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Emergence of the Second Mortgage Market Crisis

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The reform act – passed with a few votes' majority – is fragile not only because of lacking solid public support, but it also harbours a systemic risk, which in the coming 10-15 years, may lead to problems on the global capital markets of a magnitude similar to the current crisis related to American real estate.

The health reform approved by the American House of Representatives essentially means that as of 2014, the health insurance obligation is extended to 95 per cent of the population. According to the estimates of the Congressional Budget Office, the implementation of the legislative package will cost $938 billion in the next ten years, which is basically the cost of insuring 32 million new people within the system. At the present, namely, a person has sickness insurance in the U.S. if his/her employer can pay the premium. The insurance premium depends on two things: age and the health condition.

The most important task of the insurance company is to preserve its own financial balance, which means that uses all possible means to protect the risk pooling of its insured by not allowing people who are likely to cause damage to join. It does so by charging a so-called risk premium for insuring certain diseases of sick people, or completely excludes related health care from the group of charged services. This screening system can be "avoided" by a sick person if he/she takes out insurance as a member of a group, e.g. as the employee of an employer.

Obviously, the current number of 32 million people are excluded from health insurance because they are presumably suffer from an illness and are unable to pay the premium. Clearly, this number also includes those with low income, and every one in need of care can currently receive minimal health services on a welfare basis.

Obama's reform draws the practice of health risk assessment from under the control of insurance companies, that is, in the future they are required to contract with everybody. The resulting sum of $938 billion will be spent by the country on premia and risk premia in the next ten years. Financing is covered by new taxes levied on the rich, on the one hand, and by the requirement of large and medium-sized companies to provide insurance to their employees, which are otherwise subject to a fine.

This solution seems straightforward, but this measure only secures the source of revenues and not the source of expenditures. Obviously, insurance companies will account for a $938 billion surplus in revenues during the next ten years (not surprisingly, they waived the practice of risk assessment), but they are also undertaking new service obligations based on the insurance policies with risk pooling including policy holders with poorer health. This essentially means that the law prohibits insurers from denying services from patients with certain existing health conditions.

Obviously, revenue from insurance premia will not cover the service expenditures of insurance companies in the long term. There are several solutions for resolving this. Insurers will initially attempt to raise premia, which is not a good option in the long term because customers with a good risk rating would be no exception, and the loss of this profit centre is not the aim. The other obvious solution is to secure permanent budgetary support. It would not come as a surprise, however, if a state health insurer would be set up based on the model

of Freddie Mac and Fannie Mae. We should have no doubt about attempts to shift the related risks to the global money markets.

Based on the foregoing, it is difficult not to question the foundations of the congressional estimates, according to which the legislative package is expected to reduce the budget deficit by $138 billion in the first ten years, and by $1,200 billion in the second decade after its enactment.

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