overall fact that healthcare
total percent of GDP in this country is incredibly expensive because I remember and I'm thinking there's this I'm sure you as an expert like you know this category there's this I have this kind of like standard that I call this like time magazine cover solutions.
So like back in the 20,000s like when I like actively had like a times magazine and then real Newsweek subscription you'd kind of have the covers that say like electronic health records can they solve healthcare or preventive care like if you're eating healthier you're getting more checkups you're not going to need to get always expensive catastrophic things they're actually the source of most of the cost because you're just healthier overall and overall.
The argument was that those sort of reforms that were part of the broader Obamacare reform package would reduce the overall cost of health care.
So whether or not it's privately financed by the public finance we would just be spending less overall that didn't it was again this is where this gets complicated.
I would say the simple version is that the time magazine cover solution didn't quite work in the terms that I think people were colloquially.
I don't think it worked in the complicated version either.
Another way of saying it is as I said at the beginning we have two fundamental problems health insurance coverage and health care spending and Obamacare the attempts in the Clinton administration merge those two together.
They need to be separate because they're distinct problems and the reason you know on the one hand we were we want to shout from the rooftops that on the coverage dimension.
We actually think that the guy on the street who comes up to me and says every other high income country does it why can't we and I want to say well it's really complicated turns out he or she was right.

It actually on the coverage dimension it turns out to be really simple on the health care spending the you know you're invoking 2008 2009 when the buzzword was quote unquote bending the cost curve. You can spell what that means.
Yeah it means cost curve so bending the cost curve means reducing health care spending without harming patients or keeping health care spending the same but getting more bang for your buck even more health for the same spending.
So let's be clear reducing health care spending is trivial you know shut down hospitals that'll reduce health care spending but it'll be bad for patients right so so the Holy Grail is how to reduce spending without harming patients.
And the reason we don't tackle that in our book is because we don't know how and let me be very clear neither does anyone else I don't care what they're telling you on television.
As we talk about in the book that sort of there are three main buckets of yes it's not get rich quick it's save money quick solutions right.
Cutting administrative costs all those pesky red tape who wants that lowering price it is why do we pay so much for prescription drugs and doctors.
And the third is getting rid of unnecessary care you know people getting CAT scans when they have a headache and whatnot and those all sound like gosh no brainers.
Why don't we do that.
I forgot the fourth that you that you declined that our former president Trump quite enjoyed the buying across state lines which was just basically like a generic.
This was basically like the generic 2010s conservative like talking point that's that's why Trump had the quarries like he's like the lines the lines you know he's he's he's he's he's great remember to hearing that.
So yeah sorry go on.
No no but exactly and they're unlike with the it's so simple on the health insurance side as we go through in the book you know not that any of these are obviously bad ideas but none of them are are cost free.
You know it sounds like oh like red tape.
Why why would anyone want red tape.
Let's get rid of red tape.
Well they have in Medicare.
That's why administrative costs are so so low in Medicare.
But the way they get rid of red tape is there's there's no guardrails.
Doctor can order whatever the patient wants any test any procedure and Medicare spending is rising really really fast much higher than for example Medicaid spending where there are budget constraints and rules and prior authorization.
So I'm not coming out and saying prior authorization is great but like there are tradeoffs involved.
Same with high prices.
You know everyone wants to cut prescription drug prices to make them more affordable.
There's very very clear empirical evidence.
I've produced some of it.
Other scholars have produced much more of it that shows and this will shock no economist that if you reduce pharmaceutical prices and make prescription drugs less profitable fewer new

prescriptions or new drugs will be invented because the incentive for for profit pharmaceuticals. Pharmaceutical companies to engage in research and development is based partly on you know the the pot at the end of the rainbow that they're going to get if they you know if they are successful. I'm not saying therefore we shouldn't reduce pharmaceutical prices it may be that we would prefer to you know slow somewhat the rate of innovation and just have more people able to afford the innovations we currently have but let's be clear it's not a free lunch.
So to understand this and then kind of frame this in terms that I think would be helpful to you.
A huge part, a clear a clear toolkit that previous health care reform advocates policy minded folks offered politicians were.
Just that this reform you're offering will increase more coverage you're actually being responsible and you're solving a deeper problem of these growing health care costs the Balmor's cost disease point.
You are saying that moving forward a part of the rhetorical toolkit for a politician minded person like myself is I just need to separate because want to make this very clear.
I just need to separate the fact that health care costs are exploding from the insurance question because ultimately commingling these two in a way sets up the you know program for failure from a certain perspective but then be is just is just not helpful.
Exactly.
And in fact, I go a little further and say, I think it.
It confuses or muddies the clarity of purpose to you know when we say, for example, oh if we expand health insurance will get people out of the expensive emergency room and into primary care that's cheaper and more effective so will not only make people better off but will save money.
So first empirically, that turns out just not to be correct research that I've done a randomized controlled trial, as well as many other people makes it very clear that if you expand health insurance.
People actually use the emergency room more because it's become cheaper right and as we teach in economics one on one when you make things cheaper people buy more of it, but more to the point. It's setting the goal post in the wrong place right we don't say, you know, we're going to have a national defense system because it'll save us money.
We don't say we're going to build bridges and public schools to save money we do it because we think there's a job purpose that is worth the cost.
And so obviously we need to be respectful of the budget and that's why our proposal is designed to not have to increase taxes, but to come out and say we're going to have health insurance reform and expand coverage in order to save money.
Misses the point that that's not the reason we should be doing health insurance reform we should be doing it to fulfill our clear social contract to provide essential medical care when people can't afford it.
So two last questions before we wrap so question one and I'll split these into two obviously question number one would be if you're and your coauthors answer is that you just don't know the answer to the second part the exploding health care part.
What open questions or lines of inquiry should other scholars political actors policymakers.
If someone's going to write the follow up to this book, what should they be focused into.
Well, you know I don't want to give too much away because you know that's what we hope to work

on for the rest of our professional lives and no I'm kidding I mean I'd love it if someone else came up with it.
I'd say the first thing is we know we know the sort of not the full solution but the stop gap measure as it were which is the way we'll keep at least taxpayer cost for health care from exploding is to do something that's both incredibly banal but ridiculously radical in the health care space which is actually have a budget and impose it.
We don't have a health care budget in the United States in the sense of the way my kids when I give them an allowance they have a budget and they can't spend more than that and they have to choose between you know toy a and toy B or when we more seriously when when a school district has a budget that they can spend they
have to decide you know are they going to you know fund the arts program more or the athletics program or these are hard choices that have to be made.
In the Medicare program which as we've talked about some would like to see extended for all. There is no budget in the sense of a budget cap.
There's only when people talk about the Medicare budget they either mean the amount we have spent in Medicare last year or the amount were projected to spend next year there is no constraint everything you know people doctors right you know order tests do procedures
and send the bills and the government pays it.
So the first thing we need which again every other high income country has is an actual budget so that at least on the taxpayer side we can constrain costs that's that's the short term answer that the the much harder question which is how do we how do we make sure that
whatever that public budget is it's getting bet even more producing even more health and better patient outcomes at that same level or maybe even the same outcomes at low levels.
That's what a large number of very very smart health economists health services researchers physicians etc are working on.
All kinds of ideas out there better care coordination global budgets adding more incentives on the payer side putting you know so that providers are more you know they have skin in the game if they keep if they spend too much on the patient.
I will say the work that I and others have done so far unfortunately has not revealed a silver bullet.
I'd say the best thing we found so far you know if you look at sort of the history of health care payment reform over the last three four decades five decades.
What you've seen is you know one big picture idea after another that's going to come in to save things you mentioned preventive care right so in the 70s and early 80s it was man it was HMOs or prospective payment in the 90s it was managed care in the
in the aughts and after Obamacare it was the so-called accountable care organizations.
Unfortunately each one of those has ended up as you were saying with the time magazine headlines just not delivering on its progress promise hope springs eternal and and we all are continuing to work to find something until that blessed day.
I'd say the best thing we can do is to borrow a technique from my development economist colleague Esther do flow who shared the Nobel Prize in economics recently in 2019 for her experimental work to alleviate global poverty and her she has this wonderful lecture called the
economist as plumber and her argument is you know you go in you tinker with the taps you fix things where you can and I think we need some more health care plumbing so there's a series.

We've written some of them other economists have written others a series of totally non sexy very small not big picture.
Policy it's the opposite of what we're proposing for health insurance very incremental health care reforms that'll save half a percent of health care spending there another half a percent here.
Without clearly without harming patients that's not going to be a panacea but rather than keep waiting or hoping or proclaiming even worse that now we have the magic solution.
We can at least roll up our sleeves and save money where we can and you know the old expression a billion dollars here a billion dollars there soon we're talking about real money well in health care you know that probably applies ten fold over.
So in the last thirty second elevator pitch question we've jumped across fields categories you know timelines what's just your quick sum up of what you're proposing on the coverage side we said you said it earlier obviously but I just want to make it very clear take away from the
episode the proposal to address the insurance coverage side of this automatic universal basic coverage with no patient payments no premiums they don't have to sign up for they don't have to pay anything when they see the doctor but basic so automatic universal basic coverage for free with the ability to purchase supplemental
coverage if you can afford to and want more than the basic.
Awesome that's the perfect way.
Yeah please.
Can that fit on a can that fit on a bumper sticker I may have to shorten it a little more.
Well no it's the thing is just the the friendly feedback in a good way which is basically that the thing that's the thing that's a fits on the bumper sticker and would appeal left right and center is the tear down aspect.
Like that that's the critical thing like the critical thing is like you everyone is dissatisfied with the health care status quo.
The thing you're trying to convince someone if you're a political actor my useful take away if I was senator cause I'm listening.
Man I've been I've been a senator here I've been a representative we're really mixing it here my take away is basically just oh.
Tear it down don't just put another band-aid or another patchwork on it and that's actually the useful message and that's the useful starting point for anyone interested in the policy or political side of that.
I'm Amy this has been really great.
Could you just shout the book and any other relevant work you've done out for folks who want to learn more.
Our book is called We've Got You Covered Rebooting American Health Care and it's joint with my long term collaborator Loran Ainov who's a professor at Stanford.
And I would love for people to read it and hopefully do more than I can to get it actually implemented.
Thanks for joining me on the realignment.
Thank you so much.
Hope you enjoyed this episode.
If you learned something like this of mission or want to access our subscriber exclusive Q&A bonus

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