Health Insurance
(Chapters 15 and 16)
Part-2
Health Insurance

Public Spending on Health Care

- Public share of total health spending over time in the U.S.
Health Insurance
The Health Care System in the U.S.

• Two major items in public spending on health care:
  – Medicare: Federal program, funded by a payroll tax, that provides health insurance to all elderly over age 65 and disabled persons under age 65.
  – Medicaid: Federal and state program, funded by general tax revenues, that provides health care for poor families, elderly and disabled.
Health Insurance
The Medicaid Program

• How does Medicaid work?
  – It is federally mandated but administrated at the state level.
  – Who is eligible?
    • Children’s Health Insurance Program (CHIP): Introduced in 1997 to expand eligibility of children for public health insurance beyond the existing limits of the Medicaid program, generally up to 200% of the poverty line.
    • Varies by state: currently, all individuals age 18 or younger are eligible for Medicaid or Chip up to 100% of the poverty line ($20,000 for a family of four).
  – What health services does medicaid cover?
    • Varies by state: Federal government mandates the states to cover major medical expenses, but there is no requirement on the optional services such as prescription drugs and dental care.
Health Insurance
The Medicaid Program

• How does Medicaid work?
  – How do providers get paid?
    • States regulate the rate at which the physicians are reimbursed. The reimbursement is typically lower than that of private insurance, leading to unwillingness among physicians to serve Medicaid patients.
Health Insurance
The Medicaid Program

• The effects of the Medicaid program

- Increased Eligibility
  - Previously Uninsured
  - Previously Privately Insured
    - take-up
    - crowd-out

- Medicaid Coverage
  - access

- Medical Utilization

- Health Outcomes
  - program costs

- Cost-Effectiveness
Health Insurance
The Medicaid Program

• The effects of the Medicaid program
  – Take-up:
    • In 1982, 12% of individuals nationwide aged 18 or under were eligible.
    • In 2000, 46% of that age-group were eligible.
    • However, the increase in take-up has not been as much. Reasons:
      – Lack of information for the newly eligible.
      – They already had private insurance and did not switch.
Health Insurance
The Medicaid Program

• The effects of the Medicaid program
  – Crowd-out:
    • Some of the newly eligible might find it attractive to switch from their private insurance to Medicaid.
    • Some items covered under Medicaid are very expensive to be insured under private insurance, whereas Medicaid is free.
    • There are some empirical studies that find evidence of crowding-out, but it is far from full crowd-out.
Health Insurance
The Medicaid Program

• The effects of the Medicaid program
  – Health care utilization and health:
    • If the program induces those who could not otherwise be insured to be insured, then there might be an improvement in the health outcomes of the general population.
    • During the expansion era of the Medicaid, the infant and child mortality rate declined significantly (a 8.5% reduction).
Health Insurance
The Medicaid Program

• The effects of the Medicaid program
  – Cost effectiveness:
    • It costs Medicaid roughly $1 million to save the life of an infant (Currie and Gruber, 1996). This is much lower than the typical statistical value of life.
    • This finding suggests that investing in low-income health care may be a cost-effective means of improving health in the U.S.
Health Insurance
The Medicare Program

• The largest health care program in the U.S.

• **How does Medicare work?**
  – Administered at the federal level.
  – All U.S. citizens who have worked and paid payroll taxes, and their spouses are eligible. Other citizens who do not have the requisite work experience can purchase at its full cost.
Health Insurance
The Medicare Program

• Medicare is three different programs:
  – **Medicare Part A**: covers inpatient hospital costs and some costs of long-term care.
  – **Medicare Part B**: covers physician expenditures, outpatient hospital expenditures and other services
  – **Medicare Part D**: provides coverage for prescription drug expenditures
## Table 16-2

<table>
<thead>
<tr>
<th>Medicaid and Medicare</th>
<th>Medicaid</th>
<th>Medicare</th>
</tr>
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</table>
| **Eligibles**          | Families on welfare  
                        | Low-income children, pregnant women  
                        | Low-income elderly, disabled        | Retirees and spouses 65 and older  
                        | Certain disabled individuals under 65  
                        | People with kidney failure (requiring dialysis or transplant) |
| **Premiums**           | None      | Hospital coverage: none  
                        | Physician coverage: $66.60 per month  
                        | Prescription drug coverage: Variable |
| **Deductibles/copayments** | None (or very small) | Hospital coverage: $876 deductible for first 60 days  
                        | Physician coverage: $100 deductible, 20% coinsurance  
                        | Prescription drug coverage: Variable |
| **Services excluded**  | None (or very minor) | Prescription drugs (until 2006)  
                        | Routine checkups, dental care, nursing home care, eyeglasses, hearing aids, immunization shots |
| **Provider reimbursement** | Very low | Moderate (but falling) |
Health Insurance
The Effects of the Medicare Program

- **Prospective Payment System (PPS):** Medicare’s system for reimbursing hospitals based on nationally standardized payments for specific diagnoses.
  - Three key features:
    1. All diagnoses for hospital admissions were grouped into 467 “Diagnosis Related Groups,” or DRGs.
    2. The government reimbursed hospitals a fixed amount based on the DRG of patient admission.
    3. The fixed amount of reimbursement was determined by a national standard for the cost of treating that DRG.
Health Insurance
The Effects of the Medicare Program

• **The Effects of PPS:**
  – The purpose is to reduce the cost of medical expenditures by reducing the incentives for hospitals to overstate their costs.
  – There was an enormous reduction in the treatment intensity of the elderly within hospitals. The average length of hospital stay for the elderly patients fell from 9.7 days to 8.4 days in just one year.
  – Despite the decline in treatment intensity, there was no adverse impact on patient outcomes.

• **The Problems with PPS:**
  – By ‘exaggerating’ the diagnosis, hospitals attempted to increase the amount of money they receive from Medicare.
Health Insurance
The Effects of the Medicare Program

• **Medicare managed care:**
  - Starting in 1985, the federal government allowed Medicare enrollees a choice of Medicare HMOs as well.
  - A disadvantage for patients was that HMOs restricted their choice of provider and potentially engaged in other rationing devices to keep down costs that were not present in the traditional system.
Health Insurance
The Effects of the Medicare Program

Managed care enrollment (% of Medicare beneficiaries)

Health Insurance
The Effects of the Medicare Program

- **Issues with Medicare managed care:**
  - Adverse selection: only the healthiest patients choose the HMO’s, leading to higher health care costs for the government.

<table>
<thead>
<tr>
<th>Per person average cost</th>
<th>Traditional Medicare (number of people)</th>
<th>Medicare plus HMOs (number of people)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000:</td>
<td>100</td>
<td>30 to HMO</td>
</tr>
<tr>
<td>$2,000:</td>
<td>100</td>
<td>85 to HMO</td>
</tr>
<tr>
<td>$3,000:</td>
<td>100</td>
<td>15 to HMO</td>
</tr>
</tbody>
</table>

**Average cost per Medicare recipient** equals:

- Traditional Medicare: $(100 \times $1,000 + 100 \times $2,000 + 100 \times $3,000)/300 = $2,000
- Medicare plus HMOs: $(70 \times $1,000 + 85 \times $2,000 + 100 \times $3,000)/255 = $2,118

**Total cost to government** equals:

- Traditional Medicare: $(100 \times $1,000 + 100 \times $2,000 + 100 \times $3,000) = $600,000
- Medicare plus HMOs: $(70 \times $1,000 + 85 \times $2,000 + 100 \times $3,000) + 45 \times (0.95 \times $2,118) = $630,545

**Average cost per HMO enrollee** equals:

- Medicare plus HMOs: $1,333
Health Insurance
Lessons for Health Care Reform

• The issue: Rising health care costs
  – Since 1950, the Consumer Price Index for medical care has risen by 1.8 percentage points more per year than the Consumer Price Index for all items in the U.S. economy.
  – Controlling medical care costs is a tremendously difficult proposition for two reasons.
    • First, it is not clear that costs should be controlled.
    • Second, even if costs should be controlled, it is not clear how this can be done.
Health Insurance Lessons for Health Care Reform

• How to insure the ‘Uninsured’
  – **Pooling:** Efficient provision of insurance requires large pools of participants that are created independently of health status. Solving the problem of the uninsured requires developing some new pooling mechanism, either through government insurance or through private insurance pools.
  – **Affordability**
  – **Mandates:** A legal requirement for employers to offer insurance or for individuals to obtain some type of insurance coverage
Health Insurance
Lessons for Health Care Reform

• **Incremental Reforms**
  – **Incremental cost controls**
    • One approach that has been used extensively in recent years by the Medicare program is to restrict provider reimbursement, either by lowering prices or moving to more prospective reimbursement.
  – **Incremental reforms to cover the uninsured**
    • One option is to try to make the small employer and nongroup markets more hospitable to the uninsured, in the hopes of inducing the uninsured to buy insurance.
    • Another possibility for increasing insurance coverage for the uninsured is to continue to expand the public insurance safety net.
    • A third possibility (which is currently very popular) is to offer individuals new tax subsidies with which to purchase health insurance.
Health Insurance
Lessons for Health Care Reform

- **Fundamental Reforms**
  - **Public national health insurance**
    - A system whereby the government provides insurance to all its citizens, as in Canada or most European countries (including Turkey), without the involvement of a private insurance industry.
    - In Turkey, the government acts like a big HMO.
  - **Private sector solutions**
    - An alternative approach to fundamental reform would be to build on the existing hybrid of private and public insurance in the United States.
    - State governments could each set up new pools of insurance plans, akin to the pools offered by employers, from which individuals could choose insurance.