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Health Insurance Reform in the USA: Assessing Proposal Impact Using Microsimulation Approach

Abstract

At the present moment, the overall social security system in the U.S. is undergoing fundamental debates. In this study, our interest will be intended for the health care system and its reform proposals, mainly the one which pass the Senate and the House 7 November 2009 named “Affordable Health Care for America”. The debate over healthcare reform in the U.S centers around questions of a right to healthcare, access, fairness, sustainability, and quality purchased by the high sums spent. Microsimulation model will be used to run many different scenarios under the submitted proposal

Introduction
At the current moment, the social security system in the U.S. is undergoing fundamental debates and according to data compiled and published by multiple pharmaceutical trade groups, the US is the world leader in biomedical research and development as well as the introduction of new biomedical products; in the main time enrollment rules in private and public programs result in millions of Americans going without health care coverage, including old age and children and this is indeed the main reason for the health insurance reform in USA where pharmaceutical trade organizations also maintain that the high cost of health care in the U.S. has encouraged substantial reinvestment in such research and development. The Institute of Medicine of the National Academy of Sciences reports that the United States is the “only wealthy, industrialized nation that does not ensure that all citizens have coverage”

**The main aim of this study** is to assess the impact of the recent basic health insurance scheme reform on the coverage and the quality of health care. The emphasis of the policy evaluation is at the micro level from the perspective of the changes of individuals' economic burden towards health costs, the supposed impact on both small businesses and the competition between public and private insurance also will be assessed.

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**Review**

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1 Insuring America’s Health: Principles and Recommendations Institute of Medicine at the National Academies of Science, 2004-01-14, accessed 2007-10-22
The U.S. efforts to achieve universal coverage began with Theodore Roosevelt, who had the support of progressive health care reformers in the 1912 election but was defeated. President Harry S Truman called for universal health care as a part of his Fair Deal in 1949 but strong opposition stopped that part of the Fair Deal.

The Medicare program was established by legislation signed into law on July 30, 1965, by President Lyndon B. Johnson. Medicare is a social insurance program administered by the United States government, providing health insurance coverage to people age 65 and over, or who meet other special criteria. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Employment Retirement Income Security Act of 1974 (ERISA) to give some employees the ability to continue health insurance coverage after leaving employment.

Health care reform was a major concern of the Bill Clinton administration; however, the 1993 Clinton health care plan was not enacted into law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) made it easier for workers to keep health insurance coverage when they change jobs or lose a job, and also made use of national data standards for tracking, reporting and protecting personal health information. During the 2004 presidential election, both the George Bush and John Kerry campaigns offered health care proposals.

The Congressional Budget Office has argued that the Medicare program as currently structured is unsustainable without significant reform, as tax revenues dedicated to the

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2 Lee Legel (May-June, 2008), "The history of health care as a campaign issue", Physician Executive
program are not sufficient to cover its rapidly increasing expenditures. According to the Centers of Medicare and Medical Services, spending on Medicare will grow from approximately $500 billion during 2009 to $930 billion by 2018. Without changes, the system is guaranteed “to basically break the federal budget,” President Obama said at a White House news conference July 22. Here we could see that the current health system needs significant reform.

The Coverage

Increasing the proportion of people with adequate protection from financial risk due to health care expenses is a cornerstone for most proposed health policies and therefore a key metric for evaluating them.

In general, the number of people without insurance continues to increase reaching 43.4 million (16.1 percent of the population) in 1997. Recent years, it was also reported that the number of uninsured people hugely increased particularly non–elderly which increased from 44.8 million in 2005 to 47.0 million in 2006 while work based insurance coverage is neither required of nor guaranteed by employers and the overall proportion of firms that offer health benefits declined between 2000 (69 percent) and 2007 (60 percent), then rose again in 2008 to 63 percent. Firms that do not offer health benefits cite the high cost of premiums as the reason (Kaiser and HRET, 2008). Firm size (especially for smaller firms) is another important consideration.

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4 Bloomberg-Cardiologists Crying Foul over Medicare Reforms-August 2009
Employees who have employer sponsored group insurance have seen steady increases in their premiums, at faster rates than increases in inflation or workers' earnings. The average employee premium contribution has more than doubled since 1999, while rates of increase in inflation and earnings fluctuated between 2 percent and 6 percent per year.

When designing a new health care system, it is very important to look at the characteristics of people without insurance in order to target those people. However, regarding to their income, in 2007, the high cost of health insurance means that lower income groups are more likely to be uninsured. Households with incomes of less than $25,000 are nearly three times as likely to be uninsured the entire year as are households with incomes of $75,000 or more. With respect to the age, young adults are the most likely to report having been uninsured and the majority of the uninsured are under age 35. Working age adults were more likely than children or the elderly to be uninsured. Moreover, concerning the race, ethnicity, and place of birth, it was found that about one-third of Hispanics and American Indians are uninsured, compared with 12 percent of non-Hispanic whites and 18 percent of Asians, also, of uninsured persons, 78 percent are native or naturalized U.S. citizens Although recent immigrants are less likely to be insured, evidence suggests that they are not the primary cause for growth in the uninsured population (Holahan and Cook, 2005).

With respect to the efficiency, the treatment given to a patient can vary significantly depending on which health care providers they use. Research suggests that some cost-
effective treatments are not used as often as they should be, while other health care services are over-used (Baker; Fisher, and Wennberg, 2008). Although, research and reports suggest that many patients don’t trust doctors increasingly.

**The expenditure and finance**

The most recent projections (U.S. Department of Health and Human Services, 2009a) suggest an average annual growth rate of about 7 percent through 2017. Based on this prediction, U.S. health spending could reach $4.3 trillion and comprise 19.5 percent of the gross domestic product (GDP) by 2017 (U.S. Department of Health and Human Services, 2009b). Figure 1 charts past and estimated health care spending from 1965 to 2018.5

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Hence, we see that the majority of uninsured people are non-elderly people, then the cost of insured people is higher, as was found by Costa-Font and Moscone (2008), because in developed country (such Spain in their study) an aging population and a larger concentration of health care providers, as expected, tend to increase the costs of the health system. Moreover, in their study, Card, Carlos, and Maestas (2008) find evidence of routine doctor visits and access to care increase more for groups that previously lacked coverage, and experience the largest gains in coverage at age 65.

Alternatively, for low income countries, it was suggested by Heller (2006) that fiscal space for increased health spending is likely to require external financing, with a strong preference for grants. This underscores the importance of greater predictability and longer-term financing by donors if countries are to be enabled to expand employment

Source: U.S. Department of Health and Human Services, 2009a
comfortably in the health sector. Competition for such fiscal space can be anticipated, as countries confront many urgent needs across sectors. While macroeconomic policy constraints are unlikely to be encountered by expanded health sector programmes alone. Of additional importance is the viability of the health financing system, which requires that citizens accept and trust the system to ensure access to high quality care at an affordable price.

In the U.S., regarding to the fund for the new proposal, Gruber (2009) suggests a number of possible sources. One is reductions in existing government spending on health care through cost controls. Another is increased taxation of "sin goods" — cigarettes, alcohol, and high-sugar or high-fat foods that cause obesity — whose use raises the cost of health care for all Americans. The government can also look outside the health care system to increased revenues from taxes on carbon emissions or on other goods and services. Moreover, it could be financed by reducing the expensive, regressive, and inefficient subsidization of employer-sponsored insurance.

The New Health Care Proposal: “Affordable Health Care for America”

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6 http://www.kff.org/healthreform/upload/housesenatebill_final.pdf
This health care reform proposal focused on three issues: the coverage, the quality, and the cost of the new health care system.

In its last changes made during the legislative progress, this proposal requires individuals to have health insurance by create a Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or $73,240 for a family of three in 2009), and it also requires employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage.

Regarding to the quality of health care, the proposal supports comparative effectiveness research by establishing many research centers for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures, in addition to strengthening primary care and care coordination. It also conducts Medicare and Medicaid pilot program to test payment incentive models for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes. Adopt these models on a large scale if pilot programs prove successful at reducing costs. Moreover, the proposal addresses to establish many other research centers, such as the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services.
About the costs, the Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be $894 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The largest source of new revenue will come from a 5.4% surcharge imposed on families with incomes above $1,000,000 and individuals with incomes above $500,000, which is projected to raise $461 billion in revenue. Additional revenue provisions will generate $97 billion over the same time period. Congressional Budget Office (CBO) estimates the proposal will reduce the deficit by $104 billion over ten years.

Methodology

For the purpose of policy evaluation, microsimulation aims to simulate changes in individual behaviour following the introduction of a policy. At their core, microsimulation models consist of two main components: a micro-dataset and a model that informs behavioural change. Although microsimulation models differ widely due to the structure and characteristics of the model used to represent individual behaviour (Zucchelli, Jones, Rice 2010).

Hence, we are going to work on developing a quantitative modeling approach in order to fulfill the main research aim. The approach adopted could allow the estimation of the
policy effect at the individual level through the reconstruction of the population characteristics. Therefore, availability, accessibility and reliability of micro level data are fundamental to the development of microsimulation models. However, this modeling technique has been widely used in social welfare related policy evaluation by the public sector and research institutions in developed countries. One of the famous uses of this technique when it was used by British Department for Work and Pensions to simulate the income of pensioners for the next 50 years named Pensim2. It was also used in EU 15 states (Euromod), and in the United States (POLISIM).

Finally, in this research, using the history of health care in the U.S. and the economical and social circumstances, microsimulation method could be good method to be used in order to assess the efficiency of the health care proposal.

References


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