

Fixing Health Care Before It Fixes Us

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- Healthcare • Vouchers • Risk adjustment
- Global healthcare budget • Universal health insurance

Our nation faces three interrelated and grave health care crises. First, more than 47 million Americans, including 8 million children, have no health insurance coverage. In 1987, the uninsured population totaled 32 million. In two decades, there has been nearly a 50 percent rise in the number of Americans without health insurance.

Second, Medicare and Medicaid costs threaten to bankrupt the country. Today's elderly are now receiving more than \$15,000 per year, on average, from these programs. In 2030, when all 78 million baby boomers are fully retired, the average benefit will exceed \$25,000, in today's dollars. This estimate is based on optimistic assumptions about benefit growth. In 2030, the two programs' annual costs will run close to \$2 trillion in today's dollars.

These huge pending annual health care costs are largely responsible for the roughly \$70 trillion fiscal gap that separates the present values of projected federal expenditures and receipts. This fiscal gap provides the true measure of our nation's indebtedness because it puts all future net fiscal obligations, implicit and explicit, on an equal footing. Seventy trillion dollars is a huge amount of money, even for an economy as large as ours. It goes well beyond anything the nation can afford.

The third health care crisis involves enormous health care obligations facing employers, many of whom are drowning in health care bills and looking for the exit. Since 2000, the share of employees covered by employer plans has fallen by over one tenth – from 66 percent of employees to 59 percent. This decline is occurring, in part, from the closure of employer plans and, in part, from employees opting out of their employer's health care plans when their employers invite them to share in paying for premium increases.

Employer-sponsored retiree health care plans are relics in the making. Many companies are freezing their retiree health plans; others are simply renegeing in full or in part on past health care insurance promises. General Motors, for example, just handed over \$32 billion in health care obligations to the United Auto Workers to get out from under the close to \$47 billion in future health care benefits that it had promised its retirees.

The interconnections between the three crises are first order. Employers are reacting to the high cost of health care by eliminating their health plans. This is swelling the ranks of the uninsured. As the uninsured run out of funds to cover their health care bill, more and more end up on Medicaid. Since 2000, Medicaid enrollments have soared by 35 percent. And, to close the circle, the fee-for-service reimbursement system used by Medicare and, to a lesser extent, by Medicaid has contributed significantly to the overall rise in the price of health care and, consequently, to the health care costs employers now face.

DEMOGRAPHICS AND HEALTH CARE BENEFIT GROWTH—WHO'S GOING BROKE?

The United States, Spain, Japan, Norway, and Germany are some of the countries in deepest trouble, when measured by their fiscal gaps relative to the gross domestic product (GDP). The trouble stems from three sources: growth in government spending on retirement and health care benefits; growth in government purchases of goods and services; and changes in demographics.

Demographic change is already here. In Japan, 18 percent of the population is now 65 years and older. America's oldest baby boomer is now eligible for early social security retirement benefits. The

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European and Japanese workforces are already shrinking, and Japan's population growth rate is already negative. Europe's population growth rate will turn negative in just 4 years.

As **Table 1** indicates, the United States is now and will remain significantly younger than Japan and Germany. Canada's elderly population share will be similar to that of the United States for the next three decades, but then Canada will get older than the United States. By midcentury, Canada's oldsters will represent 26.7 percent of the population compared with 21.3 percent in the United States. In time, even China, which is now much younger than is the United States, will be older than the United States. Although the United States will be the young kid on the block, even the United States will look very old. The entire country will be older than current-day Florida. And there will be more than just a large number of oldsters. There will be a lot of old oldsters: people who are 85 years and older. Indeed, in 2050, there will be enough Americans who are 85 years and older to fill up all of New York City, Los Angeles, and Chicago. There will be enough centenarians to fill up all of Washington, D.C.!

Fertility is the major force determining long-run aging. As **Fig. 1** shows, postwar fertility changes have been extraordinary. In 1950, the fertility rate in China was 6.22 percent; now, it's about 1.7. In the United States, it was 3.45 percent; now, it's about 2.11. There are also amazing fertility rates in Europe and Russia. Italy's rate is currently 1.2 percent. In Japan, the rate is 1.3 percent. In Russia, it's 1.1 percent. These incredibly low fertility rates presage, of course, major declines in population.

Longevity increases are also playing and will continue to play an important role in the aging process. **Fig. 2** shows dramatic change – past and projected – in life expectancy in the United States, China, Germany, and Japan.

Consider Japanese newborns born in 2050. They will live, on average, to age 88. In 2050, the median age in Japan will be 52. In 1950, the median age in Japan was 22.

Past and projected fertility and longevity changes have important implications for total population sizes. As **Fig. 2** shows, the United States' population will expand by about 100 million people through the middle of the century. This is a projected 33 percent increase compared with the current total.

In Europe, there will be a major depopulation – by roughly 80 million – over the same time period. Russia's and Japan's populations will fall by about 20 percent. If fertility rates don't turn around, by the end of the century, Russia's and Japan's populations will be roughly half of what they are today (**Fig. 3**).

PAYING THE PIPER

These projected demographic changes are fascinating, but what are their fiscal implications? Consider the United States, which now spends over \$30,000 per old person on Social Security, Medicare, and Medicaid. Medicare is the old-age health insurance program run by the federal government. Medicaid is the government's health care program for the poor, including poor elderly in nursing homes. Because of the high costs of nursing homes, about 70 percent of total Medicaid expenditures is spent on the elderly.

If \$30,000 seems like a lot of money, it is. It's about 80 percent of United States per capita GDP. It's higher than the GDP per capita in about 200 of the world's 231 countries. However, by 2030, when the baby boomers are fully retired, the average benefit level per oldster won't be \$30,000; it will be at least \$50,000 (measured in today's dollars) and represent more than 100 percent of 2030 per capita United States GDP. The remarkably high levels of oldster benefits, current and projected, are due, in the main, to the growth in the health care component of total Social Security, Medicare, and Medicaid outlays.

The table below details real government health care benefit-level growth in the United States, Japan, Canada, and Germany between 1970 and 2002. In the case of the United States, the real

Table 1
Elderly population shares

Country	2005 (%)	2030 (%)	2050 (%)	2070 (%)
Germany	17.1	26.3	30.5	31.3
Japan	18.0	29.9	36.8	37.7
United States	12.4	19.1	21.3	21.6
Canada	13.0	23.6	26.7	27.1
China	7.6	16.3	23.5	na

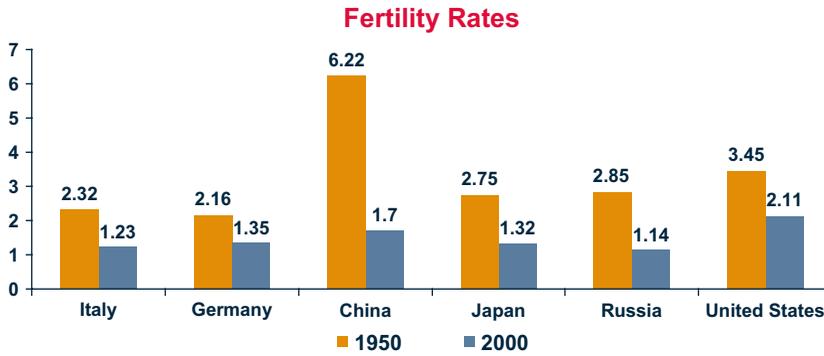


Fig. 1. Fertility rates by country, for the years 1950 and 2000.

growth rate of the benefit level (measured as Medicare and Medicaid expenditures per person at a given age) averaged 4.61 percent per year. In Germany, real benefit-level growth averaged 3.3 percent; in Japan, it averaged 3.6 percent. In the United States, the 1970–2002 health care benefit level growth rate exceeded the corresponding growth rate of per capita GDP by a factor of 2.3. The rate of growth of health care benefit levels in the United States and other countries is clearly unsustainable, but when will it end?

THINGS THAT CAN'T GO ON CAN STOP TOO LATE

The late, great economist Herb Stein was famous for saying, “Things that can’t go on will stop.” However, what Stein left out was: that things that can’t go on can stop too late. Dealing with our current \$70 trillion fiscal gap is a Herculean task. Delaying that adjustment will make the adjustment that much harder.

To get a sense of what \$70 trillion really means note that closing this gap would require an immediate and permanent doubling of United States

payroll taxes, which now represent 15.3 percent of covered wages. Alternatively, one could collect \$70 trillion in present value by eliminating all federal discretionary spending for all time. This means no military, no Air Force One, no judicial system, no pay for Congress, and no road construction, for example.

It would be nice were the \$70 trillion a figment of an errant academic’s dismal imagination. The figure, however, comes not from an academic. Instead, it comes by way of the U.S. Treasury Department; indeed, the \$70 trillion figure reflects an update of a 2002 study prepared by then United States government economists, Jagadeesh Gokhale and Kent Smetters, who prepared a fiscal gap analysis at the request of then Treasury Secretary Paul O’Neill (Table 2).

How can the United States fiscal gap be so big? When you are projecting paying \$50,000, on average, to upwards of 77 million baby boomers, you’re talking about spending close to four trillion dollars a year in today’s dollars. Yes, the United States economy will be larger when these payments are made to the boomers, but four trillion

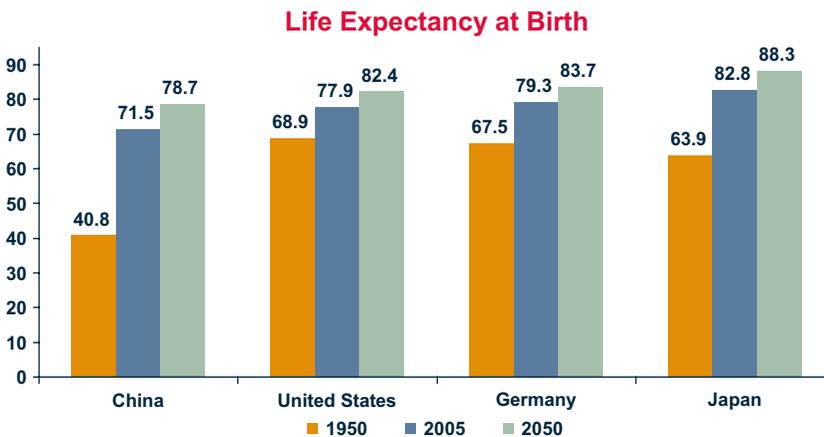


Fig. 2. Life expectancy at birth, by country, for years 1950, 2005, and 2050.

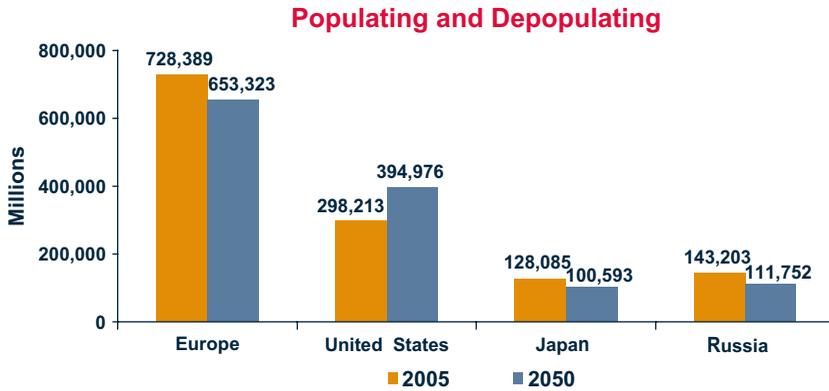


Fig. 3. Population by country/region for the years 2005 and 2050.

dollars a year is still a huge expenditure to be making each and every year.

What's particularly troubling is that the \$70 trillion fiscal gap estimate is based on quite optimistic assumptions. The estimate assumes the health care benefit growth rate will be about 3.1 percent rather than the 4.6 percent rate recorded between 1970 and 2002. Unfortunately, there is no reason to expect a decline in the growth rate of the combined Medicare and Medicaid benefit level. Indeed, in the last seven years, this benefit-level growth rate has averaged about 5.6 percent in real terms, not 3.1 percent!

MACROECONOMIC FALLOUT

Any reasonable observer considering the size of the United States fiscal gap must conclude that the United States is, quite literally, facing bankruptcy. Bankruptcy is a strong term. In a business context, bankruptcy means future earnings can't cover future costs as well as current unpaid bills. It also means defaulting on creditors. In a government context, bankruptcy means future receipts that don't cover future expenditures. It also means defaulting on creditors: all those expecting to receive

government health care, pension, welfare, and other benefits as well as all those expecting to be employed by the government. Government bankruptcy also means jacking up tax rates and printing money to "pay" for what the government spends.

No doubt, there are some people who believe that the United States is immune from fiscal meltdown and high inflation, if not hyperinflation. They should think again. Too many countries, big and small, rich and poor, have demonstrated that, sooner or later, fiscal profligacy comes at a very heavy price. Indeed, our current severe contraction is being fueled by a degree of pessimism far beyond anything we've seen in postwar recessions. This loss of confidence in the U.S. economy is surely greatly exacerbated by the public's strong sense that the federal government's long-run fiscal position is unsustainable.

There are increasing signs that Uncle Sam is driving the United States economy over the cliff and that the rest of the world is taking notice. The United States national saving rate is now running below 3 percent. In 1960, it was close to 13 percent. Our incredibly low saving rate has led to an incredibly high current account deficit, which has led to an incredibly low value of the dollar.

Table 2
1970–2002 Growth in government health care benefit levels

Country	Annual Growth in Expenditure Per Potential Recipient (%)	Annual Growth in Expenditure Per Capital (%)	Annual Growth in GDP Per Capital (%)	Ratio of Column One to Column Three
Germany	3.30	3.62	1.54	2.1
Canada	2.32	3.08	2.04	1.1
Japan	3.57	4.85	2.44	1.5
United States	4.61	5.10	2.01	2.3

Why is the United States saving rate so low? The answer is clear. The counterpart of saving too little is consuming too much. As a share of national income, the federal government is consuming at roughly twice the rate it did a decade ago. But the main explanation for the decline in United States saving is not Uncle Sam's spending. It's the spending – the consumption – of households. The households whose consumption have been rising most rapidly are those of the elderly. Since 1960, average consumption per oldster has roughly doubled relative to average consumption per youngster.

Who is paying for this growth in the consumption of oldsters? The answer, in large part, is Uncle Sam. With Medicare and Medicaid benefits, for example, the vast majority of which go to the elderly. Every year that Uncle Sam allows these benefits to grow much more rapidly than the economy – and this means virtually each of the past 60 years – the government directly expands the consumption of the elderly and, thereby, national saving. Uncle Sam has also been cutting taxes on the elderly, which has also permitted them to consume a lot more.

Uncle Sam's policy of taking ever larger resources from young savers and handing them to old spenders, increasingly in the form of in-kind medical goods and services, is showing up in the level of consumption of the elderly, in the rate of aggregate United States consumption, in the United States national saving, in the country's current account deficit, and in the value of the dollar.

FISCAL GAPS IN OTHER COUNTRIES

Unfortunately, recent fiscal gap analyses are not available from other countries for comparison with the gap in the United States, but the United States may not be alone with respect to long-term fiscal insolvency. This author contends that Spain, Japan, Norway, and Germany are also in very bad long-term shape. However, each of these countries has a health care system directly controlled by its government; each of these countries is in a much better position to stop, on a dime if need be, excessive health care spending.

Consider Canada, for example. It has a state pension system that appears to be in long-run actuarial balance and one of the lowest real health care benefit growth rates in the Organization for Economic Cooperation and Development (OECD). As **Table 2** shows, real government health care benefit levels are growing in Canada at essentially the same rate as per capita GDP. On the other hand, because of the demographics, total expenditures per capita on health care in Canada have grown more rapidly than has per

capita GDP. Canada also has a health care spending problem, but it is largely driven by demographics and it's a problem, not a crisis.

THE UNITED STATES HEALTH CARE CRISIS

Much of the recent growth in United States government health care benefit levels has to do with the number of people who are collecting benefits at a given age, but the benefit level referenced here is not benefits per Medicare and Medicaid recipient at a given age. Rather, it is the benefits per person at a given age. Growth in government health care benefits per person at a given age reflects both the growth in benefits per recipient at that age and the growth in the age-specific participation rate.

There has been an enormous increase in age-specific Medicaid participation rates since 2000. Indeed, as indicated, overall Medicaid participation has increased by over one third since President Bush took office. Part of this expansion of Medicaid reflects the recent enrollment of millions of otherwise uninsured children via what is called the State Child Health Insurance Program (SCHIP) program.

The health care crisis is not simply a problem on its own. It's a problem that greatly compounds the United States fiscal crisis. President-elect Obama has been promising to provide major health care insurance subsidies to millions of uninsured Americans while simultaneously expanding Medicaid and also leaving Medicare unreformed. The United States desperately needs universal health insurance, but it needs to be implemented in a way that doesn't put the final nail in the United States fiscal coffin.

POLITICAL "SOLUTIONS"

The major Democratic presidential candidates are advocating policies that address only one of our three health care problems: the 47 million uninsured. Their method of covering the uninsured could exacerbate the other two crises. Their plan is to place all 47 million uninsured people in a huge pool. Low-income uninsured households would receive an income-related subsidy to buy insurance. Middle- and high-income households would not. Insurers providing coverage to anyone in the pool would be required to cover everyone who applies. Under some proposals, the uninsured would be forced to either buy a policy or face a tax or some other form of punishment.

The plans also envision giving the uninsured the option to receive coverage from a new Medicare-type government entity, which, presumably, would

provide fee-for-service payments to providers in a manner analogous to the workings of Medicare Part A and Part B. This new Medicare program, which this author will call Part E, is envisioned, presumably, to ensure that middle class uninsured, with incomes too high to be subsidized, will still be able to buy a policy at a reasonable price.

The subsidization of the low-income uninsured's purchase of insurance and the creation of Medicare Part E represents the establishment of another major government health care program at a time when the existing ones are out of control, with respect to their costs, and are, on their own, fully capable of driving the nation broke.

THE GREAT UNRAVELING

Traditional employer-based health insurance is already unraveling, but the introduction of major subsidies to the low-income uninsured and the establishment of Medicare Part E could dramatically accelerate this process. Employers could well tell their low-income workers: "The government has established a new health insurance system for which you are eligible. If you opt out of our plan and join the government's, you can receive a subsidy."

This invitation by employers to their employees to, in effect, "get lost" when it comes to their health care, is, after all, what has been happening for years with respect to employer-provided health care for retirees. Employers have realized that duplicating Medicare's coverage makes no sense and that the cheaper way to go is to compensate their workers in other forms and arrange to have their workers go onto Medicare when they retire.

Even high-income workers might be induced by their employers or, indeed, compelled, if employers cancel their health plans, to switch to "uninsured's insurance." The government will be under great pressure to ensure that premiums charged by participating "uninsured's" insurers and by Medicare part E are affordable by the middle class members who won't qualify for subsidization. This is particularly the case if the government chooses to force the uninsured middle class, at pain of penalty, to buy coverage. If the government is going to force the public to buy something, it has to be something good and it has to be something affordable. If it is good coverage and affordable for the uninsured middle class, it will also be good coverage and affordable for the middle class who are currently covered by employer plans. Yes, employers who don't provide their own plans will be forced to pay a tax to help pay for their workers, but if that tax is not too high, it may well behoove

them to close their plans or encourage many of their workers to opt out of their plans. Massachusetts' health care reform provides an object lesson. The plan sets up a new, subsidized system for the uninsured and compels the uninsured to enroll. It also forces employers to pay a tax per employee if they don't cover the worker under a plan of their own. Costs of the reform have skyrocketed, even though the reform has just begun. Enrollment in the plan is twice the amount originally forecast, according to "Subsidized Care Plan's Cost to Double," *The Boston Globe*, February 3, 2008. The tax being charged employers is incredibly low: less than \$300 per year per employee. Massachusetts had planned for the federal government to pick up half of the tab of the program, but that seems highly unlikely. Indeed, Massachusetts' as well as other states' planned major expansions of SCHIP, which insures children under Medicaid, have been thwarted by repeated presidential veto.

IS UNIVERSAL HEALTH CARE AFFORDABLE?

Our country's fiscal gap is so massive that an immediate and permanent doubling of the 15.3 percent employer plus employee payroll tax would be required to close it. That represents a huge potential tax hike and one that would very badly undermine work incentives. Other taxes could, of course, be raised to close the fiscal gap, but such adjustments would be no less painful.

Given our massive fiscal gap, worsening Medicaid's finances and letting Medicare's further hemorrhage, which is precisely what our politicians are promising, will leave no money for anything else, let alone massive government subsidies to assist tens of millions of low-income uninsured households to buy insurance. Rather than help employers exit the health insurance business, these schemes permanently trap all employers in it. Worse yet, they may suggest to employers that they should dump their plans and simply pay the insurance tax for all their workers, lest the government pass a law that compels them to indefinitely maintain their current, very expensive plans.

With regard to forcing the uninsured poor to pay for their own coverage, "good luck". There is no way to force someone who is poor to buy health insurance, resulting in an army of uninsured when all is said and done. What's needed is a universal health care plan that provides a single fix for all three of our crises. This author calls the solution the "Medical Security System." The 10-point plan is simple and is described here.

THE MEDICAL SECURITY SYSTEM

1. The plan provides universal coverage. The Medical Security System would replace our current Medicare, Medicaid and employer-based health care systems.
2. The plan provides each American each year with a health insurance voucher.
3. Those with higher expected health care costs receive bigger vouchers; indeed, vouchers would be proportional to expected health care costs. (There would be with some additional adjustment to the size of the voucher for those with high upside-cost risk.)
4. Each year participants use their voucher to purchase a basic health plan.
5. Participants can change their health plans annually.
6. The basic policy will cover prescription drugs, home health care, and nursing home care.
7. An independent, government-appointed panel of doctors, hospital administrators, insurance executives, patient representatives, and government officials define the basic policy.
8. Each plan must cover the basic policy and accept any and all Americans who wish to join the plan (ie, buy the policy with their voucher).
9. Health plans are free, within limits set by the panel, to compete for participants via co-payment rates and deductibles, as well as incentives to exercise, reduce weight, stop smoking, and otherwise improve health.
10. The government fixes its total annual voucher budget as a fixed share of GDP so that the nation can't go broke due to health care expenditures.

DISCUSSION

The best part of the plan is that it requires very little new financing. Add up everything federal and state government will shortly be shelling out on health care both directly and indirectly via tax breaks; throw in some significant administrative savings; and the sum is roughly 90% of the money needed to pay for the Medical Security System.

In addition to resolving three terrible problems, the plan is highly progressive. It eliminates huge tax breaks to the rich and provides vouchers based on medical condition. Because the poor are, on average, in worse health than the rich, they will, on average, receive larger vouchers than the rich, at a given age.

Finally, The Health Care Fix preserves and, in fact, would greatly strengthen our competitive health care industry. The plan institutes universal health insurance, not universal health care per

se, although universal health care is the end result. The distinction is important.

What is being proposed here is not a government-run health care system. It is a plan for the government to redirect its current expenditures to a new system that is efficient, equitable and highly competitive — and one that won't drive our nation broke.

Each insurance company would make a small profit on the vouchers. There would still be private provision (ie, private competition by the hospitals and the doctors), but there would also be socialized finance of health insurance. This isn't universal health care per se; it's universal health insurance. The health care would continue to come from the private sector.

HOW THE MEDICAL SECURITY SYSTEM WOULD WORK

In October of each year, each American would receive a voucher with the size of the voucher depending on the person's objective health conditions. If Mr. Jones has cancer, he gets a big voucher. If he is perfectly healthy, he gets a small voucher. Each person would be individually risk-adjusted to determine the size of the voucher. Each person would spend the voucher, by January 1st, on a health plan, which would cover him or her for the year.

The government would transmit the amount of money on the voucher to the insurance company chosen. At that point, the insurance company is on the line to pay for all health care costs covered by the basic plan.

Households would be free to purchase supplemental insurance from their basic plan provider to cover health care expenditures not covered under the basic plan. Such excluded costs include paying for a private hospital room, paying for the use of new equipment and procedures not covered by the basic plan, and paying for prescription drugs not covered by the basic plan.

Each person's medical tests, scans, x-rays, prescriptions, and objective diagnoses would be entered electronically into a government health care database creating an electronic medical record (EMR) for each American. The EMRs would be used to risk-adjust each person each year. And this objective risk adjustment would, in turn, be used to determine the size of the person's voucher.

The risk adjustment would take into account regional costs, but one could not garner a larger voucher by incurring more health care expenses on one's behalf. One's health care expenses, per se, would have no impact on the size voucher one receives. Instead, one's voucher will depend

solely on objective test results and other data concerning one's health status.

Because insurers will be compensated for taking on people with pre-existing conditions, they will stop trying to cherry pick the market and start focusing on providing the best care and insurance arrangements for their clients, including the sick-est among them. In economic terms, the Medical Security System solves the adverse selection problem that plagues the private health insurance market.

However, adverse selection is not the only problem undermining private insurance and private care. This new plan also calls for medical malpractice legislation, which would limit defensive medicine and permit insurance companies, subject to appeal to the panel, the right to deny coverage for care not approved by the panel as part of the basic plan.

The Medical Security System also acknowledges that we can not perfectly risk adjust, although one can do a much better job than is being done today, for example, in Medicare Part C. To deal with imperfections in risk adjustment, the government would establish a re-insurance system that pools risks across insurance companies for covering patients who turn out to be extremely expensive.

The Medical Security System would naturally encourage insurance companies to join with providers in forming Accountable Care Organizations (ACOs) or Physician-Hospital Organizations (PHOs). Kaiser-Permanente is an example of such an organization. Insurance companies could offer either "at risk" contracts with organizations or provide administrative services for ACOs/PHOs large enough to self-insure.

Under the Medical Security System the government would also: a) provide incentives for providers to provide coordinated care and develop team approaches to health care; b) intervene to address local medical monopolies that attempt to charge prices far above national standards; c) use the EMRs inputs and outcomes data to engage in comparative effectiveness/resource-use efficiency research; d) disseminate to the public information on costs, quality, and treatment modalities; e) use EMRs to help the private sector achieve the numerous and important specific health improvements and cost savings that George Halvorson outlines in his recent book *Healthcare Reform Now!*¹; f) set up an Internet system for the public to use to spend their voucher (ie, to choose particular health plans); and g) organize default insurance plans for those

who fail to select an insurance plan by January first of each year.

SUMMARY

The current American health care system is beyond repair. It needs to be replaced in its entirety with a new system that provides every American with first-rate, first-tier medicine and that doesn't drive our nation broke. The Medical Security System proposed here may sound radical, but what's truly radical is maintaining the "suicidal" status quo.

The Medical Security System should appeal to both Democrats and Republicans. For Democrats, the plan offers universal health insurance, publicly financed, and provided on a progressive basis. For Republicans, the plan maintains our private and competitive health care provider system as well as our system of private health care insurance. It also permits insurance companies to innovate and to give people incentives to: a) neither under- or over-use the health care system; and b) to improve their health. Additionally, this new plan would make it clear to all Americans, in sending them an explicit voucher, that they are, at the margin, buying their health care and that they need to spend their voucher in a way that provides them the most value for the money.

The Medical Security System should also appeal to the uninsured, those in Medicaid and Medicare, and even those now covered by employer plans. The uninsured will obviously benefit from a system in which their basic health care is as good as everyone else's. Medicaid participants will benefit from being in a system that no longer cuts off their insurance coverage if they earn or save too much money. Medicare participants will realize that their future health care benefits are no longer jeopardized by a system that is going broke and increasingly leading their doctors to say, "I don't take Medicare." Finally, those who are covered by their employers' plans will realize that they too are uninsured under the current system because they too can end up, at any time, among the ranks of the uninsured or find they need to cover the health care costs of their uninsured friends and relatives.

No system is perfect and the Medical Security System no doubt has its shortcomings, but piecemeal United States health care reform, of the kind now being discussed, is a prescription for putting both our health care and our economy at extremely grave risk.

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