DO YOU WANT WALL STREET TO CONTROL YOUR HEALTH CARE?

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In 1963 Nobel laureate economist Kenneth Arrow wrote a classic article about health care costs and the free market. Arnold Relman summarizes Arrow's argument: "Medical care cannot conform to market laws because patients are not ordinary consumers and doctors are not ordinary vendors." Relman observes that "Arrow's argument was largely ignored in the rush to exploit health care for commercial purposes."

Private medical insurance companies, driven by a need to satisfy their investors, now take profits and management expenses that run between 17-30 percent of premiums while Medicare's overhead is estimated at 2-6 percent.

Medicare Advantage plans, private policies designed to substitute for Medicare, are expected to cost taxpayers $149 billion over the next 10 years. These plans limit providers and sometimes do not cover out-of-state care.

Touted by Republicans as a less expensive free market alternative to Medicare, these plans take an average 13 percent in administrative fees. They have not managed care nor have they reduced costs.

A good portion of administrative costs for private insurance go to bloated CEO salaries, the 2008 median of which was $12.5 million per year. The median salary for CEOs in technology, oil and gas, and financials was in the $8 million range.

When he was forced to leave UnitedHealth Group, William McGuire received a golden parachute of $1.1 billion, but the Securities and Exchange

Commission made him give back $468 million, enough to the pay the annual premiums of 78,000 American families with premiums of $500 per month.

Wendell Potter worked as a senior executive for several health insurance companies, and he recently gave testimony before a Senate committee. He maintained that medical insurance companies are one of the main reasons why our health care system is "both the most expensive and one of the most dysfunctional in the world."

Potter warned the Senators not to trust the insurance executives who just pledged cooperation with Obama in reforming our broken system. He reminded the committee that back in 1993 the same companies failed to keep their promise to create a standard benefit and to eliminate practices such as pre-existing conditions and cherry-picking.

Potter explained that Wall Street investors rate companies higher if they turn premiums to profits rather than payments to patients. As Potter states: "To help meet Wall Street's relentless profit expectations, insurers routinely dump policyholders who are less profitable or who get sick."

At a recent hearing before a House committee, insurance executives refused to end the practice of canceling the policies of those who have become ill. Potter reported that three major insurers had "cancelled the coverage of roughly 20,000 people in a five-year period, allowing the companies to avoid paying $300 million in claims."

Employees at small businesses have been especially hit hard by cancellations or increases in premiums that no one can afford. The Small Business Administration reports that since 1993 the number of small businesses that cover their employee' medical bills has decreased from 61 to 38 percent.

The most egregious example of increasing premiums was the sticker shock experienced by members of the Screen Actors Guild. In 2006 they were notified

by giant insurer CIGNA that their new premiums would be $44,000 per year. Last year CIGNA's H. Edward Hanway made $12,236,740.

In his testimony Potter related the story of Aetna's reorganization in the early 2000s. New computer systems allowed Aetna to better identify risky policy holders, and since then about 8 million Americans have lost their medical coverage with the company.

Potter predicts that consumer-driven plans, favored by Republicans and which "cherry-pick the youngest, healthiest and richest customers," will force "managed care plans to charge more to cover the sickest patients."

Private insurers play a large role in the universal coverage enjoyed in Germany, the Netherlands, Switzerland, and Japan. In Germany private insurers are not allowed to take a profit, and premiums can rise only at the rate of increase of medical costs. No one is denied coverage in these systems and all them cost about half of what Americans pay per capita.

In Japan there are more private hospitals than in the U.S. and most doctors run their own businesses. Every Japanese is required to have non-profit medical insurance and the government pays the premiums of the poor. Average premiums for everyone else are $280 per month per family and in most instances companies pick up half the cost.

The U.S. should have gone to a single payer system decades ago, but the power of the private insurers is so great that this is no longer feasible. The solution is a public insurance option such as Senate Bill 1278, which would set the standard for comprehensive, accessible coverage; and Senate Bill 1050, which would "improve transparency and accountability" in private health insurance markets.

Basic health care coverage should not be a commodity but a basic right for each and every American. Our medical futures should not be bought and sold on the stock market. Just as we could have better government if we removed private money from political campaigns, so could we have better health care if medical

insurers took care of patients' basic needs rather than looking to Wall Street's bottom line.

Nick Gier taught philosophy at the University of Idaho for 31 years. Arnold Relman's article "The Health Reform We Need and are Not Getting" can found in *The New York Review of Books* (7-9-09) and Wendell Potter's testimony can be found at www.tnr.com using the search box.