Markets for Medical Care

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An Exemplary Market: Tea

Essential requirements

Consumers are well-informed

Consumers desire to economize

Producers desire to maximize profits

Many consumers and producers, each small

Trading is frequent

An Exemplary Market: Tea

How it works

Price adjusts to balance demand and supply

Profits limited by entry, competition
Eventually, price = cost; no excess profits

Rise in demand → increase in price, profits
New producers → price, profits decline

"Invisible hand"
- Market adjusts to shifts in demand or supply
- Competition assures optimal outcome

Market for Medical Care

Suppliers tell consumers what to buy

Consumers not expected to economize

One person's health affects others' health

Technical advances often raise costs

Irregular expense – insure – third-party payer

Insurance Alternatives

Self-insure

- Probability of illness = 50%
- Cost if ill = $100
- Put aside $100 every year
- Draw on account when ill
- Bad luck → bankruptcy

Group insurance

- Members pay premium of $100
- Members receive $100 if ill
- If large group, near certainty 50% are ill
  - Insurer breaks even

Pervasive Problems of Group Insurance

Adverse selection

Moral hazard

Samaritan’s dilemma

Incomplete contracts

Pervasive Problems of Group Insurance

Adverse selection

Probabilities of illness differ
Insurer doesn't know probabilities
  Sets premium = expected average claim
Asymmetric information – consumers know
Healthy consumers see premium as too high
Healthy choose not to insure
Premium must be raised
More healthy choose not to insure

End result: Very high premium, few insured

Should premiums vary by health or income?

Pervasive Problems of Group Insurance

Adverse selection – possible responses

- Insurers seek to learn probabilities
  - Require medical exam
  - Review past health records, lifestyle
  - Reject those with pre-existing conditions or charge them higher premiums
  - Don’t renew coverage for sick

- Require all consumers to insure

Pervasive Problems of Group Insurance

Moral hazard

Insured views medical care as free, over-consumes
Insured has less incentive to avoid illness

Suppliers face little incentive to economize

Drives up use and cost; raises insurance premiums
    Exacerbates adverse selection

Moral hazard – possible responses

Introduce deductibles and co-pays
Require insurer to pre-approve services
Set lifetime limits to benefits

Pervasive Problems of Group Insurance

Samaritan's dilemma

For humanitarian reasons, uninsured still receive care
Often provided at very costly emergency rooms
Raises premiums for others
  Exacerbates adverse selection

Samaritan's dilemma – possible responses

Charge means-tested fees
Establish special program to cover needy
Require all to purchase medical insurance
  Subsidize premiums for needy

Pervasive Problems of Group Insurance

Incomplete contracts

Insurers limit services they cover
Policies abound with contingencies
Consumers can’t foresee future needs
Consumers have no bargaining power

Incomplete contracts – possible responses

Employment-based contracts, collectively bargained
Regulators specify requirements for coverage

Brief History of Health Insurance

Pre-1940: States encourage prepayment plans
Grant non-profit, tax-exempt status; no reserves
Precursors of Blues

By 1940: Just 9% have insurance

WW II: Firms offer health insurance in lieu of wages
Workers exempt from tax on employer contributions

By 1957: 75% have insurance

1965: Medicare A and B (hospital, medical), Medicaid

1997: CHIP (reduces uninsured children from 14% to 7%)

2006: Medicare D (drugs)

2014: Affordable Care Act (passed 2010)

Insurance Markets on the Eve of ACA

Health expenditures growing rapidly

Uninsured population stable %, but rising #

Insurance premiums rising sharply

Inefficiencies permeate system

Most insurance tied to employer

Health Expenditures as % of GDP

1960	5.0
1970	6.9
1980	8.9
1990	12.1
2000	13.3
2009	17.3

Source: U.S. Census Bureau

International Comparison of Health Sectors and Outcomes

	------ Health expenditures, 2014 ------					Physicians	Life	Under 5
	Total	Public	Out of pocket	Per capita		per 1K	expect	mortality
	% of GDP	% of total	% of total	PPP$		2008-14	2014	2015
US	17.1	48.3	11.0	9,403		2.5	79	7
Sweden	11.9	84.0	14.1	5,219		3.9	82	3
Switzerland	11.7	66.0	26.8	6,468		4.0	83	4
France	11.5	78.2	6.3	4,508		3.2	82	4
Germany	11.3	77.0	13.2	5,182		3.9	81	4
Austria	11.2	77.9	16.1	5,039		4.8	81	4
New Zealand	11.0	82.3	11.0	4,018		2.7	81	6
Netherlands	10.9	87.0	5.2	5,202		2.9	81	4
Denmark	10.8	84.8	13.4	4,782		3.5	81	4
Canada	10.4	70.9	13.6	4,641		2.1	82	5
Japan	10.2	83.6	13.9	3,727		2.3	84	3
Finland	9.7	75.3	18.2	3,701		2.9	81	2
Norway	9.7	85.8	13.6	6,347		4.3	82	3
Portugal	9.5	64.8	26.8	2,690		4.1	81	5
Australia	9.4	67.0	18.8	4,357		3.3	82	4
Italy	9.2	75.6	21.2	3,239		3.8	83	4
UK	9.1	83.1	9.7	3,377		2.8	81	4
Spain	9.0	70.9	24.0	2,966		4.9	83	4
Russia	7.1	52.2	45.8	1,836		4.3	70	10
Luxenberg	6.9	83.9	10.6	6,812		2.9	82	2
Poland	6.4	71.0	23.5	1,570		2.2	77	5
Mexico	6.3	51.8	44.0	1,122		2.1	77	13
Singapore	4.9	41.7	54.8	4,047		2.0	83	3

Source: World Bank, World Development Indicators, 2016

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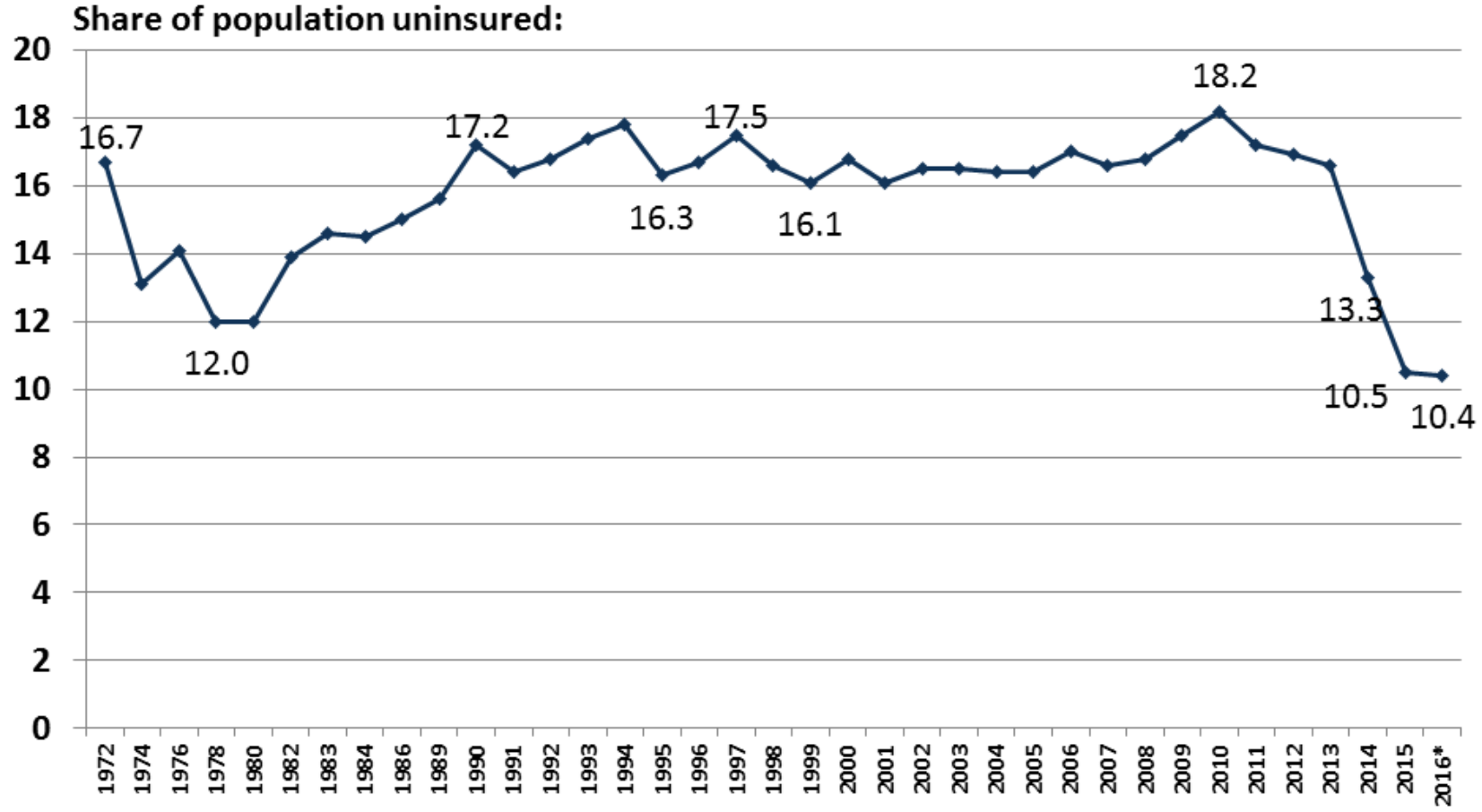
Uninsured Rate Among the Nonelderly Population, 1972-2016



Note: 2016 data is for Q1 & Q2 only.

Source: CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 and http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf.

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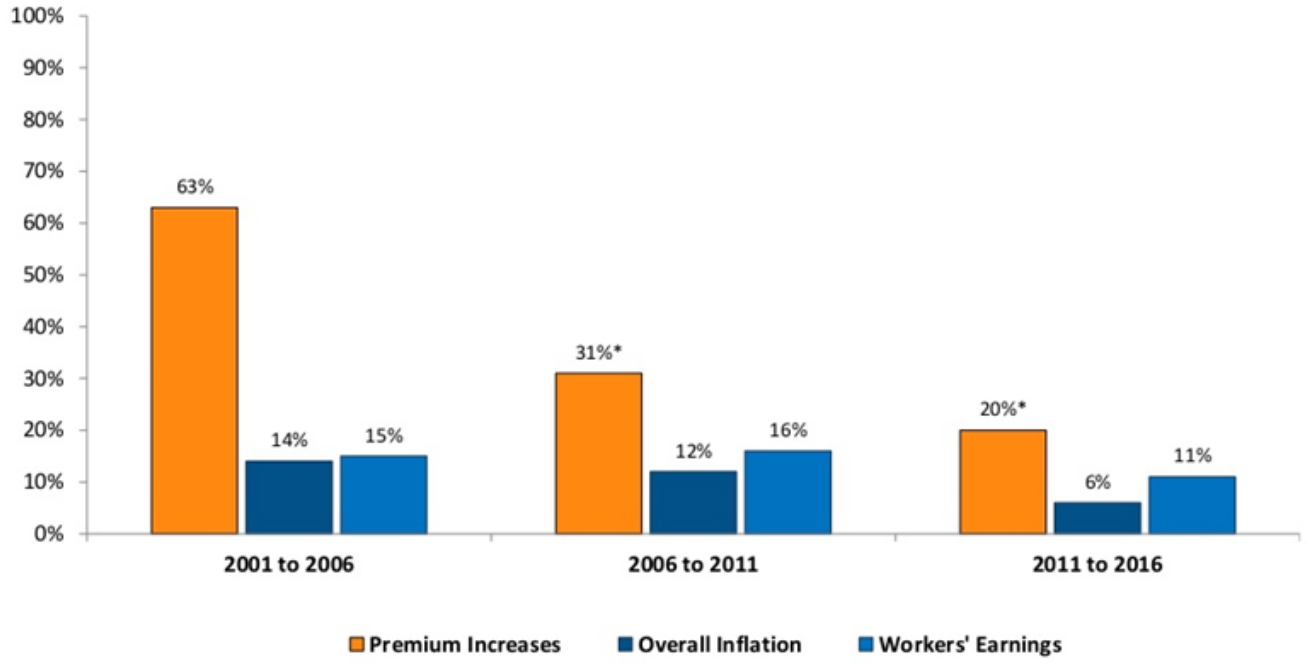
Cumulative Premium Increases for Covered Workers with Family Coverage, 2001-2016



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001-2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2001-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2001-2016 (April to April).

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Affordable Care Act (Obamacare)

Mandates insurance coverage (avoid adverse selection)

- Obtain through employer, otherwise through exchanges
  - Low-income aided by refundable tax credits, subsidies
- Elderly through Medicare
- Medicaid and CHIP expanded
- Failure to get coverage? → tax imposed

Creates new requirements for insurers

- Must ignore past health
- Keep children on parents' policy up to 26
- Fully cover preventive services
- Premiums can vary only by age
- Offer standardized selection of policies
- No limits on annual or lifetime benefits

New measures to increase revenue and control cost

Affordable Care Act (Obamacare)

What went right?

- Increased coverage, over 20 million
- Premiums brought under control for employed
- Growth of spending controlled

What went wrong?

- Insurers over-estimated enrollment of healthy (adverse selection)
- Tax penalty not high enough
- Premiums on exchanges rising sharply in some markets
- Lack of incentives to economize (moral hazard)
- Insurers increasing deductibles and copays
- Insurers withdrawing from exchanges
- Insurance still tied to employer for many
- Drug costs not controlled

Obamacare – Fix or Replace?

Fixes

Ultimate fix: Universal, single-payer – like Medicare
Patchwork: Increase subsidies and tax penalties
Federal help to exchange insurers

Replacement - House Republican Paul Ryan vision

Repeal mandate
Expand health savings accounts,
paired with high-deductible health insurance
Offer tax credits for purchase of insurance
Turn Medicaid into block grants to states
Partially privatize Medicare with “premium support” option

END