EE441 Economics of Public Expenditure

# 10. Government and the Market for Health Care

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# Outline of Topic 10

1. Private Health Insurance
   a. The Implicit Subsidy for Employer-Provided Insurance
   b. The Advantages of Employer-Provided Health Insurance
   c. Employer Provided Health Insurance and Job Lock
   d. Cost Control and Private Insurance
2. Government Provision of Health Insurance: Medicare and Medicaid
   a. Medicare: Overview
   b. Cost Control under Medicare
   c. Medicare: Impacts on Spending and Health
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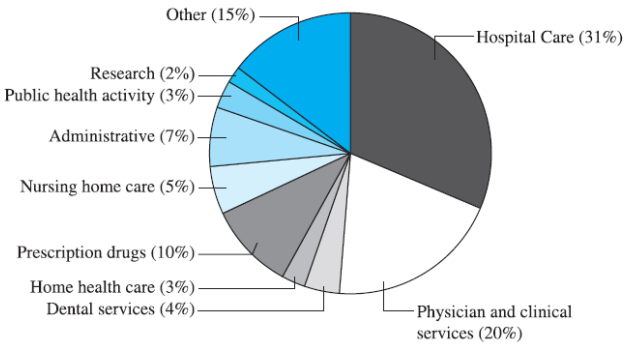
   e. Medicaid: Impacts on Health
3. Affordable Care Act of 2010
   a. Alternative Paths to Health Care Reform
   b. Single Payer Approach
   c. Market-Oriented Approach
   d. Final Thoughts



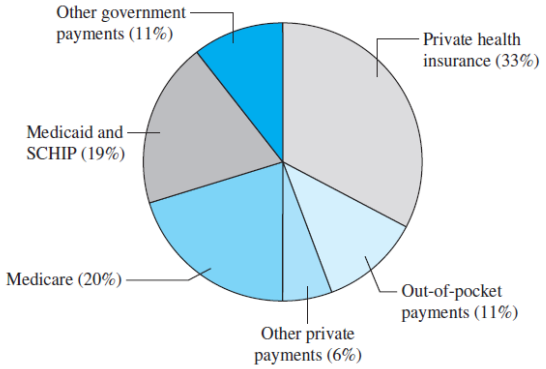
# Uses of Health Care Funds in the U.S. (2010)




Source: Centers for Medicare and Medicaid Services [2012c].



# Sources of Health Care Funds in the U.S. (2010)

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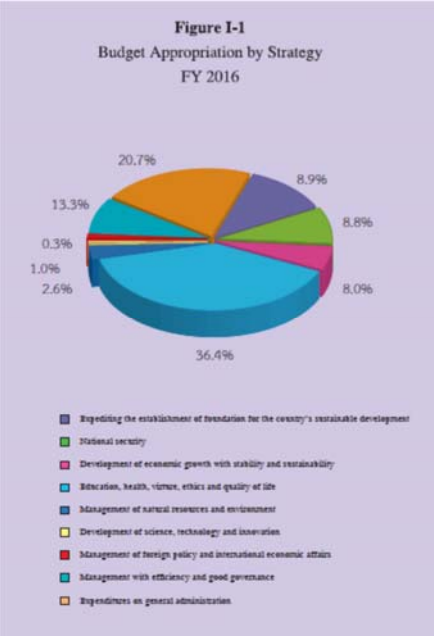





# Thailand Budget in Brief, 2016, pp.54-60

**7. Health**

Health expenditures amount to 274,231.2 million baht, or 10.1 per cent of the total expenditures. They will be applied to provision of public health services performed by the Ministry of Public Health and other government agencies. These services include planning and administration of hospital and health centre operations as well as the provision of health care information, research and development on public health.

**Table III-8**

**Appropriation for Health**

*(in million baht)*

| Health | FY 2015 | FY 2016 |
|---|---|---|
| 1. Outpatient Services | - | 1,156.5 |
| 2. Hospital Services | 110,683.3 | 119,382.9 |
| 3. Public Health Services | 4,041.9 | 4,077.6 |
| 4. Research and Development on Health | 2,483.3 | 2,773.7 |
| 5. Health not elsewhere classified | 143,904.6 | 146,840.5 |
| **Total Health** | **261,113.1** | **274,231.2** |
| **Percentage of the Total Budget** | **10.2** | **10.1** |



# Private Health Insurance

- The Implicit Subsidy for Employer-Provided Insurance
  - World War II era wage and price controls
    - These controls restricted how much an employer could pay in wages while exempting other forms of compensation such as health care coverage.
  - Federal tax subsidy
    - The exclusion of employer-provided health insurance and medical care from the income tax base costs the US Treasury about $109 billion per year in forgone tax revenues.
  - Debates over tax treatment of employee health benefits.
    - What's wrong with buying insurance?
    - Affordable Care Act of 2010: Starting 2018, employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage will be taxed at a rate of 40%.



# The Advantages of Employer-Provided Health Insurance

- Increase the risk pool
  - Large pool of people under one insurance policy.
- Reduce adverse selection
  - Typical adverse selection phenomenon may result in fewer firms offering insurance than is efficient.
  - High proportion of wages vs generous health care incentives and benefits.
- Lower administrative costs
  - The ratio of premiums to benefits decreases as the number of employees in the group plan increases.

## Employer-Provided Health Insurance and Job Lock

- *Job lock*- the tendency for workers to remain in their job in order to keep their employer-provided health insurance coverage.
  - Job lock could hurt economic efficiency if it discourages workers from moving to the jobs in which they could be the most productive.



## Cost Control and Private Insurance

- *Cost-based reimbursement (fee-for-service)*- A system under which health care providers receive payment for all services required.
- *Managed care*- Any variety of health care arrangements in which prices are kept down by supply-side control of services offered and prices charged.
  - *Capitation-based reimbursement*- a system in which health care providers receive annual payments for each patient in their care, regardless of services actually used by that patient.
  - *Health Maintenance Organizations (HMOs)*- Organization that offers comprehensive health care from an established network of providers, often using capitation-based reimbursement.
  - *Preferred Provider Organizations (PPOs)*- Organization that givers incentives to enrollees to obtain health care services from within a specified network of providers.
  - *Point-of-service (POS)*- Similar to PPO, but also assigns each enrollee a primary care provider to serve as a gatekeeper.

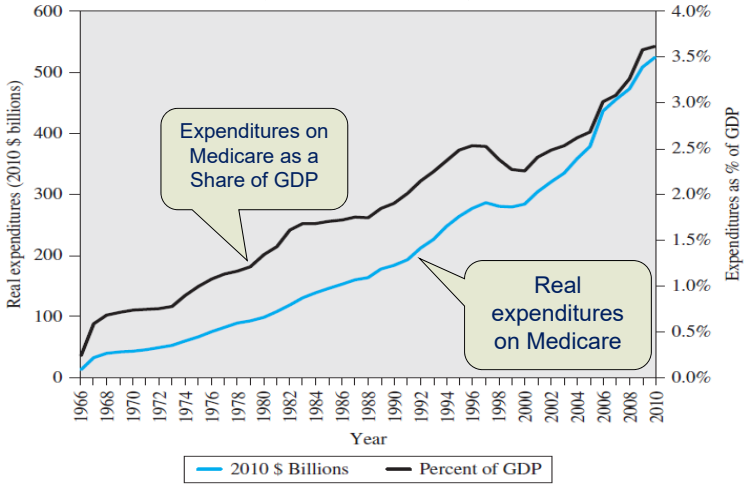


## Medicare

- Federally funded government program that provides health insurance to people aged 65 and over and to the disabled.



## Medicare Expenditures (1966-2010)




Source: Centers for Medicare and Medicaid Services [2012c].

# How Medicare Works

- Benefits
  - Part A – Hospital insurance (HI)
  - Part B – Supplementary Medical Insurance (SMI)- covers physician services and medical services rendered outside the hospital and is funded by a monthly premium and by general revenues.
- Financing
  - Payroll tax funds HI (1.45% on the employer and employee on the employee's earning, no ceiling.)
  - General revenues fund SMI



# Prescription Drug Benefit

- Prescription Drug Benefit
  - The Medicare Prescription Drug, Improvement and Modernization Act of 2003 added a prescription drug benefit to Medicare which began on January 1, 2006.



# Cost Control Under Medicare

- Medicare's *retrospective payment system*- payment system, previously used by the Medicare Hospital Insurance program, in which compensation is paid after the care is completed and thus provides little incentive to economize on costs.
- Medicare's *prospective payment system*- payment system, currently used by the Medicare Hospital Insurance program, in which the compensation level is set prior to the time that care is given.
  - *Diagnosis related groups (DRG)*- Classification system used to determine prospective compensation payments in the Medicare Hospital Insurance Program.
  - Resource-based relative value scale system- Set of values based on time and effort of physician labor used to determine physicians' fees in the supplementary medical insurance component of Medicare.



# Medicare: Impacts on Spending and Health

- Expenditures on health care for the elderly
  - Increased expenditure on the health care of the elderly.
- Health outcomes
  - No impact on mortality rates among the elderly (Finkelstein and McKnight, 2005).
    - However, Medicare estimate that by reducing the risk of large out-of-pocket health expenses, Medicare generates an annual benefit of about $500 per beneficiary, or nearly $10 billion per year (2000 dollars).
    - Program may serve as redistributive role (McClellan and Skinner, 2005).

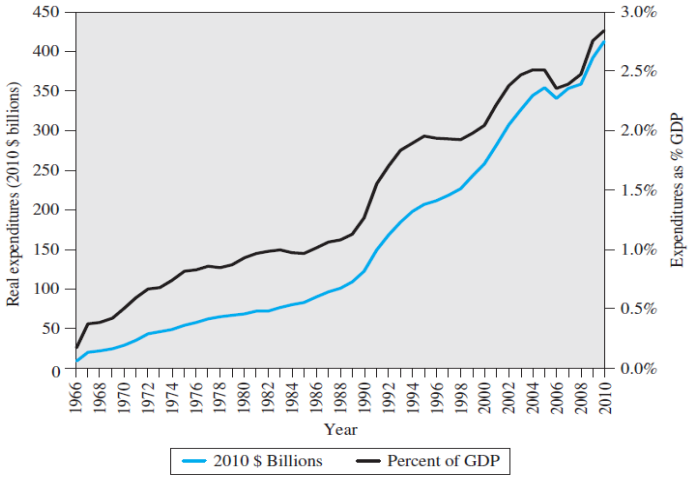
# Medicaid: Overview

- *Medicaid*- Federal-and state-financed health insurance program for the poor.
  - Established in 1965 to provide health insurance for recipients of cash welfare programs. Legislation in the 1980s expanded eligibility for Medicaid to include children in low-income two-parent families.
- *State Children's Health Insurance Program*- Program that expanded Medicaid eligibility to some children with family incomes above Medicaid limits.



# Medicaid Expenditures

(1966-2010)




Source: Centers for Medicare and Medicaid Services [2012c].



# Financing and Administration

- Joint Federal-State financing
- State administration



# Benefits

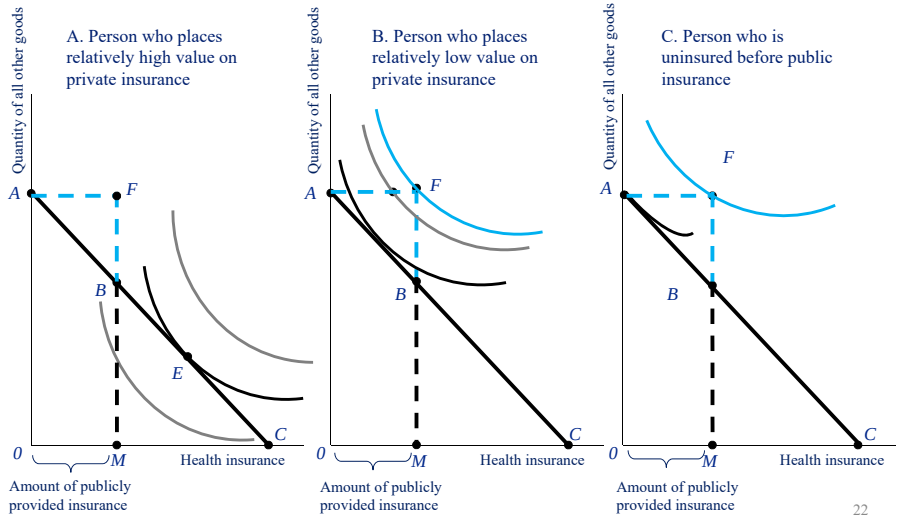
- States obligated to offer minimum package of benefits
  - eg., hospital and physician visits, prenatal care, vaccines for children.
- States may offer more generous benefits
- State administrative flexibility

# Medicaid: Impacts on Health

- Take-up rate- has this translated into better health for the poor?
- *Crowding out*- When public provision of a good leads to a reduction in private provision of the good.
- Empirical evidence: Are Medicaid expansions effective? Crowding out and taking up
  - When Medicaid started, the population was poor (Panel B). But as Medicaid eligibility ahs expanded over the years, crowding out has become a very serious concern and this needs to be taken into account if policymakers contemplate further expansions.



# Does Public Insurance Crowd Out Private Insurance?






# Health Care Reform

- International experiences
  - Canada
  - United Kingdom



# Health Care Costs and Health Outcomes: U.S., Canada, United Kingdom

| | Canada | United Kingdom | United States |
|---|---|---|---|
| Health expenditures (dollars per capita) | $4,445 | $3,433 | $8,233 |
| Administrative costs (dollars per capita) | $144 | $74 | $570 |
| MRIs (per million people) | 8.2 | 5.9 | 31.6 |
| Wait > 4 months for elective surgery (percent in need of surgery) | 25% | 21% | 7% |
| Life expectancy at birth (years) | 80.8 | 80.6 | 78.7 |
| Infant mortality rate (per 1,000 live births) | 5.1 | 4.2 | 6.1 |

Sources: Organization for Economic Cooperation and Development 2012b and Commonwealth Fund [2010].

Note: All data are for 2008 or 2010, except the United Kingdom's administrative cost, which is for 1999. Dollar amounts are in 2010 dollars.

# Final Thoughts

- Security vs. efficiency
- No free lunch
- Connection between health care expenditures and health