

## Talking Again with Jon Gruber

*Conversazione tra Paul Krugman e Jonathan Gruber*

I've spoken before with Jonathan Gruber, one of America's leading health economists; I decided to talk again after reading a remarkable new paper he co-wrote about the effects of immigration on healthcare for native-born seniors — bottom line: the attack on immigrants will send thousands of us to an early grave.

**Paul Krugman:** Hi everyone. This week I'm talking for a second time with [Jon Gruber](#), one of the world's best healthcare economists. I wanted to talk with him about some of his new work which I think is really important. It's at the intersection between healthcare and immigration policy. So first off, healthcare. We've actually had a major change in health policy, sort of by default, which is the end of enhanced subsidies for the Affordable Care Act. Are you tracking how that's going and where we are so far?

**Jonathan Gruber:** Yeah, Paul, let's cover for a minute what happened. So a key pillar of the Affordable Care Act were tax subsidies to make health insurance affordable on the exchanges. And the way we set it up was that you pay a sliding scale percent of your income. So if you're very poor, you're on Medicaid, unless you're one of those ridiculous states that didn't expand Medicaid. Then you paid about \$20 if you're near poor, ramping up to at a maximum of about 10% of your income. And that maximum was set at four times the poverty line, which is a little bit more than median income in the US.

Under COVID, President Biden put an expanded version of those subsidies and he made three critical changes. One is the 20 became zero. And it turns out that matters a lot. It turns out zero matters a lot for some people. There's a surprising amount of evidence that even if someone takes things like life-saving drugs, a \$5 copayment really deters people from taking them.

So the zero helped a lot. He lowered the slope so people paying 8% of income were then paying 6. But he also got rid of that cliff at the top. And you might think, for people above the median income, I'm not that sympathetic. But if you're an older person in a high cost state, health insurance can be very, very expensive. So those were first put in place for two years and extended for three more years. They expired within this past year because they were not extended.

What does that mean? That means that a bunch of very low income people are now going to stop paying zero and pay something. People in the middle will pay some more. And then people at the top of the scale—sort of above middle income but not rich—those people are to suddenly face unaffordable health insurance costs. So it's very personal to me. I have friends who are 60-year-olds in Massachusetts like me. I have a friend who's going from paying \$8,000 a year to \$25,000 a year for health insurance. I don't know what his income is, but even if your income was \$100,000, that's 25% of your income. That's a lot of money. That's unaffordable.

The projections from my research, my independent research, and actually the Congressional Budget Office agreed, were that over time about four million people would lose health insurance from this. I think it's always good to explain to people what that means. The best estimates suggest, based on the Affordable Care Act, that for every 800 people who lose health insurance, one person dies every year. So 4 million people losing health insurance is 5,000 more deaths a year.

So far, looks like enrollment's down about a million and a half. So far it's smaller than expected, but the expectation was a 4 million person drop would arise over time. I think it takes people time to adjust. Part of it is some states have reacted by filling the gap. So Massachusetts has announced that it will continue subsidies at that level paid for solely by the state, \$250 million. Several other states have as well. And that may be part of why enrollment has dropped less than we might have expected so far.

**Krugman:** Yeah, and the fact that states can even get anywhere close to doing that is telling us that there really isn't that much money involved. That making a health care program that kind of made the United States almost a civilized country for universal health insurance really didn't cost very much beyond what we were already spending.

**Gruber:** You know, here's a way to think about it, Paul. The cost of extending these subsidies for a decade is one-tenth of the increase in the deficit from the Trump tax cuts. \$300 million for subsidies, \$3.3 trillion for the Trump tax cuts. So what we're saying is we'll spend ten times as much to make tax cuts for the rich as we are to make insurance affordable for the middle class.

**Krugman:** Wow, yeah. I don't have the ICE budget in my head right away, but it's clearly gotta be bigger.

**Gruber:** I believe the ICE budget is up to 80 billion a year. So right there, that was about a 70 billion a year increase. That's twice what you'd need every year to have these subsidies put in place.

**Krugman:** I mean, you talk about loss of health insurance and dying, but it's also true that for a lot of people the financial hardship is just huge. You're taking people who are sort of better off than the median income, though not rich by any stretch of the imagination, and they're suddenly faced with intolerable health care bills.

**Gruber:** You know, there's a large literature now showing the financial benefits of health insurance, showing that people who are insured go into bankruptcy less, they have less delinquent debt. Here's the finding that I think is most striking about this, Paul. There was a famous study called the Oregon Health Insurance Experiment run by Amy Finkelstein and Kate Baker. I was affiliated with it, but they really ran it. That study was essentially a random allocation of health insurance through a lottery in Oregon. And there were lots of findings. What was most striking to me immediately was that depression in the [insured] population fell by 30%. That's not Prozac. That is the loss of stress, of not worrying every day about being bankrupted by your medical bills. And this is the kind of well-being that health insurance gives people. This is why other countries have universal coverage, because it's an unnecessary stress in people's lives.

**Krugman:** Yeah, I have to say just a very, very tiny echo of all that was when I retired from the Times. I had to switch plans from UnitedHealthcare, which I had through the Times to another plan through the City University of New York. And obviously Medicare is involved, too. But somehow or other things got screwed up and they put me on the wrong plan just as I was starting to have some health problems. And the

amount of sheer anxiety created by a brief visit to the emergency room, not knowing right at the moment if it will be paid for.

**Gruber:** First of all, you don't know what the price is gonna be. So we can talk about problems in the healthcare system, a lack of transparency. You have no idea what you're in for. My daughter drives an ambulance. There are people who she wants to pick up who say, "Please don't put me in the ambulance, I can't afford it. I don't have health insurance." These are people making life altering choices for reasons and they're worried about not having insurance.

You know, [I gave a Ted talk on this](#) and the story I started with is the story of two women, both who were diagnosed with breast cancer at age 36, both with small children. One did not have insurance, but she delayed treatment and eventually died. The other is my wife, who because she had good insurance was well treated and is perfectly healthy today. And you know, those stories are replicated all over this country.

**Krugman:** Okay, just to add one more thing, I assume that you follow [Charles Gaba](#), the amazing sort of autodidact, self-taught health care expert who's become invaluable since the early days of Obamacare. But he's been saying that just looking at the number of people with insurance is not enough. We need to look at people downgrading, getting worse policies.

**Gruber:** You know, this is a harder one, Paul, because defining underinsurance is very difficult. So let me give you two examples. There's two senses in which people downgrade. One is they move to plans with higher deductibles and higher out-of-pocket cost sharing. Now that depends really on your income. The truth is, people like you and I should have high cost sharing. That's the honest truth. We can afford it.

The story I like to tell about this is, you know, I hurt my knee playing tennis. It was still hurting a couple weeks later. It was the weekend. My wife said I should go to the emergency room and get it looked at. I went to the emergency room and got an MRI. It cost me 50 bucks. They looked at it. They said, stop being a whiny bitch. Go home. You're fine. That cost my insurer \$1,000. If it had cost me \$1,000, I would have waited another week. So cost sharing is mixed. For low income people, it can be a barrier to

getting needed care. For high income people, it's not. So that's one sense of what you're upgrading, narrowing.

The other sense of underinsurance is this big issue about narrow networks, about people not having the choice of provider. And on this one, I think actually the evidence, Paul, is pretty clear that narrow networks are not problematic, that people have seen their choice limited, but it hasn't really negatively affected their health. There are some horror stories, don't get me wrong, but on average, I think of narrow networks like the way we thought about airline deregulation. You know, no one wants to pay hugely high prices for a very broad network, just like no one wants to pay very high prices to have nice silverware again on airplanes.

And so, I agree we should worry some about it but I think the focus once again should be on an income basis, which is lower income people facing high cost sharing and protecting them from that.

**Krugman:** I always think of driving down Route 1 in New Jersey, where there are lots of billboards advertising, "Our emergency room is best." It's a horrible thing if people are choosing emergency rooms based on who has the best billboard.

So, okay. You have this really interesting and actually quite upsetting paper about immigration and healthcare. It's really kind of startling.

**Gruber:** Yeah, so basically, the hypothesis we're testing is: does changing the number of immigrants change the health outcomes of our nation's seniors? We focus on the nation's seniors partly because that's where the action is in terms of mortality. That's where the data is. We have excellent data for the Medicare program. And also because they're not the immigrants. You can't be on the Medicare program if you're an immigrant unless you've been in this country for a while and worked and things.

So it's really a separate population. We're looking at the effects of a flow of immigrants into the care of our nation's seniors on Medicare. And it turns out that a lot of the care for our nation's elders is very labor intensive, in particular the care they get for their long-term care needs, both at home and in nursing homes. And it turns out a lot of those workers in those sectors are immigrants. Immigrants are disproportionately represented in the healthcare sector in general and the caring part of the healthcare sector in particular.

However, it's not obvious that more immigration would improve care. First of all, you have to argue that more people improves care. There's some evidence on that, but you have to argue that. The second is, look, a lot of care might be about communication. If immigrants cannot communicate well with the elders, if elders are racist, if they're not able to work with the immigrants, maybe it wouldn't improve their care. So we want to ask the question, does having more immigration actually improve the care and health outcomes of seniors?

The results are basically that when there's more immigration, there's a large rise in the number of caregivers, particularly the number of aids and other people in that part of the healthcare spectrum. Second, it does not lead to reductions in the number of native caregivers. They're not taking the jobs of native caregivers. Actually, we find there's a slight increase in the number of native doctors when there's more immigration. We think because there's more the doctors can do because they have more people who can work with them. But there's no evidence they're reducing the size of the native pool working in that sector. And then we find a significant and quite striking reduction in the odds that elderly people will die when there's more immigration to their community.

Interpreting these numbers are hard, but let me sort of give you a number. I think it's a good way to hang on to it. What our results imply is that if there's a 25% rise in legal immigration in the US—325,000 people—that would lead to 5,000 fewer elder deaths per year. Let's put it another way. Haitians are disproportionately represented in the healthcare sector. Our estimates imply that if you deport 330,000 Haitians, which is what the revocation of TPS would do, you will cause 9,000 more elder deaths per year. So this is really striking evidence that immigrants are just a vital part of our network that's caring for our nation's elders.

**Krugman:** There's a couple of points in there. One is, I have to admit I'm a little annoyed at myself. There's a kind of general proposition that immigrant workers in the United States mostly do not compete head to head with native-born workers because they tend to be in quite different occupations. And I always talk about farm labor and construction and food processing. But healthcare, somehow I never mentioned that. Yet, the share of home health aides that are foreign born is immense.

**Gruber:** Yeah, they're really a very important part of our ecosystem of caring throughout the healthcare system, all the way up to doctors. Many of our best doctors are immigrants, but we're focused more on the unskilled immigration. And it is a huge share. My wife is a nursing home ombudsman. She sort of is a volunteer checking quality at local nursing homes.

The bottom rung is called Certified Nurse assistants, CNAs. They're virtually all immigrants. These are hard jobs. These are jobs where you're changing the bedpans of elderly patients, turning them in their bed to make sure they don't get bed sores, things like that. These are jobs which in Massachusetts pay slightly more than working at Starbucks. And they're jobs that natives, by and large, don't want.

Look, one in three home care workers are immigrants. 18% of all healthcare workers are immigrants. They are a huge and vital part of our system. And let's remember one important fact. I'm sure you've talked about this, Paul, in the context of our fiscal situation, about our aging population, creating a dire fiscal situation. Our aging populations create a massive new demand for long-term care. We have a population that's rapidly aging. We are about 10 to 15 years away from peak long-term care demand in our country as the boomers reach their late 70s, early 80s. We already are vastly understaffed in our long-term care sector. We have a billion people who would be delighted to come to America and work at the wage they're willing to offer to help take care of our seniors and they're wonderful, caring people. And yet we're moving the opposite direction, kicking them out.

**Krugman:** Yes. This is one of those things, by the way, where the normal distinction between over 65 and under 65 doesn't fully capture what's going on. You know, I'm about to turn 73, but there's a world of difference between 66-year-olds and 80-year-olds. So although the baby boomers are basically all over 65 now, the kind of age-adjusted population of seniors is still going to be cresting much, much higher.

**Gruber:** Yeah, Paul. I still remember when you were a young 33-year-old pup in 1985 teaching me international trade. Time does fly. And look, it is true. First of all, it's not just over 65. A lot of the caring is actually for the disabled who are under 65. So it's not just over 65. We focus on elder care in this paper. But there's a lot of disabled

people who need this care. They're a very important, significant part of our population. But it's not just the oldest. The oldest is old.

I actually have [a book I wrote with Kathleen McGarry at UCLA](#), which is comparing long-term care systems around the world. We have descriptions of the long-term care system in 10 different countries. And for each country, we show there's not just a rapid growth in the over 65 share. Within the over 65, there's a rapid growth in the over 85 share. And this is the peak care. One in three people will use the nursing home at some point.

More than half the people will need formal long-term care of some kind at some point. This is going to be a huge demand and quite frankly a huge opportunity for our economy to provide in an economy where AI is taking a lot of low-skilled jobs. These are low-skilled jobs AI can't do. These are low-skilled caring. Maybe someday we can have robots do this, but that's a long way away. So this is job where a lot of low-skilled workers that might be displaced from other sectors can provide care to the elders who need it.

**Krugman:** Yeah. It's interesting. The strategy you use for estimating does rely a lot on the fact that immigrants don't go to all places equally. So the most acute health care shortage, or lack of health care workers, is probably occurring in places where immigrants don't go. I was wondering about that a little bit.

**Gruber:** It's a great point. Immigration alone is not going to be enough to address the coming crisis of a dramatic increase in long term care needs. We're also going to have to deal with the low wages we pay. And I have a plan for that I'm happy to discuss with you. We've actually put together a pilot program here in Massachusetts to try to deal with that. But it's hard to imagine given our fiscal situation that we're going to be able to afford the increase in pay

that will call forth the supply without immigrants as well. So immigrants need to be part of the strategy. If we simply try to raise pay enough to have this done domestically, the pay increase would bankrupt the government. So I think we need a joint strategy. And I would argue there's three pieces. One piece is immigration, which we're discussing. Another piece is higher pay. The third piece, and this is what we're doing

in Massachusetts, and it's really critical, is to recognize the important role of career ladders in this sector.

So in the nursing home, you can be a CNA, that's the lowest level. The next level up is called the Licensed Practical Nurse, an LPN. They largely exist just in nursing homes. This is below an RN, the nurse you typically deal with, above a CNA. They're growing in other sectors, but they're largely focused in nursing homes. A CNA makes 22 bucks an hour. An LPN makes 40 bucks an hour. Okay? So that's a pretty good living. You only need one year of school if you're a CNA to become an LPN.

So, we did a survey in Massachusetts of all the CNAs and said, why aren't you becoming LPNs? And they all said, "we can't afford the school, we can't afford the time off." So we got a \$6 million grant from the state to set up a pilot program here in Massachusetts called the Career Ladders Program. You can look it up where we are paying for CNAs to get half a year, 50% time off paid and free tuition to become LPNs. And the money doesn't come from the government, it's repaid by their employers because their employers are so desperate for these LPNs. They were willing to make this a revolving fund where they repaid the money in. We need to get creative in thinking about how we can make this a more attractive sector.

**Krugman:** Okay, so you're actually out there in the field trying to do stuff, which is really impressive.

**Gruber:** We have to be.

**Krugman:** But I have to say, in a way this ties in with the question about upfront costs and co-pays and failure to seek treatment. I think it's difficult for people like us to whom life has been kind to appreciate how close to the edge lots of people are. That even though, you know, we would look and say the payoff of your income over the next 15 years from taking a year off and going to school would easily self-justify, people can't do that.

**Gruber:** They can't. I mean, they are working three jobs. They have kids to take care of. There's a [great book by Mulleinathan and Shafer](#) about the mental stress that low-income people are under and the fact that it doesn't get in their bandwidth to make investments. They call it the poverty trap. Basically, when you're poor, you're so busy trying to survive, you can't make the investments that let you move out of poverty.

And this is just not appreciated by those of us who aren't in poverty, who have had a lot of beneficial aspects of their life, that poor people really need a hand up to just make the investments that will allow them. It's not that they're lazy. They just don't have the time to make those investments. So I'm hoping we can set up programs like this, which will promote that kind of human capital development. And then even if the CNA job is not that highly paid, it's something new for a couple of years on your way up to a more highly paid position.

**Krugman:** Okay, so it's not just more immigration, although God knows that's where we're gonna get the people to fill these frontline jobs, but it's also then improving conditions. And of course, when we talk about immigrants and senior citizens, we talk about the fiscal side and the fact that the federal government is in large part a vehicle for taxing working-age people and supporting older people. Immigrants help with that because they generally come during their working age, but it's also the supply side. So it's both. And of course, what we're doing is moving in the opposite direction.

**Gruber:** Exactly. At a time when those needs are growing, we are moving in the opposite direction. And we need to figure out a politically acceptable way. I understand immigration is a fraught issue, and clearly we might have gone too far in the Biden years. And so the question is how we get back to a more rational immigration policy that recognizes that we need these bodies. Tara Watson at the Brookings Institution has proposed specific increases in quotas for health care workers. We can think about ways to really use our immigration system more productively.

**Krugman:** Yeah, it's interesting. The number that you use in the paper is a 325,000 increase in immigration. But that also turns out to be roughly in the same ballpark as the number of people ICE has arrested in the past year. And of course, Stephen Miller keeps on wanting 3,000 deportations a day, so, more than a million. And by the estimates you had, that would mean something like 15,000 extra deaths per year.

**Gruber:** You know, these are folks who are contributing. If you look at the data, a very small fraction try to be criminals. The majority of these people are contributing to our society and critically in ways that our natives don't want to contribute. Not because they're bad people, just because the wages are bad and they have other things they'd rather do. And healthcare has become a very partisan issue.

**Krugman:** Yeah.

**Gruber:** But I feel like long-term care doesn't have to be. Republicans have moms too. And I feel like we can really think about trying to make this an issue that we can come together on, and think about how we can treat our nation's seniors with some dignity. I wrote an editorial with Richard Frank of the [Brookings Institution](#) pointing out that during COVID, you know, we shut down our economy and spent \$3 trillion largely to save the lives of our senior citizens. Yet now that COVID's over, we go back to putting them in shitty nursing homes and not given the dignity that they deserve. Why can't we continue to care for our nation's elderly in the way that they deserve?

**Krugman:** Yeah, I mean, care can be very expensive, but we're already spending a lot and...

**Gruber:** We're already spending a lot. So the other thing we did, working with Richard Frank of the Brookings Institution, we developed a program for universal home care for the elderly. We've designed a program where everyone on Medicare would get government funded care in their home, because people don't want to go to nursing homes. Let's be blunt. And we think actually the main mechanism through which our effect is operating in this paper is by keeping people at home and out of institutions, hospitals and nursing homes.

And we have a proposal for a universal home care program that would be funded by the government, but with individual co-payments. So richer people would pay in, poor people would get it for free. And we estimate that you could provide a universal home care program that's very reasonable for about \$40 billion a year, which is really, once again, chump change compared to the maxes we're talking about.

**Krugman:** I didn't realize it was that cheap. And if you've had elderly loved ones, it's so emotionally wrenching to deal with all of that. And the idea that we could sort of make it a fundamental part of our society that we treat older people decently for so little money. I'm actually shocked by that.

**Gruber:** You know, it's not just that. Don't forget, what does it do? It frees up children—largely women, largely daughters—to reenter the labor force and deploy their skills where they're most valuable. It creates jobs for immigrants and natives, and hopefully ladders to good paying jobs. And it really just reduces the intergenerational

stresses that are caused by caring. We have this very strange, unlevel playing field in long-term care in our country, Paul, where when your parents are in a nursing home or assisted living if you're wealthy, everything's kind of taken care of. Their food, their medical care, everything. When they're home, you've got to arrange it all. You've got to arrange their food, you've got to arrange their medical care, you've got to arrange their caregivers. And that's very taxing, it's very expensive, it's just tough on relationships. And there's no reason why we can't afford this in our society.

**Krugman:** 95% of Americans can't afford that now. I'd say that basically textbook royalties were what made my mother-in-law's final years decent.

But, can you talk about research methodology on this?

**Gruber:** Well, a shout out to another Nobel Prize winning economist, [David Card](#). David Card is one of the early pioneers in research on immigration. He was more interested in the effects of immigrants on the labor market. And he said, "Let's say I want to know the effect of immigration to an area on native workers. Well, the problem is why do immigrants come to an area? Maybe they come to an area because opportunity is going up." So, you might find that more immigrants cause native workers to do better. That's not because the immigrants came. It's because immigrants came to places that were going to do better anyway. This is a common confusion of causation and correlation that drives empirical work in economics. So what David Card came up with was a very clever, what we call an instrument in economics, or a very clever natural experiment. He noted, as you said, that immigrants tend to cluster. So when Haitians come to America, they tend to go to certain spots. When Mexicans come, they tend to go to certain spots. My daughter-in-law is Brazilian. Brazilians from Minas Gerais in Brazil tend to come to Framingham, Massachusetts. And he said at the same time, there are large national waves of immigration that are caused for reasons that are independent of the US. There's an earthquake. There's a humanitarian crisis. So let's take Haiti. There's a dictator in Haiti. Hundreds of thousands of people leave Haiti. They come to America. That's an experiment. And they go to places that are predictable.

So what he said is, when there are waves of certain immigrant types, you look at the places where they tend to go. And then that's sort of an experiment. So when there's a

dictator deposed in Haiti, and hundreds of thousands of people leave Haiti, that's essentially a parachute drop of Haitians into Springfield Mass, and a couple other places where they're concentrated. And then that is a real experiment. That's essentially what we do. We use his method, we adjust a little and say, well, we're really gonna focus on groups that particularly work in healthcare, like Haitians. We adjusted for that and we actually asked when there's these parachute drops of people into places, what happens to the mortality rate of the elderly people?

And one thing that's changed since you and I started research so long ago, Paul, is we now have all these extra tests that we do in empirical work. And one very common test is to say, well, if this is really an experiment, then nothing should be going on beforehand. If it's something where, gee, immigrants are moving where elderly people are dying less for some other reason, then you should see elderly people dying less over time in those areas. But that's not true. You see elderly mortality is pretty flat, the immigrants arrive, and then elderly mortality drops. So it really is a pretty compelling application of what David Carr came up with to show that this sort of parachute drop of immigrants is really improving lives.

We then turn to try and understand the mechanisms, which, quite frankly, we don't understand as well as we'd like. It looks like there's both less use of medical institutions and better treatment in nursing homes from having more immigrants around. So it looks like it's really about this long-term care nexus, which is where it's focused. But we can't prove that. We can prove that mortality's dropped, but we're weak on the mechanisms. And I think that's why there needs to be more work in this area.

**Krugman:** This is a complete side issue, but yeah, there's been this empirical revolution in economics where people really look at the data. David Card's most famous venture into all that is probably his work on the minimum wage with Alan Kruger. Instead of [merely talking about] supply and demand and abstracting what ought to happen, they actually looked at what actually happened when New Jersey raised the minimum wage and Pennsylvania did not. And it was a shocking thing because the job losses that everyone was saying should happen didn't. And that's the start of a now huge body of literature that has forced us to change the way we thought

about labor markets. I have to say, in a lot of ways, lots of things have gotten worse since I was younger, but I think that a lot of economic research has gotten better.

**Gruber:** Yeah, we can have a long, old-bane conversation about this, but I sit in these conferences now and hear young people present papers, and I'm almost sort of embarrassed by what I called research 35 years ago. I mean, you know, a typical paper now has a 125-page appendix with everything you could check and all this. It's really incredible. Research has gotten quite amazing.

**Krugman:** Yeah, another trade person said to me, "You know, none of the papers that got you a Nobel Prize would be publishable now. Where's the empirical work?" That's true. But yeah, no, it's great.

**Gruber:** Hahaha!

**Krugman:** So, where do think we're going? I've been trying to think a little bit past this moment of the crisis on the affordable care subsidies and future for health care reform. I mean, you were certainly part of the intellectual nexus that got us the Affordable Care Act, which even in its somewhat damaged form makes a huge difference. But what next? Do you think we can actually move forward and get the system better, besides just restoring the subsidies?

**Gruber:** Yeah, I think obviously restoring the subsidies is a big deal. But in terms of insurance coverage, I think it's going to be modest changes. I mean, essentially, even if we restore the subsidies, we'll have 30 million uninsured Americans. Who are they? 10 million are undocumented immigrants. There's zero political consensus for writing them insurance. About 10 million are people who simply think they're too healthy to pay for insurance, and without a mandate we're not going to get them.

**Krugman:** Right. The original conception for Obamacare was that you would be required to have insurance and pay a penalty if you didn't, which made absolutely good sense and everybody hated it. But anyway, yeah.

**Gruber:** Well, once again, that was an idea out of the Heritage Foundation adopted by a Republican governor in Massachusetts. Let us not forget. But the remaining 10 million are people who can actually get insurance and just maybe don't know it. It's very cheap. They haven't signed up for it. So I'm doing some research on international healthcare systems. The big thing that other countries do is they make health insurance

seamless in a way we don't. It's not necessarily about having a single payer. Germany has many insurance payers. Switzerland has many insurance payers. But it's still universal coverage because they make it easy and seamless in a way we don't.

So really, increasing coverage is going to involve a significant move in that direction, which I don't see happening. I think the focus is going to shift to the supply side. And what do we do about the supply of health care workers? And what do we do fundamentally about health care prices, which are just out of whack? We pay much more for health care services than anywhere else in the world. We know why. Kenneth Arrow taught us why in 1963, when he wrote the first article on health economics and said there's no market with more market failures than health care.

And when I teach basic economics at MIT, I start by saying the market is great, but I say the market isn't so great when the market fails. And the market fails nowhere worse than in health care. And every other country in the world has recognized that, and they regulate the prices paid in health care. We haven't. So I think that's going to be the next big debate: why is health care becoming unaffordable? It's being shifted to people and what they can pay.

And so we need to both increase the supply of people in the sector and regulate the prices that are paid in the sector. I think that's the next big battle. And then, the last thing I would say in sort of my poor prognostication, I really do think the focus is going to turn to this long-term care issue. I really do think this is going to become an issue we're going to discuss more and more as more and more people are entering this age range. As people see their parents or themselves entering this age range, they're gonna realize we have a crisis on our hands of an inability to properly care for our nation's elderly. And, honestly, this is something that smart politicians can jump on and get ahead of, and think of this as a winning issue.

**Krugman:** Yeah, it has to be. It's just so visible in your face and it's so obvious, the system is cruel and dysfunctional and I think the only thing that allows it to persist is that most Americans don't know that it doesn't have to be this way.

**Gruber:** That's very well put and I think partly the question is how we educate people on that and how we get them to understand that this is a solvable crisis, and an affordably solvable crisis.

**Krugman:** It's funny, we do pay medical expenses for seniors. Medicare, by international standards, is a very lavishly funded program. And the reason that we've been able to get this big expansion at relatively low cost under the Affordable Care Act is that younger people are kind of cheap. But although we treat elderly generously with hospital expenses, ironically, we don't take care of them if they aren't in the emergency room. And that's a really shocking thing.

**Gruber:** You know, it's really interesting, Paul. When we wrote up this Oregon health insurance experiment and newspapers covered it, one of the major findings was, in the short run, health insurance didn't improve health. That's been proven to be overtaken by events. But we did find this enormous reduction in depression. And the articles would be like, you know, "Program Doesn't Affect Health." The last sentence would say, "Oh, but mental health improved." It comes to this view of health as acute physical health care where, in fact, I think increasingly we're realizing a more holistic concept about mental health and social determinants of health. Basically, the truth is we need to be thinking about what makes people well, not what makes people physically healthy.

**Krugman:** You almost sound a little bit like RFK Jr. except that your opinion is actually based on reality.

**Gruber:** Look, the one positive thing that he's doing is starting interesting conversations, thinking about the larger picture of wellness. I mean, the prescriptions are all wrong, but the conversations are right. And I think here is the challenge we face, Paul: measuring outcomes is harder. When you go to the hospital after a car accident, we can measure part of the quality of care by whether you died or not. Or maybe whether you end up back in the hospital.

**Krugman:** Right.

**Gruber:** If someone is treated poorly as a senior in a nursing home, they're gonna die anyway. The question is whether their life will be miserable along the way. Partly that's on economists and policy experts to come up with better ways to help the public understand the consequences and the measures of what it's costing. You know, in economics we talk about quality adjusted life years.

**Krugman:** Yeah.

**Gruber:** We talk about not just how long you live, but the quality of those years. We're very bad at measuring the quality part.

**Krugman:** Yeah. Just to say, all of this seems a lot more urgent to me at this point in my life than it did 40 years ago. Let's hope that your research and proposals will help move the needle, and if we get past the current nightmare, maybe we can actually make some progress on really making things better.

**Gruber:** I hope so.