Unhealthy Handouts for Health Care

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With a welcome sense of urgency, many of the candidates for President are talking about affordable, high quality universal health care. Before voters can critically appraise the affordability, quality, and equity of proposals, we decided to look for where taxpayers' dollars can be saved by eliminating programs that don't contribute to quality health care. In this way, we hope to shed light on the wisdom of some of the candidates' proposals. Fortunately, important research has already been done, and this paper brings together some of that work. Proposals fall into two categories: first, directly helping people purchase private health insurance, and second, employing the income tax system by providing deductions, credits, and shelters to help buy insurance.

Today the US pays 15.3% of its gross domestic product (GDP) on health care, and still leaves 46 million people without coverage and an even greater number under-insured who face debt and bankruptcy if hit by a serious illness.[1] (The number of uninsured is projected to rise to 56 million in five years.) In contrast, France spends 10.7% of GDP and covers everyone, without requiring patients to wait in line for care, the bête noire of the anti-government-medicine forces. Canada spends 6.9% of its GDP on health care and perhaps should spend more, since Canadians do spend more time waiting than the French do. With less than satisfactory coverage of our population, the US government already ponies up two-thirds of the nation's health care expenditures.[2]

I. The Private Market and Medicare.

Medicare was designed to care for elderly and disabled patients by allowing them to choose their own doctor or other health care provider who would be paid by the government on the basis of fee-for-service. Under Republican aegis, Medicare was amended, so it now provides handouts in two forms: subsidies to companies that provide health care and subsidies for the prescription drug program. The idea behind Medicare+Choice" and "Medicare Advantage" (the latter created by the Medicare Prescription Drug Improvement and Modernization Act of 2003) was to offer beneficiaries a choice among health plans and drug plans – the word "choice" has an alluring aura of freedom -- although most people seem to care about choice of a doctor, rather than choice of an insurance company.

Congress turned to these private programs in the belief that private companies could provide health care better and cheaper than the government could. First they offered to pay private companies 95% of the Medicare rate. No company signed up. Then private companies were offered the same rate as Medicare paid; still none signed up.

So Congress enacted increasingly generous subsidies to lure private managed-care companies (HMOs, PPOs, and others that restrict a patient's choice of health-care provider) and insurance companies, which could then boast that they would offer patients some better benefits more efficiently and

[1] Elizabeth Warren, Harvard Law professor and expert on bankruptcy, found that 1 million Americans plus their dependents – mostly middle-class -- had to declare bankruptcy in 2004 because of illness. Three-fourths of them had insurance, but with deductibles, co-payments, and coverage exclusions. *Washington Post*, February 5, 2005.

[2] The figure is that of Princeton professor Ewe E. Reinhardt. The government share is 61 %, according to Thomas M. Selden, economist with the Agency for Healthcare Research and Quality. All government programs, including premiums paid for public employees, total $1.2 trillion. Reinhardt would add another 5% to the government share because of the federal mandate that hospitals provide free care to the uninsured.

economically than traditional Medicare. Insofar as better benefits were offered, they were specifically designed to sign up healthier Medicare beneficiaries, who are less costly, and fewer sick ones. As Medicare beneficiaries can attest, the subsidies were spent on a lot of marketing: mail touting Medicare Advantage landed in mailboxes; ads adorned the sides of buses and popped up on subway station walls. In fact, some of the marketing was false, deceptive and high-pressure.[3] Sicker patients give a higher priority to choosing a doctor and being able to keep that doctor. Very sick patients experience great distress when their doctors are suddenly dropped from their PPO list or from their HMO.

According to the Medicare Payment Advisory Committee (MedPac), a body that advises Congress on Medicare payment policy, at least half of the subsidy/overpayment goes toward profit, marketing, and administration. Moreover, as Medicare Advantage has increased the over all cost of the Medicare, the long-term finances of the program (the Medicare Insurance Trust Fund -- Part A) program are damaged, and premiums of the 35 million elderly and disabled beneficiaries who stayed with regular Medicare have been increased. Under current law, premiums paid by all beneficiaries of Medicare Part B (doctor visits and other out-patient care) must be raised as the total cost of Medicare rises.[4] A 45% limit was set arbitrarily on the proportion of Medicare funding from general tax revenue. The remaining 55% must come from increased taxes and premiums or cuts in spending, such as for paying doctors and hospitals.

Under Medicare's original design, the Hospital Trust Fund would be financed by the payroll tax, supplemented by general revenue, as necessary. Part B—care outside the hospital—would be financed partially by general revenue (raised by the progressive income tax), and by premiums paid by beneficiaries, which are less progressive, although better-off beneficiaries now pay a higher premium. The Democratic 110th Congress House of Representatives voted to eliminate that 45% limit on use of general revenue. Liberals would avoid additional increases in premiums or cuts in services by making taxes more progressive and by closing abusive corporate tax shelters or scaling back income tax cuts for the wealthiest Americans.[5]

Private insurance fit the fervently held beliefs of Republicans and some centrist Democrats that private enterprise is efficient, while government is wasteful. But the facts proved otherwise.

At hearings of the House Ways and Means Committee Health Subcommittee chaired by Representative Pete Stark (D-CA), leaders of such groups as the California Medical Association and the American Medical Association testified that Medicare Advantage sales representatives misrepresented their benefits, that higher costs contribute to company profits, not higher pay for doctors. In fact, the plans do not help doctors, but often require higher co-payments for some costly services in order to deter doctors from offering those services and dissuade sicker patients from enrolling.

The nonpartisan Commonwealth Fund reported that in 2005 private health-care plans for the elderly and disabled cost taxpayers $5.2 billion more than traditional Medicare coverage. That was $922 or 12.4% more per person enrolled in plans offered by corporations such as United Health Group, Inc. and Humana, Inc, than if Medicare paid doctors and hospitals directly.[6] By 2006, private insurers were paid about $1,000 more per person. The insurance lobby now claims the higher cost arises because they provide important supplemental coverage for low-income beneficiaries. In fact, many more low-income Medicare

[3] Robert Pear, "Hard Sell Cited as Insurers Push Plans to Elderly," *New York Times*, May 7, 2007; Coalition on Human Needs, June 29, 2007, reporting on a hearing before the House Energy and Commerce Subcommittee on Oversight.
[4] Edwin Park and Robert Greenstein, "Curbing Medicare Overpayments to Private Insurers Could Benefit Minorities and Help Expand Children's Health Coverage," Center on Budget and Policy Priorities, May 10, 2007.
[5] Robert Greenstein and James Horney, "House SCHIP Legislation Would Repeal Dubious '45-Percent Threshold' Provision," Center on Budget and Policy Priorities, July 30, 2007.
[6] "Medicare Costs Rise with Private Care Plans," *Washington Post*, December 1, 2006.

beneficiaries receive supplementary assistance -- help with premiums, co-payments and deductibles -- from Medicaid than from Medicare Advantage.[7]

Confirming the Commonwealth Fund's finding, in 2007 the nonpartisan Congressional Budget Office (CBO) determined that Medicare Advantage costs the government on average 12% more per beneficiary than traditional Medicare, and projected that the differential will likely increase in the years ahead. It concluded that reverting to traditional Medicare would *save taxpayers $50.1 billion over 5 years, $157 billion over 10 years* -- even though private corporations cared for only 8 million of Medicare's 43 million beneficiaries.[8] Eliminating the overpayments would add three years to the life of the Part A Medicare Hospital Insurance Trust Fund -- extending it to 2022 -- and reduce the size of benefit cuts or tax and premium increases.[9] Private fee-for-service plans that permit patients to choose a doctor are 19% costlier than traditional Medicare, which has always allowed that choice.

In the 110th Congress, during the summer of 2007, the Democrats in the House of Representatives decided that a good way to raise enough money to extend the State Children's Health Insurance Program (SCHIP) to 8 million more needy children would be to reduce those Medicare Advantage subsidies – gradually, to ease the transition for patients in the Medicare Advantage program—until 2011 when private companies would be paid no more than traditional Medicare.[10] President Bush promised to veto the SCHIP bill (which included other savings and simplifications) based on his all-purpose ideological mantra: private good, government bad.

The Medicare Part D prescription drug program is another instance of wasteful privatization. Dean Baker of the Center for Economic and Policy Research has estimated that taxpayers could save nearly $30 billion a year if Medicare negotiated for lower drug prices, as the Democrats' bill would have done, but prohibited by the Medicare Prescription Drug Improvement and Modernization Act of 2003. Another $5 billion in administrative costs would be saved if the government offered prescription drugs under its own program.[11] And an additional $2 billion of taxpayers' money were wasted when low-income elderly were required to enroll in Medicare Part D, instead of continuing to receive medicine via Medicaid.[12]

Under the current Part D program, Medicare elderly and disabled beneficiaries must choose from among dozens of private health plans, each offering a different formulary of drugs at different prices (which they can and do change at will). Choosing a plan proved bewildering, partly because beneficiaries could seek favorable prices for the drugs they now take, if they now take any, but have no way of predicting what medications they might need next week or next month. Private insurance companies can and do negotiate for lower prices, but their leverage is far less than the federal government's, as the VA and Department of Defense, Canada, and European countries demonstrate.

The House of Representatives of the new Democratic-controlled 110th Congress passed a bill requiring Medicare to negotiate lower prices, but the CBO doubts that this alone would generate significant savings, unless the government runs the prescription drug program directly, eliminating private companies'

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[7] Edwin Park and Robert Greenstein, *op.cit*., May 10, 2007.
[8] Saul Friedman, "Groups Pushing Medicare Reform Will Weaken System," *Newsday*, July 21, 2007.
[9] Edwin Park, "House Health Legislation Would Curb Medicare Overpayments to Private Plans, While Aiding Medicare Beneficiaries Overall," Center on Budget and Policy Priorities, August 1, 2007.
[10] Robert Pear, "Democrats Press House to Expand Health Care Bill," *New York Times*, July 23, 2007. Unlike the preceding Republican-controlled Congresses that borrowed to pay for war and tax cuts – in effect, telling their children and grandchildren to pay off the nation's credit card—the Democrats promised that this generation should pay for increased expenditures by budget cuts or tax increases, a policy otherwise known as "pay-go."
[11] CEPR Report issued July 25, 2006, based on CBO figures.
[12] Milton Freudenheim, "A Windfall from Shift to Medicare," *New York Times*, July 18, 2006.

high administrative and marketing costs.[13] The government could save even more by having a formulary, but the word "formulary" has become a bugaboo, so the Democrats have foolishly opposed that. The VA's formulary offers most drugs that Medicare beneficiaries take, and VA patients can receive non-formulary drugs if the prescribing doctor explains why it is preferred. (No private insurance plan offers all possible drugs at the lowest prices.)[14]

Moreover, for all its unnecessary costs, the Part D prescription drug program provides only partial coverage, as a result of the infamous "doughnut hole." When the cost of drugs (including what the insurance company pays) reaches $2,250, a Medicare beneficiary pays the full cost of drugs until the cost reaches $5,100. At that point, the beneficiary must pay 95% of the cost. This gimmick was adopted to hide the true cost of the private approached to drug coverage and to game federal-government budget projections. Unfortunately, patients who must take many drugs for cancer, multiple sclerosis, and HIV/AIDS can easily find themselves falling through the doughnut hole into debt. According to economist Dean Baker, eliminating waste in the program would save twice the amount saved by creation of the doughnut hole.[15]

While ideological bias may partially explain why Congress would adopt such a raid on the US Treasury, special interest spending surely played a part. From January 2005 to June 2006, the Pharmaceutical Research and Manufacturers of America (PhRMA) and the big drug companies funneled $182 million into lobbying and political contributions. From 1998 to 2004, the pharmaceutical industry out-spent all other industries on lobbying.[16]

Former Senator Fred Thompson has a different solution to escalating health care costs. He proudly announced that he opposed the Medicare prescription drug benefit from the get-go, dubbing it "a $17 trillion add-on to a program that's going bankrupt."[17] Presumably, rather than cut out subsidies, paperwork, profits, marketing, and waste, he would eliminate the entire drug program, even though the rising cost of medications has been the major source of escalating medical care costs in recent years.

II. Using the Income Tax to Fund Health Insurance

Budget gurus at the CBO refer to tax deductions, credits, and tax shelters as "tax expenditures," which is a useful concept. Congress's policy goals can be achieved either via deductions, credits, and shelters or by direct appropriations. The CBO calculates tax expenditures so Congress can see their effect on the current budget and long-term budget projections. However, it's up to Congress to decide whether to appropriate funds directly or to manipulate the tax system to further its policy objectives. Politically, legislators like to tell constituents that they're cutting their taxes, rather than spending their money, but they don't talk about who will benefit most from the tax gimmicks. From the standpoint of balancing the budget, they're the same, except that direct appropriations tend to be the more efficient method to achieve policy goals.

President Bush has been a big enthusiast of Health Savings Accounts (HSAs), enacted in 2003, which he and the Republicans in the 109th Congress wished to expand. The rationale is that a taxpayer would

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[13] Robert Pear, "House Democrats Pass Bill on Medicare Drug Prices," *New York Times*, January 13, 2007. The vote was 255-170, with all Democrats and 24 Republicans voting for the bill. It is unlikely that the Senate will pass the bill in its current form, especially inasmuch as President Bush has promised he would veto it.

[14] Dean Baker, "Post Pushes Drug Industry Line, Again," *American Prospect Online Edition*, January 13, 2007.

[15] "Medicare Drug Benefit: Why the Doughnut Hole is Unnecessary," Center for Economic and Policy Research, July 25, 2006.

[16] M. Asif Ismail, "Spending on Lobbying Thrives: Drug and health products industries invest $182 million to influence legislation," Center for Public Integrity, April 2007.

[17] David S. Broder, "Fred Thompson's Gamble," *Washington Post*, August 16, 2007, based on a two-hour interview with Thompson.

purchase an inexpensive health insurance policy with a high deductible (at least $1,050 for an individual or $2,100 for a family), and pay for ordinary medical expenses out of HSA funds. High-deductible policies, not so inexpensive by regular people's standards, can cost as much as $10,000 annually for a family. The taxpayers can set aside in an HSA the amount of their policy's deductible, up to $2,700 for individuals and $5,450 for families in 2006, and deduct that amount from their taxable income. They can invest the money in the HSA any way they like, paying no tax on the earnings. Withdrawals are tax-free if used for out-of-pocket medical costs.

The expensive Republican bill would have allowed taxpayers to set aside that much, even if their policies' deductibles were less. In his 2006 State of the Union address, President Bush proposed increasing the allowable amount that can be stashed in an HSA to the total amount of out-of-pocket expenses for health services under the high-deductible plan, up to $5,250 for individuals and $10,500 for families. Unlike IRAs, there is no income limit on who may put money into an HSA. Nor is there a requirement that the funds be spent. Most well-to-do taxpayers have tended not to spend the funds put in their HSA, using it as an investment tax shelter.[18] No other savings account offers both tax-deductible additions and tax-free withdrawals. The Bush administration estimates that its HSA proposal would cost $156 billion over 10 years, but this estimate is probably too low, since well-to-do taxpayers are likely to move savings from other instruments into more favorable HSAs.[19]

According to the Government Accountability Office (GAO), in 2004 the average person who opened an HSA had an income of $132,000. This is not surprising: first, only better-off individuals can afford to put more than $1,000 into a tax-free savings account; second, because wealthier individuals pay income taxes at a higher rate, they benefit more from reducing their taxable income; and third, most people with income over $100,000 already have health insurance. Moreover, healthier individuals tend to choose HSAs and high-deductible health insurance, whereas people with some health problems need expensive comprehensive, low-deductible policies, and their higher health costs will lead to higher premiums for this kind of policy. Thus, more and more people will find health insurance unaffordable. In other words, the pool of risks will be fragmented.[20] Fewer and fewer workers have employer-based health insurance, where premiums are relatively affordable since based on a large risk pool of healthy and sick families.[21]

Rudy Giuliani has endorsed a big tax deduction toward the purchase health insurance in the private market, just as President Bush proposed in his 2007 State of the Union address ($15,000 for a family; $7,500 for an individual).[22] John McCain (R-AR) has proposed a $3,000 tax credit[23] – less regressive than a deduction – but still wouldn't buy much health insurance. Health-insurance policies that rely on deductions from personal taxable income push everyone from employer-based insurance into the less affordable private health insurance market and swell the number of uninsured. Bush proposes taxing employees whose employer provides health insurance on any cost greater than $15,000 for a family, $7,500 for an individual.

[18] Citizens for Tax Justice, "A Parting Shot? Lame Duck Republicans to Attach Expanded Tax Shelters Disguised as Healthcare Policy to Extenders Package," *CTJ's Tax Justice Digest,* August 9, 2007.
[19] Center on Budget and Policy Priorities, "A Brief Overview of the Major Flaws with Health Savings Accounts," April 5, 2006.
[20] Jason Furman, "Expansion of Tax Breaks Is Larger – More Problematic – Than Previously Understood," Center on Budget and Policy Priorities, February 4, 2006; Citizens for Tax Justice, September 28, 2007.
[21] MIT economist Jonathan Gruber calculates that HSAs will lead to a 600,000 net increase in uninsured Americans, despite spending more than $10 billion annually, as cited by Center on Budget and Policy Priorities, *op. cit*., April 5, 2006.
[22] Jonathan Cohn, "Why Giuliani Wants Millions of Americans to Stay Uninsured," *New Republic Online,* August 1, 2007. For a good explanation of the Bush proposal and its impact, see Edwin Park, "Administration's Proposed Tax Deduction for Health Insurance Seriously Flawed," Center on Budget and Policy Priorities, July 31, 2007.
[23] Citizens for Tax Justice, *Tax Digest,* August 17, 2007.

(Bush also would no longer allow employers to deduct the cost of providing health insurance to employees, so even fewer employers will provide it.).[24]

The Commonwealth Fund has noted that half of the uninsured pay no income tax, so they won't be helped at all by an income-tax deduction. A refundable tax credit would be some help for lower-income families that pay little or no income tax, but that's not in the Bush/Guiliani plan. According to the Center on Budget and Policy Priorities, a married couple with a taxable income between $15,000 and $60,000 (the second to lowest, 15%, bracket) would receive a tax benefit of $2,250, not enough to buy a $12,000 group health insurance policy (much less a non-group policy). *Washington Post* economic columnist Allan Sloan amends that calculation by noting that Bush would permit the deduction from the employee share of Social Security taxes, 7.65%, so the benefit in that bracket would be about $3,400 ($4,545 if self-employed) – still not much help.[25]

The Kaiser Family Foundation has found that 90% of the uninsured with less than perfect health would not be able to purchase health insurance at the standard rate and thereby benefit from the Bush/Giuliani standard deduction. And Robert D. Reischauer, former CBO director, has pointed out that people with certain pre-existing medical conditions, 37% of the uninsured, would be denied health insurance in the private market at any price.[26]

So what would be the effect of the Bush/Giuliani proposal? According to the US Census Bureau, 175 million Americans (including public employees) have private health insurance through their employers; 27 million are covered by insurance they buy, 46.6 had no insurance all in 2005, 5.4 million more than in 2001, as more and more employers stop providing insurance. Over 80 million more would be uninsured, were it not for direct government programs: Medicare, Medicaid, and military and veterans health care.[27] So the Bush/Giuliani proposal would push 175 million additional Americans into the costly private market.[28]

III. Conclusion and Recommendations

Employer-provided health insurance – for current employees and retirees—has been cited as a major impediment to American competitiveness in the global market. What do the candidates propose? While some of the Democratic candidates have questioned the employer-based model – notably Rep. Dennis Kucinich (D-OH) and former Senator Mike Gravel (D-AK), most of them continue to rely heavily on it, as do the Massachusetts and California models, all of which entail helping people purchase expensive private insurance, whether via an employer or individually. The most glaring flaw of the private market, besides the added cost, is the freedom of insurers to charge higher rates to sick people and their families, or to deny them coverage entirely.

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[24] Sheryl Gay Stolberg and Robert Pear, "Bush Urges Tax to Help Cover the Uninsured," *New York Times*, January 21, 2007. Citizens for Tax Justice, *Tax Digest*, January 26, 2007. Estimates vary on how many would lose employer-based insurance. The Commonwealth Fund puts the figure at 12.1 million, 2.3 million left with no insurance at all. The CBO estimates 7.8 million would lose employer-based insurance, 1.5 million would be left uninsured. The Joint Committee on Taxation estimates 6 million would lose employer-based insurance, 500,000 would be left uninsured. Edwin Park, "Administration's Proposed Tax Deduction For Health Insurance Seriously Flawed," Center on Budget and Policy Priorities, July 31, 2007.

[25] Allan Sloan, "What Bush Didn't Say About Social Security, *Washington Post*, January 30,2007. Sloan notes that less money would be paid into the Social Security Trust Fund, weakening that program and decreasing the employees' future benefits, especially those for lower-income workers.

[26] Robert Pear, "Experts See Peril in Bush Health Proposal," *The New York Times*, January 28, 2007. The amount of the Bush-proposed deduction would be indexed to the Consumer Price Index, not to health-insurance premiums, which are rising faster.

[27] For the public sector numbers, Daniel Gross, "National Health Care? We're Halfway There," *New York Times*, December 3, 2006, citing as his sources the Employee Benefits Research Institute and the Centers for Medicare & Medicaid Services.

[28] Stolberg and Pear, *op cit*.

An estimated 63% of Americans get their insurance through their employer or through a family member's job. While getting health care coverage via employment is cheaper than the private market for the worker, the cost to workers increased 79% from 1996 to 2003. In one year, 2003, coverage cost for a single person increased by 9.2% and for a family by 10%.[29]

Journalist and long-time consumer expert Jane Bryant Quinn believes that Medicare for All is the only solution, a comprehensive program with one set of premiums, co-payments, streamlined paperwork, no marketing costs, no screening people in or out and concocting exclusions, only 1.5% for overhead (compared to 13-16% or $120 billion in the private sector), and no $40 billion in profits (2006).[30]

One enterprising reporter has compared the initial implementation of Medicare with the implementation of Medicare Part D. Medicare was enacted in 1965, implemented in 1966, covering services at 6,600 hospitals, 250,000 physicians, 1,300 home health agencies, and some nursing homes. At that time, *The New York Times* reported the smooth start on its first day, when 160,000 eligible patients who were in the hospital at the moment nationwide and in Puerto Rico were covered immediately. By the end of the first year, more than 95% of eligible patients and doctors participated, and 90% of the 43 million eligible older and disabled individuals were enrolled -- all before computers. He contrasted that impressive record for a system whose design Lyndon Johnson turned over to government professionals, with the chaotic, confusing enrollment in Medicare Part D, designed by private insurance companies, drug companies, and lobbyists.[31] Medicare is an efficient single-payer system that pays for hospital and outpatient care.

Why does American health care cost almost twice as much per capita as the average of other industrialized countries, with no better and in some cases worse, outcomes for health? We would spend $477 billion a year less if our spending patterns were like those of the other advanced countries. President Bush and the Republicans base their enthusiasm for Health Saving Accounts on the contention that we spend too much on health care because people make needless visits to the doctor, but no evidence supports that assumption. The real reasons are: first, our doctors have higher incomes (only partially justified by the debt incurred because of the high cost of medical education in this country, whereas medical education is free in most of Europe, or malpractice insurance) because our doctors perform more procedures and see more patients; second, hospitals – even so-called non-profit hospitals -- charge more because they spend on marketing, administration, and profits; third, our government doesn't negotiate prices with drug companies, which earn exorbitant profits and spend billions on marketing (far more than on research); fourth, administration of the private sector of the health system costs $84 billion a year, $30 billion of that in after-tax profits of health-insurance companies, and $32 billion on marketing and figuring out the premium for individuals and groups. Extending coverage to the uninsured via the private market, without reining in costs, would add another $77 billion annually in unnecessary expenditures.[32]

The 110th Congress House of Representatives made a good start in June by voting to phase out subsidies for Medicare Advantage. The next step should be to stop trying to fund health insurance via tax expenditures: deductions, credits, and HSA tax shelters. It's time for the American public to wise up to the cost of tax gimmicks. Finally, we need to recognize that providing health care for our people is a basic right, not a commodity like toothpaste, breakfast cereal, or cars where the public is well served by competition in the private market (albeit still requiring government regulation to ensure safe products). Jane Bryant Quinn is not alone in her conviction that high-quality health care can be delivered efficiently, equitably, and economically by Medicare for All or another single-payer plan that eliminates subsidies to competing private companies,

[29] US Agency for Healthcare Research and Quality, as reported in *Washington Post*, August 25, 2005.
[30] Jane Bryant Quinn, "Health Care for All – Medicare Is the Model," *Newsweek*, July 30, 2007.
[31] Saul Friedman, "A Tale of Two Medicare Plan Rollouts," *Newsday*, May 27, 2006.
[32] Research conducted by McKinsey Global Institute, as reported by Steven Pearlstein, *Washington* Post, February 14, 2007.

excessive paperwork, high insurance premiums, wasteful administration and marketing by corporations whose primary interest is their bottom-line.