

The Market for Health Insurance

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Types of Insurance

- Two opposing views:
 - Indemnity or casualty insurance
 - Social insurance
- U.S. uses a combination of these
- Policy types:
 - Hospitalization
 - Physicians' services
 - Outpatient services
 - Dental
 - Vision
 - Disability income protection
 - Long-term care

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Health Insurance Providers

- Commercial insurance carriers
- Blue Cross and Blue Shield associations
- Managed care organizations (HMOs & PPOs)
- Some employers self-insure
- About 90% of civilian population under 65 has hospital or surgical insurance, or both
- About 60% of Medicare recipients (65 or +) carry supplemental coverage
- About 9.1% of population uninsured

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Private Insurance Demand

- Traditional indemnity insurance contracts
 - Term life insurance, Property-casualty
- Health insurance similar to these; Early policies paid a specific amount for a broken leg or severed limb.
- But problems in applying concept to health
 - Verification of seriousness of health event
 - Wide variation in cost of treatment
- Led to development of service-benefit policy, which covers billed expenses

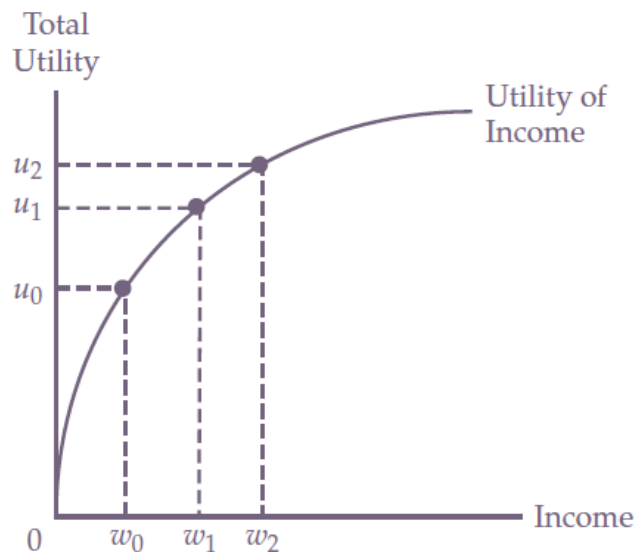
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Theory of Risk and Insurance

- People enter into insurance contracts to share the uncertainty of financial risk
- When combined in a large enough group, the probability that someone in the group will become ill can be systematically estimated
- Attitudes toward risk shown by a diminishing marginal utility of income, measuring the rate of change of the total utility of income

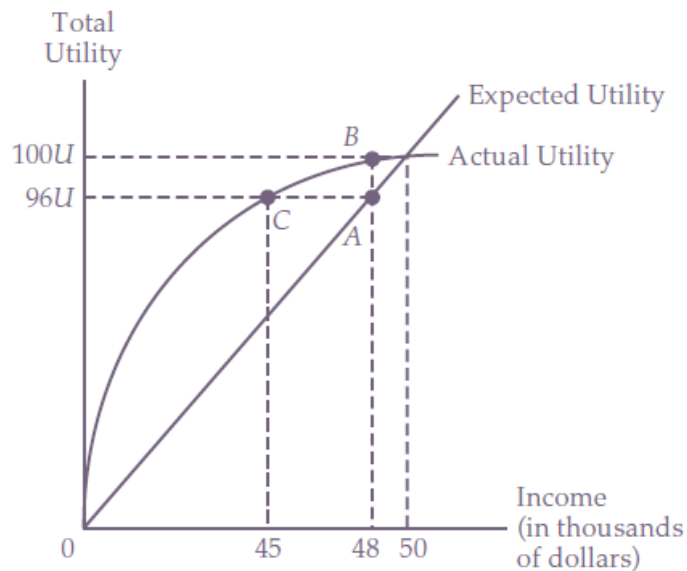
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Total Utility of Income Curve



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Utility & Choice of Insurance



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Health Insurance & Market Failure

- Dominant feature is reliance on third-party payment
- Emergence of health insurance as an employment-based, tax-free benefit has expanded coverage to medical services that normally would not be covered if insurance were purchased individually
- A strong incentive for overconsumption
- Providers have less incentive to provide care efficiently, which limits competition, raises costs, and lowers the quality of services

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Information Problems

- Most challenging problems that arise because of costly information are due to unequal access to information
- Several issues arise when information not distributed equally:
 - Consumer information problems
 - Moral hazard
 - Adverse selection

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Consumer Information Problems

- For a market to work, consumers must behave rationally, have income to spend, and know their own preferences
- When they have trouble gathering and understanding information, their ability to make informed decisions is compromised
- Quality of information in health care markets is poor, difficult to understand
- Decision making requires that consumers know the prices paid for services they buy

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The Economics of Moral Hazard

- Moral hazard occurs anytime there is an opportunity to gain from acting differently from the implied principles of a contract
- Because private actions are hidden from view, both parties have an opportunity to gain from unpredictable behavior
- Having insurance:
 - Increases the likelihood of purchasing medical services
 - Induces higher spending in the event of illness

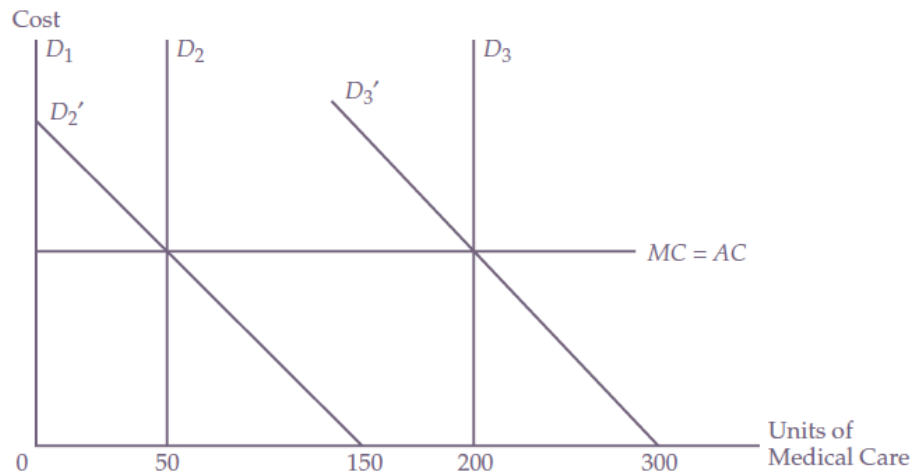
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Adverse Selection

- Arises because people have more information about expected medical expenditures than insurance companies, and may conceal it.
- Insurer has difficulty identifying prospective risk and charging premiums that reflect risk
- Too many high risk users result in an unrepresentative risk pool; premiums rise
- Low-risk users drop out to seek cheaper coverage

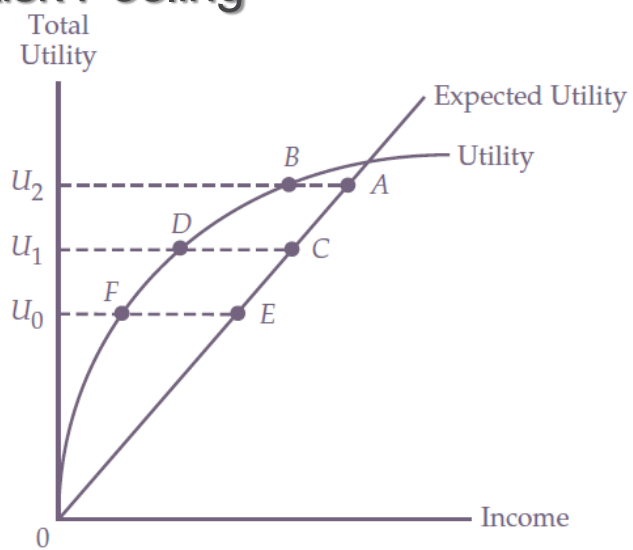
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Effect of Moral Hazard



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Impact of Adverse Selection on Risk Pooling



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Insurers' Response to Information Problems

- Deductibles (consumer must pay a set amount before coverage begins)
- Coinsurance (consumer pays 10–20% of each claim)
- Insurer's response to adverse selection:
 - Underwrite only prospective risk (not pre-existing conditions)
 - Refuse to insure known ailments (pre-existing condition)

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The Optimal Insurance Plan

- Balances the benefits of greater risk sharing with the costs of moral hazard
- Make people responsible for more of their own care
- Requires higher deductibles and larger copays
- Pools high risk people into pools with other high risk people, and charges premiums to reflect that risk.

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State Level Insurance Regulation

- Most states, largely responsible for insurance regulation, have 40-60 mandates
- Passage of ACA required Secretary of HHS to define the benefit packages for all qualified plans; four tiers
 - Bronze (covers 60% of actuarial value)
 - Silver (70%); Gold (80%); Platinum (90%)
- Also required, guaranteed issue, renewability, restrictions on exclusions of pre-existing conditions, and modified community-rated premiums

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State Level Insurance Regulation

- Also required by ACA:
 - Guaranteed issue
 - Guaranteed renewability
 - Restrictions on exclusions of pre-existing conditions
 - Children < the age of 26 are covered under their parents' plan
 - Modified community-rated premiums

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The Economics of Mandates

- Mandates are not free
- Mandates will have long term consequences on the ability of the health care system to provide access to quality care at affordable prices
- In general, research indicates that mandates increase the costs of health care systems
- Many working poor remain uninured because state mandates make private insurance unaffordable for many

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The Practice of Self-Insurance

- Currently, over half of private insurance is provided in plans where the employer assumes all or a significant part of the risk
- An employer may be able to accurately predict medical expenses from year to year
- Firms place funds previously paid in insurance premiums into a reserve account from which they pay medical bills directly
- Many have insurers handle claim processing

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Medical Care for the Uninsured

- Most recent estimate of uninsured is 29 million
- Most are working poor and their dependents
- Almost 25% make less than \$25,000/year
- Prior to passage of ACA, many earned too much to qualify for Medicaid
- Under ACA, individuals who earn up to 250% of the FPL are eligible for premium and copayment subsidies.

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The Duration of Uninsurance

- The pool of the uninsured changes, and is a temporary phenomenon for most
- Counting people who cycle into and out of the pool of uninsured each year; almost 85 million without coverage for at least one month (1996–1999)

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Demographics of the Uninsured

- In 2015, 54.9% of all uninsured people were employed in full-time or part-time jobs
- 1 of 4 were nonworking adults, the remainder were dependent children
- 29 million uninsured in 2015. 9.1% of the U.S. population
- Insurance is associated with level of income
- Race is also a factor

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Small Group Factors

- 3 primary reasons why workers lack insurance coverage:
 - Employer does not offer a health plan
 - Employer offers a health plan, but employee is not eligible as a part-timer
 - Employer offers a plan and employee is eligible, but employee does not purchase because too expensive, or employee can get insurance through spouse's employment, or employee does not perceive a need for a health plan

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Relationship Between Insurance & Health

- Two parts to the connection:
 - How does lack of insurance affect access to medical care?
 - Does poor access result in poor health outcomes?
- Significant differences of opinion re whether lack of insurance leads to poor health
- Except for those who are poor and sick, there seems to be no relationship between health status and insurance status

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Safety Net for the Uninsured

- Since 1985, it has been illegal for a hospital emergency department to deny care to anyone requesting it
- The hospital must provide medically appropriate screening, and then treat or stabilize and transfer to a facility can treat
- Most of this care financed from municipal budgets, Medicaid subsidies or Medicare
- Universal coverage requires accepting the principles of subsidization

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That's all for Chapter 7!