B. HEALTH INSURANCE IN THE U.S.

GOAL: Explain complex institutional features & terms such as FFS

B.1 INTRODUCTION TO HEALTH INSURANCE CONCEPTS

B.2 HEALTH INSURANCE COVERAGE IN THE U.S.

B.3 FEE FOR SERVICE (FFS)

B.4 RAND HEALTH INSURANCE EXPERIMENT

B.5 MANAGED CARE (HMO, PPO, POS, HDHP)

B.6 EMPLOYER-SPONSORED INSURANCE

B.7 GOVT. INSURANCE: MEDICARE AND MEDICAID

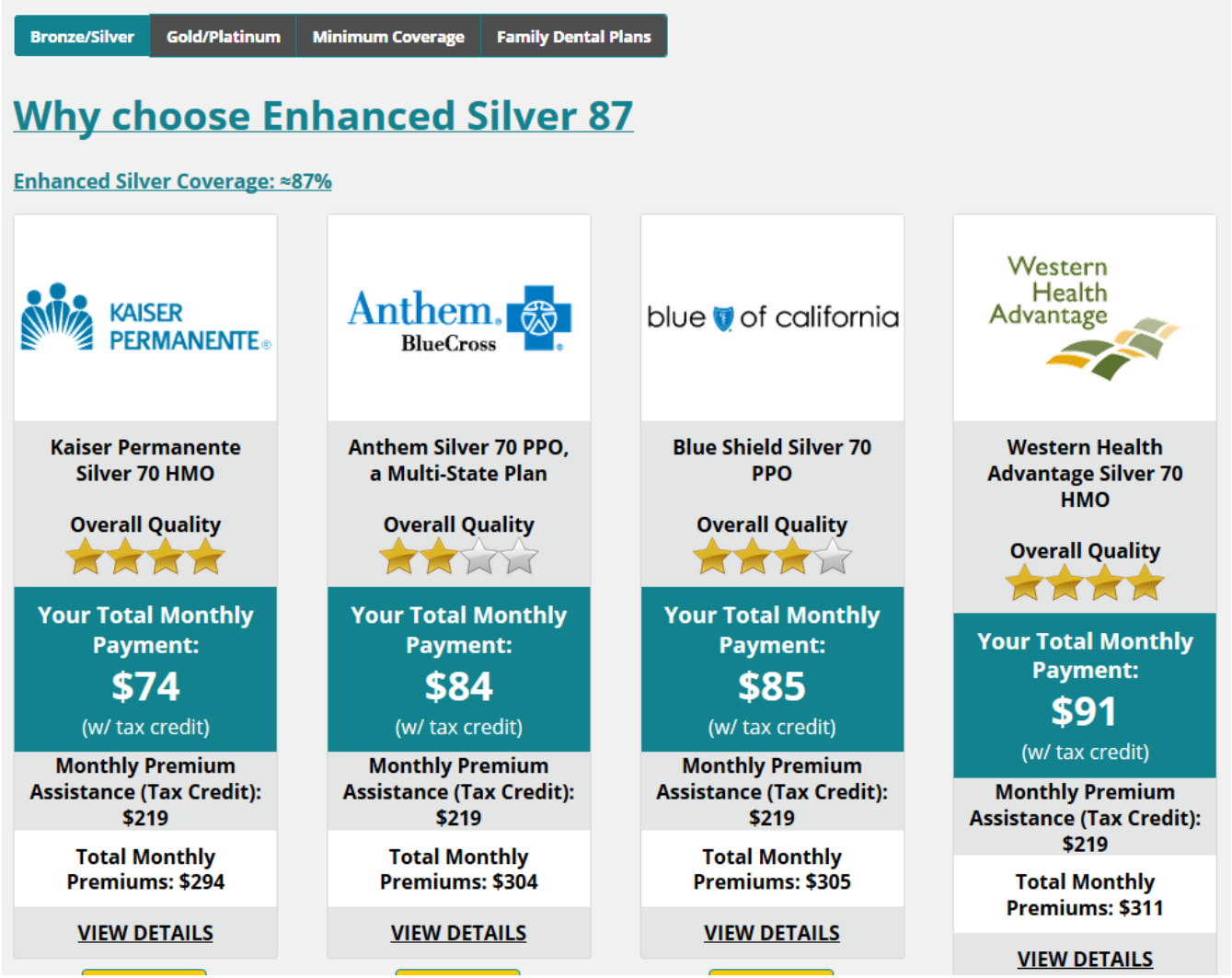
B.8 UNINSURANCE

B.9 2010-2014 HEALTH REFORM

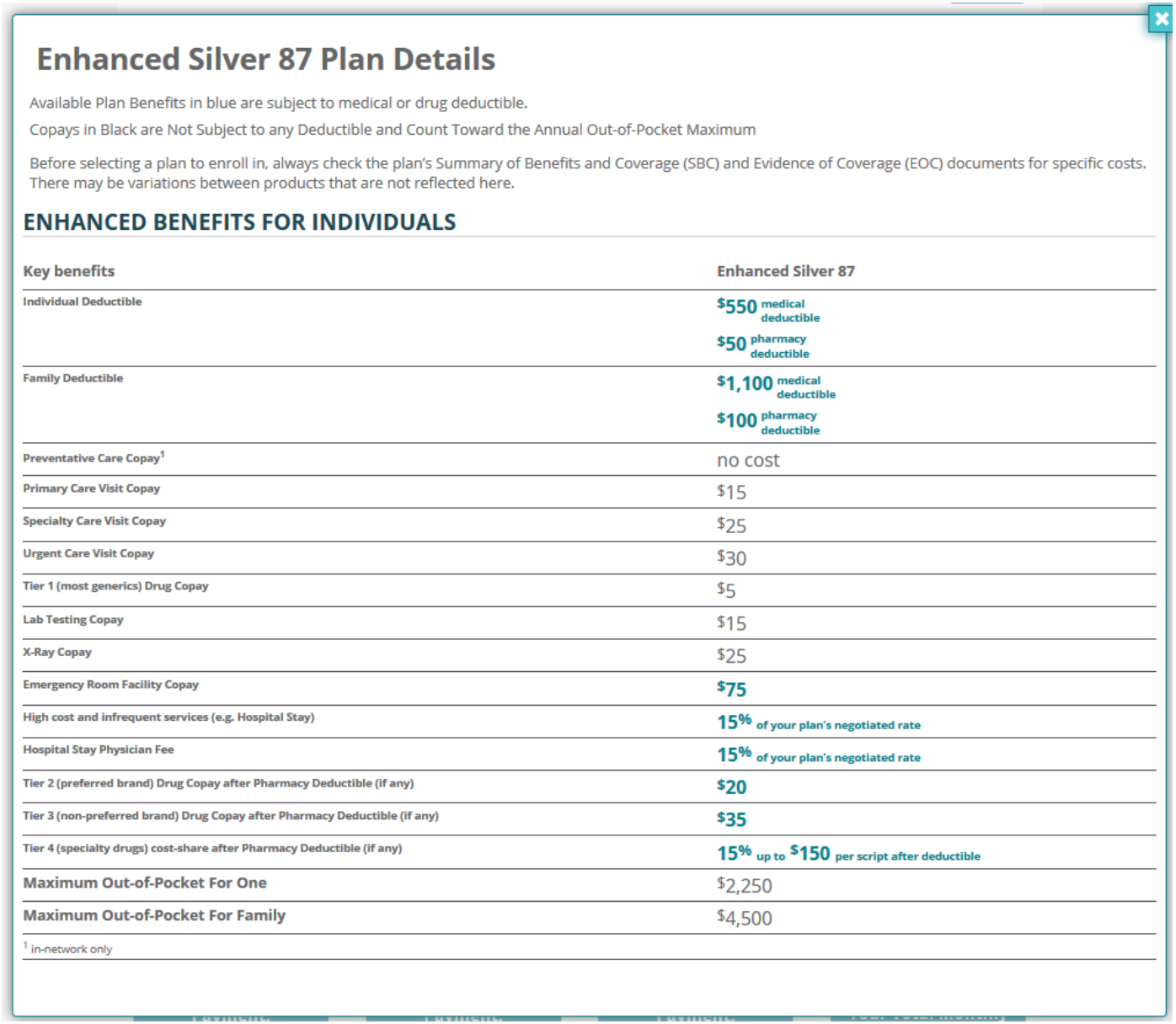
Bhattacharya, Hyde and Tu Chapter 18: The American Model

COVERED CALIFORNIA

2016 for 25 year-old in zip code 95616



What is HMO, PPO, copay, deductible ?



Enhanced Silver 87 Plan Details

Available Plan Benefits in blue are subject to medical or drug deductible.

Copays in Black are Not Subject to any Deductible and Count Toward the Annual Out-of-Pocket Maximum

Before selecting a plan to enroll in, always check the plan's Summary of Benefits and Coverage (SBC) and Evidence of Coverage (EOC) documents for specific costs. There may be variations between products that are not reflected here.

ENHANCED BENEFITS FOR INDIVIDUALS

Key benefits	Enhanced Silver 87
Individual Deductible	$550 medical deductible $50 pharmacy deductible
Family Deductible	$1,100 medical deductible $100 pharmacy deductible
Preventative Care Copay[1]	no cost
Primary Care Visit Copay	$15
Specialty Care Visit Copay	$25
Urgent Care Visit Copay	$30
Tier 1 (most generics) Drug Copay	$5
Lab Testing Copay	$15
X-Ray Copay	$25
Emergency Room Facility Copay	$75
High cost and infrequent services (e.g. Hospital Stay)	15% of your plan's negotiated rate
Hospital Stay Physician Fee	15% of your plan's negotiated rate
Tier 2 (preferred brand) Drug Copay after Pharmacy Deductible (if any)	$20
Tier 3 (non-preferred brand) Drug Copay after Pharmacy Deductible (if any)	$35
Tier 4 (specialty drugs) cost-share after Pharmacy Deductible (if any)	15% up to $150 per script after deductible
Maximum Out-of-Pocket For One	$2,250
Maximum Out-of-Pocket For Family	$4,500

[1] in-network only

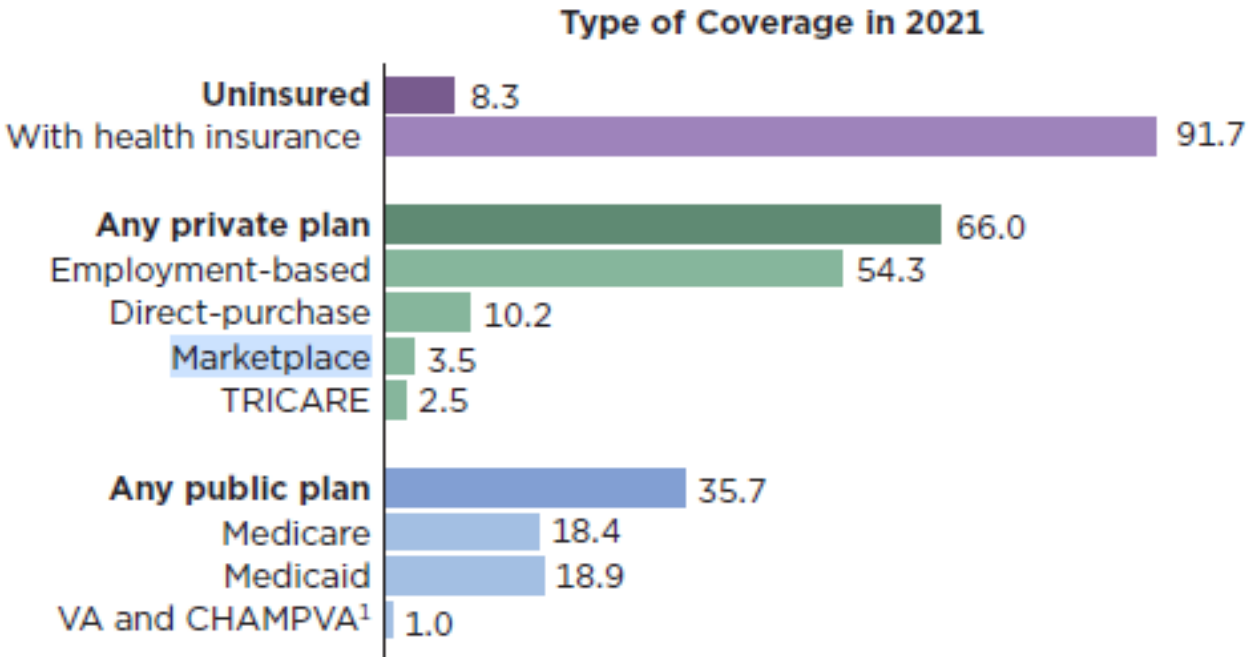
B.1 INTRODUCTION TO HEALTH INSURANCE CONCEPTS

- Most get health care through insurance – centrally important.
- There are four major health insurance concepts – studied later.
- 1. **Risk pooling**
  - risks are reduced by grouping individuals into insurance pools
  - variability of the group average is less than individual variation.
- 2. **Risk aversion**
  - people are willing to pay for insurance to reduce risk exposure.
- 3. **Moral hazard**
  - once insured demand may increase due to lower effective price.
- 4. **Adverse selection**
  - insurance markets may fail if only the riskier (less healthy) choose to buy insurance (worst case: insurance death spiral).

Health Insurance Terminology

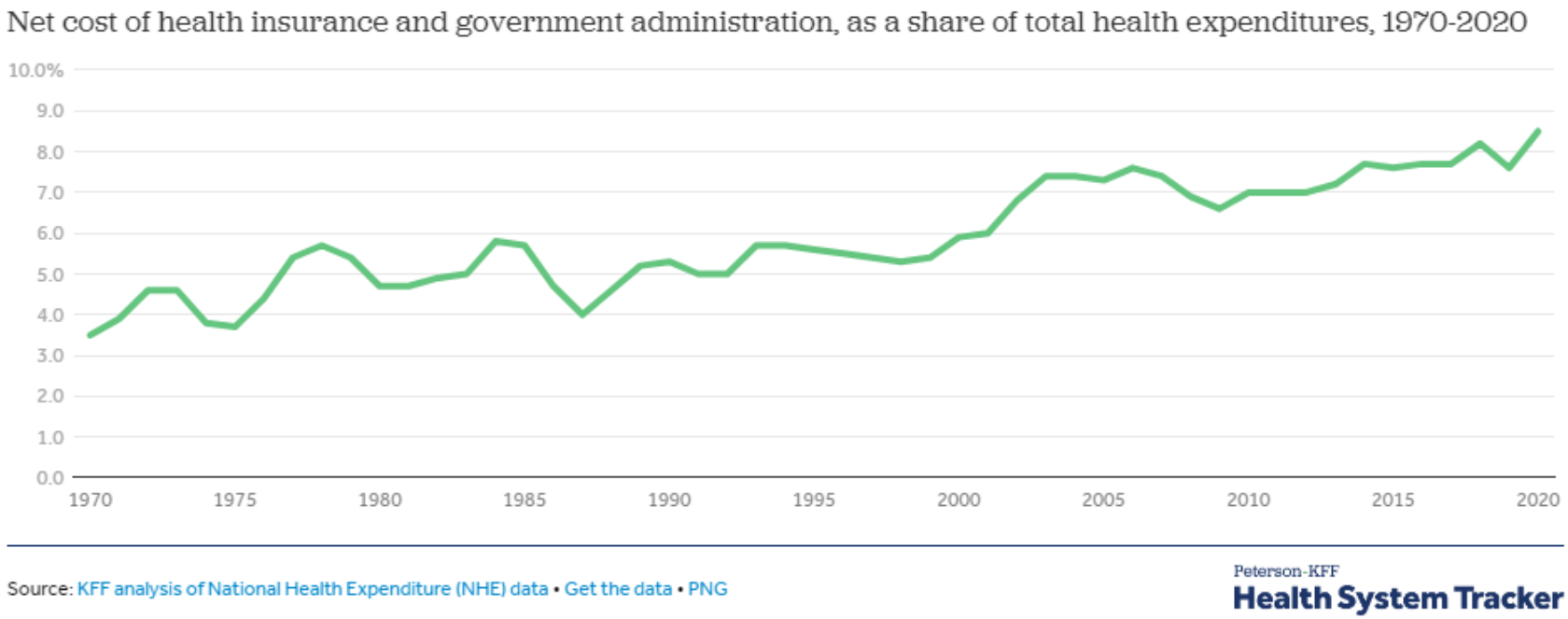
- Copayment – a lump sum paid by insured per service e.g. $20
- Coinsurance – a percentage paid by insured per service e.g. 10% (and % cover is percentage covered by insurer=100–coinsurance)
- Deductible – an annual amount paid before any insurance cover e.g. $2,000
- Premia – the price of a health insurance policy.
- Pre-existing conditions – health conditions that may not be covered.
- Cost-effectiveness – the cost of a given health outcome e.g. $20,000 per year of life saved.

B.2 HEALTH INSURANCE COVERAGE IN THE U.S. 2021



- From CPS ACEC P60 report
- Figures add to > 100 as people can have more than one policy.
- Nonelderly get insurance primarily through employment.
- Elderly get insurance primarily through Medicare.
- Many uninsured is an unusual feature of U.S.

- All the different insurance schemes add overhead.



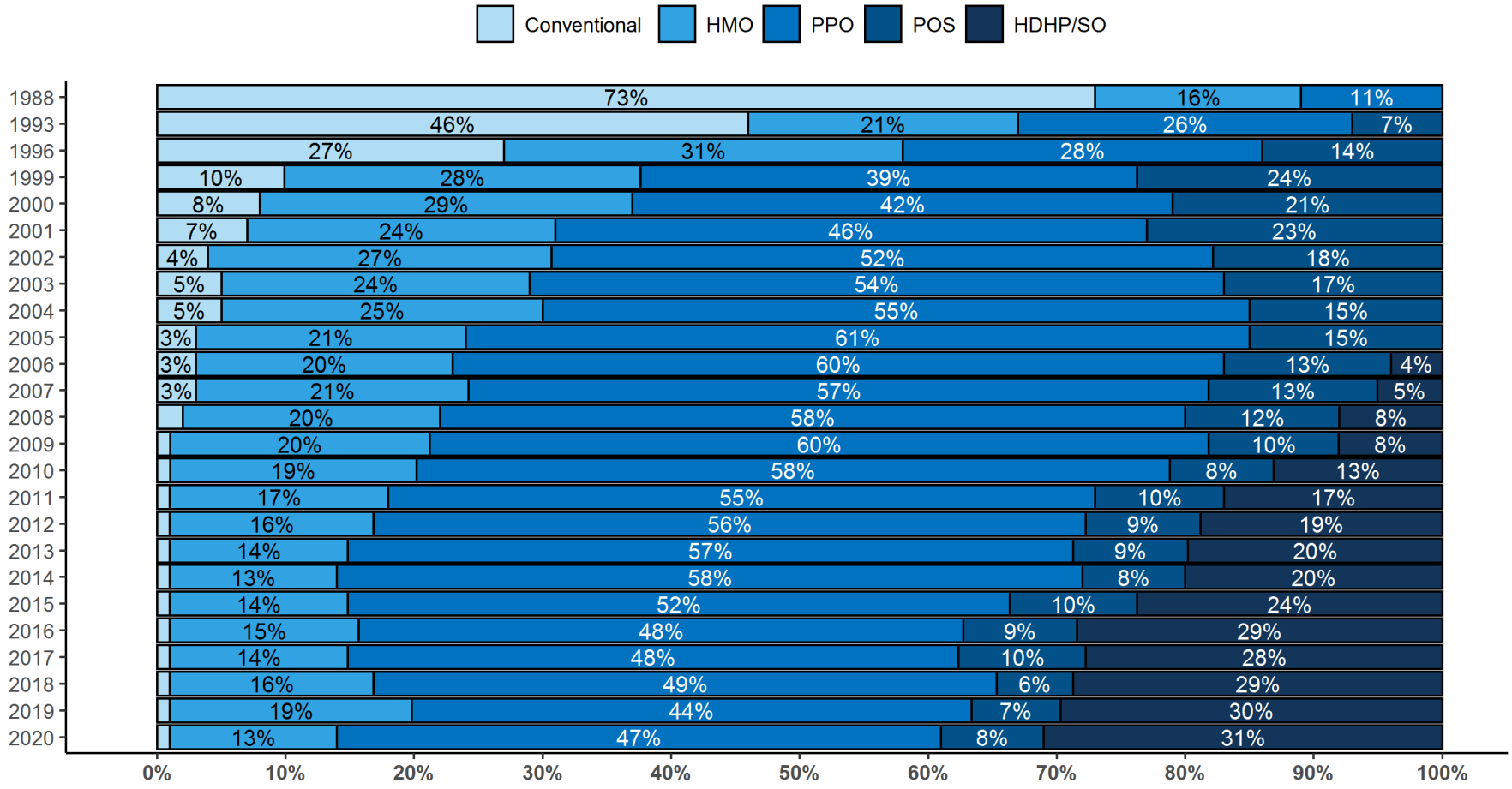
In 2020, administrative expenses – which include the cost of administering private insurance plans and public coverage programs but not the administrative costs of health providers – represented 8.5% of total national health expenditures, up from about 3.5% in 1970, and 7.6% in 2019.

Source: https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/

TYPES OF HEALTH INSURANCE IN U.S.

- FFS – Fee for service (indemnity)
  - insured has great choice of treatment and provider
  - now disappeared but was dominant until late 1980's.
- HMO – health maintenance organization
  - restricted choice of both treatment and provider
  - introduced in 1980's, peaked in 1996, much less now.
- PPO – preferred provider organization (restricted FFS)
  - FFS if use network doctors + can pay more for out-of-network
  - introduced in 1990's, most common form now.
- POS – point-of-service (less restricted form of HMO)
  - HMO if use network doctors +can pay more for out-of-network
- HDHP – high deductible health plan
  - much higher deductibles, copays than traditional HMO, PPO
  - highly tax favored with health savings account (HCA) option
  - introduced in mid 2000's and increasingly popular.

Figure 5.1
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2020

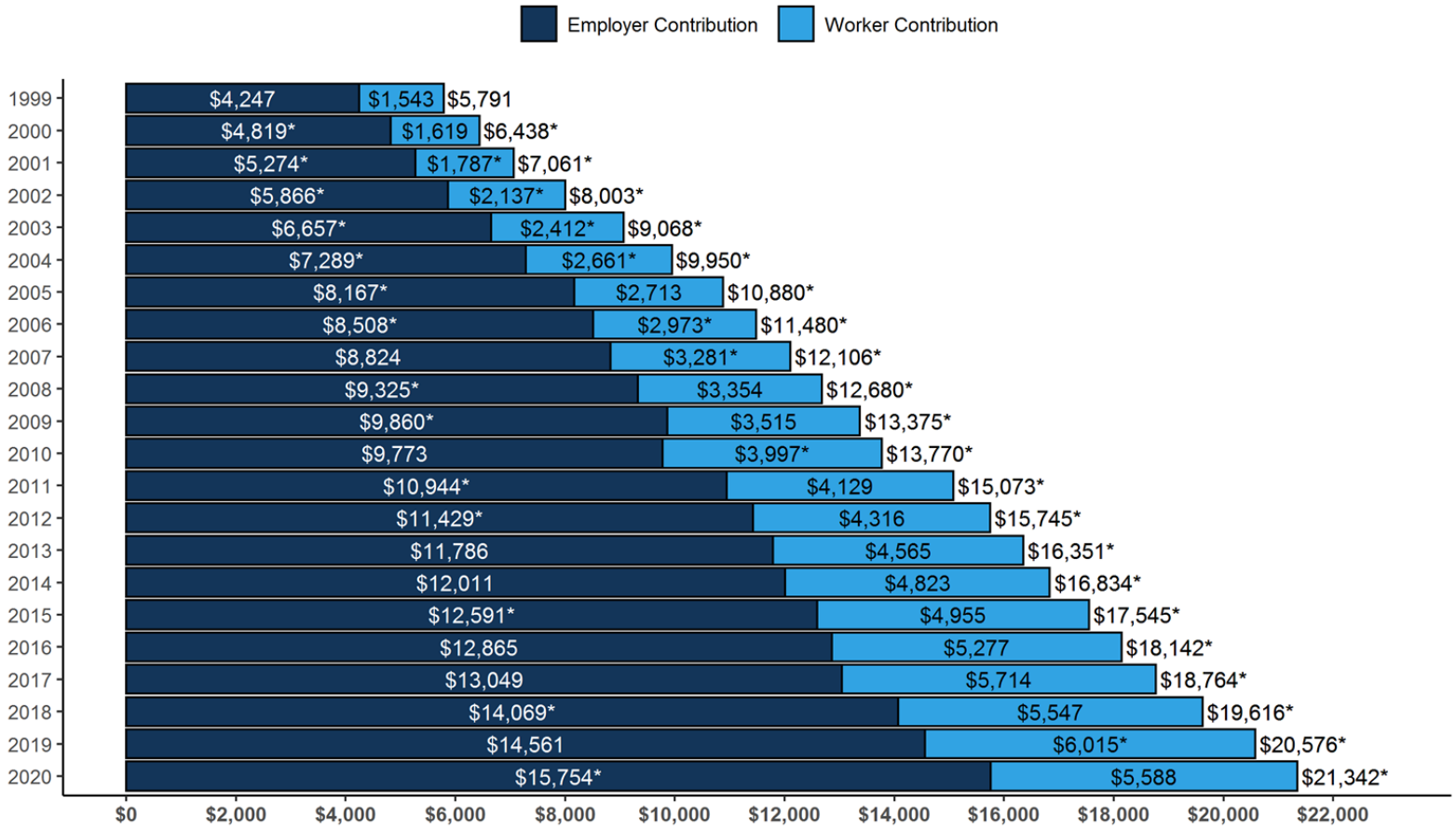


NOTE: Information was not obtained for POS plans in 1988 or for HDHP/SO plans until 2006. A portion of the change in 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; The Health Insurance Association of America (HIAA), 1988.

Figure 6.5

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Not cheap! Employees pay on average 26% of premia.

B.3 FEE FOR SERVICE INSURANCE (FFS)

- Technically called indemnity insurance by insurers
  - most common form of insurance generally (auto, home, …).
- Insured has great choice on treatment and provider
  - insured pays a portion (copay, coinsurance, deductible)
  - this portion can vary with type of service
  - insurer pays the rest.
- Dominant form of insurance in U.S. until 1980's.
- Problem: little restraint on health care costs
  - consumers over-consume (moral hazard)
  - providers benefit financially (supplier-induced demand).
- Solution: Movement to managed care.

B.4 HEALTH INSURANCE: RAND STUDY

Willard Manning et al. (1987), "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment", *A.E.R.*, May 1987, pp.251-277.

[Focus on pages 251-256, 258-260, and later 267-271].

Traditional studies: more insurance associated with more health care.

But correlation does not impy causation.

e.g. More need to see doctor leads to more insurance.

So run an experiment. Randomly give different people different levels of health insurance. Big deal !

Finds that **demand for medical services responds to price.**

This leads to **moral hazard**.

And the welfare loss due to moral hazard is found to be large.

TABLE 1—NUMBER OF PERSONS AT ENROLLMENT AND NUMBER OF PERSON-YEARS IN ESTIMATION SAMPLE

Plan	Site							
	Dayton	Seattle	Fitch-burg	Frank-lin County	Charles-ton	George-town	Enroll-ment Total[a]	Esti-mation Sample Total[b]
Free	301	431	241	297	264	359	1893	6822
25 Percent[c]	260	253	125	152	146	201	1137	4065
50 Percent	191	0	56	58	26	52	383	1401
95 Percent	280	253	113	162	146	166	1120	3727
Individual Deductible	105	285	188	220	196	282	1276	4175
Total	1137	1222	723	889	778	1060	5809	20190

[a] Persons.

[b] Person-years.

[c] Includes those with 50 percent coinsurance for dental and mental health and 25 precent coinsurance for all other services.

People in for 3-5 years over the period 1974-80.

TABLE 2—SAMPLE MEANS FOR ANNUAL USE OF MEDICAL SERVICES PER CAPITA

Plan	Face-to-Face Visits	Outpatient Expenses (1984 $)	Admissions	Inpatient Dollars (1984 $)	Prob. Any Medical (%)	Prob. Any Inpatient (%)	Total Expenses (1984 $)	Adjusted Total Expenses (1984 $)[a]
Free	4.55	340	.128	409	86.8	10.3	749	750
	(.168)	(10.9)	(.0070)	(32.0)	(.817)	(.45)	(39)	(39)
25 Percent	3.33	260	.105	373	78.8	8.4	634	617
	(.190)	(14.70)	(.0090)	(43.1)	(1.38)	(0.61)	(53)	(49)
50 Percent	3.03	224	.092	450	77.2	7.2	674	573
	(.221)	(16.8)	(.0116)	(139)	(2.26)	(0.77)	(144)	(100)
95 Percent	2.73	203	.099	315	67.7	7.9	518	540
	(.177)	(12.0)	(.0078)	(36.7)	(1.76)	(0.55)	(44.8)	(47)
Individual Deductible	3.02	235	.115	373	72.3	9.6	608	630
	(.171)	(11.9)	(.0076)	(41.5)	(1.54)	(0.55)	(46)	(56)
Chi-Squared (4)[b]	68.8	85.3	11.7	4.1	144.7	19.5	15.9	17.0
P Value for *chi*-Squared (4)	<.0001	<.0001	.02	n.s.	<.0001	.0006	.003	.002

Note: All standard errors (shown in parentheses) are corrected for intertemporal and intrafamily correlations. Dollars are expressed in June 1984 dollars. Visits are face-to-face contacts with MD, DO, or other health providers; excludes visits for only radiology, anesthesiology or pathology services. Visits and expenses exclude dental care and outpatient psychotherapy.

[a]The figures in this column are adjusted for the imbalance of plans across sites as follows: the site-specific responses on each plan (simple means by site) are weighted by the fraction of the sample in each site and summed across sites. In the case of the 50 percent plan, which has no observations in Seattle, the weights are renormalized excluding Seattle.

[b]The *chi*-square statistic with 4 d.f. tests the null hypothesis of no difference among the five plan means. The *chi*-square statistic is a Wald test from the robust estimate of the information matrix (see Brook et al., 1984, for further details). It is used in lieu of the usual *F*-statistic because of the difficulty of computing such a statistic while allowing for intertemporal and interfamily correlation.

95% confidence interval for Free Adusted Total = $750 \pm 2 \times 39 = (672, 828)$

TABLE 3—VARIOUS MEASURES OF PREDICTED MEAN ANNUAL USE OF MEDICAL SERVICES, BY PLAN

Plan	Likelihood of Any Use (%)	One or More Admissions (%)	Medical Expenses (1984 $)
Free	86.7	10.37	777
	(0.67)	(0.420)	(32.8)
Family Pay			
25 Percent	78.8	8.83	630
	(0.99)	(0.379)	(29.0)
50 Percent	74.3	8.31	583
	(1.86)	(0.400)	(32.6)
95 Percent	68.0	7.75	534
	(1.48)	(0.354)	(27.4)
Individual Deductible	72.6	9.52	623
	(1.14)	(0.529)	(34.6)

These are obtained from predictions from four-part model, whereas Table 2 used actual outcomes.

TABLE 6—USE OF DENTAL SERVICES BY DENTAL PLAN: SAMPLE MEANS

Dental Insurance Plan	Year 1 of Dental Coverage			Year 2 of Dental Coverage		
	Probability (%)	Visits	Expenses per Enrollee ($)	Probability (%)	Visits	Expenses per Enrollee ($)
Free	68.7	2.50	380	66.8	1.93	261
	(1.19)	(.065)	(18.0)	(1.18)	(.049)	(12.5)
25 Percent	53.6	1.73	224	52.6	1.51	190
	(3.39)	(.138)	(32.8)	(3.34)	(.111)	(28.0)
50 Percent	54.1	1.80	219	53.0	1.50	177
	(2.41)	(.118)	(31.3)	(2.55)	(.103)	(32.3)
95 Percent	47.1	1.39	147	48.3	1.44	179
	(2.59)	(.098)	(18.7)	(2.62)	(.099)	(24.9)
Individual Deductible	48.9	1.70	242	48.1	1.33	158
	(2.12)	(.104)	(24.1)	(2.12)	(0.080)	(20.4)

Note: Expenses were converted to January 1984 dollars using the dental fee component of the Consumer Price Index. There has been no adjustment for regional differences in prices, or differences in population characteristics across plans and years. Standard errors (shown in parentheses) are corrected for intrafamily correlations.

For free dental expenses were $380 in year 1 and much lower $261 in year 2.

Price Elasticity of Demand

- Table 9 converts table 2 and 3 results into a **price elasticity estimate.**
- The price elasticity is defined as $\varepsilon = -[dQ/Q]/[dp/p]$ so that $\varepsilon > 0$. The **arc elasticity** measure is used, evaluating at average Q & p.
- e.g. move from the 25 percent plan with **effective** average coinsurance rate of 16% to the free plan with coinsurance rate of 0% then all care expenses from Table 3 rose from $630 to $777.
- The price elasticity is then

$$\frac{-(777 - 630) / [(777+630)/2]}{(0 - 16) / [(0+16)/2]} = \frac{147/703.5}{16/8} = \frac{0.209}{2} = 0.10.$$

Thus going from a generous insurance to free care the price elasticity of demand is 0.10.

TABLE 9—ARC ELASTICITIES FOR VARIOUS TYPES OF CARE CALCULATED FROM AVERAGE COINSURANCE RATES

Range of Nominal Coinsurance Variation	Range of Average Coinsurance Variation	All Care	Outpatient Care
0–25 Percent	0–16	.10	.13
25–95 Percent	16–31	.14	.21

Source: Calculated from data in Table 2 (outpatient) and Table 3 (total). For those who wish to calculate arc elasticities with the 50 percent plan, from the data in Tables 2 or 3, the average coinsurance rate in the 50 percent plan is 24 percent.

B.5 MANAGED CARE (HMO, PPO, POS, HDHP)

- Managed care organizations (MCOs) reduce costs by
  - negotiating lower payments with in-network providers
  - restricting consumer choice (gatekeeper and utilization review)

- Gatekeeper is an assigned primary care physician who approves most medical care. E.g. G.P., Ob/Gyn, internal medicine.

- Utilization review (UR) reviews patient/doctor decisions (second opinion, preauthorize hospitalization before surgery, case manage if expensive case, substitution of generic drugs, ...)

- MCO's enabled by better information technology
  - 1973 HMO Act that eliminated earlier bans on corporate medicine.

Health Maintenance Organization (HMO)

- Closed HMO's were the initial MCO
  - treatment only by HMO doctors and these doctors are salaried
  - Kaiser Permanente was the original large one.
- Open HMO's
  - contract with providers who are usually not paid FFS
  - instead capitation: fixed dollar per capita (PMPM: per member per month) used for gatekeeper and in some cases hospital.
  - and negotiated per diem (payment per day): most often for hospital patient bed day.
- HMO's have incentive to keep costs down.
- In both insured have less choice but lower copays (and premia).

Health Maintenance Organization (HMO) continued

- Consequences
  - HMO's did lead to reduced growth in health costs in 1990's
  - And studies suggest no decrease in quality of care
  - But backlash from consumers due to restricted choice.
  - This led to PPO's.

Preferred Provider Organization

- FFS but with network providers
  - there is usually no gatekeeper but there is utilization review
  - can pay more to get out-of-network care.

Point of Service

- HMO with out-of-netwrok option
  - like HMO for in-network care
  - but can pay more and get out-of-network care.

High Deductible Health Plan (HDHP)

- Higher annual deductible than usual insurance
  - catastrophic insurance
  - though some basic preventive measures may be fully covered
  - HDHP could be for FFS, PPO. POS or HMO insurance
  - direct advantage to consumer is lowered premium
  - also tax incentives given for tax-free health savings accounts
  - best for the healthy and wealthy
- Introduced by President Bush in 2003
  - increasingly popular.

Summary:

- In increasing order of level of management:

  FFS → PPO → POS → HMO (open, closed)

MANAGED COMPETITION

- Problem: Consumers do not react enough to price of care.
  Solution: Instead have them shop around for health insurance.
- Policies with a common set of basic benefits and community rating compete against each other on price (and quality).
  - Proposed by Alain Enthoven in NEJM 1978
- Many large organizations do this e.g. U.C. Davis
  - And so do Obamacare policies.
- Studies show consumers do take plan price into account
  - Buchmueller & Feldstein (1996) and Cutler & Reber.
- But there is reduced power for insurer to negotiate with providers if all plans must provide the same network of doctors.

MANAGED CARE AND QUALITY OF CARE

- Miller and Luft (1997), Health Affairs, Sept/Oct, 9-25
  - review 35 studies published 1993-97
  - compare FFS with HMO
  - based on tests of statistical significance (at 5%).

- More recent is Miller and Luft (2002), Health Affairs, July/Aug, 63-86 which gives qualitatively similar results.

- Find that quality of care consequences are:
  - managed care overall appears to have had little effect on quality (good or bad).

TESTS OF DIFFERENCES IN MEANS

SETUP:	Sample 1	Sample 2
Population mean	μ_1	μ_2
Standard deviation	σ_1	σ_2
Sample mean	$\bar{x}_1$	$\bar{x}_2$
Sample standard dev.	s_1	s_2
Standard error	$s_{\bar{x}1} = s_1 / n_1^{1/2}$	$s_{\bar{x}2} = s_2 / n_2^{1/2}$

- $\mu_1 = \mu_2$ if $\mu_1 - \mu_2 = 0$. See if $\bar{x}_1 - \bar{x}_2 \approx 0$.

- Formally test $H_0: \mu_1 = \mu_2$ against $H_a: \mu_1 \neq \mu_2$

- Use $t = (\bar{x}_1 - \bar{x}_2) / \text{sqrt}(s_{\bar{x}1}^2 + s_{\bar{x}2}^2)$.

- Reject H_0 at significance level 5% if $|t| > 1.96$.

Test example: Mammography screening rate

HMO $\bar{x}_1 = 0.75$ $s_{\bar{x}1} = 0.02$

FFS $\bar{x}_2 = 0.80$ $s_{\bar{x}2} = 0.01$

Then $t = (\bar{x}_1 - \bar{x}_2) / \text{sqrt}(s_{\bar{x}1}^2 + s_{\bar{x}2}^2)$

$= (0.75 - 0.80) / \text{sqrt}(0.02^2 + 0.01^2)$

$= -0.05 / \text{sqrt}(0.0005) = -0.05 / 0.02236$

$= -2.236$

Since $|t| = 2.236 > 1.96$ we reject H_0: $\mu_1 = \mu_2$.

Conclude that there is a statistically significant difference at 5%.

EXHIBIT 3
Quality-Of-Care Performance In HMO Versus Fee-For-Service Plans

HMO results	Observations	Studies[a]
Better (statistically significant)	3	2
Preponderance of better (some results statistically significant)	2	2
Pattern of better results (not significant)	5	4
Similar, or mixed (better and worse) results	8	6
Pattern of worse results (not significant)	1	1
Preponderance of worse results (some results statistically significant)	2	2
Worse results (statistically significant)	3	3

SOURCE: Authors' tabulations of published materials.
NOTE: HMO is health maintenance organization.
[a] Studies are counted more than once if they had observations in two or more categories of results.

CONCLUSIONS OF MILLER AND LUFT

- While focused on quality they also considered quantity.
- Resource use:
  little difference aside from less costly procedures
- Enrollee satisfaction:
  Financial higher in HMO
  Nonfinancial lower in HMO
- Quality:
  Some favor HMO, some FFS, and some no diff.

B.6 EMPLOYER-SPONSORED INSURANCE

- Most common form of insurance for adults < 65 and their dependents.
  - historical accident as introduced as way to get around World War II wage controls by offering better benefits.
  - also favored by tax laws as a benefit not subject to income tax
    e.g. 25% marginal rate on single income $40k-$100k
  - and is a benefit not subject to social security taxes.
- Combats adverse selection by combining good and bad risks.
- Good risks may seek higher paid job with no insurance
  - firm specific human capital gives reason to stay at current job.
- Bad risks may be reluctant to leave job and lose insurance
  - job lock
  - COBRA act of 1985 allows workers to continue insurance up to 18 months after leave job (though must pay premia).

B.7 GOVERNMENT: MEDICARE AND MEDICAID

MEDICARE

- For aged over 65 &/or disabled &/or end-point kidney disease.
- Established in 1965 (parts A & B).
- Federal program financed by 1.45% employer + 1.45% employee payroll tax (part of social security taxes of 7.65%+7.65%).

Part A (Hospital)	free (if contribute to soc sec > 10 years)
+ Part B (Physician & Outpatient)	premia is heavily subsidized
+ Part C (Medicare Advantage)	optional HMO plan replaces A and B
+ Part D (Prescription Drugs)	is heavily subsidized (began in 2006).

- Part A reimburses hospitals for diagnosis related group (DRG)
  - a fixed sum paid for the problem e.g. tonsillectomy
  - incentive for hospital to monitor costs
- Part B Traditional Medicare reimburses by prices Medicare sets by relative value scales (otherwise Medicare Advantage).
- Parts C and D and MA are run by private insurance companies.

MEDICAID

- For those indigent (poor)
- Established in 1965 (Social Security Act Title XIX)
- Federal / state program financed out of their general revenues.
- Great variation from state to state (Medical in California) in state contribution (50%-80%), eligibility and benefits.
- Includes nursing home for low income elderly (not covered by Medicare).
- Most costs are for disabled and old even though most people in Medicaid are young.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

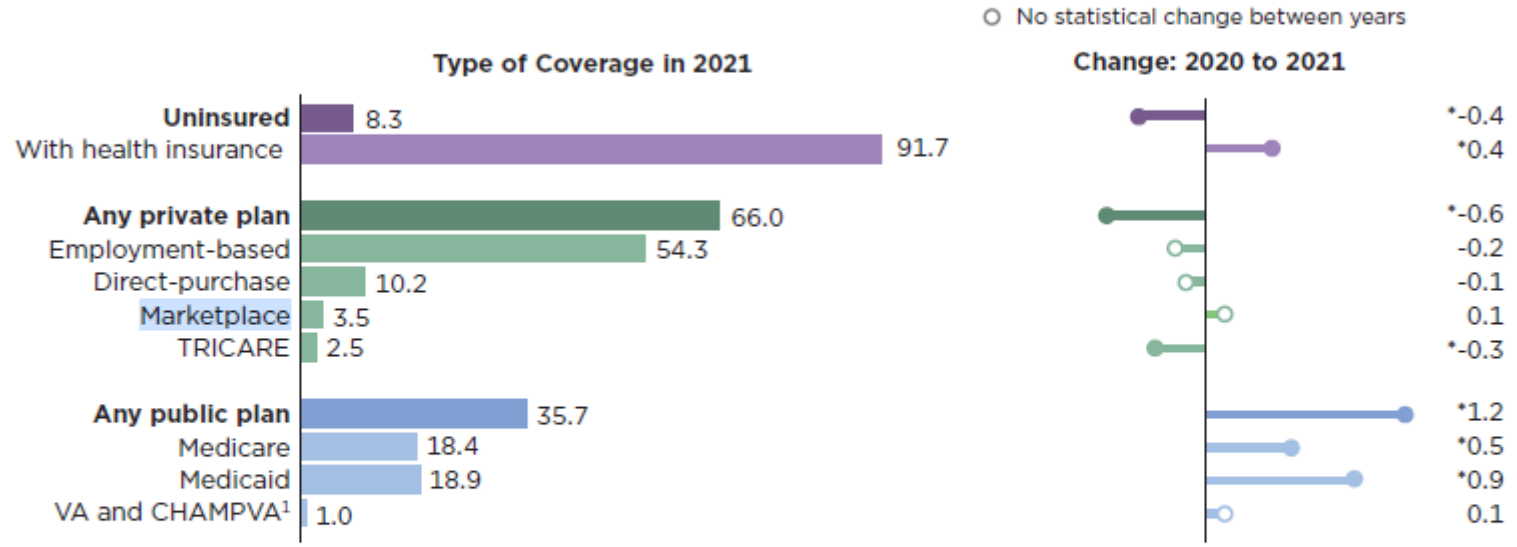
- Created in 1997 to cover all children whose parents have modest incomes too high to qualify for Medicaid.
- Joint federal / state. $21 billion in FY 2021.

Many different types of insurance and can have more than one type.

Figure 1.

Percentage of People by Type of Health Insurance Coverage and Change From 2020 to 2021

(Population as of March of the following year)



* Denotes a statistically significant change between 2020 and 2021 at the 90 percent confidence level.

[1] Includes CHAMPVA (Civilian Health Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA) and the military.

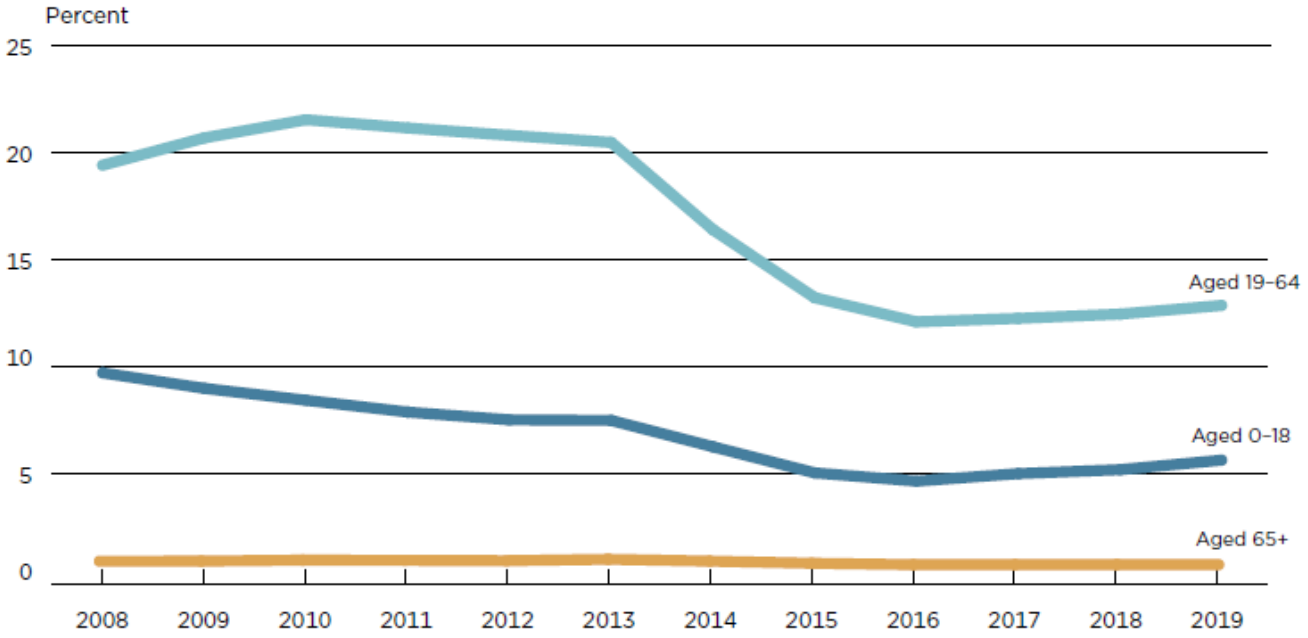
Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar22.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2021 and 2022 Annual Social and Economic Supplements (CPS ASEC).

B.8 UNINSURANCE

- About 8% uninsured – recent drop with Obamacare.

Figure 3.
Percentage of People Without Health Insurance Coverage by Age: 2008 to 2019
(Civilian noninstitutionalized population)



Note: Estimates reflect the population as of July of the calendar year. For information on confidentiality protection, sampling error, nonsampling error, and definitions in the American Community Survey, see <https://www2.census.gov/programs-surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2019.pdf>.
Source: U.S. Census Bureau, 2008 to 2019 American Community Surveys (ACS), 1-Year Estimates.

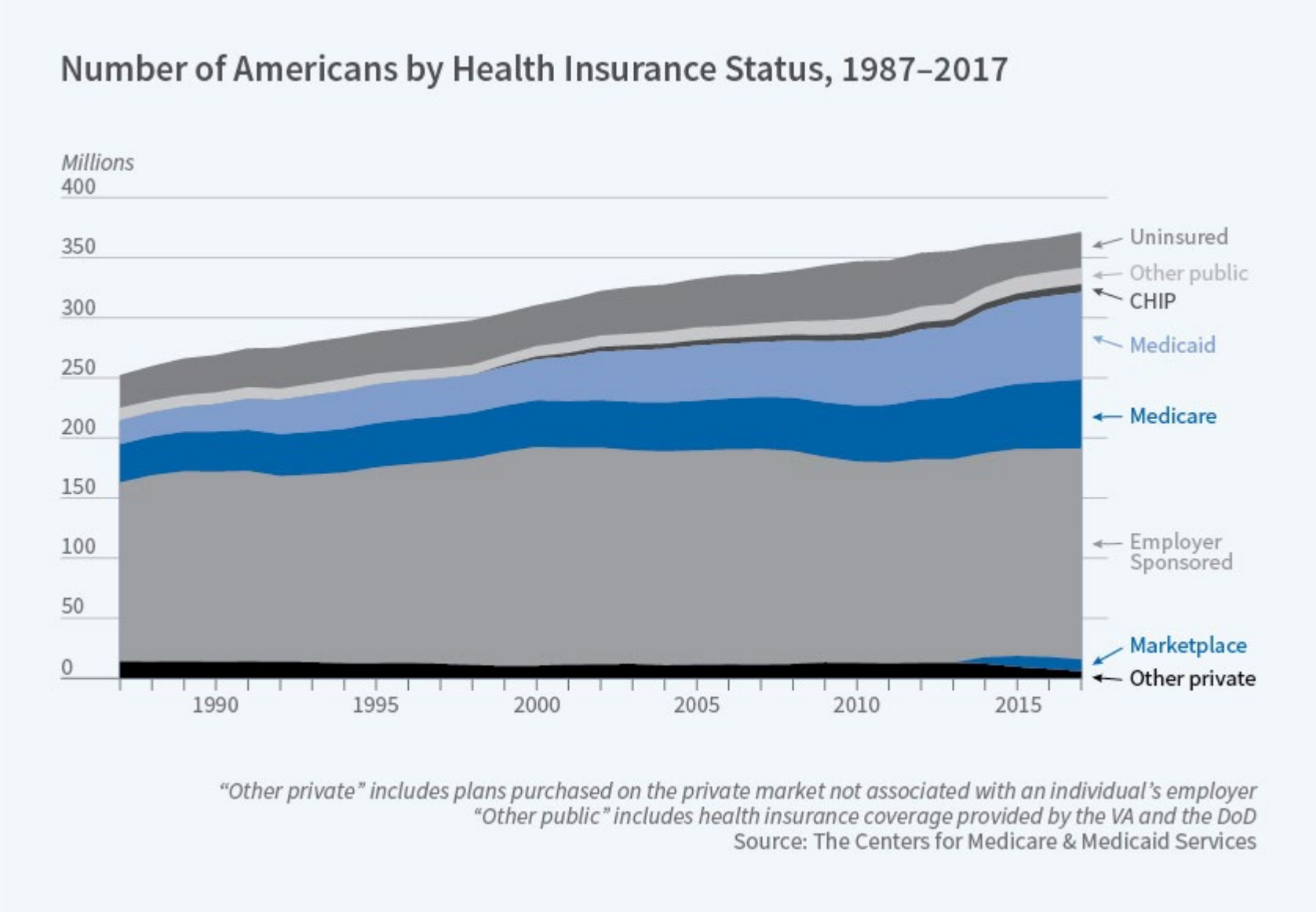
- Main uninsured are young adults (18-34) & older adults (45-64). (children may get Medicaid and CHIP and seniors get Medicare).
- Minority groups are much less likely to be covered (and if covered to be on Medicaid).
- Percentage not covered falls as education increases.
- Even many full-time workers are not covered.
- Poor persons much less likely to be covered.
- Foreign-born and non-citizens are much less likely to be covered than natives.
- Uninsured still get some care – self-pay, emergency room, hospitalization.

B.9 2010 HEALTH REFORM ("OBAMACARE")

- Patient Protection and Affordable Care Act signed by President Obama on March, 2010 and implemented in January 2014. [Source: http://www.kff.org/healthreform/upload/8061.pdf.]
- **Insurance has three components:**
- 1. Employer-provided insurance
  - Employer mandate – must offer insurance if more than 50 employees or face penalty (of $2,000 per full-time employee).
- 2. Public insurance to be expanded
  - Medicaid available to adults with income<135% of federal poverty level (though not all states chose to participate)
- 3. Privately purchased insurance
  - Purchase through geographic area health exchanges
  - Subsidies for lower income people (but not so low as to qualify for Medicaid) to purchase insurance.

- **To reduce adverse selection:**
  - all individuals must have insurance (mandate dropped in 2018)
  - in return insurers cannot exclude due to pre-existing conditions
  - standardized policies are sold at community-rated prices.
- **Cost containment:**
  - Medicare and Medicaid lower reimbursement
  - Greater emphasis on prevention and wellness programs
- **Quality:**
  - Patient-Centered Outcomes Research Institute to compare clinical effectiveness of various treatments
  - Increased payments to primary care physicians.
- **Overall:** Goal is 32 million more insured. Not reached.
  (16 million Medicaid, 24 mill exchanges, -8 mill other private)
  Costs (2010-19): Approx $1 trillion for Medicaid expansion, offset by $610 billion Medicare savings and $200 bill other.
- **More recent:** 2017 attempt to repeal led to drop mandate.

TRENDS


Number of Americans by Health Insurance Status, 1987–2017
Millions
400
350
300
250
200
150
100
50
0
1990
1995
2000
2005
2010
2015
Uninsured
Other public
CHIP
Medicaid
Medicare
Employer Sponsored
Marketplace
Other private
"Other private" includes plans purchased on the private market not associated with an individual's employer
"Other public" includes health insurance coverage provided by the VA and the DoD
Source: The Centers for Medicare & Medicaid Services