25

PAYING FOR HEALTH CARE

Thomas Bodenheimer and Kevin Grumbach

Health care is not free. Someone must pay. But how? Does each person pay when receiving care? Do people contribute regular amounts in advance so that their care will be paid for when they need it? When a person contributes in advance, might the contribution be used for care given to someone else? If so, who should pay how much?

Health care financing in the United States evolved to its current state through a series of social interventions. Each intervention solved a problem but in turn created its own problems requiring further intervention. This chapter will discuss the historical process of the evolution of health care financing. The enactment in 2010 of the Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act, ACA, or "Obamacare," created major changes in the financing of health care in the United States.

MODES OF PAYING FOR HEALTH CARE

The four basic modes of paying for health care are out-of-pocket payment, individual private insurance, employment-based group private insurance, and government financing (Table 25.1). These four modes can be viewed both as a historical progression and as a categorization of current health care financing.

Out-of-Pocket Payments

> Fred Farmer broke his leg in 1913. His son ran 4 miles to get the doctor, who came to the farm to splint the leg. Fred gave the doctor a couple of chickens to pay for the visit. His great-grandson, Ted, who is uninsured, broke

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his leg in 2013. He was driven to the emergency room, where the physician ordered an x-ray and called in an orthopedist who placed a cast on the leg. The cost was $2,800.

One hundred years ago, people like Fred Farmer paid physicians and other health care practitioners in cash or through barter. In the first half of the twentieth century, out-of-pocket cash payment was the most common method of payment. This is the simplest mode of financing—direct purchase by the consumer of goods and services (Fig. 25.1).

People in the United States purchase most consumer items and services, from gourmet restaurant dinners to haircuts, through direct out-of-pocket payments. This is not the case with health care (Arrow, 1963; Evans, 1984), and one may ask why health care is not considered a typical consumer item.

Need Versus Luxury

Whereas a gourmet dinner is a luxury, health care is regarded as a basic human need by most people.

For 2 weeks, Marina Perez has had vaginal bleeding and has felt dizzy. She has no insurance and is terrified that medical care

TABLE 25.1 ■ Health Care Financing in 2013[a]

Type of Payment	Percentage of National Health Expenditures, 2013
Out-of-pocket payment	12%
Individual private insurance	3%
Employment-based private insurance	30%[b]
Government financing	47%
Other	8%
Total	100%
Principle Source of Coverage	**Percentage of Population, 2013**
Uninsured	13%
Individual private insurance	7%
Employment-based private Insurance	47%
Government financing	33%
Total	100%

Note: These figures precede implementation of most of the Affordable Care Act.

[a]Because private insurance tends to cover healthier people, the percentage of expenditures is far less than the percentage of population ˙covered. Public expenditures are far higher per population because the elderly and disabled are concentrated in the public Medicare and Medicaid programs.

[b]This includes private insurance obtained by federal, state, and local employees which is in part purchased by tax funds.

Source: Data extracted from Hartman M et al. National health spending in 2013; growth slows, remains in step with the overall economy. *Health Aff* 2015;34:150–160; US Census Bureau: Health Insurance Coverage in the United States, 2013. September, 2014.

might eat up her $500 in savings. She scrapes together $100 to see her doctor, who finds that her blood pressure falls to 90/50 mm Hg upon standing and that her hematocrit is 26%. The doctor calls Marina's sister Juanita to drive her to the hospital. Marina gets into the car and tells Juanita to take her home.

If health care is a basic human right, then people who are unable to afford health care must have a payment mechanism available that is not reliant on out-of-pocket payments.

Unpredictability of Need and Cost

Whereas the purchase of a gourmet meal is a matter of choice and the price is shown to the buyer, the need for and cost of health care services are unpredictable. Most people do not know if or when they may become severely ill or injured or what the cost of care will be.

Jake has a headache and visits the doctor, but he does not know whether the headache will cost $100 for a physician visit plus the price of a bottle of ibuprofen, $1,200 for an MR1, or $200,000 for surgery and irradiation for brain cancer.

The unpredictability of many health care needs makes it difficult to plan for these expenses. The medical costs associated with serious illness or injury usually exceed a middle-class family's savings.

Patients Need to Rely on Physician Recommendations

Unlike the purchaser of a gourmet meal, a person in need of health care may have little knowledge of what he or she is buying at the time when care is needed.

Jenny develops acute abdominal pain and goes to the hospital to purchase a remedy for her pain. The physician tells her that she has acute cholecystitis or a perforated ulcer and recommends hospitalization, an abdominal CT scan, and upper endoscopic studies. Will

FIGURE 25.1 ■ Out-of-Pocket Payment Is Made Directly From Patient to Provider

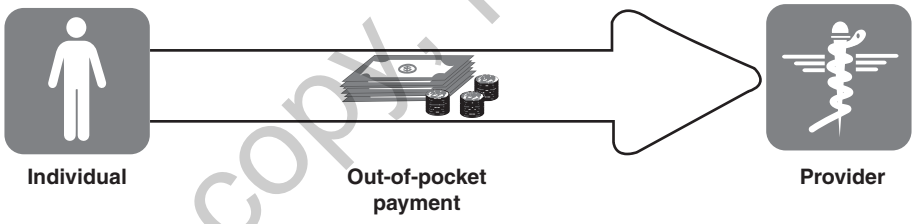
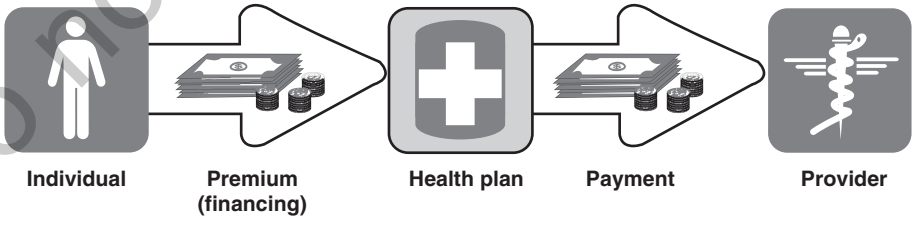


FIGURE 25.2 ■ Individual Private Insurance



Note: A third party, the insurance plan (health plan), is added, dividing payment into a financing component and a payment component. The ACA added an individual coverage mandate for those not otherwise insured and federal subsidy to help individuals pay the insurance premium.

Jenny, lying on a gurney in the emergency room and clutching her abdomen with one hand, use her other hand to leaf through a textbook of internal medicine to determine whether she really needs these services, and should she have brought along a copy of Consumer Reports to learn where to purchase them at the cheapest price?

Health care is the foremost example of asymmetry of information between providers and consumers (Evans, 1984). A patient with abdominal pain is in a poor position to question a physician who is ordering laboratory tests, x-rays, or surgery. When health care is elective, patients can weigh the pros and cons of different treatment options, but even so, recommendations may be filtered through the biases of the physician providing the information. Compared with the voluntary demand for gourmet meals, the demand for health services is partially involuntary and is often physician- rather than consumer-driven.

For these reasons among others, out-of-pocket payments are flawed as a dominant method of paying for health care services. Because the direct purchase of health services became increasingly difficult for consumers and was not meeting the needs of hospitals and physicians to be reliably paid, health insurance came into being.

Individual Private Insurance

In 2012, Bud Carpenter was self-employed. To pay the $500 monthly premium for his individual health Insurance policy, he had to work extra jobs on weekends, and the $5,000 deductible meant he would still have to pay quite a bit of his family's medical costs out of pocket. Mr. Carpenter preferred to pay these costs rather than take the risk of spending the money saved for his children's college education on a major illness. When he became ill with leukemia and the hospital bill reached $80,000, Mr. Carpenter appreciated the value of health insurance. Nonetheless he had to feel disgruntled when he read a newspaper story listing his insurance company among those that paid out on average less than 60 cents for health services for every dollar collected in premiums.

With private health insurance, a third party, the insurer is added to the patient and the health care provider, who are the two basic parties of the health care transaction. While the out-of-pocket mode of payment is limited to a single financial transaction, private insurance requires two transactions—a premium payment from the individual to an insurance plan (also called a health plan), and a payment from the insurance plan to the provider (Fig. 25.2). In nineteenth-century Europe, voluntary benefit funds were set up by guilds, industries, and mutual societies. In return for paying a monthly sum, people received assistance in case of illness. This early form of private health insurance was slow to develop in the United States. In the early twentieth century, European immigrants set up some small benevolent societies in US cities to provide sickness benefits for their members. During the same period, two commercial insurance companies, Metropolitan Life and Prudential, collected 10 to 25 cents per week from workers for life insurance policies that also paid for funerals and the expenses of a final illness. The policies were paid for by individuals on a weekly basis, so large numbers of insurance agents had to visit their clients to collect the premiums as soon after payday as possible. Because of the huge administrative costs, individual health insurance never became a dominant method of paying for health care (Starr, 1982). In 2013, prior to the implementation of the individual insurance mandate of the ACA, individual policies provided health insurance for 7% of the US population (Table 25.1).

In 2014, Bud Carpenter signed up for individual insurance for his family of 4 through Covered California, the state exchange set up under the ACA. Because his family income was 200% of the federal poverty level, he received a subsidy of $1,373 per month, meaning that his premium would be $252 per month (down from his previous monthly

premium of $500) for a silver plan with Kaiser Permanente. His deductible was $2,000 (down from $5,000). Insurance companies were no longer allowed to deny coverage for his pre-existing leukemia.

The ACA has many provisions, described in detail in the Kaiser Family Foundation (2013a) Summary of the Affordable Care Act. . . . One of the main provisions is a requirement (called the "individual mandate") that most US citizens and legal residents who do not have governmental or private health insurance purchase a private health insurance policy through a federal or state health insurance exchange, with federal subsidies for individual and families with incomes between 100% and 400% of the federal poverty level ($24,250 to $97,000 for a family of four). Details of the individual mandate are provided in Table 25.2.

Employment-Based Private Insurance

Betty Lerner and her schoolteacher colleagues each paid $6 per year to Prepaid Hospital in 1929. Ms. Lerner suffered a heart attack and was hospitalized at no cost. The following year Prepaid Hospital built a new wing and raised the teachers' prepayment to $12.

Rose Riveter retired in 1961. Her health insurance premium for hospital and physician care, formerly paid by her employer, had been $25 per month. When she called the insurance company to obtain individual coverage, she was told that premiums at age 65 cost $70per month. She could not afford the insurance and wondered what would happen if she became ill.

The development of private health insurance in the United States was impelled by the increasing effectiveness and rising costs of hospital care. Hospitals became places not only in which to die, but also in which to get well. However, many patients were unable to pay for hospital care, and this meant that hospitals were unable to attract "customers."

In 1929, Baylor University Hospital agreed to provide up to 21 days of hospital care to 1,500 Dallas school-teachers such as Betty Lerner if they paid the hospital $6 per person per year. As the Great Depression deepened and private hospital occupancy in 1931 fell to 62%, similar hospital-centered private insurance plans spread. These plans (anticipating health maintenance organizations [HMOs]) restricted care to a particular hospital. The American Hospital Association built on this prepayment movement and established statewide Blue Cross hospital insurance plans allowing free choice of hospital. By 1940, 39 Blue Cross plans controlled by the private hospital industry had enrolled over 6 million people. The Great Depression reduced the amount patients could pay physicians out of pocket, and in 1939, the California Medical Association set up the first Blue Shield plan to cover physician services. These plans, controlled by state medical societies, followed Blue Cross in spreading across the nation (Starr, 1982; Fein, 1986).

In contrast to the consumer-driven development of health insurance in European nations, coverage in the United States was initiated by health care providers seeking a steady source of income. Hospital and physician control over the "Blues," a major sector of the health insurance industry, guaranteed that payment would be generous and that cost control would remain on the back burner (Law, 1974; Starr, 1982).

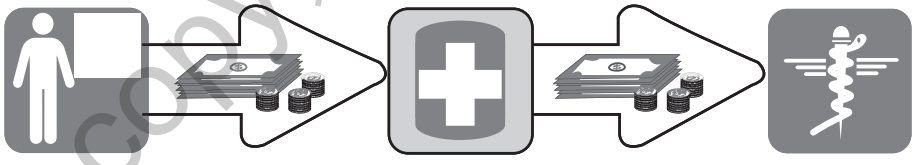
The rapid growth of employment-based private insurance was spurred by an accident of history. During World War II, wage and price controls prevented companies from granting wage increases, but allowed the growth of fringe benefits. With a labor shortage, companies competing for workers began to offer health insurance to employees such as Rose Riveter as a fringe benefit. After the war, unions picked up on this trend and negotiated for health benefits. The results were dramatic: Enrollment in group hospital insurance plans grew from 12 million in 1940 to 142 million in 1988.

TABLE 25.2 ■ Summary of the Individual Mandate Provisions of the Affordable Care Act (ACA), 2015

U.S. citizens and legal residents are required to have health coverage with exemptions available for such issues as financial hardship. Those who choose to go without coverage pay a tax penalty of $325 or 2% of taxable Income in 2015, which gradually increases over the years. People with employer based and governmental health Insurance are not required to purchase the insurance required under the Individual mandate.
Tax credits to help pay health insurance premiums increase in size as family incomes rise from 100% to 400% of the Federal Poverty Level. In addition subsidies reduce the amount of out-of-pocket costs individuals and families must pay; the amount of the subsidy varies by income.
Under the individual mandate, health Insurance is purchased though insurance marketplaces called health insurance exchanges. Seventeen states have elected to set up their own exchanges, the remainder of states are covered by the federal exchange, Healthcare.gov.
Insurance companies marketing their plans through the exchange offer benefit categories: Bronze plans represent minimum coverage, with the insurer paying for 60% of a person's health care costs, with high out-of-pocket costs but low premiums Silver plans cover 70% of health care costs, with fewer out-of-pocket costs and higher premiums Gold plans cover 80% of costs, with low out-of-pocket costs and high premiums Platinum plans cover 90% of costs, with very low out-of-pocket costs and very high premiums
Most people who have obtained Insurance through the exchange have picked Bronze or Silver plans, and 87% have received a subsidy. A family of four with income at 150% of the federal poverty level receives an average subsidy of $11,000. At 300% of the federal poverty level the subsidy is about $6,000.

Source: Kaiser Family Foundation. Summary of the Affordable Care Act, 2013. http://kfforg/health-reform/fact-sheet/summary-of-the-affordable-care-act. Accessed March 12, 2015.

FIGURE 25.3 ■ Employment-Based Private Insurance



Note: In addition to the direct employer subsidy, indirect government subsidies occur through the tax-free status of employer contributions for health insurance benefits.

With employment-based health insurance, employers usually pay much of the premium that purchases health insurance for their employees (Fig. 25.3). However, this flow of money is not as simple as it looks. The federal government views employer premium payments as a tax-deductible business expense. The government does not treat the health insurance fringe benefit as taxable income to the employee, even though the payment of premiums could be interpreted as a form of employee income. Because each premium dollar of employer-sponsored health insurance results in a reduction in taxes

collected, the government is in essence subsidizing employer-sponsored health insurance. This subsidy is enormous, estimated at $250 billion per year (Ray et al., 2014).

The ACA made a change in employer-based health insurance, requiring employers with 50 or more full-time employees to offer coverage or pay a fee to the government; the fee is meant to discourage employers from dropping employee health insurance, which they might be tempted to do since their employees could buy individual insurance through the health insurance exchanges (Kaiser Family Foundation, 2013b).

The growth of employment-based health insurance attracted commercial insurance companies to the health care field to compete with the Blues for customers. The commercial insurers changed the entire dynamic of health insurance. The new dynamic was called experience rating. (The following discussion of experience rating can be applied to individual as well as employment-based private insurance.)

> Healthy Insurance Company insures three groups of people—a young healthy group of bank managers, an older healthy group of truck drivers, and an older group of coal miners with a high rate of chronic illness. Under experience rating, Healthy sets its premiums according to the experience of each group in using health services. Because the bank managers rarely use health care, each pays a premium of $300 per month. Because the truck drivers are older, their risk of illness is higher, and their premium is $500 per month. The miners, who have high rates of black lung disease, are charged a premium of $700 per month. The average premium income to Healthy is $500 per member per month.
>
> Blue Cross insures the same three groups and needs the same $500 per member per month to cover health care plus administrative costs for these groups. Blue Cross sets its premiums by the principle of community rating. For a given health insurance policy, all subscribers in a community pay the same premium. The bank managers, truck drivers, and mine workers all pay $500 per month.

Health insurance provides a mechanism to distribute health care more in accordance with human need rather than exclusively on the basis of ability to pay. To achieve this goal, funds are redistributed from the healthy to the sick, a subsidy that helps pay the costs of those unable to purchase services on their own.

Community rating achieves this redistribution in two ways:

1. Within each group (bank managers, truck drivers, and mine workers), people who become ill receive benefits in excess of the premiums they pay, while people who remain healthy pay premiums while receiving few or no health benefits.
2. Among the three groups, the bank managers, who use less health care than their premiums are worth, help pay for the miners, who use more health care than their premiums could buy.

Experience rating is less redistributive than community rating. Within each group, those who become ill are subsidized by those who remain well, but among the different groups, healthier groups (bank managers) do not subsidize high-risk groups (mine workers). Thus the principle of health insurance, which is to distribute health care more in accordance with human need rather than exclusively on the ability to pay, is weakened by experience rating (Light, 1992).

In the early years, Blue Cross plans set insurance premiums by the principle of community rating, whereas commercial insurers used experience rating as a "weapon" to compete with the Blues (Fein, 1986). Commercial insurers such as Healthy Insurance Company could offer cheaper premiums to low-risk groups such as bank managers, who would naturally choose a Healthy commercial plan at $300 over a Blue Cross plan at $500. Experience rating

helped commercial insurers overtake the Blues in the private health insurance market. While in 1945 commercial insurers had only 10 million enrollees, compared with 19 million for the Blues, by 1955 the score was commercials 54 million and the Blues 51 million.

Many commercial insurers would not market policies to such high-risk groups as mine workers, leaving Blue Cross with high-risk patients who were paying relatively low premiums. To survive the competition from the commercial insurers, Blue Cross had no choice but to seek younger, healthier groups by abandoning community rating and reducing the premiums for those groups. In this way, many Blue Cross and Blue Shield plans switched to experience rating. Without community rating, older and sicker groups became less and less able to afford health insurance.

From the perspective of the elderly and those with chronic illness, experience rating is discriminatory. Healthy persons, however, might have another viewpoint and might ask why they should voluntarily transfer their wealth to sicker people through the insurance subsidy. The answer lies in the unpredictability of health care needs. When purchasing health insurance, an individual does not know if he or she will suddenly change from a state of good health to one of illness. Thus, *within a group*, people are willing to risk paying for health insurance, even though they may not use it. *Among different groups*, however, healthy people have no economic incentive to voluntarily pay for community rating and subsidize another group of sicker people. This is why community rating cannot survive in a market-driven competitive private insurance system (Aaron, 1991).

In a major reform contained within the ACA, insurers are severely limited in using experience rating to set premiums; they can only vary premiums based on family size, geographic location, age, and smoking status. The ACA also limits how much premiums can differ between older and younger individuals (Kaiser Family Foundation, 2013b).

The most positive aspect of health insurance—that it assists people with serious illness to pay for their care—has also become one of its main drawbacks—the difficulty in controlling costs in an insurance environment. With direct purchase, the "invisible hand" of each individual's ability to pay holds down the price and quantity of health care. However, if a patient is well insured and the cost of care causes no immediate fiscal pain, the patient will use more services than someone who must pay for care out of pocket. In addition, particularly before the advent of fee schedules, health care providers could increase fees more easily if a third party was available to foot the bill.

Thus health insurance was originally an attempt by society to solve the problem of unaffordable health care under an out-of-pocket payment system, but its very capacity to make health care more affordable created a new problem. If people no longer had to pay out of their own pockets for health care, they would use more health care; and if health care providers could charge insurers rather than patients, they could more easily raise prices, especially during the era when the major insurers (the Blues) were controlled by hospitals and physicians. The solution of insurance fueled the problem of rising costs. As private insurance became largely experience rated and employment based, persons who had low incomes, who were chronically ill, or who were elderly found it increasingly difficult to afford private insurance.

Government Financing

> In 1984 at age 74 Rose Riveter developed colon cancer. She was now covered by Medicare, which had been enacted in 1965. Even so, her Medicare premium, hospital deductible expenses, physician copayments, short nursing home stay, and uncovered prescriptions cost her $2,700 the year she became ill with cancer.

Employment-based private health insurance grew rapidly in the 1950s, helping working people and their families to afford health care. But two groups in the population received little or no benefit: the poor and the elderly. The poor were usually unemployed or employed in jobs without the fringe benefit of health insurance; they could not afford

insurance premiums. The elderly, who needed health care the most and whose premiums had been partially subsidized by community rating, were hard hit by the trend toward experience raring. In the late 1950s, less than 15% of the elderly had any health insurance (Harris, 1966). Only one program could provide affordable care for the poor and the elderly: tax-financed government health insurance.

Government entered the health care financing arena long before the 1960s through such public programs as municipal hospitals and dispensaries to care for the poor and through state-operated mental hospitals. But only with the 1965 enactment of Medicare (for the elderly) and Medicaid (for the poor) did public insurance payments for privately operated health services become a major feature of health care in the United States. Medicare Part A (Table 25.3) is a hospital insurance plan for the elderly financed largely through social security taxes from employers and employees. Medicare Part B (Table 25.4) insures the elderly for physician services and is paid for by federal taxes and monthly premiums from the beneficiaries. Medicare Part D, enacted in 2003, offers prescription drug coverage and is paid for by federal taxes and monthly premiums from beneficiaries. Medicaid (Table 25.5) is a program run by the states that is funded by federal and state taxes, which pays for the care of millions of low-income people. In 2013, Medicare and Medicaid expenditures totaled $586 and $450 billion, respectively (Hartman et al., 2015).

With its large deductibles, copayments, and gaps in coverage, Medicare paid for only 58% of the average beneficiary's health care expenses in 2012. Ninety percent of the 50 million Medicare beneficiaries in 2012 had supplemental coverage: Thirty-three percent of beneficiaries had additional coverage from their previous employment, 19% purchased supplemental private insurance (called "Medigap" plans), 24% were enrolled in the Medicare Advantage program, and 14% were enrolled in both Medicare and Medicaid (Kaiser Family Foundation, 2015a).

The Medicare Modernization Act (MMA) of 2003 made two major changes in the Medicare program: the expansion of the role of private health plans (the Medicare Advantage program, Part C) and the establishment of a prescription drug benefit (Part D). Under the Medicare Advantage program, a beneficiary can elect to enroll in a private health plan contracting with Medicare, with Medicare subsidizing the premium for that private health plan rather than paying hospitals, physicians, and other providers directly as under Medicare Parts A and B. Beneficiaries joining a Medicare Advantage plan sacrifice some freedom of choice of physician and hospital in return for lower out-of-pocket payments and are only allowed to receive care from health care providers who are connected with that plan. Two-thirds of beneficiaries with Medicare Advantage plans are in health maintenance organizations (HMOs) . . . ; the remainder are in private fee-for-service plans. In order to channel more patients into Medicare Advantage plans, the MMA provided generous payments to those plans, with the result that they initially cost the federal government 14% more than the government paid for health care services for similar Medicare beneficiaries in the traditional Part A and Part B programs. The ACA reduced payments to Medicare Advantage plans with the goal of saving the Medicare program $136 billion over the following 10 years. In 2012, HMO Medicare Advantage plans on average cost the federal government 7% less than traditional Medicare while fee-for-service plans cost 12% to 18% more than traditional Medicare (Biles et al., 2015).

Medicare Part D provides partial coverage for prescription drugs. In 2013, 73% of Part D was financed through tax revenues, and 75% of Medicare beneficiaries had enrolled in the voluntary Medicare Part D program. Part D has been criticized because (1) there are major gaps in coverage, (2) coverage has been farmed out to private insurance companies rather than administered by the federal Medicare program, and (3) the government is not allowed to negotiate with pharmaceutical companies for lower drug prices. These three features of the program have caused confusion for beneficiaries, physicians, and pharmacists and a high cost for the program. Two-thirds of beneficiaries on Medicare Part D are enrolled in one of the 1,001 stand-alone private prescription drug plans and one-third receives their

TABLE 25.3 ■ Summary of Medicare Part A, 2015

Who is eligible?
Upon reaching the age of 65 years, people who are eligible for Social Security are automatically enrolled in Medicare Part A whether or not they are retired.
A person who has paid into the Social Security system for 10 years and that person's spouse are eligible for Social Security. People who are not eligible for Social Security can enroll in Medicare Part A by paying a monthly premium.
People under the age of 65 years who are totally and permanently disabled may enroll in Medicare Part A after they have been receiving Social Security disability benefits for 24 months. People with amyotrophic lateral sclerosis (ALS) or end-stage renal disease requiring dialysis or a transplant are also eligible for Medicare Part A without a 2-year waiting period.

How is it financed?
Financing is through the Social Security system. Employers and employees each pay to Medicare: 1.45% of wages and salaries. Self-employed people pay 2.9%.
The 2010 Affordable Care Act Increases the employee care for higher-income taxpayers (incomes greater than $200,000 for individuals or $250,000 for couples) from 1.45% to 2.35% starting in 2013.

What services are covered?[a]

Services	Benefit	Medicare Pays
Hospitalization	First 60 days[b]	All but a $1,260 deductible per benefit period
	61st to 90th day[b]	All but $315/day
	91st to 150th	All but $630/day
	Beyond 90 days if lifetime reserve days are used up	Nothing
Skilled nursing facility	first 20 days	All
	21st to 100th day	All but $157.50/day
	Beyond 100 days	Nothing
Home health care	Medically necessary care for homebound people	100% for skilled care as defined by Medicare regulations
Hospice care	As long as doctor certifies person suffers from a terminal illness	100% for most services, copays for outpatient drugs and coinsurance for inpatient respite care
Unskilled nursing home care	Care that is mainly custodial is not covered	Nothing

[a]For patients in Medicare Advantage plans, covered services and patient responsibility for payment changes based on the specifics of each Medicare Advantage plan.

[b]Part A benefits are provided by each benefit period rather than for each year. A benefit period begins when a beneficiary enters a hospital and ends 60 days after discharge from the hospital or from a skilled nursing facility.

[c]Beyond 90 days. Medicare pays for 60 additional days only once in a lifetime ("lifetime reserve days").

Part D coverage through a Medicare Advantage plan. Sixty-three percent are enrolled in one of five large companies. Different plans cover different medications and require different premiums, deductibles, and coinsurance payments. The standard benefit in 2015 has a $320 deductible and 25% coinsurance up to $2,960 in total drug costs, followed by a coverage gap. During the gap, enrollees are responsible for a larger share of their total drug costs until their total out-of-pocket spending reaches $4,700. Thereafter, enrollees pay only a small percentage of drug costs. The coverage gap, called the "donut hole," is a major problem for patients with chronic illness needing several medications. The ACA gradually reduces the amounts beneficiaries must pay in the donut hole (Kaiser Family Foundation, 2015b).

In 2009, the trustees of the Medicare program estimated that the Part A trust fund would be depleted by 2017. The ACA, by raising social security payments and reducing expenditures, extended Medicare's solvency through 2030.

The Medicaid program is jointly administered by the federal and state governments, with the federal government contributing at least 50% of the

TABLE 25.4 ■ Summary of Medicare Part B, 2015

Who is eligible?
People who are eligible for Medicare Part A who elect to pay the Medicare Part B premium of $104.90 per month. Some low-income persons can receive financial assistance with the premium. Higher income beneficiaries (over $85,000 for individual, $170,000 for couple) have higher premiums related to income.

How is it financed?
Financing is in part by general federal revenues (personal income and other federal taxes) and in part by Part B monthly premiums.

What services are covered?[a]

Services	Benefit	Medicare Pays
Medical expenses Physician services Physical, occupational, and speech therapy Medical equipment Diagnostic tests (no coinsurance for laboratory services)	All medically necessary services	80% of approved amount after a $147 annual deductible
Preventive care	Pap smears; mammograms; colorectal/prostate cancer, cardiovascular and diabetes screening; pneumococcal and influenza vaccinations; yearly physical examinations	Included in medical expenses, and for some services the deductible and copayment are waived
Outpatient medications	Partially covered under Medicare Part D	All except for premium, deductible, coinsurance, and "donut hole," which vary by Part D plan
Eye retractions, hearing aids, dental services	Not covered	Nothing

[a]For patients in Medicare Advantage plans, covered services and patient responsibility for payment changes based on the specifics of each Medicare Advantage plan.

TABLE 25.5 ■ Summary of Medicaid Under the Affordable Care Act (ACA), 2015

Medicaid is a federal program administered by the states.
Eligibility
From 1965 through 2014, Medicaid while designed for low-income Americans, did not cover all poor people. In addition to being poor, Medicaid had required that people also meet "categorical" eligibility criteria such as being a young child, parent, pregnant, elderly or disabled, leaving out nonpregnant adults with dependent children. Income eligibility for Medicaid varied by state, typically children were covered up to 100%, adults to 61% and the elderly or disabled to 74% of the Federal Poverty Level. The federal government paid between 50% and 76% of total Medicaid costs; the federal contribution being greater for states with lower per capita incomes.
In 2015, Medicaid under the ACA varies widely between states participating in the Medicaid expansion and those not participating; for the latter states, the provisions summarized for the 1965 to 2014 period still apply. Participating states must make all individuals with incomes up to 138% of the federal poverty level eligible for coverage, with no categorical eligibility criteria. To finance Medicaid expansion for the participating states, the federal government pays 100% of the costs of the newly eligible from 2014 to 2016, decreasing to 90% in 2020 and beyond. Undocumented immigrants are not eligible for Medicaid.
State waivers
States can be granted waivers by the federal government to make changes in which services they provide to Medicaid recipients and whether recipients are required to receive the services through managed care plans.

funding to match state expenses for operating Medicaid programs. Although designed for low-income Americans, not all poor people have traditionally been eligible for Medicaid. In addition to being poor, until enactment of the ACA Medicaid required that people also meet "categorical" eligibility criteria such as being a young child, pregnant, elderly, or disabled.

The ACA (Table 25.5) eliminated the categorical eligibility criteria and required that beginning in 2014, states offer the program to all citizens and legal residents with family income at or below 138% of the Federal Poverty Line—about $16,000 in 2015. The ACA did not change Medicaid policies that continue to exclude undocumented immigrants from eligibility for federal funding, The ACA intended that it be mandatory for states to expand Medicaid eligibility, and provided states an incentive for expansion by having the federal government pay almost all the cost of the increased Medicaid enrollment (100% of the cost of expanded enrollment in 2014 to 2016, phased down to 90% in 2020 and thereafter). However, in June 2012, the Supreme Court ruled that the ACA's Medicaid expansion was optional for states. In February 2015, only 28 states plus the District of Columbia had expanded Medicaid (Obamacare Facts, 2015). Medicaid now covers one in six people in the United States, making it the single largest health program in the nation. Enrollment grew dramatically in recent years even before implementation of the ACA in 2014, with enrollment increasing from 32 million to 60 million people between 2000 and 2013 (9 million of whom were "dual eligibles" receiving both Medicare and Medicaid). By the end of 2014, an additional 6 million people had enrolled in states participating in ACA Medicaid expansion—falling short of the goal of 16 million new enrollees, if all states had participated in the expansion (Rosenbaum, 2014).

From 2000 to 2013, Medicaid expenditures rose from $200 billion to $450 billion. To slow down this expenditure growth, the federal government ceded to states enhanced control over Medicaid programs through Medicaid waivers, which allow states to make alterations in the scope of covered services, require Medicaid recipients to pay part of their costs, and obligate Medicaid recipients to enroll in managed care plans. . . . In 2014, more than half of Medicaid recipients were enrolled in managed care plans. Because Medicaid pays primary care

physicians an average of 58% of Medicare fees, the majority of adult primary care physicians limit the number of Medicaid patients they will see.

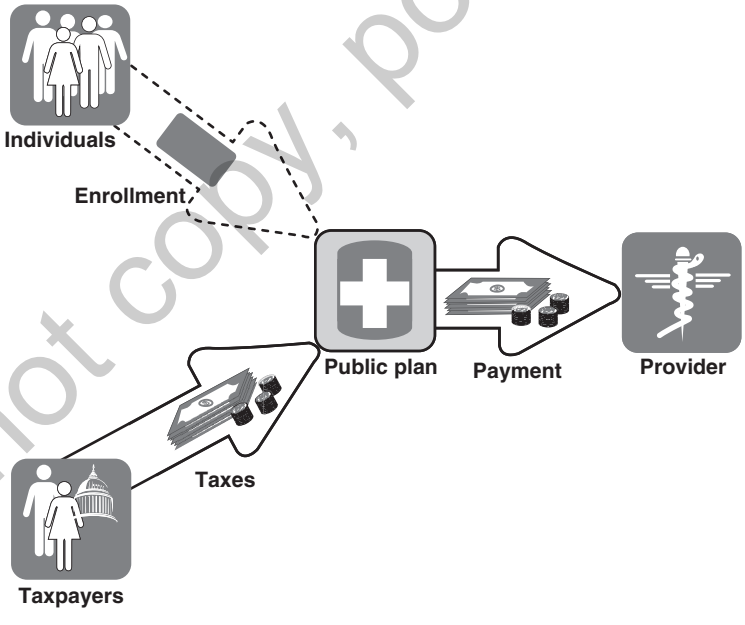
In 1997, the federal government created the State Children's Health Insurance Program (SCHIP), a companion program to Medicaid. SCHIP covers children in families with incomes at or below 200% of the federal poverty level, but above the Medicaid income eligibility level. States legislating an SCHIP program receive generous federal matching funds. In 2012, 8 million children were enrolled in the program, some of whom are transitioning to Medicaid under the expanded eligibility criteria enacted in the ACA.

Government health insurance for the poor and the elderly added a new factor to the health care financing equation: the taxpayer (Fig. 25.4). With government-financed health plans, the taxpayer can interact with the health care consumer in two distinct ways:

1. The social insurance model, exemplified by Medicare, allows only those who have paid a certain amount of social security taxes to be eligible for Part A and only those who pay a monthly premium to receive benefits from Part B. As with private insurance, social insurance requires people to make a contribution in order to receive benefits.
2. The contrasting model is the Medicaid public assistance model, in which those who contribute (taxpayers) may not be eligible for benefits (Bodenheimer & Grumbach, 1992).

It must be remembered that private insurance contains a subsidy: redistribution of funds from the healthy to the sick. Tax-funded insurance has the same subsidy and usually adds another: redistribution of funds from upper- to lower-income groups.

FIGURE 25.4 ■ Government-Financed Insurance



Note: Under the social insurance model (e.g., Medicare Part A), only individuals paying taxes into the public plan are eligible for benefits. In other models (e.g., Medicaid), an individual's eligibility for benefits may not be directly linked to payment of taxes into the plan.

Under this double subsidy, exemplified by Medicare and Medicaid, healthy middle-income employees generally pay more in social security payments and other taxes than they receive in health services, whereas unemployed, disabled, and lower-income elderly persons tend to receive more in health services than they contribute in taxes.

The advent of government financing improved financial access to care for some people, but, in turn, aggravated the problem of rising costs. The federal government and state governments have responded by attempting to limit Medicare and Medicaid payments to physicians, hospitals, and managed care plans.

THE BURDEN OF FINANCING HEALTH CARE

Different methods of financing health care place different burdens on the various income levels of society. Payments are classified as progressive if they take a rising percentage of income as income increases, regressive if they take a falling percentage of income as income increases, and proportional if the ratio of payment to income is the same for all income classes (Pechman, 1985).

What principle should underlie the choice of revenue source for health care? A central purpose of the health care system is to maintain and improve the health of the nation's population. . . . Rates of mortality and disability are far higher for low-income people than for the wealthy. Burdening low-income families with high levels of payments for health care (i.e., regressive payments) reduces their disposable income, amplifies the ill effects of poverty, and thereby worsens their health. It makes little sense to finance a health care system—whose purpose is to improve health—with payments that worsen health. Thus, regressive payments could be considered "unhealthy."

> Rita Blue earns $10,000 per year for her family of 4. She develops pneumonia, and her out-of-pocket health costs come to $1,000, 10% of her family income.

> Cathy White earns $100,000 per year for her family of 4. She develops pneumonia, and her out-of-pocket health costs come to $1,000, 1% of her family income.

Out-of-pocket payments are a regressive mode of financing. According to the 1987 National Medical Care Expenditure Survey, out-of-pocket payments took 12% of the income of families in the nation's lowest-income quintile, compared with 1.2% for families in the wealthiest 5% of the population (Bodenheimer & Sullivan, 1997). This pattern is confirmed by the 2000 Medical Expenditure Panel Survey (MEPS, 2003). Many economists and health policy experts would consider this regressive burden of payment as unfair. Aggravating the regressivity of out-of-pocket payments is the fact that lower-income people tend to be sicker and thus have more out-of-pocket payments than the wealthier and healthier.

> Jim Hale is a young, healthy, self-employed accountant whose monthly income is $6,000, with a health insurance premium of $200, or 3% of his income.

> Jack Hurt is a disabled mine worker with black lung disease. His income is $1,800 per month, of which $400 (22%) goes for his health insurance.

Experience-rated private health insurance is a regressive method of financing health care because increased risk of illness tends to correlate with reduced income. If Jim Hale and Jack Hurt were enrolled in a community-rated plan, each with a premium of $300, they would respectively pay 5% and 17% of their incomes for health insurance. With community rating, the burden of payment is regressive, but less so than with experience rating. Most private insurance is not individually purchased but rather obtained through employment. How is the burden of employment-linked health insurance premiums distributed?

> Jill is an assistant hospital administrator. To attract her to the job, the hospital offered her

a package of salary plus health insurance of $6,500 per month. She chose to take $6,200 in salary, leaving the hospital to pay $300 for her health insurance.

Bill is a nurse's aide, whose union negotiated with the hospital for a total package of $2,800 per month; of this amount $2,500 is salary and $300 pays his health insurance premium.

Do Jill and Bill pay nothing for their health insurance? Not exactly. Employers generally agree on a total package of wages and fringe benefits; if Jill and Bill did not receive health insurance, their pay would probably go up by nearly $300 per month. That is why employer-paid health insurance premiums are generally considered deductions from wages or salary, and thus paid by the employee (Blumberg et al., 2007). For Jill, health insurance amounts to only 5% of her income, but for Bill it is 12%. The MEPS corroborates the regressivity of employment-based health insurance; in 2001 to 2003, premiums took an average of 10.9% of the income of families in between 100% and 200% of the Federal Poverty Line compared with 2.3% for those above 500% of poverty (Blumberg et al., 2007). In 2012, employer-sponsored health insurance premiums represented 58% of family income for the bottom 40% of American families compared with 4% for the top 5% (Blumenthal & Squires, 2014).

Larry Lowe earns $10,000 and pays $410 in federal and state income taxes, or 4.1% of his income.

Harold High earns $100,000 and pays $12,900 in income taxes, or 12.9% of his income.

The progressive income tax is the largest tax providing money for government-financed health care. Most other taxes are regressive (e.g., sales and property taxes), and the combined burden of all taxes that finance health care is roughly proportional (Pechman, 1985).

In 2009, 46% of health care expenditures were financed through out-of-pocket payments and premiums, which are regressive, while 47% was funded through government revenues (Martin et al., 2011), which are proportional. The sum total of health care financing is regressive. In 1999, the poorest quintile of households spent 18% of income on health care, while the highest-income quintile spent only 3% (Cowan et al, 2002). Overall, the US health care system is financed in a manner that is unhealthy.

CONCLUSION

Neither Fred Farmer nor his great-grandson Ted had health insurance, but the modern-day Mr. Farmer's predicament differs drastically from that of his ancestor. Third-party financing of health care has fueled an expansive health care system that offers treatments unimaginable a century ago, but at tremendous expense.

Each of the four modes of financing health care developed historically as a solution to the inadequacy of the previous modes. Private insurance provided protection to patients against the unpredictable costs of medical care, as well as protection to providers of care against the unpredictable ability of patients to pay. But the private insurance solution created three new, interrelated problems:

1. The opportunity for health care providers to increase fees to insurers caused health services to become increasingly unaffordable for those with inadequate insurance or no insurance.
2. The employment-based nature of group insurance placed people who were unemployed, retired, or working part-time at a disadvantage for the purchase of insurance, and partially masked the true costs of insurance for employees who did receive health benefits at the workplace.
3. Competition inherent in a deregulated private insurance market gave rise to the practice of experience rating, which made insurance premiums unaffordable for many

elderly people and other medically needy groups.

To solve these problems, government financing was required, but government financing fueled an even greater inflation in health care costs.

As each "solution" was introduced, health care financing improved for a time. But rising costs have jeopardized private and public coverage for many people and made services unaffordable for those without a source of third-party payment. The problems of each financing mode, and the problems created by each successive solution, have accumulated into a complex crisis characterized by inadequate access for some and high costs for everyone.

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