Social Security as designed is unsustainable. It depends on early death of beneficiaries who will lose virtually all their money, like most participants in a lottery. Like a pyramid scheme, it requires constant growth of the working population. Increased longevity and lower post-Baby Boom birthrates are narrowing the base of the age pyramid, spelling an earlier end to Social Security than was anticipated. But like a pyramid scheme, it would inevitably run out of enough new "investors," as it is impossible for any population to increase without limit.

In addition to the aging population, more working-age Americans are dropping out of the labor force. The U.S. now has 90.6 million "non-institutionalized" men and women over age 16 who are not working, with total employment at 144.3 million.[3]

Workers are hoping (but are not guaranteed even a penny) that successive generations of people will pay more money into a big fund, and that the money is not spent by politicians, so that they will receive a prize of money upon retirement.

What should working people call Social Security? A gamble? Gaming? A swindle? Will they continue to participate if they can avoid it? What does it mean for past "investors" dependent on continued payouts? For similar schemes, Charles Ponzi and Bernard Madoff went to prison.

But remember, governments that run a lottery are immune from punishment under the law.

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Healthcare Is Not an Insurable Risk

Ralph O. Butz, M.D.

When the U.S Supreme Court noted in *National Federation of Independent Business v. Sebelius* that virtually everyone would at some point use healthcare, it essentially admitted that healthcare is not an insurable risk because insurable risks are random and infrequent.

If one demands that the free market deliver health insurance for all, then it must fail because the demand is impossible to meet. The government cannot do the impossible either. What it calls national health insurance, or universal healthcare, is not actually insurance, but a socialist scheme to redistribute wealth.

What Is an Insurable Risk?

Insurable risks involve a pure loss. Unlike a speculative risk, an insurable risk is not offset by potential gains. The loss must be determinable and measurable. For example, loss of life (death) or a fire either occurs, or it does not occur. The loss must be accidental or random and unintentional. Those who engage in dangerous activities assiduously try to avoid deadly accidents, preserving an acceptable degree of randomness. Suicide (intentional death) is excluded in many life insurance contracts, and arson of course is excluded in fire insurance contracts. Catastrophic losses are also uninsurable; these would include war and "acts of God."

The loss to be indemnified in casualty insurance is specified in the contract. A value is set on the loss of a key person such as a breadwinner. The replacement cost of a house or car is specified. In case of high-frequency losses, economic feasibility applies. To insure the life of a 99-year-old man would require premiums, including reserve provisions and administration costs, greater than the benefits. When the chance of loss exceeds about 40 percent, the expense generally exceeds the indemnification.[1]

Why Healthcare Costs Are Not Insurable

People want good medical care because they want good health, a condition that is never completely achieved but can be improved with diminishing returns by increasing medical care. Can one calculate the risk of loss and hence the premiums?

Life tables over a century of a population history fail to reveal the underlying heterogeneity that causes individual deaths to depart from the statistics of the whole population. Insurance companies seek to adjust for some of these individual variations through medical examinations and histories that can lead to changes in premiums or even refusal to insure.

But consider the "cost of medical care." The heterogeneity

is astronomical. Combinations of the numbers of diseases with known treatments, associated examinations, opinions, and continual care lead to enormous variations in costs. There are now huge catalogs of diagnoses and procedures that list the costs that will be reimbursed. These not only do not solve the problem; they add considerable management expense. Heterogeneity is so great that any effort to divide the population into groups of insurable, homogenous units eliminates the possibility of large enough numbers to develop statistical tables. There are also the costs of medical services that are still unknown.

"Medical care" is a vague and slippery concept. Theft is theft and fire is fire, so that fire or theft insurance is fairly clear-cut. Although there is the moral hazard of insured persons burning down their own unprofitable store or house or staging a fake theft, this is generally manageable. Medical care, on the other hand, can expand indefinitely.[2]

The increasing costs of medical care with age made the burden of the non-productive pensioners' premiums economically unfeasible. With Medicare, the government obligingly took over the cost of medical care for people over the age of 65, using such criteria as "medically necessary" to define and measure the costs that they would "insure." Not surprisingly, the government too became overwhelmed by the burden. It resorted to price controls, rationing, and subsidies, solutions denied to private contractors.

Insurance companies have written contracts seeking to reduce some of the largest unexpected costs of medical care, even attempting to standardize contract forms, since the early 1900s. In the 1940s, insurance companies offered contracts in which monetary indemnification was offered for specific disabilities, or specific diseases, or specifically listed surgical procedures. This could cover only a small percentage of possible medical losses.

Health "insurance" contracts today do not pay a specified indemnity to an individual who has a specific disease, but generally pay for specific procedures, with the insurer deciding what procedures it will pay for and how much it will pay. Critical illness insurance does pay an indemnity by diagnosis, which the individual could spend in any way he chooses.

Unlimited benefits create incentives for the insured to use medical care for which he would not be willing to pay the market price. Three types of limits are written into the contracts to decrease these incentives: 1) a limit on the time period of the coverage of the contract, requiring periodic new contracts under new terms reflecting any new conditions; 2) a maximum, total monetary benefit established for the period of the contract (or lifetime); 3) partial payment of the medical care costs by the insured—either a minimal total payment of costs before benefits begin, or payment of percentage of each billing, or both; 4) exclusion of benefits for certain conditions.

Removal of these limits, as "ObamaCare" purports to do by eliminating lifetime caps or underwriting for pre-existing conditions, makes it even plainer that the cost of medical care is an uninsurable risk. Interestingly, "ObamaCare" is re-introducing high deductibles and higher out-of-pocket limits, mechanisms that were deplored as "barebones coverage" when applied in a private market for insurance.

The Destruction of Medical Insurance

The slide from defined medical loss insurance to insurance of medical care costs could never have occurred in an unfiltered market. A growing stream of government programs and regulations has resuscitated this monster each time it staggered under market forces. To the extent that we have insurance of medical care costs—insurance of the uninsurable—we have abandoned the market.

When government efforts fail to resuscitate private insurance, the outcry for government "insurance" rises. Of course, government does not offer insurance, which is a free-market phenomenon involving voluntary contracts. Government imposes a scheme of taxes (rather than voluntary premiums) and benefits that are arbitrarily set and changed by government without contractual obligation. Everyone must participate; thus there is no adverse selection. Government distributes medical care by legislation and regulation—i.e. by rationing, not risk control. Unlike in a free market, there is no capital calculation and no information about patient values. Soon the individual values the offered medical care less than the other desirable goods he has forfeited to pay the taxes.

Market Distribution vs. Socialism

In a free market, individuals through voluntary transactions can try to optimize benefits and minimize risks. One mechanism of minimizing risk is insurance—which only works for insurable risks. To meet life's needs, individuals rely on voluntary transactions. If we returned medical care to market distribution, then there would be some who could not afford medical care. They would have to, once again, rely on charity. Before insurance, hospitals were largely charitable institutions, and doctors frequently reduced fees and provided free care for the indigent.

The free market has been the engine for social wealth and peace. The generation of unprecedented wealth in the United States provided the means of charity. Charity helps to keep peace, and it helps to strengthen the bonds of society.

Government "insurance" or "social insurance"—which really amounts to socialism—does not generate wealth but simply redistributes it and reduces its production. Since one person's gain is another person's loss, it disturbs peaceful relations and sets the stage for constant conflict. And it is associated with constantly increasing constraints on freedom.

The hallmarks of a free society are a free market and charity. Attempts to insure the uninsurable destroy both.

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