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Health insurance reform: The impact of a Medicare buy-in

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ABSTRACT

The steady-state general equilibrium and welfare consequences of a Medicare buy-in program, optional for those aged 55–64, is evaluated in a calibrated life-cycle economy with incomplete markets. Incomplete markets and adverse selection create a potential welfare improving role for health insurance reform. We find that adverse selection eliminates any market for a Medicare buy-in if it is offered as an unsubsidized option to individual private health insurance. The subsidy needed to bring the number of uninsured to less than 5 percent of the target population could be financed by an increase in the labor income tax rate of just 0.03–0.18 percent depending on how the program is implemented.

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1. Introduction

A primary goal of health care reform in the United States is to provide group health insurance to individuals who do not have access to this through their employers. In this way, relatively expensive patients with preexisting health conditions are pooled with healthy individuals who rarely see a doctor so that health care is provided to everyone at an affordable price independent of health status. A free market, however, has difficulty providing this kind of insurance due to adverse selection. That is, healthy individuals can obtain even less expensive insurance by seeking out coverage that is priced according to this individual's own health status. As a result, the market for group insurance unravels and no equilibrium price exists.

The framework introduced by the “Patient Protection and Affordable Care Act” (ACA) signed by President Obama in March 2010 is designed to achieve this goal through a combination of features that include penalties associated with not purchasing insurance (an insurance mandate), income based subsidies, and restrictions on the type of insurance contracts that can be written. Much of the complexity of this reform comes from the fact that it provides a mechanism for overcoming the adverse selection problem and increasing access to group insurance using *private* insurance companies. This paper considers a much simpler approach that was considered at the time the ACA was being debated and has the feature that participation is entirely voluntary and would offer group insurance through a *public option* that would compete with other types of insurance plans. This policy allows individuals who are between 55 and 64 to have the option of enrolling in Medicare – a Medicare buy-in program.¹

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E-mail addresses: ghansen@econ.ucla.edu (G.D. Hansen), minchunghsu@grips.ac.jp (M. Hsu), junsanglee@skku.edu (J. Lee).¹ See Jacobson et al. (2009) and Smolka and Thomas (2009) for discussion of the specific proposals put forward.

In his State of the Union address in each of the last three years of his presidency, Bill Clinton proposed allowing individuals of age 62–64 buy into this program. Later, in December 2009, the possibility of an optional Medicare buy-in was debated in congress as an alternative to the ACA (see [Hitt and Adamy, 2009](#)). This is perhaps not surprising given that polls conducted in 2000, 2004 and 2009 by the Kaiser Family Foundation indicate that about three-quarters of adults in the U.S. support the idea of allowing a Medicare buy-in for those of age 55–64. In addition, this proposal targets a population of individuals who are more likely to be unhealthy. Again according to the Kaiser Family Foundation, in 2008 only 13 percent of the individuals 55–64 are uninsured, but 26 percent of those uninsured are unhealthy. In contrast, 28 percent of individuals 19–34 are uninsured, but only of 7 percent of these uninsured are unhealthy (see [Jacobson et al., 2009](#)).

Even in the post ACA era, a Medicare buy-in continues to be debated. In April 2013, The National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and Alan Simpson, have proposed increasing the eligibility age for Medicare to 67, but allow people to buy into Medicare at age 65.²

Given that the this paper is being written prior to the actual implementation of the ACA, we evaluate the general equilibrium and welfare consequences of this policy reform from the perspective of a benchmark calibrated to the pre-ACA economy. The existing Medicare program for individuals aged 65 and over is heavily subsidized by the government. A key question addressed in this paper is how much subsidy is required to overcome the adverse selection problem and to induce most of the currently uninsured in the 55–64 age bracket to voluntarily purchase this coverage.

This policy analysis is carried out using a calibrated life-cycle economy with incomplete markets and endogenous labor supply. In our model, working age individuals face idiosyncratic productivity shocks, choose whether or not to work (labor is indivisible), accumulate claims to capital, and can purchase private health insurance if they do not receive group health insurance through their employer. They face uncertainty each period about their future health status, medical expenditures and the length of their life. Retired individuals receive social security and Medicare which, along with accumulated savings, is used to finance consumption and medical expenditures. Individuals who retire early, between age 55 and 64, might be offered group retiree health insurance.

In this environment, incomplete markets and adverse selection, which restricts the type of insurance contracts available in equilibrium, creates a potential role for health insurance reform. However, the price of such a program, if it is to be self-financing, depends crucially on who chooses to enroll. Relatively healthy individuals may prefer individual health insurance or self-insurance and their exit from the pool would raise the cost of the buy-in program for those who remain. In fact, in our calibrated economy, this adverse selection problem eliminates any market for a self-financing Medicare buy-in program.

Hence, if this voluntary program is to have any impact, it must be partially subsidized by the government to make it more attractive to healthy individuals. We therefore compare our benchmark economy, in which there is only individual health insurance or employer provided group insurance for those under age 65, with economies with a Medicare buy-in program that is subsidized at various rates by the government.

We find that by subsidizing the buy-in program, it is possible to bring the number of individuals aged 55–64 without insurance to below 5 percent without incurring large tax increases to finance the program. In particular, a 30 percent subsidy brings the fraction uninsured down from 30 percent in the benchmark to 4.5 percent. Due to the general equilibrium effects of introducing this policy, total labor taxes only need to be increased by 0.18 percentage points above the tax rate for the benchmark economy. Lifetime utility, however, is somewhat lower for an individual born in this economy compared with that of an individual born in the benchmark economy. This is due to the higher taxes that are paid by both young and old individuals, while only the relatively old enjoy the benefits of the program.

We also consider an experiment in which the subsidized Medicare buy-in program is accompanied by the elimination of group insurance provided by employers for those who qualify for the buy-in program. It turns out that the subsidy implicitly provided by the tax deductibility of employer provided insurance is greater than the subsidy offered by the Medicare buy-in program and, hence, tax rates are lower when it is eliminated in favor of the buy-in. This implies that this economy is associated with higher steady-state welfare than the benchmark economy.

Our paper contributes to the literature pioneered by [Auerbach and Kotlikoff \(1987\)](#) using calibrated general equilibrium life cycle models to study dynamic fiscal policy and social programs such as social security. It also builds on the quantitative literature using dynamic general equilibrium models with incomplete markets pioneered by [Aiyagari \(1994\)](#), [Huggett \(1993\)](#) and [Imrohoroglu \(1989\)](#). While this literature has grown to be quite large, there are relatively few papers that have applied this approach to the study of health insurance programs.

Three exceptions are [Attanasio et al. \(2010\)](#), [Jeske and Kitao \(2009\)](#) and [Pashchenko and Porapakkarm \(2013\)](#). The first of these uses a model similar to ours to evaluate alternative funding schemes for Medicare given demographic projections for the next 75 years. [Jeske and Kitao \(2009\)](#) study the role of adverse selection in a model where individuals choose whether to or not to purchase health insurance, which is either group insurance, provided through employers, or individual insurance. The paper argues that a regressive tax policy that subsidizes insurance for those receiving it through their employers by making premiums tax deductible is welfare improving since it encourages healthy individuals to stay in the program rather than seek private insurance. That is, the tax policy serves a role similar to the subsidizing the Medicare buy-in in our model. [Pashchenko and Porapakkarm \(2013\)](#) use a model similar to ours to evaluate the positive and normative consequences of the 2010 Affordable Care Act.

The remainder of the paper is organized as follows. We describe the theoretical model in [Section 2](#) and the model calibration in [Section 3](#). Results are presented in [Section 4](#), and concluding comments are given in [Section 5](#).

² See [Bowles and Simpson \(2013\)](#). In addition, [Berenson et al. \(2013\)](#) from the Urban Institute make a similar proposal.

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