

The Demand and Supply of Health Insurance

The Demand for Insurance

The Economics of Risk and Insurance

Why do we buy insurance? On average we pay more in premiums than we receive in benefits
 Why do people buy lottery tickets? For every \$1 you bet, you receive back \$.50

The fact that the outcomes of some events are uncertain, cause us to change our standard utility theory.

First we will talk about the problem in general and then will apply it to the health care market.

Example 1:

Get \$900 for sure OR 90% chance to get \$1,001

Which do you prefer?

Example 2:

Lose \$900 for sure OR 90% chance to lose \$1,001

Which do you prefer?

Expected Utility

Rational decision makers will choose the course of action that has the highest expected utility

Think about how you feel about your chances of winning \$1million (or your chances of contracting a deadly disease) as your probability improves by 5 percentage points:

- a. from 0-5%
- b. from 5-10%
- c. from 60-65%
- d. from 95-100%

Are these the same?

Going from 0-5 is probably different than going from 60-65 possibility effect.

Likewise going from 95-100 probably is also different from 60-65 – certainty effect.

Most (not all) people tend to have the following preferences

	Gains	Losses
High Probability Event	95% chance to win \$10,000 Fear of Disappointment RISK AVERSE Accept unfavorable settlement	95% chance to lose \$10,000 Hope to avoid loss RISK SEEKING Reject favorable settlement
Low Probability Event	5% chance to win \$10,000 Hope of large gain RISK SEEKING Reject favorable settlement	5% chance to lose \$10,000 Fear of a large loss RISK AVERSE Accept unfavorable settlement

Note the bottom left cell would be the possibility effect – this would explain lottery ticket purchases

The top right is getting at the idea that when people are faced with very bad options tend to take desperate gambles.

The bottom right is where the market for insurance comes from.

A *Risk Averse* Utility Function:

WHY PEOPLE BUY INSURANCE (or the demand for insurance):

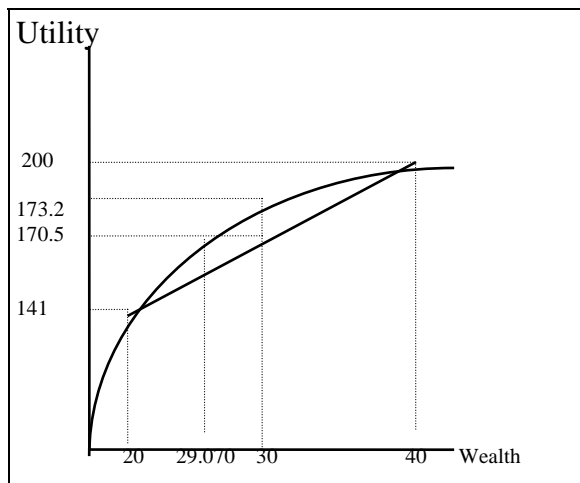
We can use this theory to explain the market for health insurance

Suppose you think there is a .5 probability you will need surgery with a cost of \$20,000 and suppose your income is 40,000.

Suppose your utility function is $U(W) = \sqrt{W}$

So that $U(20,000) = 141$

and $U(40,000) = 200$ and the expected utility of no insurance is 170.5



Now suppose you are offered an insurance policy that will cover all of your expenses in the event of illness and this will cost \$10,000. Will you buy this?

If you do, you get 30,000 for sure and $U(30) = 173.2$. So yes, you would buy the insurance. You will be better off with the insurance than without (but note your expected income is 30k in both cases).

How much would you be willing to pay for insurance? Or at what income for sure

would you be just indifferent to having no insurance? $EU(\text{no insurance}) = 170.5$

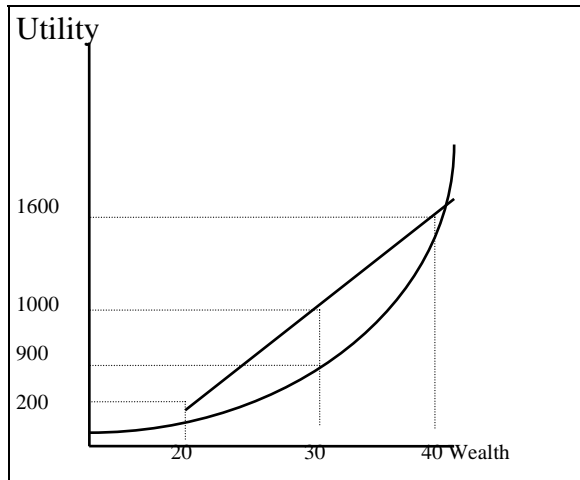
so find the W that solves: $\sqrt{W} = 170.5$ or $w = 170.5^2 = 29,070$

so if the insurance policy was $40,000 - 29,070 = 10,930$ you would be just indifferent to buying the policy.

This is known as a *Certainty Equivalent*

The more concave the utility function the larger this amount - or the more the person would be willing to pay to avoid risk.

Note that Pete Rose wouldn't buy insurance:



His utility from no insurance is 1000, but if he gets 30k for sure his utility is only 900 so he wouldn't want it. He would only buy insurance if the expected utility was higher with it than without it. So without it he will get an expected utility of 1000 find the wealth for sure that gives 1000 or $X^2 = 1000 = 31623$ so he would only pay 8377 for insurance.

But note that the insurance company would not be willing to sell insurance for this price!!

So the more risk averse a person is - or the more concave their utility function is - the more likely they will be to buy insurance

Also the lower your assessed probability of getting sick, the less likely you will be to buy insurance

Many are younger with low probability of getting sick, and who may not be very risk averse.

So many are uninsured by choice

Note it is the uncertainty that is important here, not necessarily the high cost of the adverse events. There are many high cost events in our lives that we do not have insurance for (my sons needed braces, they will want to go to college, etc.) But the difference is that I know this and can plan for it. But with health care, the problem is that many events are not predictable. If I knew that in 5 years I would need heart surgery, I could (in theory) save enough to pay for it by then. But the problem is with uncertainty – there is a small chance that I will need it this year. It is this risk that insurance gets us out of.

An alternative way of looking at the insurance issue is from the standpoint of ability to pay. Note that heart surgery is pretty expensive, and even if I knew it was coming I might not be able to pay for it no matter how well I planned. But since it is a relatively unlikely event, it will only occur to a small fraction of the population. So insurance transfers money from healthy people to the sick and enables them to pay for highly valuable services they would otherwise be unable to afford.

Conclusions:

- i. Insurance can be sold only in circumstances where there is diminishing marginal utility of wealth or income – risk aversion.
- ii. Even though people will have less wealth as a result of the purchase of insurance, the increased well-being comes from the elimination of risk.
- iii. Insurance, by pooling large groups of people with a low rate of incidence allows people to have more access to care than they would otherwise.

The supply of insurance

Now consider the insurance company's problem:

From the insurer's perspective it is about profits. Profit = TR-TC. If we think of buying policy's in 500 increments, and they are paying a premium of 10%. The profit per unit of coverage will be:

Profit = 50 - (Prob of illness * cost of illness) - (prob of no illness * cost of no illness). Assume at first that the only cost are medical so if the consumer is not ill the insurance has no costs, then if there is a 5% chance of illness:

Profit = 50 - (.05*500) = \$25. So positive profits at this price. Note that this can't last in a competitive market since entry will occur which will bid the price down. Entry will occur until profits are zero. In this case the price gets bid down until the premium is .05 or the premium is equal to the probability of illness.

Now lets say that we allow a \$5 per unit administrative cost. Then the zero profit price will be a .06:
 $.06*500 - (.05*500) - (.95*5) = 0$.

Let a be the premium in fractional terms, q the payout, p the probability of illness and t the administrative (or transaction) costs. Then:

$$\text{Profit} = aq - (pq+t)$$

If the market is competitive, then profit = 0

$$0 = aq - pq - t \text{ Solving for a gives}$$

$$a = p + t/q$$

so t/q is the administrative (or loading costs) as a percentage of the policy value.

This is known as the **actuarially fair premium**

Asymmetrical Information and Agency

The assumption in economics is typically that individuals have perfect information about their relative choices. As we saw last time, if there is uncertainty, markets for insurance arise. One of the side effects of health insurance is the over consumption caused by the reduction in risk to the consumer (moral hazard).

In this section we will talk about two more problems that arise with lack of information: the case of information asymmetry is when one party of a transaction has private information. We will see that this causes problems in the market. This occurs in two places: in the market for insurance the consumer may have better information about his health than the insurer, and thus the market for insurance may operate inefficiently. Secondly, physicians may have better information about the health of the patient, and thus may be able to exploit this (this, known as Supplier Induced Demand (or SID) will be addressed later

Asymmetric Information and the Lemons Principle

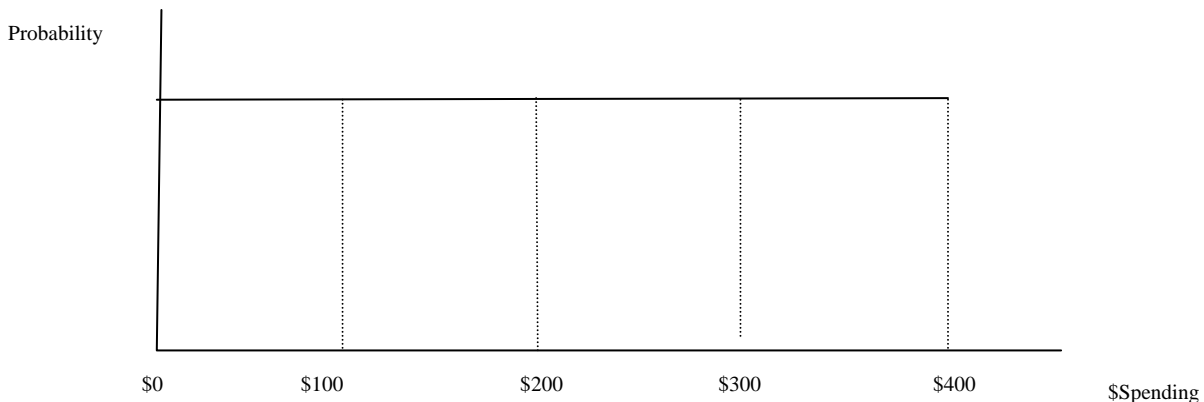
The guy who first described the problem applied it to the used car market, so it makes sense to begin there, then move to the market for health insurance. The idea is that the sellers of used cars have better information about the quality of the car than the buyer. If the buyers know the distribution of quality then when a seller offers a car at a particular price the buyer infers something about the quality and so adjusts his/her willingness to pay. In the end only lemons are offered for sale. This is known as Adverse Selection – when the good products are pushed out of the market by the inferior ones.

Note this is NOT the same as imperfect information, if both were in the dark about the quality of cars, the market would work just fine.

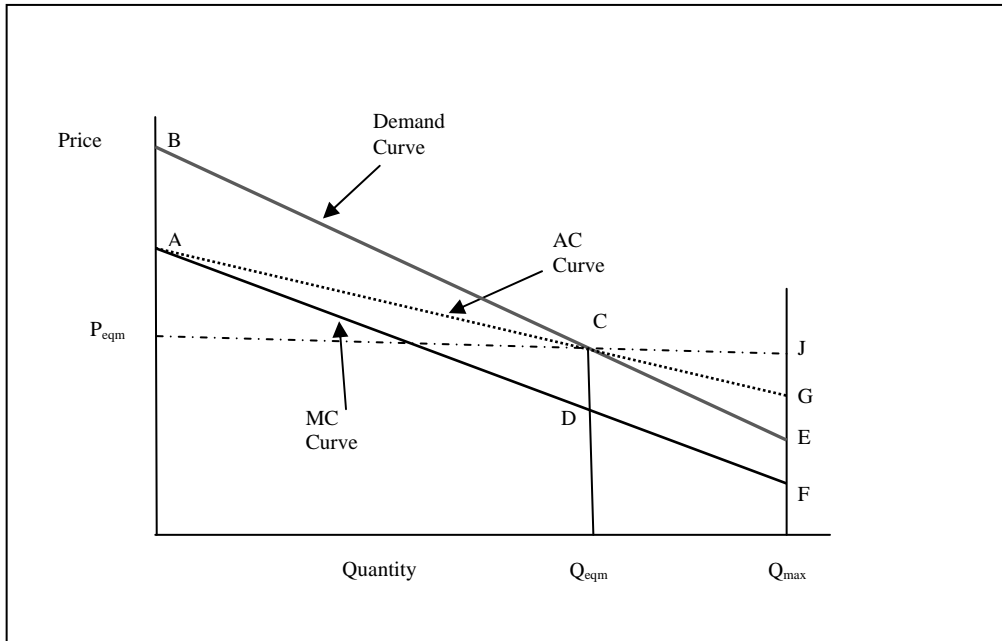
This problem is solved (or reduced) in the market of used cars through:

- Markets for information – you can pay a mechanic to give an assessment of a used car
- Reputation
- Warranties

I. let's look at the theory of adverse selection as it applies to health insurance



Let's go in a little more detail



The above figure shows how adverse selection might work in the simplest case in healthcare. For simplicity assume perfectly competitive, risk neutral firms offering a single insurance contract. Risk-averse individuals differ only in their (privately known) probability of incurring a loss. Also there are no other frictions (i.e., administrative or loading costs, something we'll come back to).

The vertical axis represents price (and expected cost) of the contract and the horizontal axis indicates the quantity of insurance demand. Since this is an either or situation (an assumption we can relax) the quantity of insurance is the fraction of insured individuals. With risk neutral insurers with no admin costs the social (and firms') costs associated with providing insurance are the expected claims (payouts on policies).

The demand curve above reflects the cumulative distribution of individuals' willingness to pay for the contract. A risk-averse individual's willingness to pay for insurance is the sum of the expected cost and risk premium (certainty equivalent) for that individual. If we assume constant risk aversion (high risk people have the same aversion to risk as low risk people) the willingness to pay for insurance is increasing in their risk type. So the demand curve starts at point B with the most risky people and adds less and less risky people as we move down the demand curve to point E. Thus their willingness to pay for insurance is increasing in their risk type – their probability of loss, which is privately known. This means the marginal cost (MC) curve is downward sloping: those who are willing to pay the most for coverage are those that have the highest expected cost. The downward sloping MC curve is the case of adverse selection. The individuals who have the highest willingness to pay for insurance are those who are expected to be the most costly for the firm to cover.

Note the link between the demand and the cost curve – in most markets these are independent, but in insurance markets the shape of the cost curve is driven by the demand-side customer selection. An individual's risk type not only affects demand but also directly determines cost.

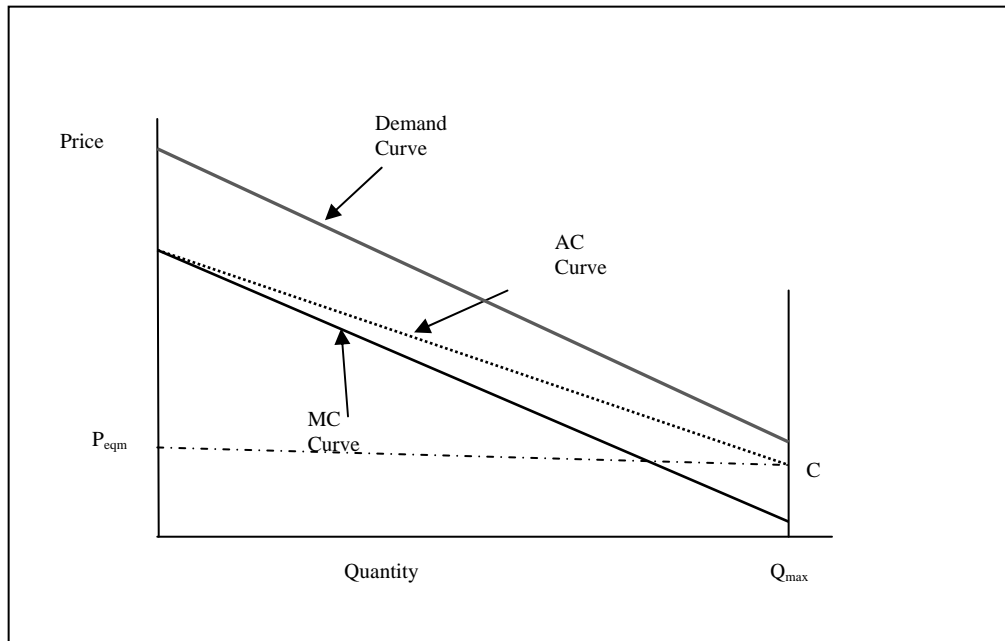
The risk premium is the vertical distance between MC and demand. Since we are assuming risk averse and no other frictions, the MC is always below the demand curve and therefore it is efficient for all individuals to be insured ($Q_{\text{eff}}=Q_{\text{max}}$).

In the case of private information, firms must offer a single price for a pool of observationally identical (but, in fact, heterogeneous) individuals. The competitive equilibrium price will be equal to the firms average cost at that price – Point C in the figure above. Note the average cost is downward sloping but not as steep as the MC. Why?

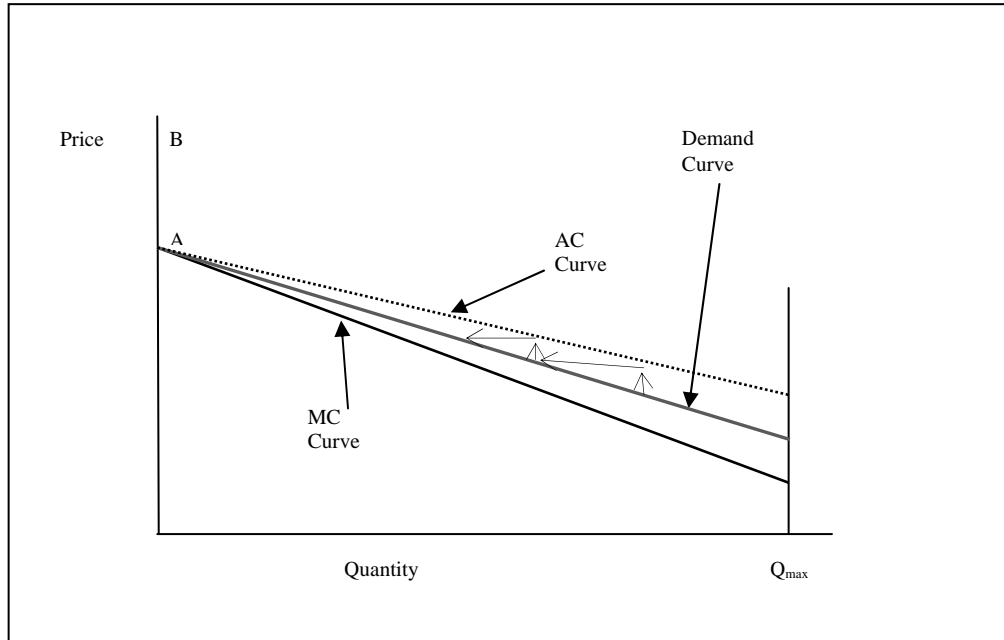
So because of the common price, the market produces Q_{eqm} which is less than Q_{max} . The efficient allocation is determined by the relationship between *marginal cost* and demand, but equilibrium is determined by the relationship between *average cost* and demand.

In this case the welfare loss due to the under-insurance is a function of the lost surplus (the risk premium) of those individuals who remain uninsured. This is represented by the area CDEF above.

Consider two extreme cases



Note that in this figure, even though there is adverse selection in the market, the market equilibrium is still the efficient level (full coverage at Q_{max}). This could happen if, say individuals do not vary too much in their unobserved risk (that is MC and, therefore, MC are pretty flat) and/or individuals' risk aversion is high (so the demand curve lies well above the MC curve).



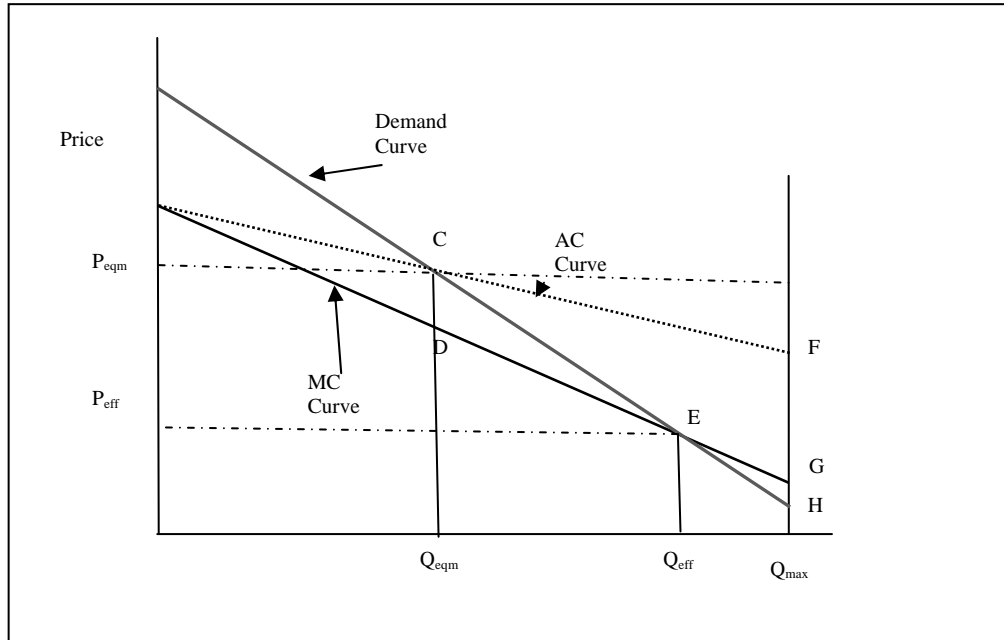
The above figure shows a complete unraveling or “death spiral” in the insurance market. The AC curve lies always above the demand curve, even though the MC curve is always below it (so the efficient level of insurance is still Q_{max}). Suppose individuals with the greatest risk are certain to incur a loss, so their risk premium is zero and their willingness to pay is the same as their expected costs. Here the competitive equilibrium is that no individual in the market is insured.

This can also show the death spiral dynamic. If insurance pricing is naively set by dynamically adjusted to reflect the average cost from the previous period (which is, in fact, a common practice in many insurance settings), the market will gradually shrink until it completely disappears. Think: the individual/small employer market.

So how do we fix this problem?

1. Mandate. Going back to the first figure the benefits of the mandate would be the welfare loss area of CDEF – which is a function of the shape and location of the cost and demand curves.
2. Subsidize insurance coverage. Suppose we gave a lump sum subsidy toward the price of coverage, this would shift demand out, leading to a higher equilibrium quantity and less under-insurance. A subsidy equal to the line segment GE would get everyone insured. Note both of these have a cost.

Now let’s add a few complications. First, consider a loading factor on insurance – additional administrative cost associated with selling and servicing insurance, advertising, marketing, verifying and processing claims. These can be quite large in health insurance.



Note here it is no longer efficient to insure everyone. Even though everyone is still risk averse, the additional cost of providing an individual with insurance may be greater than the risk premium for certain individuals, making it socially efficient to leave them uninsured. In the above figure the marginal cost curve now crosses the demand curve (in the first figure marginal cost was always below demand). The additional loading costs shift up the costs curves but do not affect the demand curve.

So now MC crosses the demand curve “internally” (as opposed to a “corner solution”) – at a point less than Q_{max} at point E. the cost of insuring those beyond point E are greater than the benefits of doing so.

Note there is still adverse selection since the market still produces at the place where AC crosses the demand curve at $Q_{eqm} < Q_{eff}$. Now the welfare loss of adverse selection is the triangle CDE.

But now it gets tricky when we start talking about policy. In the first figure, we had unambiguous welfare gain if we could mandate insurance. But now that a mandate gives the benefit of CDE but also entails the loss of EGH. People for whom the benefits of insurance are less than the cost. So it depends on the sizes of the two triangles.

Rather than a mandate – attempts to lower the administrative or loading cost might be better – or at least used in conjunction with a mandate.

How does the market solve this problem?

The main way is by the provision of insurance through the employer - this tends to pool risk and takes the adverse selection problem out of the buyer's hands, Individuals typically do not have the choice to accept or not accept the insurance.

People who obtain insurance outside of employment or some other type of risk pooling arrangement are typically given stringent screening tests and evaluations to determine an individual's expected cost. So not only are individual policies more expensive because they are riskier to insure (because they have a smaller risk pool than group policies), but also because they are susceptible to adverse selection problems.

Why do insurance companies not allow pre-existing conditions in new policies?

COBRA and adverse selection

The "death spiral" in the individual insurance market.

Also high deductibles tend to screen out high risk individuals. Accepting a high deductible policy signals you as a low risk individual. High co-payments also serve this purpose.

Cream skimming

How do the elderly fit in to this analysis? Note that in the absence of Medicare, the elderly would be required to participate in private insurance markets. Would this work? It may be quite difficult to screen elderly patients adequately (note most will be retired) and thus the higher the price they charge the larger the portion at the top of the distribution that gets chopped.

Medicare+Choice vs. Medicare Advantage

Note to that to a certain extent insurance linked to employment creates it own adverse selection problem - only the relatively healthy (and young) are the ones who are employed, leaving the highest risk group without coverage, thus in order to get coverage, they must charge very high prices. This gives validation to the notion of government provision of health insurance to the poor and elderly. Note that these are not optional, everyone participates (by paying taxes) with community rating

Community Rating vs. Experience Rating.

Many insurance plans use experience rating systems. In the case of employer-provided health insurance, premiums are based on the past experience of the group, or other risk-rating systems to project expenditures. Automobile insurance, on the other hand, is individually experienced rated. It is important that any program that has a community rating aspect to it be involuntary. Since in a community rating system each person pays for some average of the total expenditure, a voluntary types system would give incentives for the "light" users to opt out of the system or to wait until they need it, etc. Thus it is important that participation be compulsory if rates are set at community rates. At the same time, though, experience rating plans will tend to separate out the heavy users from the light users as each person will pay his/her own costs. This alleviates adverse selection, but note that it makes it more difficult for the heavy users to pay for their care.

So Health savings accounts would tend to reduce adverse selection incentives (and moral hazard-types of behavior), but would create separating equilibrium between light and heavy users to the extent participation is voluntary.

The impetus of Managed care was to alleviate the over-consumption (or moral hazard) associated with fee-for-service insurance. But one of the criticisms managed care has received is that of “cream skimming” or “cherry picking.” That is selecting out the most healthy patients so that expenditures are lower. Through experience rating the HMOs are able to share some of these savings with their enrollees. The problem then is that the more risky patients are left on their own, making it more expensive for them to obtain insurance.

Imperfect Information: Supplier Induced Demand

I. The Principal Agent Problem

A big issue here is something known as the principal-agent problem. The idea is that there is a principal (the patient, etc) who has some objective (improve his or her health) and they hire individuals to help them achieve their goals -- agents (physician) who are supposed to represent the principal's interest. But a problem arises if the agents do not have the same incentive as the principal. Generally this requires asymmetric information.

Compensation for a worker could be based on inputs (hours of work), or on output (number of widgets produced per day, total sales, etc.), or some overall measure of company performance (stock options). What is the reasoning behind this?

The Principal-Agent problem occurs when agents pursue some of their own objectives in conflict with achieving the goals of the principal.

How do we know the physician is acting in the best interest of the patient? Often he/she is compensated based on the number of tests/procedures/visits (inputs) rather than based on some measure of output.

Marcus Welby Medicine.

Ideally we'd like to compensate physicians based on outcomes – did I get better? (this is true for teachers too!). But note there are measurement problems here, especially in tough to diagnose situations (back pain). Also, as we know, health care is not the only input into producing health and so the physician would have a tough time controlling these things.

The perfect agent physician chooses as the patients themselves would choose if the patients had the same information the physician does. Medical codes of ethics are intended to do this.

The problem for the principal is to determine that the agent is acting in the principal's best interest.

Reputation good – the idea is that it is tough to know ahead of time how much utility you will derive from the good before you consume it. This is often the case, but we can figure it out over time through trial and error (experience goods), but this is expensive in health care. So we rely on the information from those around us to make our decisions.

Patients often establish long term relationships with the physician. This allows the patient to more carefully monitor the physician's behavior and referrals.

But this leads to another issue in health care dealing with information. Often the physician has better information about the good than do the patients. Thus health care providers may be able to use their superior knowledge to influence demand for their own self interests. This is known as Supplier Induced Demand (or SID).

Supplied-Induced-Demand (SID) - health care providers have and use their superior knowledge to influence demand for self-interest.

Doesn't only apply to health care -
mechanics
shampoo - lather rinse repeat
advertising in general

The key idea is the asymmetric information of the market - physicians have a better understanding of the "good" than do consumers, thus suppliers are able to shift out the demand for their good.

SID and Economics

What is difficult for economists to explain is why we see an increase in consumption when the supply of physicians in an area increases. Often the conclusion is that the market becomes more competitive so physicians induce demand to increase their revenue and increase profits. But why do providers not simply induce fully all the time? What is the mechanism through which they induce demand? How does inducement change in the face of increased supply?

Disutility

One model to understand this incentive begins with the notion that physicians attempt to maximize their utility (U) which is a function of income (Y), hours of work (W), and discretionary influence to induce demand (D):

$$U = U(Y, W, D)$$

Y has a positive effect on utility, W and D have a negative effect. Physicians prefer not to induce demand, but this is counterbalanced by the increase in utility from additional income. In this framework, a physician will induce demand to the point where the marginal utility of the additional income equals the marginal disutility of the added work plus the marginal disutility of the demand inducement.

“Reforming” Healthcare

Two Big Issues

1. Access
 - a. 49 million or about 18 percent of the nonelderly population do not have health insurance
 - b. What do we do with this diverse group of individuals without access to medical care?
2. Cost
 - a. Too much insurance? The wrong type of insurance
 - b. Technology -- who has access, how do we adopt?
 - c. Who gets to have it? What are we willing to pay for? When is it not worth it? Cost effectiveness.

The Current health reform deals pretty much exclusively with issue 1, and gives only cursory coverage to issue 2.

Access
Nonelderly Source of Insurance in the US, 2010

	People (millions)	Percentage of Population
Total Population	266	100%
Private	164.1	61.7%
Employment-Based	149.5	56.2%
Individual Market	14.63	5.5%
Public	52.7	19.8%
Uninsured	49.2	18.5%

62 Percent of the nonelderly population has insurance through private coverage – 57% through their employer (risk pooling, taxes) and 5% individual purchased. Almost 19% are uninsured.

Who are the uninsured?

- Lower than average income – 2/3 have income below twice the poverty line
- 20% are in families with incomes above 50k
- 61% work in families with one or more full-time worker but are not offered insurance or do not take it up.
- Modal uninsured is “working poor,” below median income but not among the poorest.
- Roughly 30% are eligible for free or highly subsidized care.
- About 63% have no education beyond high school.
- 81% are native or naturalized US citizens.
- 34% of Hispanics and 23% of African Americans are uninsured, compared to 14% of whites
- Young adults (aged 19-29) have the highest uninsured rate of any age group at 32%.
- The uninsured tend to be in worse health.
- More than 70% of the uninsured have gone without health coverage for more than a year.

Why are they uninsured?

Too expensive – individuals may be unwilling to purchase insurance if it is not available at an actuarially fair price.

Administrative costs

Irregularities in insurance market – small families subsidize large families

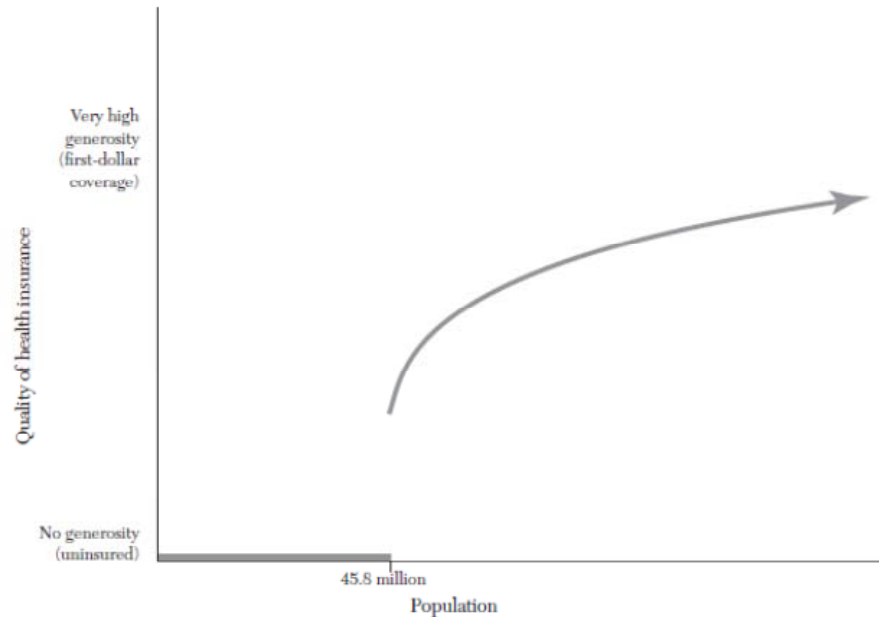
Adverse selection

- some of the administrative costs of private insurance are the costs devoted to screening potential applicants
- standard lemons pricing – prices will be higher to reflect the subset of individuals who choose to insure.

Note that high prices of insurance has certainly been a cause of reduced coverage, but it has been tough to distinguish rises in the underlying cost of medical care from changes in the value of insurance against risk. If insurance companies are just charging more for the same benefits, this would lead to reduced coverage, but if insurance companies are charging more because it costs more to treat illness, then this would lead to *fewer* uninsured assuming they have a constant coefficient of relative risk aversion (being poorer should make them less likely to want to undertake the risk of being uninsured). Liquidity constraint – people would be willing to borrow against future wealth to insure against losses, but are unable.

Implicit insurance through uncompensated care

Over insurance – most insurance is too generous – there is not a smooth gradient in generosity of coverage – it is as if there are only BMWs and Acura’s on the market and no Honda Fits or Nissan Versa.



Offset hypothesis – first dollar coverage means patients take care of the little things before they become big things. RAND experiment suggests the opposite. (though Gruber finds that primary care for low income chronically ill patients does seem to lower costs)

- Tax subsidy. Large tax subsidy leads to a large rise in health spending among firms that do offer insurance.
- Regulation
- Psychological motivations – people with self-control problems may use insurance as a commitment device. Or individuals may not like associating financial transactions with medical care (insurance allows them to pay up front to avoid dealing with difficult decisions at the time of care).

We don’t really know how much of the above explains.

Why do we care about the uninsured?

Externalities

- Physical externalities associated with communicable diseases – this can’t explain too much.

- Financial externalities – imposed by the uninsured on the insured through uncompensated care. But note this amounts to “only” \$57.4 billion in 2008 – quite small relative to the \$2 trillion health economy.

Labor market inefficiency – job lock

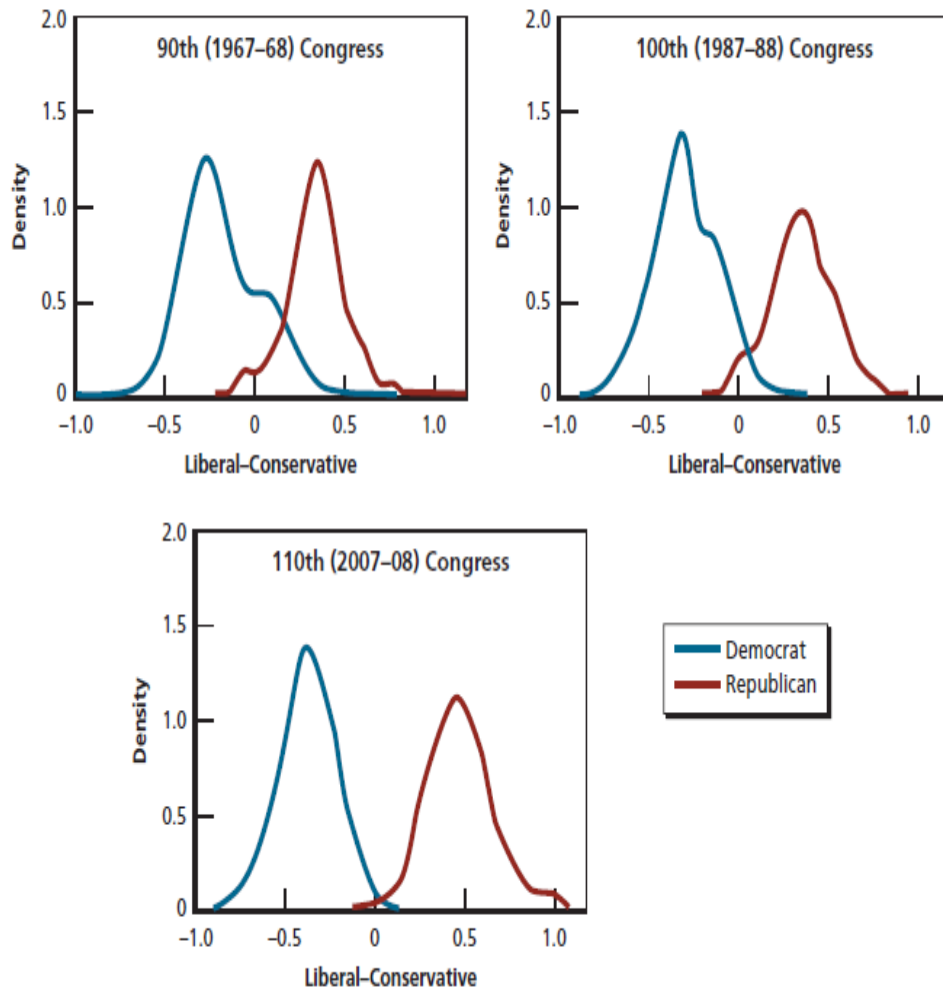
Paternalism – the concern that individuals may be harming themselves by not buying insurance. Those without insurance have a 25% higher mortality risk – 180,000 die each year because of a lack of insurance (IOM, 2005). Note these are correlations but not necessarily causations. Other studies have made the causal link though. A study looking at Canada’s staggered introduction of national health insurance across the nation’s provinces found it was associated with a 4 percent decline in infant mortality, and an 8.9 percent decrease in the incidence of low birth weight among single mothers. A study looking at the removal of eligibility for public insurance in California (due to a fiscal crisis) found that blood pressure rose among hypertensive patients, leading to a 40 percent increased risk of death. Etc.

Redistribution – the uninsured are disproportionately low income and insurance is expensive relative to their incomes. Thus we may want to redistribute health care resources – again paternalism, or failure of intrahousehold utility maximization whereby providing health insurance to poor children offsets the failures of their parents to sufficiently provide for their care.

Two types of solutions;

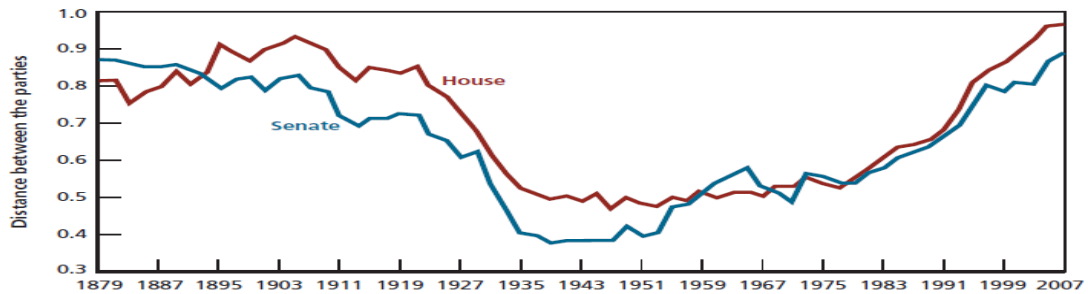
Sweeping Universalism – 170 million people are mostly happy with their current situation (think loss aversion), while about 50 million are not insured and are not happy. It is pretty much impossible to see any sort of sweeping policy. Plus when you add the interest of private insurance it is even harder to imagine. Private insurance industry -- \$925 billion in claims paid annual. It is hard to imagine this will be legislated out of business – *Not in God’s Lifetime*.

Figure 7
Polarization in 90th, 100th, and 110th Congresses



SOURCE: Carroll et al., 2008.
RAND OP291-7

Figure 8
Party Polarization, 1879-2007



SOURCE: McCarty, Poole, and Rosenthal, "Polarized America" Web site, no date.
RAND OP291-8

That leaves us with:
Incremental Universalism

3 Critical issues with incremental universalism

Pooling

- If pools are too small, or attract high risk, insurers will be reluctant to offer insurance – fear of adverse selection or high cost exposure.
- Currently we have large pools for Medicare/Medicaid and large Employers – but most w/out insurance do not work for an employer that offers insurance.
- Solving the problem of the uninsured requires developing some new pooling mechanism – government, private insurance purchasing arrangements

Affordability

- Health insurance is expensive! Average cost of employer sponsored family coverage in 2011 was \$15,073 – for those without a large pool it is much higher
- For a family of four at 200% of the poverty line (income = 44,700) family coverage this is about 1/3 of before tax family income.
- Even if those w/out insurance with low incomes had access to large pooling arrangement, they would still need subsidies.

Mandates

- Even large subsidies will not be sufficient. – many of the uninsured are eligible for free public insurance or highly subsidized employer-provided, and still do not take it up.
- Full insurance requires a mandate
- More effective risk pooling – the transfer from those who are currently healthy to those who are currently sick.
- Note there is an implicit subsidy already – the uninsured generate 30 billion in uncompensated care delivered by hospitals each year – these costs are shifted to insured patients.
- Some uninsured may be making rational decisions, others may not fully understand the risks – either way a mandate would prevent people from opting out of hi and would provide a more efficient subsidization.

Should the uninsured be covered through public or private insurance?

- ii. Public insurance already targeted to low income groups most likely to lack insurance – 18 percent of nonelderly and all the elderly covered by public insurance
- iii. Administrative savings of public insurance – in US 12% of premium vs 1.3 in Canada
- iv. National vs regional level of public coverage?

- Nationally determined set of benefits may have disadvantages due to differences in incomes, medical practices, etc. Would end up w/a package that is “wrong” for most Americans.
- Minimum national standards with flexibility at local level
But complete public program seems highly unlikely
- Majority of Americans have private insurance, giving that up would be difficult.
Some argue for expansion primarily through private markets
Tax credits to purchase HI from private vendors. – addresses affordability but not pooling or mandate issues. This would be a costly and uncertain way to expand coverage. Note that half of the uninsured don’t pay taxes. Further, if I have a 15-year old with cancer and can’t get insurance, a \$2,000 tax credit doesn’t help much.

Bang for the buck

Given the above, it is important to pay attention to efficiency of any policy reform. Note that a key concept will be the extent to which new public spending is directed to those who would otherwise be uninsured – as opposed to buying out the base of (or crowding out) existing insured individuals. This is a notion referred to as *targeting*.

Think about the uninsured as tuna and those who already have insurance as dolphins. The goal of environmentally conscious fishermen is to catch as many tuna as possible in their nets, while minimizing the number of dolphins. If the uninsured tunas were swimming in a separate ocean from the insured dolphins, the problem would be easy. And if the uninsured tunas greatly outnumbered the insured dolphins then we’d be ok too. But there are 47 million tunas swimming with 190 million dolphins!

Health Insurance Coverage by Poverty Level

The uninsured cover a broad range of income groups.

- One third of them have incomes below 20k per year and make up over one third of the total population.
- Another 40 percent of the uninsured have incomes between 20k and 50k per year and make up about a quarter of the population in this income range.
- One seventh of the uninsured have incomes between 50 and 75k, and make up less than one seventh of the total population in that group.
- Finally another one seventh of the uninsured have incomes above 75k and make up only 7 percent of the population.

So the conclusion here is that the uninsured are in parts of the population where they make up less than one-quarter of the population making targeting a real challenge.

Any policy that sets a simple income cut off for eligibility will catch a lot more dolphins than tunas!

It is even more complicated – most insurance is provided through firms, and take-up of employer provided insurance is only partial. Roughly one-quarter of the uninsured work in firms that offer insurance. But these are costly tuna to collect, because those uninsured who are offered insurance represent only about 7 percent of the total pool that is offered. So targeting this 7 percent of uninsured within firms without providing government subsidies to the other 93 percent already insured will be very difficult.

Is reform a state issue?

Pros

Decentralization allows states to match the unique landscapes of their health economies and tastes of state consumers.

States with high insured rates may find a MA type approach attractive, while in other states with higher uninsured populations, they may want to take more radical steps such as setting up a monopoly connector to enforce new pooling mechanisms.

States may vary in the level of minimum standards for insurance coverage

Multiple state approaches could foster innovation and perhaps even competition and continued improvement across states

Cons

States left to their own devices may well evolve with very different “affordability” standards across states leading individuals to pay different rates to meet the targets. So somebody will have to monitor state reforms to ensure the standard of universal coverage is met.

Either way it is not possible without a massive injection of federal funds.

COSTS

Keep in mind there are two competing objectives with reform – the uninsured, and costs. Most reform deals with uninsured. Cost controls are likely to be modest – this stuff is expensive!

Controls such as electronic medical records, increased preventative care, reduced medical errors, will reduce costs by at best a few percentage points.

To control costs society will need to be willing to deny care that does little for health but consumers nevertheless want.

Government could implement policy that limits the use of new technologies, medical standards that limit the use of high cost, low benefit care, global provider budgets that limit what is spent and force providers to set priorities within that total.

This is a can of worms!

The current bill focuses on reducing administrative costs in private insurance and cutting costs for Medicare and Medicaid in various ways. Not much hope that this will have a large effect on costs (though it will probably make life a little more difficult for hospitals)

Some argue that the only way we are going to get any type of cost control is to first get the coverage issue resolved. In Massachusetts once they got universal coverage going they learned pretty quickly that they'd better get costs under control or they wouldn't be able to afford the program. They set up a commission that is working on legislation to move to a new physician reimbursement system and attempt to deal with the powerful hospitals in the market. So it is the push they needed to get something done.