Cell Phone Insurance versus Health

We only “lightly” regulate most insurance markets:

- What happens to you if you don’t have insurance?
- What happens to me if you don’t have insurance?
- What is insurance?
Insurance markets have many issues. Some are:

- Discounting of the future at higher rates than seems reasonable
- Moral Hazard
- Adverse Selection
- Externalities
- Incentives for insurers and providers
- Cost/payment models
How to Evaluate a Health Insurance Policy?

Factors that may matter:

- Health
  1. Overall or average health
  2. Distribution or equality

- Responsiveness
  1. Overall or average
  2. Distribution or equality

- Cost, and distribution of cost

- Freedom to contract
World Health Organization [link] weights:

- Health: 50%
  - 1. Overall or average health 25%
  - 2. Distribution or equality 25%

- Responsiveness 25%
  - 1. Overall or average 12.5%
  - 2. Distribution or equality 12.5%

- “Fair” financial contribution: 25%

- Freedom to contract 0%
The WHO rankings: [link]

- 1 — France
- 2 — Italy
- 3 — San Marino
- 4 — Andorra
- 5 — Malta
- 6 — Singapore
- 7 — Spain
- 8 — Oman
- 9 — Austria
- 10 — Japan
- 11 — Norway
- 18 — United Kingdom
- 20 — Switzerland
- 22 — Columbia
- 30 — Canada
- 36 — Costa Rica
- 37 — United States of America
- 38 — Slovenia
Responsiveness

U.S. ranks first in responsiveness

- Respect for persons: 50%
  - Respect for dignity: 16.7%
  - Confidentiality: 16.7%
  - Autonomy: 16.7%
- Client orientation: 50%
  - Prompt attention: 20%
  - Quality of amenities: 15%
  - Access to social support networks: 10%
  - Choice of provider: 5%
U.S. Federal Spending – Fiscal Year 2012 ($ Billions)

- **Total**: $3,539 B
- **Net Interest**: $223 (6%)
- **Medicare & Medicaid**: $802 (23%)
- **Social Security**: $768 (22%)
- **Defense Department**: $670 (19%)
- **Discretionary**: $615 (17%)
- **Other Mandatory**: $461 (13%)

*Source Data: CBO Historical Tables*
The Risks of Growing Entitlement Spending

Sometime between 2030 and 2040, mandatory spending will exceed government revenues.

Source: GAO Citizen’s Guide 2007
Spending: It’s not Age

Projected Federal Spending on Medicare and Medicaid (% GDP)

- It is the rate of spending per individual that will have the most impact, rather than the quantity / demographics of an aging population.
For people retiring in 2011, the average person paid $114,000 into medicare and will take out $355,000.
Non-health “bureaucratic” overhead is higher in the U.S.:
- 31% in the United States
- 16.7% in Canada

“Overhead” is lower in medicare:
- 2% for medicare
- 17% for private insurance (excluding marketing costs and profits)
What We Value

People and on average countries vary in what they value:

- Equality versus efficiency
- Equality versus excellence
- Other examples: universities
- U.S. has long had distrust of government
"What do I think? I think you need surgery. Then again, the boys in there think you just need a good night's rest."
Is it a Market?

- Are medical prices set?
- People are price sensitive: Rand experiment
- How is supply allocated when demand equated when demand is higher than supply?
- How does this happen without prices?
Differences: Uncertainty

Presence of Uncertainty

- Demand is irregular and uncertain
- Should we deny someone lifesaving care if they have an unexpected illness or an accident?
- Why not have a two-tier health system? Government guarantees minimum, and you can buy more.
Differences: Information

Supply side: it is difficult to understand the product

- Asymmetric Information
  - Physicians know more than patients, who don’t even understand treatments
  - Patients may not even know that they are sick: trust
- Different physicians may suggest different treatments
- Hard to judge quality
  - We don’t directly observe the quality of treatment. We just observe if we get better or worse
  - Governments and insurers can try to regulate quality
Medicare Spending per Beneficiary, by Hospital Referral Region, 2006

National Average = $8,304

< $7,000
$7,000 – $7,500
$7,500 – $8,000
$8,000 – $9,000
> $9,000
Not populated

Note: Data adjusted for age, race, and sex but not price. Category definitions as in source document.
When researchers adjust for payment factors and health status, the number of very high and very low states shrinks.

Unadjusted Medicare Spending per Beneficiary, by State, 2006

Source: THEORI analysis of the Acute Inpatient Prospective Payment System, Physician Fee Schedule and Medicare Advantage data published by the Centers for Medicare & Medicaid Services.
When researchers adjust for payment factors and health status, the number of very high and very low states shrinks.

Medicare Spending per Beneficiary Adjusted for Wages, Risk, and DGME/IME/DSH, by State, 2006

Source: THEORI analysis of the Acute Inpatient Prospective Payment System, Physician Fee Schedule and Medicare Advantage data published by the Centers for Medicare & Medicaid Services. Note: Adjustment removes teaching and DSH payments and standardizes by the risk score and wage adjustments. DGME= direct graduate medical education. IME= indirect medical education. DSH= disproportionate share payments made to hospitals that may see a greater proportion of low-income beneficiaries.
Percent of Adults Ages 18+ Who Are Obese, by State, 2008

Differences: Insurance

Prominence of Insurance

- People buy or are given insurance
- With a third party paying most of the costs of medical care, individuals are insulated from price signals
- Demand may be higher if you don’t pay the full costs
- Recommended treatment are adjusted to insurance: good or bad?
- Principle-Agent problem with all insurers: their interests are not your interests
Differences: Externalities

Externalities

- Communicable diseases
  - Diseases that are transmitted through direct contact with an individual or through a vector such as mosquitoes for malaria
  - The reeducation of such diseases is probably the biggest improvement in health the past century or two (the other being the availability of food)

- Individuals are not insured but we pay for them anyways

- Individual risk behaviors: smoking, eating too much
  - Direct impact on the health of the person and others (smoking)
  - Pacts the cost of health for everyone
  - Slippery slope to serfdom?
Externalities

- Individual risk behaviors: smoking, eating too much
  - Direct impact on the health of the person and others (smoking)
  - Impacts the cost of health for everyone
- Causes of deaths in the U.S. in 2000:
  - 18% due to smoking
  - 17% due to poor diet and physical inactivity
  - 4% alcohol consumption
- Slippery slope to big brother?
High Degree of Regulation

- Limits on physician behavior: not profit maximizing
- Extreme delegation
- Licensing and education standards: limiting competition
- Pooling of unequal risks
- More or less regulation?
Social Security decreases poverty among the elderly
Per capita Social Security expenditures and poverty rate for 65+, 1959–2010

Note: Shaded areas denote recession. No formal data exists in the years between 1959 and 1966 for the percentage of elderly persons living in poverty. The dotted line denotes a linear extrapolation between the earliest data point (1959) and the beginning of the complete series (1966).
