

Next time, chapter 17

Medicare

A: HI ("hospital insurance")
1.45% of wages & salaries,
X2 (employer & employee
both paying). No wage-salary
cap, unlike rest of payroll
tax.
Must be a qualifying worker or
connected to one, or buy
it.
If qualified, in at 65.

B: Visits to doctor.
Pay about \$90/month; This is
about 1/4 of actual costs.
That ^{missing} revenue comes from general
tax revenue.

D: Prescription drug program.
Private plan, publicly assisted
and regulated.
Providers suffering adverse
selection get financial support.

Coverage:

- none of the first \$250 drug costs.
- 75% of costs for next \$2250 ^{you and your} of drug spending.
- 0% of costs for next \$3600 of drug spending.
- 95% of everything above this point (\$5100).

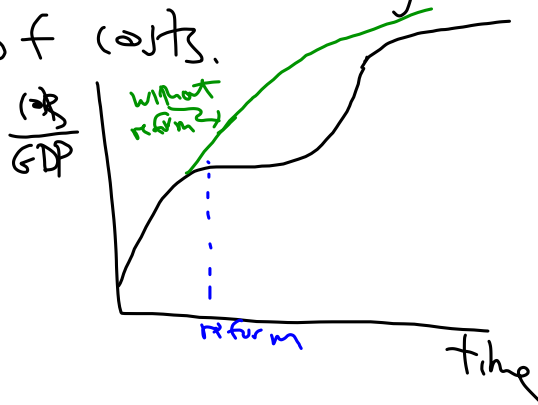
Makes little sense if the goal is consumption smoothing, even recognizing need to manage moral hazard. Key question always is, would recipient of care prefer the money the care is buying (at the true resource cost) to the care itself? Is that happening for the 95% group?

(Politically, worked great, got some coverage to a lot of people.)

To manage costs, use a prospective payments system.

When implemented, big reductions in length of hospital stays, no effect on health happens.

But hasn't done much long term to control growth rate of costs.



"DGS creep"

For payment purposes, code illnesses with more lucrative codes.

Fraud, criminal, jail.

Similarly, Medicare HMOs did not control costs. Healthiest people enrolled, overcompensated. Re HMOs government costs \uparrow , HMOs did well financially.

Health care reform

* Controlling costs.

Seems needed:

-- Health outcomes worse than in similar countries / for similar populations, but level of costs per capita are double, growth rate of costs in US is faster.

* Not covering everyone, number of uninsured is increasing.
(both equity and efficiency issues).

Gruber argues that the slope (rate of increase) driven by things that are different from those driving the level.

Can get one-time benefits from reducing moral hazard, fraud, admin. costs, but fast cost increase rate will return.

⇒ That comes from technological improvement increasing the quality of care.

Presumably we like that.

⇒ 20% of GDP will come, later than sooner if we make reforms. So what?

Are we getting the quality increase?

-- No, popular perception, but also IOM has whole series on quality of care.

Medical error. Overtreatment is a source of adverse outcomes.

(Staph infections, sometimes deadly, \Rightarrow risks associated with treatment

drug interaction effects,

\Rightarrow risks associated with treatment

not clear we are doing better our time)

(May be getting the quality ^{improves} Gruber suggests, but it is essential that a proper acknowledgement of risks associated with care be known to patients for efficiency)

-- Yes. David Cutler, at least for major life saving procedures.

Are Europeans not doing them? Or, are their costs lower because they aren't paying for the research?

Focus of reform on coverage.
(as far as Guber/Katler concerned).
(all want waste & fraud out)

Big government, Medicare like program for everyone. "Single payer."

How will this contain "costs"? Need to limit waste, fraud, people get sick.

Private sector:

States set up ^{risk} pools of people.

Everyone has to buy insurance from employer, get it through public program, or private sector (that is using the pool).

Low income people will get subsidies ^{→ actually fair for the pool.} so they can afford to buy it.

Many worry about cross-state migration ⇒ adverse selection if only some states do it. (MASS doesn't seem to be worried). If every state does it, less of a problem.