Facts about health care & health insurance in the U.S.

1. Differentiate health care from health insurance.
2. 84% of Americans have health insurance
   - 60% via employer (why?)
   - 9% purchase privately
   - 27% government
     - 13% Medicare (elderly)
     - 10% Medicaid (poor)
     - 1% Military (pre-iraq data)
   - 47 million uninsured
     - (who?)
3. Skewed distribution of benefits
   - Top 1% of medical care users account for 30% of spending.
   - Top 25% of medical care users account for 75% of spending.

4. Every other developed country has universal coverage.
   - Some via national health care (doctors work for govt.)
     i.e. England, Italy
   - Some via private provision (doctors work for private sector)
     i.e. Canada, France

5. More costs
   - Health costs = leading cause of personal bankruptcy in the U.S.
   - Health cost increases have been four times faster than wage increases
   - 30 percent (!) of costs are administrative. Compare to 4.5 percent in other countries.

Sources: Cutler and Zeckhauser; www.nchc.org/facts/cost.shtml

5. Spending
   - 2009 health care spending in the US = $2.5 trillion ($8086 per person)
   - projected to reach $4 trillion by 2015.
   - HC spending = 17 percent of GDP
   - projected to reach 20 percent in the next decade.
   - Components:
     - Home health care: 10%
     - Prescription drugs: 5%
     - Hospital care: 31%
     - Physical and clinical services: 20%

8. Total Health Expenditure per Capita, U.S. and Selected Countries, 2008

Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland are OECD estimates. Figures are PPP adjusted.


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Adverse selection in Health Insurance

1. Suppose a medical condition affects 1 in 100.
   Surgery costs $50,000.
   Insurance: - everybody pays $500
   - surgery covered.

2. Suppose 50 are high risk (2/100 chance) and 50 are zero-risk (0/100 chance)
   The zero-risk people drop out.
   Insurance only collects $25,000 (1/2 cost of operation)
   Must charge $1000 premium to break even.
   Only high-risk people buy the policy.

3. Suppose among the 50 high-risk people ...
   25 have medium risk (1/100)
   25 have very high risk (3/100)
   $1000 is too high for the 1/100 people. They drop out.
   $1000 is good deal for the 3/100 people.
   25 very high risk people buy the policy. The insurance company collects $25,000, and in an average year pays out $37,500 (25 x 3/100 x $50,000).
   Insurance company must charge $1500 premium.

4. Suppose among the 25 very high risk, 10 are super-high and 15 are medium ....

The economic problem ....

Tradeoff between
(a) risk sharing (standard insurance problem)
(b) information asymmetries
- adverse selection
- moral hazard
  - by patients
  - by doctors (supply-induced demand)

Optimal coinsurance:
patients pay up to point where ...
  marginal loss from less risk sharing = marginal benefits from less wasteful care.

More adverse selection

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Two parts to HI ....
(A) real insurance against unforeseen events
(B) prepayment for expected services
So why not unsure against catastrophic health events, but not expected outlays?

Answer ... because expected outlays = preventive care. Once I have insured you, I want you to incur preventive care expenses.

- reduce moral hazard
- example: contraceptive coverage

Solution: subsidize preventive care, but not completely.

- premium plus copayment ("Coinsurance")

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**Patient Protection and Affordable Care Act of 2009**

1. Require individuals to purchase HI, or pay fine = $695-$2085 or 2.5 percent of income.
2. Require large employers (payroll > $500k) to either
   (a) offer HI, or
   (b) pay fine = $2000 per employee
3. Require insurance co.’s to offer and renew HI
   Allow rating variation based only on age, geography, family composition, and tobacco use.
4. Expand Medicaid from 100% to 133% of Federal Poverty Line (2011 FPL = $22k for family of 4).
5. Tax subsidies for people between 133 and 400% of FPL.
7. Medical Loss Ratio: must spend 80-85% on clinical services etc.