

Organization of Public Health in the U.S.

HPAM 7600

Historical Overview

- Prior to about 1910, doctors did not really benefit patients, so costs were low
- Many hospitals were built in the 20s-30s, and patients started to not be able to pay
- Hospitals started hospital cost prepayment plans to groups of employees (teachers, etc.) called Blue Cross in the 1930s
- Hospitals set up to treat acute problems (infections, trauma), not well adapted for chronic problems of today

History, continued

- During WWII, freeze on wages and prices so firms trying to attract workers offered health insurance
- Government became involved in:
 - 1953: federal Department of Health, Education, and Welfare
 - 1965: Medicare and Medicaid implemented
 - WWII: health care for military

Major Attempts at Reform

- 1935: National health insurance dropped from Social Security Act
- 1945: Truman tried for national health insurance and failed
- 1974: 22 different bills for expanding public insurance under consideration; no one plan dominated and health reform was dropped
- 1993: Clinton's Health Security Plan failed

Historical Views on National Insurance

- Large firms afraid of govt meddling; small firms against employer mandates
- Insurers want the business so against
- Physicians (AMA) afraid of govt meddling
- Labor unions supported it so they wouldn't have to negotiate for health benefits
- PharMA afraid of drug price setting

Current US System Overview

- Third-party payer system (not single-payer):
 - Patient is consumer
 - Physician or hospital is provider
 - Insurance company is payer
- Mix of fee-for-service and managed care schemes (capitation, etc.)
 - Power struggle between providers and insurers

Insurance

What is insurance?

If one of us will have \$3000 injury this year, with equal probability, then if we each gave \$100 (25 of us), we could insure us all from the majority of the cost.

Definitions

- Premium = pay some amt for insurance (\$100)
- Coverage = amount insured for (\$2500)
- Copayment = \$ amt payment you make when each event happens (\$50)
- Deductible = must pay this amt first before insurance applies (\$150)
- Coinsurance = required to pay a fraction of the cost if the event happens (10% = \$300)

Two problems with insurance

- Moral hazard is the increased usage of services when their costs are low due to insurance
- Adverse selection is the tendency for people who need insurance (the unhealthy) to be more likely to have insurance
 - More generally, it involves splitting the risk pool because people have a choice about insurance

Fee-for-Service and Managed Care

- Fee-for-service induces moral hazard; supplier induced demand
- MC deals with moral hazard – changes the incentives of patients and providers through a variety of interventions
 - Capitation: pay provider per patient, whether they use care or not
 - Gatekeeper: must see primary physician before you can see specialist

Current US System Overview, *continued*

- Mostly employer-provider private insurance, although this is declining
- Medicare and Medicaid/SCHIP
- Safety net providers (local hospitals and clinics)
- Special systems for specific groups (veterans, military)

Distribution by Insurance Status, 2005-6

• Employer	159m	54%
• Individual private	15m	5%
• Medicare	35m	12%
• Medicaid	38m	13%
• Champus/VA/military	3m	1%
• Uninsured	47m	16%

28% of children covered by Medicaid/SCHIP
Source: <http://statehealthfacts.org>

Employers

- Employers & health insurance coverage

Tax subsidy:

- Insurance premiums paid directly by worker are exempt from federal and state income tax, and from Social Security and Medicare payroll taxes
- Insurance premiums paid by employer are exempt from payroll taxes
- Subsidy is slightly more than \$200 billion in 2006

Favors rich over poor, big employers over self-employed

Impact of tie between employers and insurance

- Employers negotiate lower group rates than individuals can get
- Reduces adverse selection because choose job not insurance plan
- Reduces job mobility, early retirement for fear of losing insurance
- Employees perceive benefits as free (& demand more) when they are really paying for them with lower wages

Why should employers care about health?

Healthy employees

- Use fewer benefits
- More productive
- Absent less often
- Attract productive job applicants

Investing in community health

- Is a corporate social responsibility
- Develops future workforce
- Improves reputation

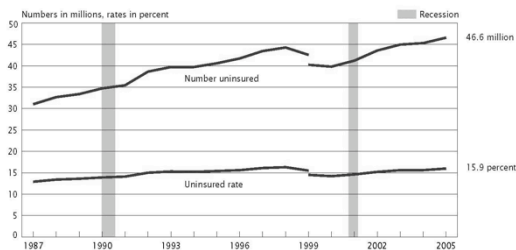
What can employers do?

- Push for higher quality care, e.g. Leapfrog Group
- Reduce risk-profile of employees (smoke-free policies, discourage drinking, reduce stress, exercise facilities, healthy food options nearby)
- Workplace safety programs (OSHA)

However...

When costs are rising, employers drop health insurance coverage...

Figure 7.
Number Uninsured and Uninsured Rate: 1987 to 2005



Notes: Respondents were not asked detailed health insurance questions before the 1988 Current Population Survey. Implementation of Census 2000 based population controls occurred for the 2000 ASEC, which collected data for 1999. These estimates also reflect the results of follow up verification questions which were asked of people who responded "no" to all questions about specific types of health insurance coverage in order to verify whether they were actually uninsured. This change increased the number and percentage of people covered by health insurance, bringing the CPS more in line with estimates from other national surveys.
The 2004 data have been revised to reflect a correction to the weights in the 2005 ASEC. The estimates also reflect improvements to the algorithm that assigns coverage to dependents.
The data points are placed at the midpoints of the respective years.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements.

Uninsured – 3 types

- Working & healthy
 - Health insurance is luxury, throwing \$ away if always healthy
 - Related to adverse selection
- Working & not able to get insurance
 - Work for small business, self-employed
 - High risk pools (beauticians, childcare givers)
- Eligible for Medicaid
 - Essentially insured (go to hospital if sick)

Uninsured & public health

- More likely to go without needed care
 - Externalities (infectious diseases)
- More likely to seek safety-net providers
 - Expensive
 - Public health centers must devote resources to individual health care rather than population health mission

Underinsured

- Preventive services
 - Catch problems later when more costly, harder to treat
- Mental illness
 - Urgency of providing care to severe cases erodes funds available for prevention of mental illness
- Substance abuse treatment
- Oral health care
 - Indicator and affects general health
