

Health Insurance

Chapters 15 and 16 of Gruber textbook

131 Undergraduate Public Economics

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MOTIVATION

Despite the huge benefits reaped from the U.S. health care system, all is not completely well: (a) US health care is very expensive (18% of GDP relative to 10% in other OECD countries), (b) growing too fast, (c) 1/6 of population is uninsured

There are enormous disparities in medical outcomes across demographic groups in the US

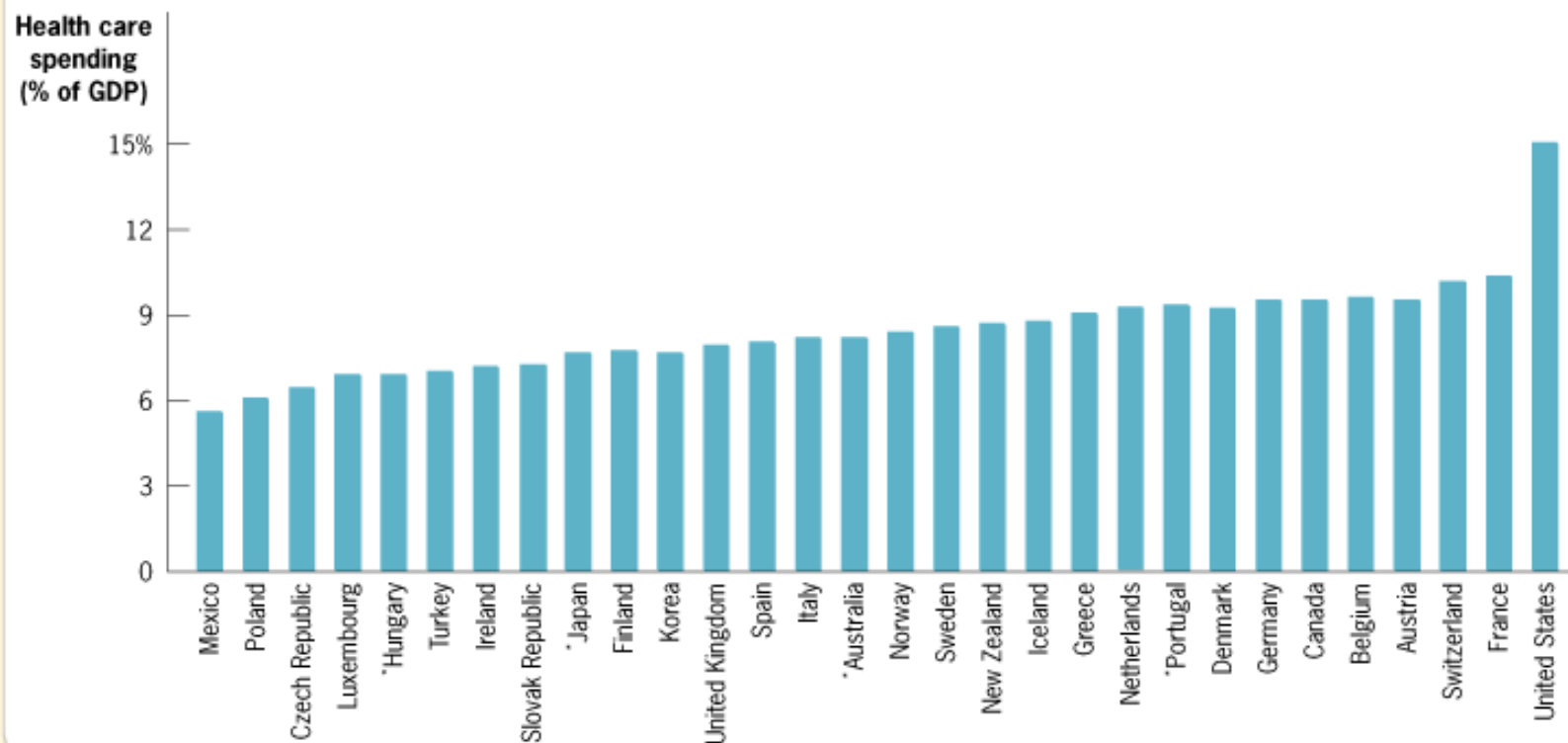
The United States was the only major industrialized nation that does not endeavor to provide universal access to health care for its citizens

Recent Obamacare law should reduce drastically the number of uninsured from 50m to 25m in next decade

15.1

An Overview of Health Care in the United States

■ FIGURE 15-1



Health Care Spending in OECD Nations in 2007 • Health care spending is much higher in the United States than in the typical industrialized nation.

*Japan, Hungary, Australia, Portugal all based on 2006 figures.

UNIVERSAL HEALTH INSURANCE

All OECD countries (except the US) provide universal health care insurance funded by taxation:

Individuals who get sick can have health care paid for by the government

Government either directly controls doctors/hospitals (like National Health Service in the UK) or government reimburses private health care providers (like in France)

Government controls costs and limits health-care over-consumption through:

- 1) Regulation (govt picks allowed treatments based on cost effectiveness, bargains for prices, rations care)
- 2) Patient co-payments (patients share part of the cost)

US HEALTH INSURANCE

US has a mix of public and private insurance:

1) Government provided insurance

(a) Medicare for the elderly (65+), (b) Medicaid for the poor,
(c) Veterans benefits

2) Privately provided insurance:

(a) Employer provided health insurance (large), (b) Direct private purchase (small)

3) Uninsured: (1/6) of population (before Obamacare)

In the US, health insurance solely restricts treatments on effectiveness (not cost effectiveness) \Rightarrow Huge incentives for health providers to supply new expensive treatments

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An Overview of Health Care in the United States

■ TABLE 15-1

Americans' Source of Health Insurance Coverage, 2007

	People (millions)	Percentage of population
Total population	301.5	100.0%
<i>Private</i>	201.0	66.7%
Employment-based	176.3	58.5%
Direct purchase	26.8	8.9%
<i>Public</i>	87.4	29.0%
Medicare	43.0	14.3%
Medicaid	42.6	14.1%
TRICARE/CHAMPVA	11.6	3.8%
<i>Uninsured</i>	46.3	15.4%

Note: Estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

More than two-thirds of insured Americans have private health insurance, largely through employers, while the remaining have public health insurance. Roughly one-sixth of Americans are uninsured.

WHY EMPLOYERS PROVIDE PRIVATE INSURANCE

1) risk pooling: The goal of all insurers is to create *large insurance pools with a predictable distribution of medical risk.*

The statistical law of large numbers states that as the size of the pool grows, the odds that the insurer will be unable to predict the average health outcome of the pool falls.

2) tax incentive: employer provided health insurance is a non-taxable form of compensation for employees (not subject to payroll taxes or individual income tax) ⇒ Better to get insurance through employer (non-taxable) than to purchase it directly as an individual (with after-tax income)

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An Overview of Health Care in the United States

Private Insurance

Why Employers Provide Private Insurance,
Part II: The Tax Subsidy

tax subsidy to employer-provided health insurance Workers are taxed on their wage compensation but not on compensation in the form of health insurance, leading to a subsidy to health insurance provided through employers.

■ TABLE 15-2

Illustrating the Tax Subsidy to Employer-Provided Insurance

	Marginal Product, Wage	Employer Health Insurance Spending	Pre-Tax Wage	After-Tax Wage	Personal Health Insurance Spending	After-Tax, After-Health Insurance Income
Jim	\$30,000	0	\$30,000	\$20,000	\$4,000	\$16,000
Peter	\$30,000	\$5,000	\$25,000	\$16,666	0	\$16,666

Jim and Peter both have the same marginal product of labor, but Peter chooses to take insurance through his employer, accepting a \$5,000 reduction in wages as a result, while Jim purchases it on his own for \$4,000. Even though Jim's insurance is cheaper, Peter ends up with \$666 more income after taxes than Jim due to the subsidy to employer-provided insurance.

THE OTHER ALTERNATIVE: NONGROUP INSURANCE

Nongroup direct insurance market: The market through which individuals or families buy insurance directly rather than through a group, such as the workplace.

The nongroup insurance market is not a well-functioning market

Nongroup insurance is not always available due to **adverse selection**

Those in the worst health (pre-existing conditions) are often unable to obtain coverage (or obtain it only at an incredibly high price).

MEDICARE

Started in 1965 as a universal health insurance system for the elderly and nonelderly on disability insurance.

Federal program that provides health insurance to all people over age 65 and disabled

Every citizen who has worked for 10 years (or their spouse) is eligible.

Financed with an uncapped payroll tax totaling 2.9%

Physician reimbursement fairly generous (but not as high as private insurance)

MEDICAID

Provides health care for the poor (means-tested benefit)

Financed from general revenues

Targets welfare recipients, low income kids and elderly (for non-Medicare costs such as long-term care)

70% of recipients are mothers/kids but 66% of expenditure goes to long-term care for elderly.

Program eligibility criteria have been expanded over time (higher incomes allowed)

Physician reimbursement very low \Rightarrow many doctors refuse Medicaid patients.

Big variation across states in Medicaid generosity (costs are shared between state/feds)

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The Medicare Program

The largest public health insurance program in the United States is Medicare.

■ TABLE 16-2

Medicaid and Medicare

	Medicaid	Medicare
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: \$1,068 deductible for first 60 days Physician coverage: \$135 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)

Medicaid provides health insurance for low-income individuals, covering a wide range of health services at little cost to those individuals. Medicare provides health insurance for those age 65 and over, covering many, though not all, health services at some cost to those individuals.

THE UNINSURED

50 million individuals in the U.S. have no insurance.

They tend to have below-average incomes.

Two-thirds of the uninsured are in families with incomes below 200% of the poverty line.

70% of the uninsured are in families with a head of household who is a full-time, full-year worker.

Over one-fifth of the uninsured are children.

Obamacare reform will provide insurance to 25m of the 50m uninsured by subsidizing employers and individuals to get insurance (and fined with extra taxes if not insured)

Why Are Individuals Uninsured?

- 0) They simply can't afford the high costs of health insurance.
- 1) Risk-averse individuals may be unwilling to purchase insurance if it is not available at an actuarially fair price.
- 2) Insurers may be unwilling to insure the worst risks because of fears of adverse selection [individuals with pre-existing conditions typically can't buy insurance]
- 3) They may be rationally forgoing insurance because the odds of illness are low.
- 4) They are not appropriately valuing insurance coverage.

Many uninsured get health care only in emergencies. Huge subsequent bills can lead to bankruptcy or they are too poor to pay (and hospitals pick up the tab)

Why Care About the Uninsured?

There are equity motivations for caring about the uninsured

Becoming uninsured is a concern/risk for millions of individuals who currently have insurance.

Health insurance availability may inhibit productivity-increasing job switches (job lock): you do not want to quit a job offering health insurance

Care is not delivered appropriately to the uninsured.

There is a significant financial externality imposed by the uninsured on the insured.

There are physical externalities associated with communicable diseases.

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An Overview of Health Care in the United States

EMPIRICAL EVIDENCE

HEALTH INSURANCE AND MOBILITY

Is job lock an important problem in reality?

Initially, a large literature compared the mobility rate of those who have and do not have health insurance.

A more sophisticated literature in the 1990s surmounted this problem in two different ways:

- Studies used a difference-in-difference strategy that compared a treatment group of those who valued health insurance particularly highly with a control group of those who did not.
- Studies examined the impact of state laws that allowed workers to continue to purchase their employer-provided health insurance for some period of time after leaving their jobs.

The results from these studies support the notion that job lock is quantitatively important.

Is Universal Health Care Desirable?

People face difference health risks (pre-existing conditions) ⇒ Those facing high health risks face very high insurance costs in private market

Should the government insure people for health risks? Yes if health risks outside people's control (age, genetics). Not necessarily if health risks due to choices (diet, exercise). Virtually all OECD countries answer yes and provide universal health care

Not providing universal health care creates other issues: **adverse selection** if private insurers cannot observe risks or cannot charge based on risks ⇒ Even those with low risks cannot get actuarially fair insurance

In all cases (private and public), health insurance needs to deal with moral hazard (over-provision, over-consumption)

Optimal Health Insurance: Consumer Side

As with other insurance, optimal generosity determined by the trade off between consumption- smoothing benefit and moral hazard cost.

Consumption when sick = $c_s < c_h$ = consumption when healthy

Insurance raises c_s and lowers $c_h \Rightarrow$ higher expected utility if risk averse.

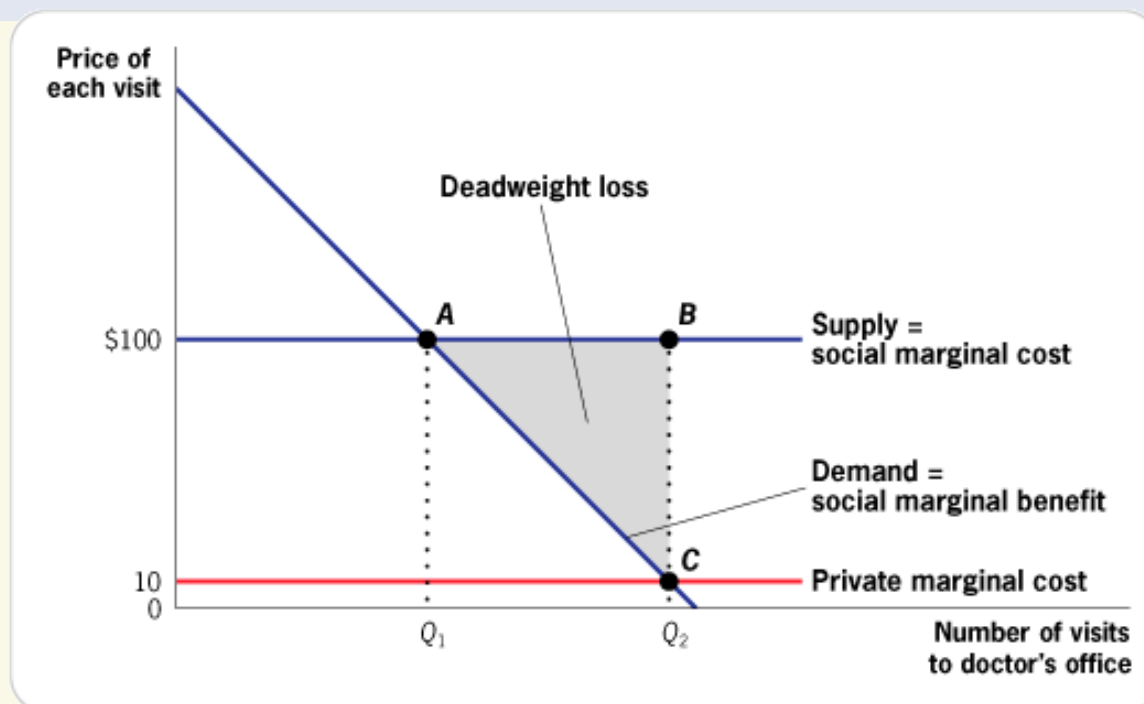
Moral hazard: overconsumption of healthcare because insured individual pays only a fraction of health care costs when he/she is sick. Fraction paid by individual is called the **co-payment**

15.2

How Generous Should Insurance Be to Patients?

Moral Hazard Costs of Health Insurance for Patients

■ FIGURE 15-3



Patient-side Moral Hazard • With no insurance, at a cost of \$100 per visit, individuals would consume Q_1 doctor's office visits, where marginal costs and benefits are equal. With only a \$10 copayment, however, individuals consume Q_2 worth of visits, where private marginal costs equal social marginal benefit; this overconsumption of health care leads to a deadweight loss of ABC.

How Elastic Is the Demand for Medical Care? The RAND Health Insurance Experiment

The best evidence on the elasticity of demand for medical care comes from one of the most ambitious social experiments in U.S. history: the RAND Health Insurance Experiment (HIE) in late 1970s

\$150m expenditure involving 6000 people tracked over 3 years

Random assignment of health plans with different co-payment parameters: Copayment rates from 0% to 95%.

All families given \$1000 to participate, so no one was made worse off from the experiment.

The RAND Health Insurance Experiment: Results

The findings of the HIE were striking:

Medical care demand is somewhat price sensitive: individuals who were in the free care plan used 46% more care than those paying 95% of their medical costs.

Overall, 10% rise in the price of medical care to individuals \Rightarrow use 2% less care (elasticity = .2). Medical utilization not very sensitive to price but distortion still large due to very low co-payment rates in most insurance programs

Those who used more health care due to the lower price did not, on average, see a significant improvement in their health.

For those who are chronically ill and don't have sufficient income to easily cover co-payments, there was some deterioration in health.

Oregon Medicaid Health Insurance Experiment

- In 2008, Oregon had a limited budget \Rightarrow used lottery to select individuals on waitlist to be given a chance to apply for Medicaid insurance coverage
- 30,000 “lottery winners” (treatment group) out of 90,000 participants (lottery losers are control group)

Not all winners received coverage. Some non-winners later received insurance on their own.

But it is still the case that winning the lottery increases probability of having health insurance by 29 percentage points

- Finkelstein et al. (2012) use lottery as instrument to estimate causal effect of insurance coverage itself

Two way to report the results:

ITT (intention to treat): just compare winners and losers

LATE (local average treatment effect): Inflate estimates by $1/[\text{difference in fraction insured between winners and losers}] = 1/.29 = 3.5$

Oregon Medicaid Health Insurance Experiment

- Data sources: admin data from hospitals, credit reporting data, and survey responses regarding utilization, health, and financial outcomes
- Key results: winning the Medicaid lottery leads to:
 - 1) higher health care utilization (including primary and preventive care as well as hospitalizations)
 - 2) lower out-of-pocket medical expenditures and medical debt (including fewer bills sent to collection)
 - 3) better self-reported physical and mental health

Table V: Health Care Utilization (Survey Data)

	Extensive Margin (Any)				Total Utilization (Number)			
	Control Mean	ITT	LATE	p-values	Control Mean	ITT	LATE	p-values
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Prescription drugs currently	0.637 (0.481)	0.025 (0.0083)	0.088 (0.029)	[0.002] {0.005}	2.318 (2.878)	0.100 (0.051)	0.347 (0.176)	[0.049] {0.137}
Outpatient visits last six months	0.574 (0.494)	0.062 (0.0074)	0.212 (0.025)	<0.0001 {<0.0001}	1.914 (3.087)	0.314 (0.054)	1.083 (0.182)	<0.0001 {<0.0001}
ER visits last six months	0.261 (0.439)	0.0065 (0.0067)	0.022 (0.023)	[0.335] {0.547}	0.47 (1.037)	0.0074 (0.016)	0.026 (0.056)	[0.645] {0.643}
Inpatient Hospital admissions last six months	0.072 (0.259)	0.0022 (0.0040)	0.0077 (0.014)	[0.572] {0.570}	0.097 (0.4)	0.0062 (0.0062)	0.021 (0.021)	[0.311] {0.510}
<i>Standardized treatment effect</i>		0.050 (0.011)	0.173 (0.036)	<0.0001		0.040 (0.011)	0.137 (0.038)	[0.0003]
<i>Annual spending^a</i>					3,156	226 (108)	778 (371)	[0.037]

Table VIII: Financial Strain (Survey Data)

	Control Mean	ITT	LATE	p-values
	(1)	(2)	(3)	(4)
Any out of pocket medical expenses, last six months	0.555 (0.497)	-0.058 (0.0077)	-0.200 (0.026)	[<0.0001] {<0.0001}
Owe money for medical expenses currently	0.597 (0.491)	-0.052 (0.0076)	-0.180 (0.026)	[<0.0001] {<0.0001}
Borrowed money or skipped other bills to pay medical bills, last six	0.364 (0.481)	-0.045 (0.0073)	-0.154 (0.025)	[<0.0001] {<0.0001}
Refused treatment bc of medical debt, last six months	0.081 (0.273)	-0.011 (0.0041)	-0.036 (0.014)	[0.01] {0.01}
<i>Standardized treatment effect</i>		-0.089 (0.010)	-0.305 (0.035)	[<0.0001]

Table IX: Health

	Control Mean (1)	ITT (2)	LATE (3)	p-values (4)
Panel A: Administrative data				
Alive	0.992 (0.092)	0.00032 (0.00068)	0.0013 (0.0027)	[0.638]
Panel B: Survey Data				
Self reported health good / very good / excellent (not fair or poor)	0.548 (0.498)	0.039 (0.0076)	0.133 (0.026)	[<0.0001] {<0.0001}
Self reported health not poor (fair, good, very good, or excellent)	0.86 (0.347)	0.029 (0.0051)	0.099 (0.018)	[<0.0001] {<0.0001}
Health about the same or gotten better over last six months	0.714 (0.452)	0.033 (0.0067)	0.113 (0.023)	[<0.0001] {<0.0001}
# of days physical health good, past 30 days*	21.862 (10.384)	0.381 (0.162)	1.317 (0.563)	[0.019] {0.018}
# days poor physical or mental health did not impair usual activity, past 30 days*	20.329 (10.939)	0.459 (0.175)	1.585 (0.606)	[0.009] {0.015}
# of days mental health good, past 30 days*	18.738 (11.445)	0.603 (0.184)	2.082 (0.64)	[0.001] {0.003}
Did not screen positive for depression, last two weeks	0.671 (0.470)	0.023 (0.0071)	0.078 (0.025)	[0.001] {0.003}
<i>Standardized treatment effect</i>		0.059 (0.011)	0.203 (0.039)	[<0.0001]

Source: Finkelstein et al. 2012

Table X: Potential Mechanisms for Improved Health (Survey Data)

	Control Mean (1)	ITT (2)	LATE (3)	p-values (4)
Panel A: Access to care				
Have usual place of clinic-based care	0.499 (0.500)	0.099 (0.0080)	0.339 (0.027)	[<0.0001] {<0.0001}
Have personal doctor	0.490 (0.500)	0.081 (0.0077)	0.280 (0.026)	[<0.0001] {<0.0001}
Got all needed medical care, last six months	0.684 (0.465)	0.069 (0.0063)	0.239 (0.022)	[<0.0001] {<0.0001}
Got all needed drugs, last six months	0.765 (0.424)	0.056 (0.0055)	0.195 (0.019)	[<0.0001] {<0.0001}
Didn't use ER for non-emergency, last six months	0.916 (0.278)	-0.0011 (0.0043)	-0.0037 (0.015)	[0.804] {0.804}
<i>Standardized treatment effect</i>		0.128 (0.0084)	0.440 (0.029)	[<0.0001]

Source: Finkelstein et al. 2012

Consumption-Smoothing Benefits

Consumption-smoothing benefits bigger for large shocks

Some events, like a check-up, are minor and predictable

Others, like a heart attack, are expensive and unpredictable.

Insurance is much more valuable for expensive, unpredictable events

Small shocks lead to small fluctuations in marginal utility

Also less moral hazard for large, unpredictable shocks

⇒ Optimal policy: large deductibles and very generous coverage for “catastrophes”

Application: Medicare Prescription Drug Benefit

Starting in 2006, Medicare “Part D” covers drug expenses.

In return for a monthly premium, this program pays for

0% of the drug costs up to \$250

75% of the costs for the next \$2,250

0% of the costs for the next \$3,600 (“donut hole”)

95% of the costs above \$5,100

Middle bracket with 75% refund: exactly opposite of optimal design!

Rationale: political. Help the most people in this way (but do not maximize expected welfare).

Obamacare eliminates the “donut hole”

Estimating Health Benefits

Another approach of evaluating benefits of a health insurance program: look directly at health outcomes instead of consumption-smoothing benefit

How to implement this?

Simply comparing those enrolled in Medicaid to those not enrolled will suffer from bias.

Factors such as income and health status will bias the results.

Series of studies by Currie and Gruber: use Medicaid expansions and diff-in-diff strategy to evaluate value of programs

Table 1**Medicaid Eligibility Changes Across and Within States****Variation by State: Eligibility for Children**

Year	Missouri eligibility	Michigan eligibility
1982	12%	20%
2000	76%	34%

Variation by age: Eligibility in Washington D.C.

Year	Age 14 eligibility	Age 0 eligibility
1982	18%	48%
2000	59%	56%

Effect of Medicaid Expansions on Health

Currie and Gruber find that these reductions in the number of uninsured had positive effects on health outcomes in pregnancies.

1) Utilization of health services increased: Early prenatal care visits rose by more than 50%

2) Health care outcomes improved: Infant mortality declined by 8.5% due to the expansions in Medicaid for pregnant women.

⇒ Highly cost-effective policy.

Costs Per Life Saved of Various Regulations

Regulation concerning ...	Year	Agency	Cost per life saved (\$ millions)
Childproof lighters	1993	CPSC	\$0.1
Food labeling	1993	FDA	0.4
Reflective devices for heavy trucks	1999	NHTSA	0.9
Medicaid pregnancy expansions	1996	Currie & Gruber	1.0
Children's sleepware flammability	1973	CPSC	2.2
Rear/up/should seatbelts in cars	1989	NHTSA	4.4
Asbestos	1972	OSHA	5.5
<i>Value of statistical life</i>			7.0
Benezene	1987	OSHA	22
Asbestos ban	1989	EPA	78
Cattle feed	1979	FDA	170
Solid waste disposal facilities	1991	EPA	100,000

Effect of Medicare on Health

Medicare becomes available when you turn 65 \Rightarrow Can do a **regression discontinuity design** to see what happens when you cross age 65 threshold. Two recent papers use this strategy:

1) Card-Dobkin-Maestas “The Impact of Nearly Universal Insurance Coverage on Health Care Utilization and Health: Evidence from Medicare” AER 2008

Examines impacts across groups; with an interest in evaluating impacts on inequality in utilization

2) Card-Dobkin-Maestas “Does Medicare Save Lives?” QJE 2009

Examines impacts on outcomes (mortality following hospital admission)

Basic idea is to draw graphs of outcomes based on age for various groups

The discontinuity at 65 captures **short-term** changes in health care utilization and mortality from shift from < 65 to > 65

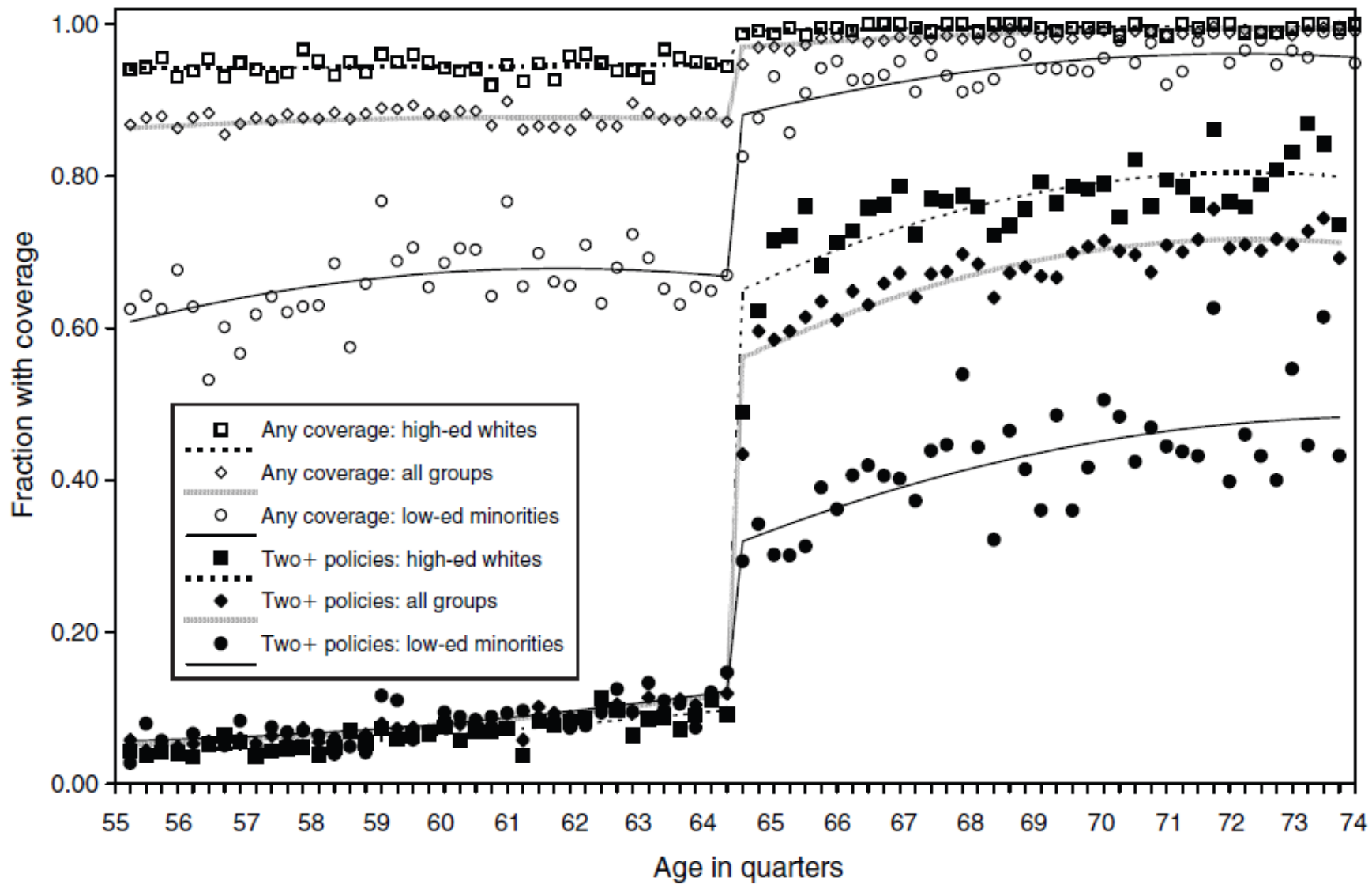


FIGURE 1. COVERAGE BY ANY INSURANCE AND BY TWO OR MORE POLICIES, BY AGE AND DEMOGRAPHIC GROUP

First stage: sharp increase in coverage; more for disadvantaged
 (From NHIS; age measured in quarters) FIGURE 1

Hospital discharge data (CA, FL, NY 1992-2002), ages 60-70

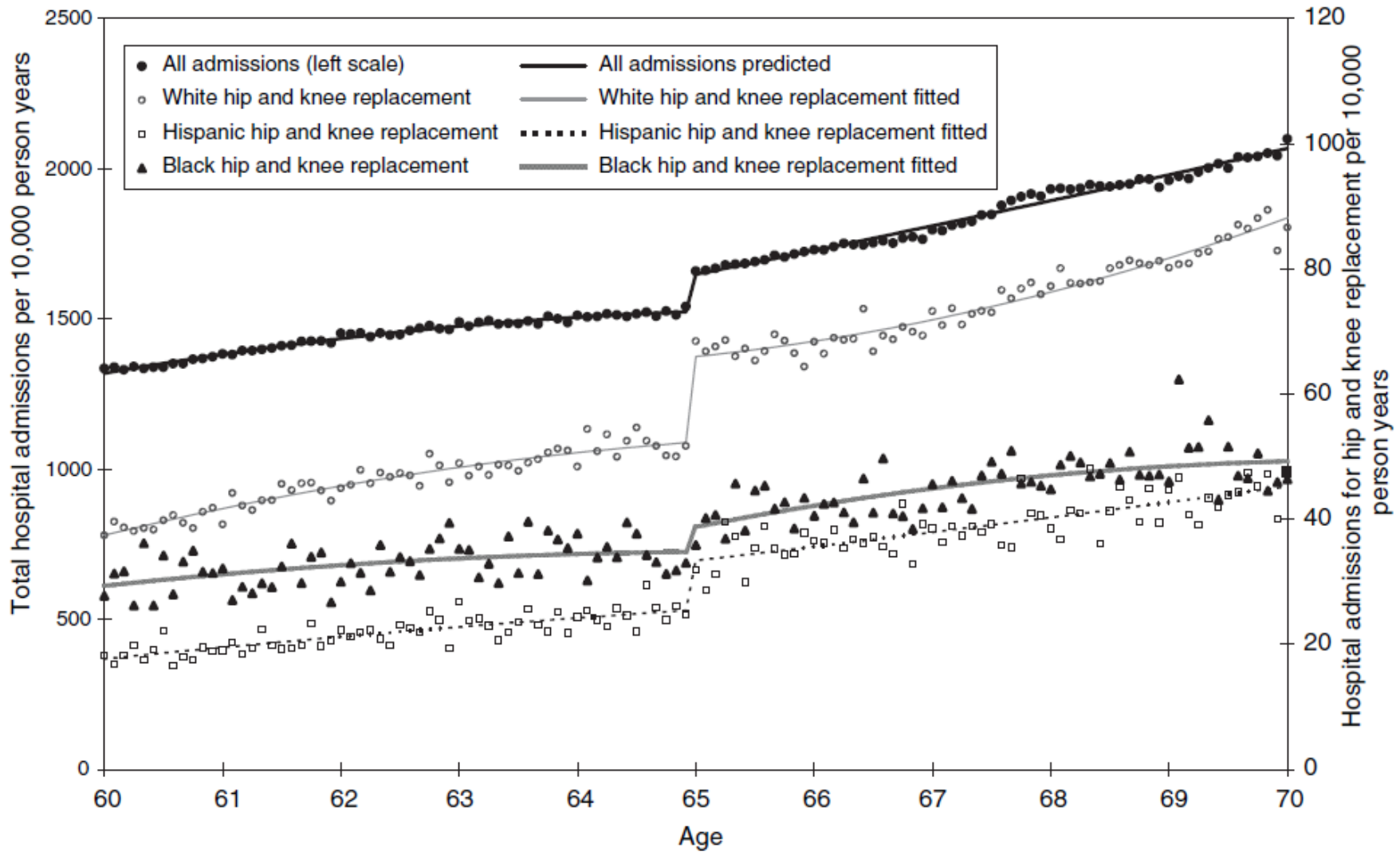


FIGURE 3. HOSPITAL ADMISSION RATES BY RACE/ETHNICITY

Increase is driven by discretionary medical care, diagnostic heart treatments.

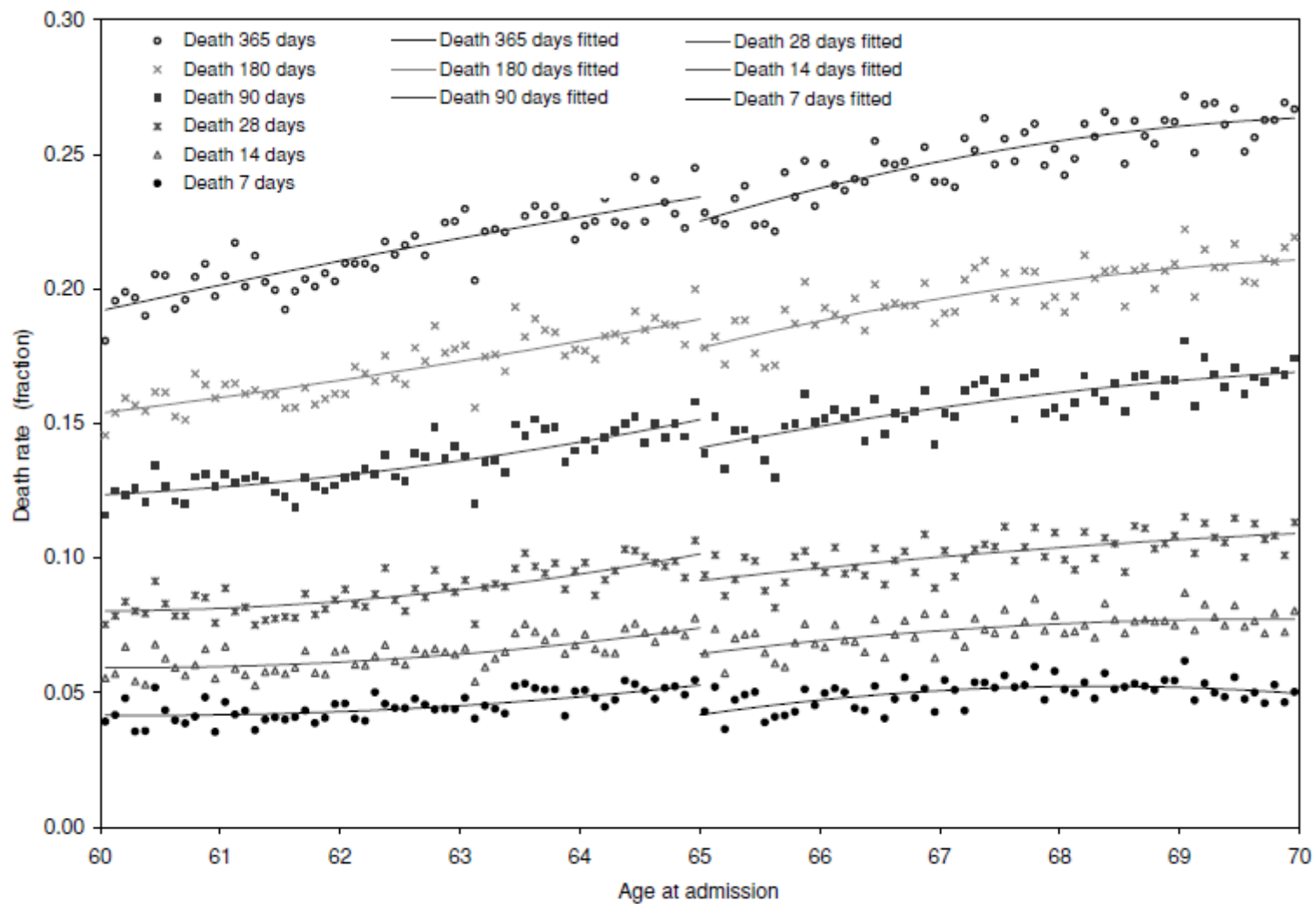


FIGURE VI
Patient Mortality Rates over Different Follow-Up Intervals

Nontrivial decrease in mortality.

Effects of Medicare on Health

- 1) Big increase in health insurance coverage, especially for disadvantaged groups
 - 2) Big increase in health care utilization
 - 3) Visible decrease in mortality after admission for conditions requiring ER immediate hospitalization (so that likelihood of going to hospital is the same before 65 and after 65)
- ⇒ Medicare health insurance does save lives

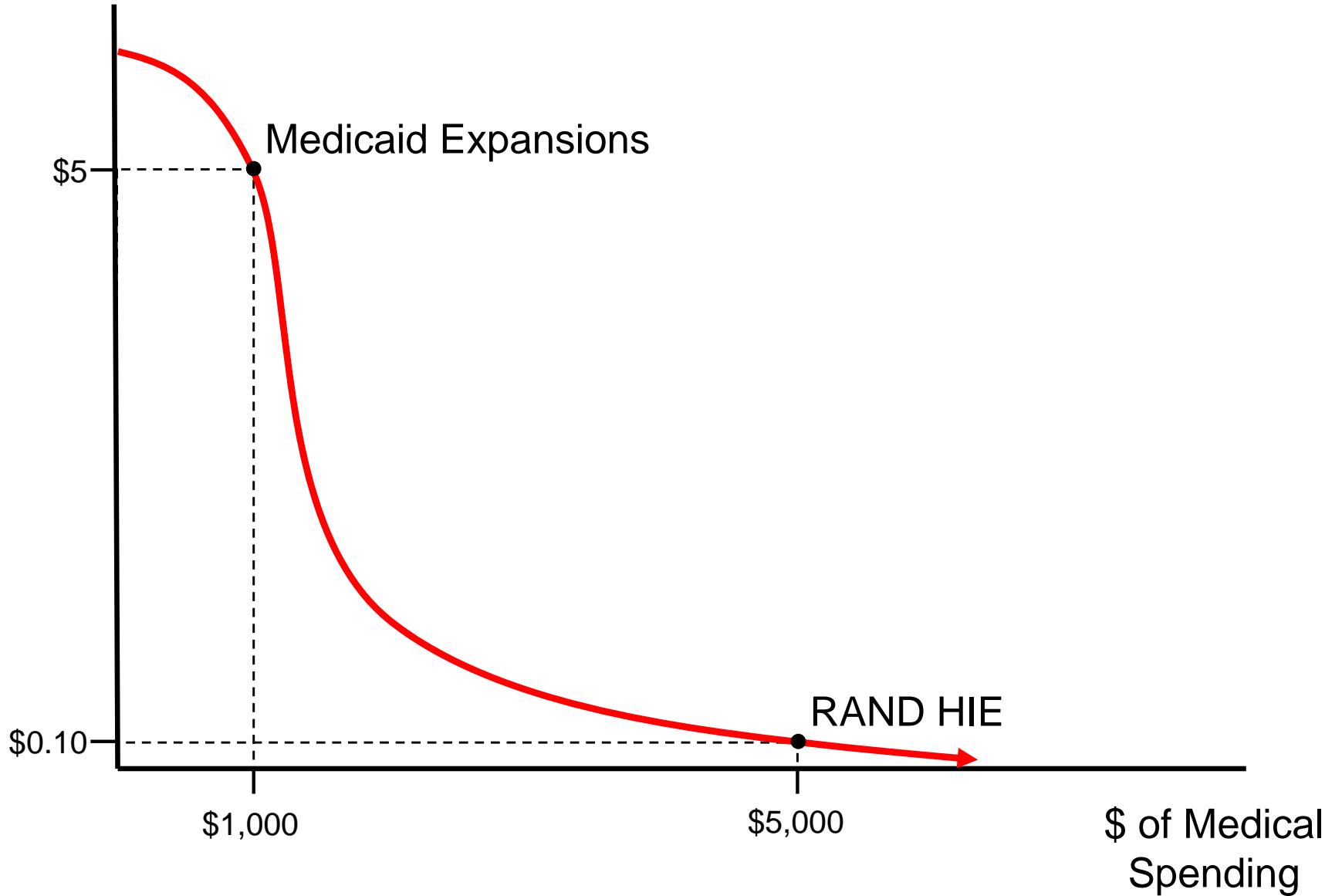
Effects of Insurance on Health Outcomes

Medicaid and Medicare results contrast with those of RAND experiment, which found no impact on health outcomes?

How to reconcile the two results?

- 1) The studies examine different parts of the “medical effectiveness curve.”
- 2) Moving individuals from uninsured to having some insurance has an important positive effect.
- 3) Adding to the generosity of current insurance, does not seem to cause significant changes.

\$ of Marginal Health Benefits



Optimal Health Insurance: Provider Side

Preceding analysis of optimal insurance assumes patient makes entire healthcare decision:

This assumed a passive doctor, in the sense that doctor provides whatever treatment patient requested.

Clearly reality is closer to the opposite!

Incorporating supply side issues is critical in understanding health insurance

Question: choice of payment schemes for physician.

Retrospective (fee-for-service) vs. prospective (diagnosis based fixed payments).

Optimal Health Insurance: Provider Side

Intuition: if patient doesn't choose level of care, healthcare may be inefficiently high

If physician is compensated for all costs because it is in his interest to do lots of procedures (e.g. too many C-section births)

Optimal Health Insurance: Provider Side Model

Payment for physician services is $P = \alpha + \beta \cdot c$

α =fixed cost payment for practice

β =payment for proportional costs c (tests, nurses)

Various methods of payment (α, β)

1. Fee-for-service ($\alpha = 0, \beta > 1$): No fixed payment for practice, but insurance company pays full cost of all visits to doctor + a surcharge.
2. Salary ($\alpha > 0, \beta = 1$): practice costs paid for as well as marginal costs of treatment.
3. Capitation ($\alpha > 0, \beta = 0$): varying by type and # of patients but not services rendered

Optimal Health Insurance: Provider Side

General trend has been toward higher α , lower β

Private market has shifted from FFS to HMO capitation schemes

Medicare/Medicaid shifted in 1980s to a prospective payment scheme.

Tradeoff: lower β provides incentives for doctors to provide less services. But they may provide too little!

⇒ Lower costs, but complaints of lower quality of care

Evidence: Payment Schemes and Physician Behavior

1) In 1983, Medicare moved from retrospective reimbursement to prospective reimbursement.

2) **Prospective payment system (PPS)** is Medicare's system for reimbursing hospitals based on nationally standardized payments for specific diagnoses.

All diagnoses for hospital admissions were grouped into Diagnosis Related Groups (DRGs).

Government reimbursed a fixed amount per DRG. More severe DRGs received higher reimbursement.

Evidence: Payment Schemes and Physician Behavior

Cutler (1993) finds that PPS led to:

1. A reduction in treatment intensity. For example, the average length of hospital stay for elderly patients fell by 1.3 days.
2. No adverse impact on patient outcomes despite the reduction in treatment intensity.

Evidence that doctors put some weight on profits

Suggests they are practicing “flat of the curve” medicine: too much treatment before.

3. Cost growth slowed dramatically in the five years after PPS but then accelerated again.

Evidence: Payment Schemes and Physician Behavior

Why did costs accelerate? PPS not a perfect capitation scheme:

- 1) DRG creep: although the price per diagnosis was fixed, hospitals reacted by changing the DRG categorization (“up-coding”)
- 2) The design of the DRGs used actual treatments (e.g., a person with heart trouble might be assigned the DRG “pace-maker implantation” or “coronary bypass”).
- 3) This effectively creates a retrospective reimbursement system.

Technology Growth and Health Care Growth

1) Health care technology contributes to rising survival rates (many examples)

2) Many new technologies have modest health effects and are very costly and yet are adopted because Medicare/Private insurance accept any health effective treatment (with little regard for cost)

⇒ fuels the development of new technologies, especially testing which leads to growing costs and over-treatment

3) Countries which are the most successful at containing costs choose to use only the cost effective new treatments: reduces costs while having very little effect on health outcomes

4) US has inefficient health care system because it spends too much on the insured (where marginal value of care is small) and spends too little on the uninsured (where marginal value of care is high)

Key US health policy challenges is to: (a) cover the uninsured, (b) reduce non-cost effective health spending

OBAMACARE

2010 Affordable Care Act tries to remedy the issue of non-insurance following the Romneycare model of Massachusetts

- 1) Expands Medicaid and provides heavily subsidized coverage up to 400% of poverty line
- 2) Forces all large employers to provide insurance (or pay \$2000 per employee), gives tax credits to small employers
- 3) Creates health care exchanges for individual purchase of health insurance: forbids denying/stopping coverage due to pre-existing conditions
- 4) Mandate: All individuals need to get insurance or pay a small fine
- 5) Starts trying to control costs

16.6

Lessons for Health Care Reform in the United States

▶ APPLICATION

The Massachusetts Experiment with Incremental Universalism

Incremental reform is not necessarily inconsistent with universal coverage. In 2006, Massachusetts introduced a plan that filled in the holes in its existing system of private and public coverage to move toward universal coverage:

- ▶ A new program was established (“Commonwealth Care”) to provide free insurance coverage for all residents below 150% of the poverty line and heavily subsidized coverage for those up to 300% of the poverty line.
- ▶ While there were no subsidies available above 300% of the poverty line, there were major changes to improve the insurance market.
- ▶ The law specified that all adults in the state must be covered by health insurance, but only to the extent that such insurance was deemed “affordable” .

The Massachusetts reform has successfully achieved its goals. Yet while it decreased the numbers of uninsured, it did not explicitly address the more difficult issue of cost control, and health care costs continue to rise faster than personal incomes in the state. ◀