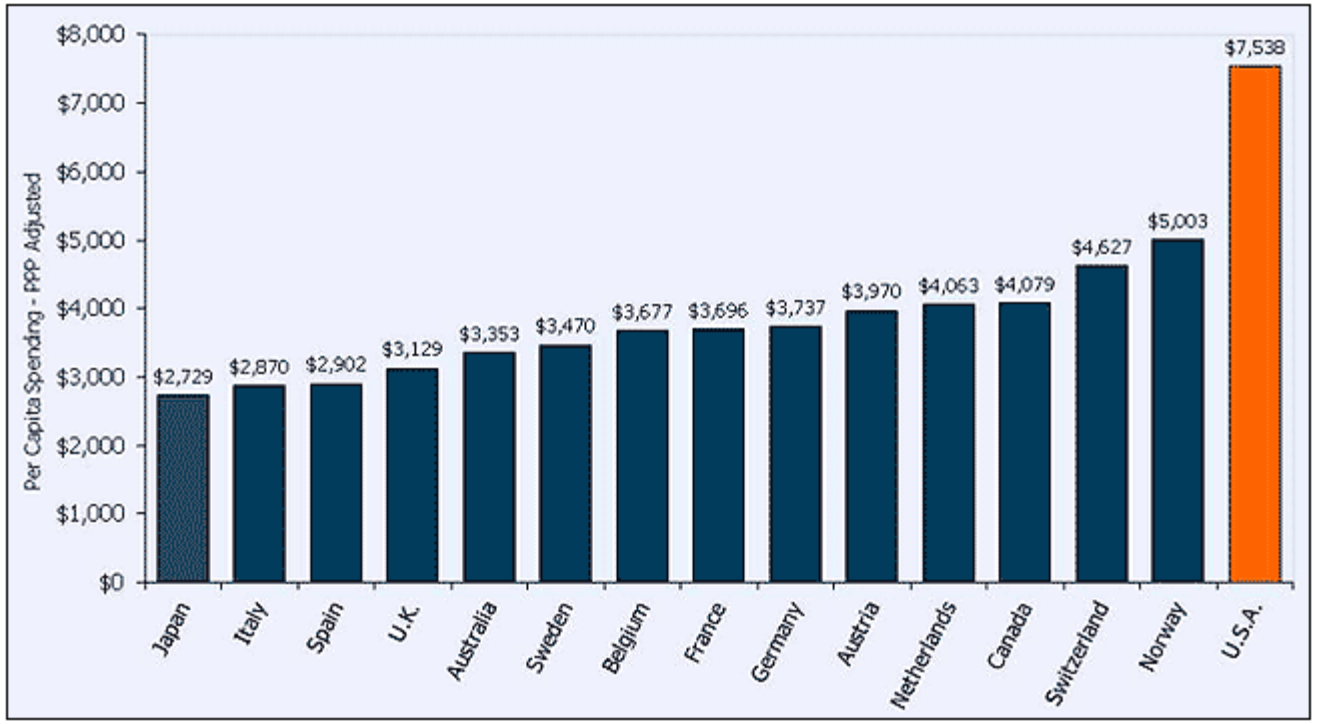
WWS594E, Week 4

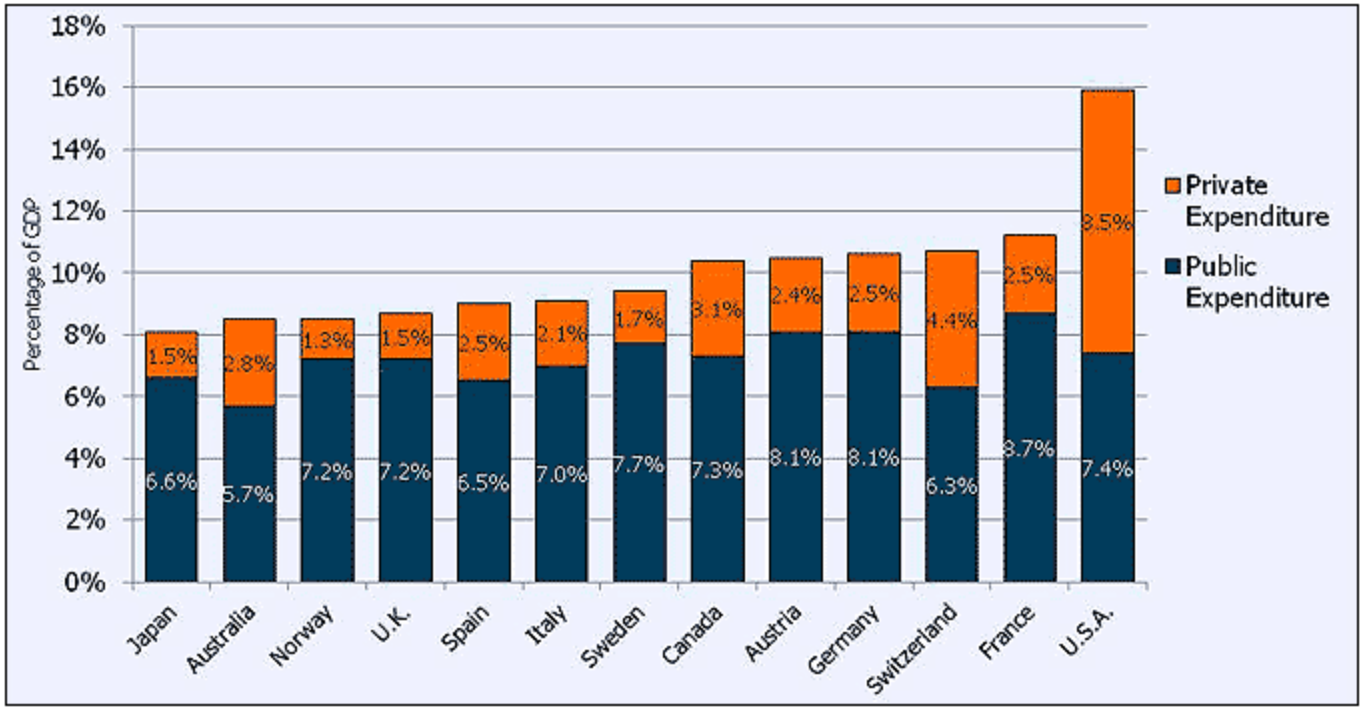
PK

Exhibit 1
Total Health Expenditure per Capita, U.S. and Selected Countries, 2008



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011).
Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted.

Exhibit 10
Public and Private Health Expenditures as a Percentage of GDP, U.S. and Selected Countries, 2008



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Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada,

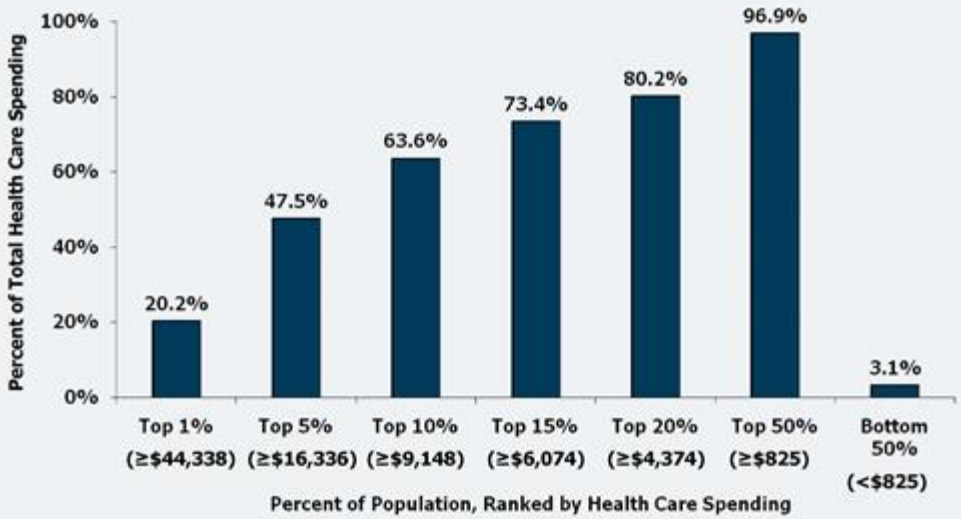
UNCERTAINTY AND THE WELFARE ECONOMICS OF MEDICAL CARE

By KENNETH J. ARROW*

I. *Introduction: Scope and Method*

This paper is an exploratory and tentative study of the specific differentia of medical care as the object of normative economics. It is contended here, on the basis of comparison of obvious characteristics of the medical-care industry with the norms of welfare economics, that the special economic problems of medical care can be explained as adaptations to the existence of uncertainty in the incidence of disease and in the efficacy of treatment.

Concentration of Health Care Spending in the U.S. Population, 2008



Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2008.

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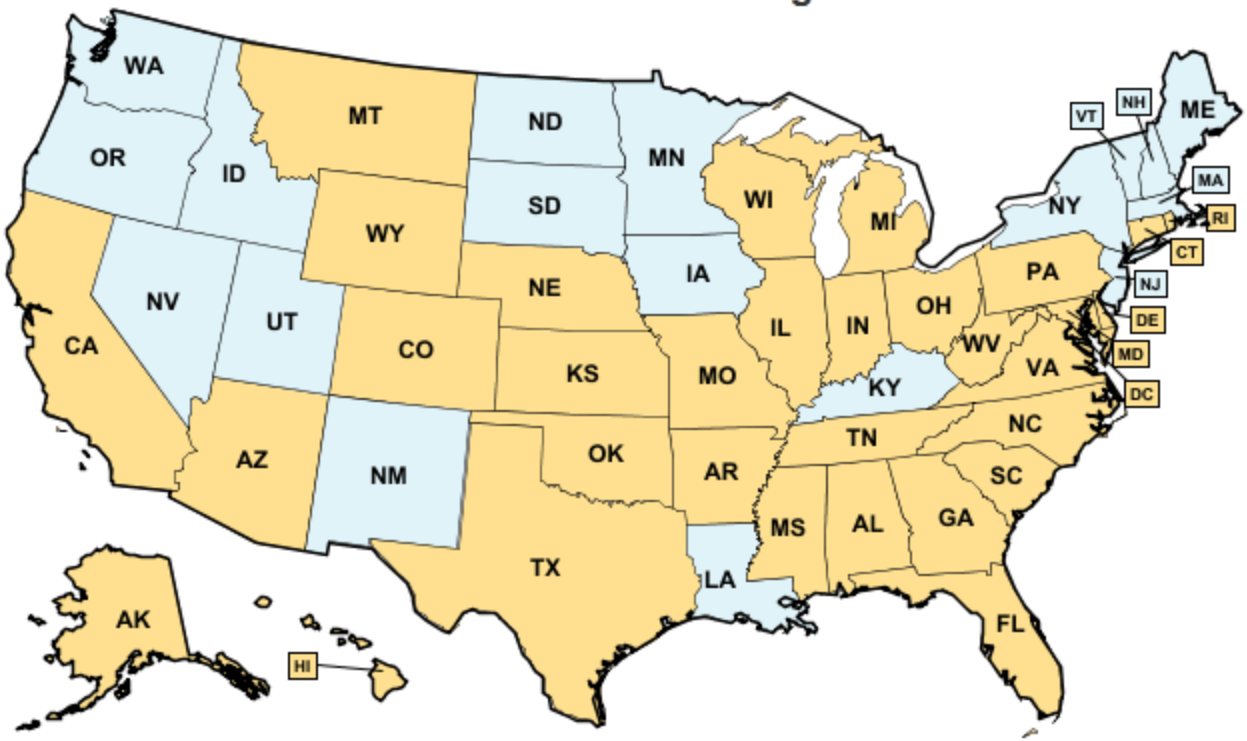
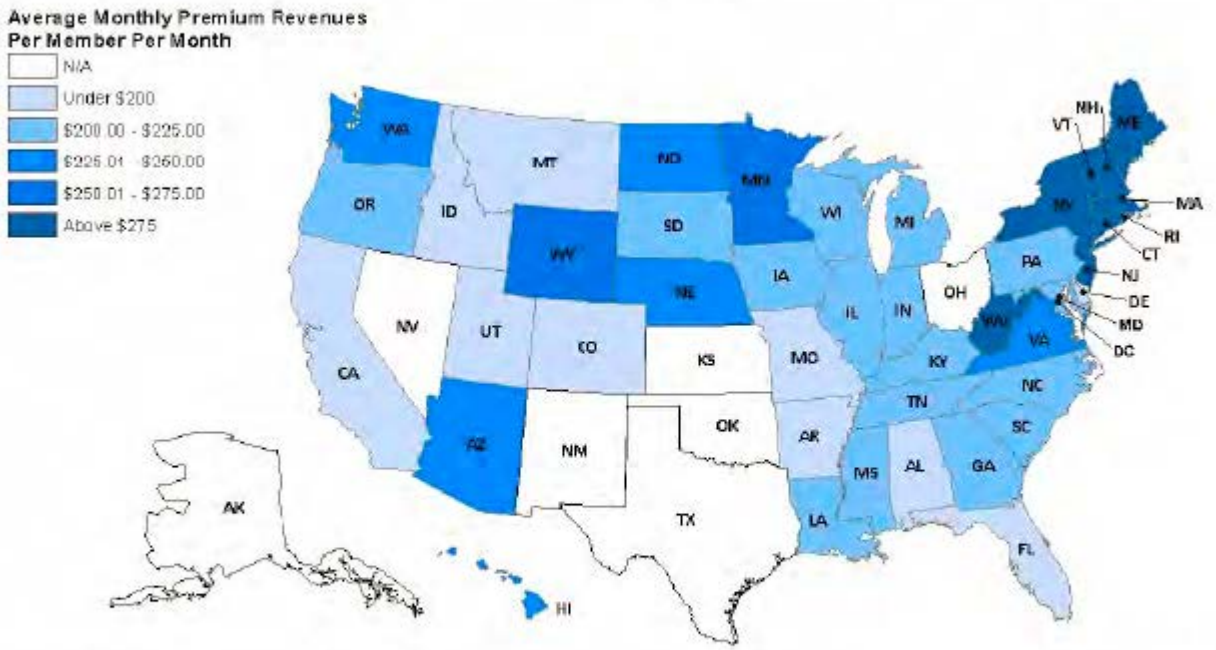
Routes to coverage:

1. Private insurance, unregulated: US individual market in California
2. Private insurance, community rating; US individual market in NY
3. Private insurance, subsidized and community rating; US employment-based
4. Mandates, community rating, subsidies: Germany, Massachusetts, US if Obama wins
5. Single-payer: Canada, Americans over 65, France sort of
6. Government as provider: UK, VHA

Limits on Rating?



Health Insurance Premiums in the Individual Market in 2010



Source: Kaiser Family Foundation analysis of 2010 insurer filings to the National Association of Insurance Commissioners using the Mark Farrah Associates Health Coverage Portal. The Average premium is calculated as total premium revenues in a state divided by the number of tota member months. The per member per month premium is an average across adults and children, so will be lower than a premium typically charged to a single adult.

In California, premium data are not available for HMOs in the individual market. The data in this analysis come from Anthem Blue Cross's Wellpoint plan, which represented 57% of California's individual market enrollment in 2010.

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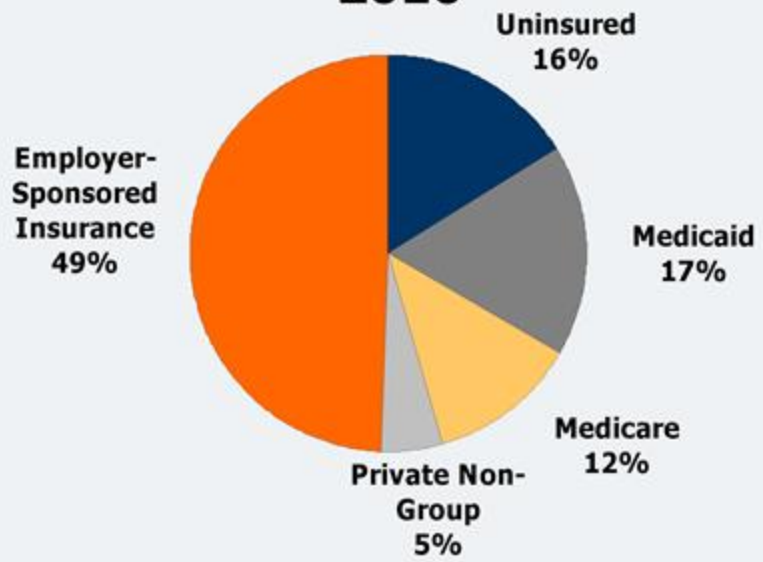
Behind those proximate causes, several forces contribute to the rising cost of outpatient care across the entire range of settings, not just same-day hospital stays and visits to physicians' offices. For starters, outpatient care is highly profitable—US hospitals earn a significant percentage of their profits from elective same-day care—which prompts investments in the facilities and people supporting it. These investments can be recouped only by offering more (and more expensive) services. The significant degree of discretion that physicians have over the course and extent of outpatient treatment also probably plays a role, as does the fee-for-service reimbursement system, which creates financial incentives to provide more outpatient care.

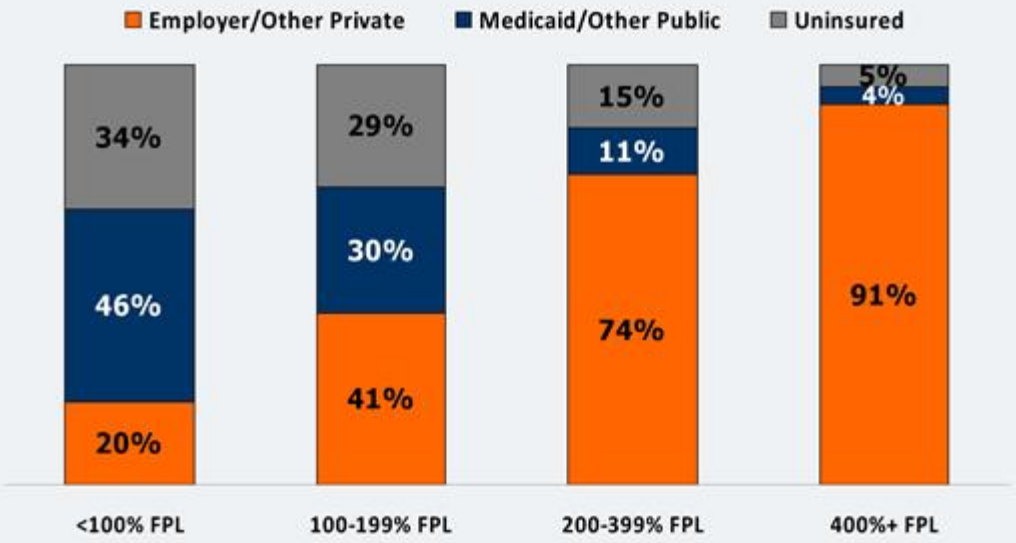
Health Insurance Coverage in the U.S., 2010



Total = 305.2 million

* Medicaid also includes other public programs: CHIP, other state programs, military-related coverage. Numbers may not add to 100 due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2011 ASEC Supplement to the CPS.

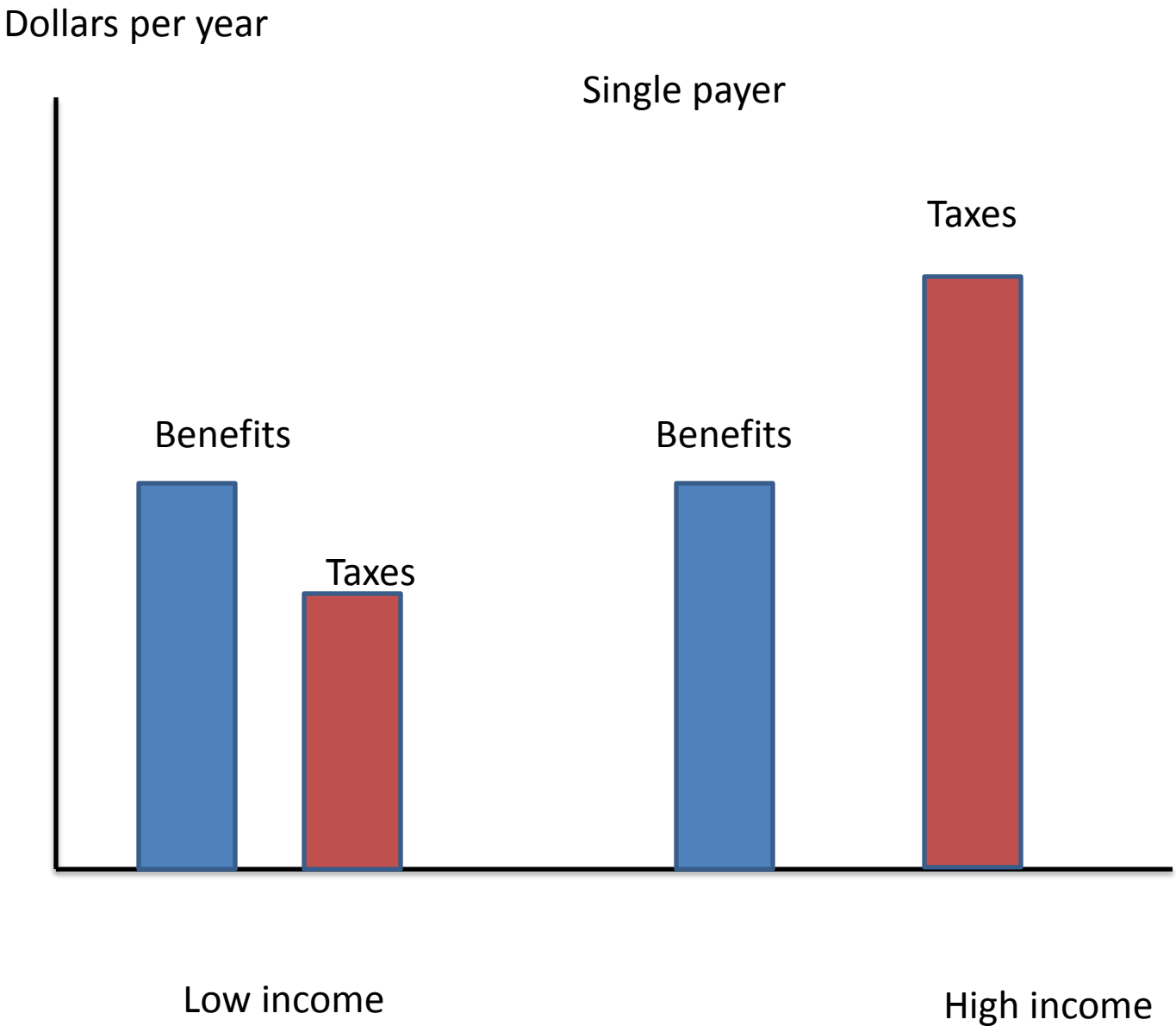
Health Insurance Coverage of the Nonelderly by Poverty Level, 2010



FPL= Federal Poverty Level. The FPL was $22,050 for a family of four in 2010.
Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2011 ASEC Supplement to the CPS.

The ACA: a three-legged stool

1. Non-discrimination
2. Mandate
3. Subsidies


Dollars per year
Single payer
Taxes
Benefits
Benefits
Taxes
Low income
High income

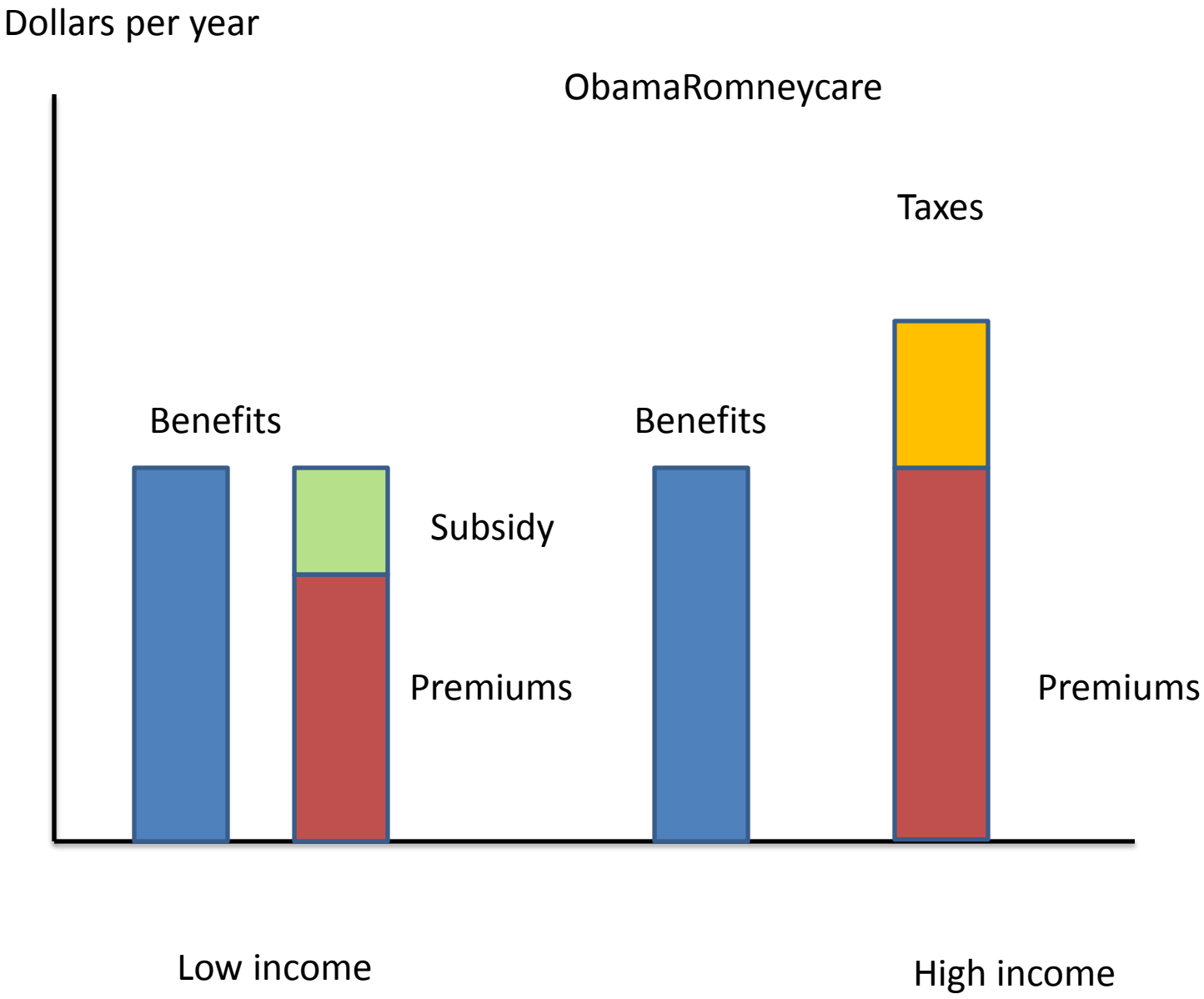

Dollars per year
ObamaRomneycare
Taxes
Benefits
Benefits
Subsidy
Premiums
Premiums
Low income
High income

Table 1. Estimate of the Effects on the Deficit of the Reconciliation Proposal Combined with H.R. 3590, as Passed by the Senate

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM INSURANCE COVERAGE PROVISIONS [a,b]												
Effects on the Deficit	3	7	9	10	49	87	132	154	164	172	78	788
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING DIRECT SPENDING [c]												
Effects on the Deficit of Changes in Outlays	3	3	-7	-28	-50	-60	-70	-86	-101	-116	-79	-511
NET CHANGES IN THE DEFICIT FROM OTHER PROVISIONS AFFECTING REVENUES [d]												
Effects on the Deficit of Changes in Revenues	*	-9	-12	-38	-50	-48	-59	-65	-69	-71	-109	-420
NET CHANGES IN THE DEFICIT [a]												
Net Increase or Decrease (-) in the Budget Deficit	6	1	-10	-56	-51	-20	3	4	-5	-15	-109	-143
On-Budget	6	1	-10	-55	-50	-18	8	10	2	-6	-108	-114
Off-Budget [e]	*	*	1	-1	-1	-2	-5	-6	-7	-9	-1	-29

Table 4. Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate

EFFECTS ON INSURANCE COVERAGE /a (Millions of nonelderly people, by calendar year)		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	50	51	51	51	51	51	52	53	53	54
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid & CHIP	*	-1	-2	-3	10	15	17	16	16	16
	Employer	*	3	3	3	4	1	-3	-3	-3	-3
	Nongroup & Other /c	*	*	*	*	-2	-3	-5	-5	-5	-5
	Exchanges	0	0	0	0	8	13	21	23	24	24
	Uninsured /d	*	*	-1	-1	-19	-25	-30	-31	-31	-32
Post-Policy Uninsured Population											
Number of Nonelderly People /d		50	50	50	50	31	26	21	21	22	23
Insured Share of the Nonelderly Population /a											
Including All Residents		81%	82%	82%	82%	89%	91%	92%	92%	92%	92%
Excluding Unauthorized Immigrants		83%	83%	83%	83%	91%	93%	95%	95%	95%	94%

Figure 1.

Shares of Spending on Health Care for a Typical 65-Year-Old with a Standardized Health Insurance Benefit

(Percentage of total spending with a private plan)