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# Government Provided Health Insurance


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Medicare, Medicaid and the new Obama Affordable Care Act make health care possible for those unable to provide it for themselves. With all systems there are people who take advantage of these opportunities for personal gain. Even with corruption in the system, the help it provides those in need of it are more important. These programs offer vital support to people who would otherwise have nothing. Are you willing to watch others die or suffer to save a few extra dollars in taxes?

Medicare was created during the Johnson administration's Great Society of the 1960s. In its first full year in operation in 1967, the cost of benefits totaled \$2.7 billion (Guell 262). Medicare and Social Security are the two most important programs helping the elderly. Medicare guarantees heavily subsidized health insurance for everyone over 65. It helps pay for elderly care in hospitals, nursing home facilities, hospice care, doctors' services, prescription drugs and some home health care. The program is being questioned with potential cuts to help reduce the nation's deficit (Barry).

Medicaid is a joint federal and state program that helps people pay for health care costs. Since the 1900s the United States has been subsidizing medical care for citizens whose incomes are extremely low. In 1967 Medicaid came into full nutrition and since millions of Americans have benefitted from free medical care (Guell, 261). Today 32 million children and 25 million adults have roughly all their medical expenses paid for by Medicaid (Guell 261). Those who are eligible include families that are eligible for Temporary Assistance to Needy Families (TANF) or Supplemental Security Income (SSI) (Guell 262).

Medicaid's primary advantage is reduced costs for low-income individuals, however the program also benefits the doctors and facilities that support the program as well. Practitioners who accept Medicaid patients are guaranteed a steady stream of customers and guaranteed

payment from the federal government. This allows the establishments to determine their revenues and create budgets without being concerned about receiving payments or adjusting their fees to make the care more affordable to the patients they are treating.

In 2010 the Affordable Care Act was implemented which over several years holds insurance companies more accountable, increases insurance coverage for young adults, offers small-business tax credits, and provides access to insurance for many uninsured Americans living with pre-existing conditions. Private insurance agencies have their own corruption issues, the Affordable Care Act forces those insurance companies to follow stricter guidelines. These guidelines include; prohibiting them from dropping your coverage if you get sick, billing you into bankruptcy because of annual or lifetime limits or discriminating those with pre-existing conditions from receiving health coverage (Health Insurance).

When the recession hit many people lost jobs, making the number of active job seekers increase. Young adults fighting for jobs out of college had to worry about finding not only a job but also one that offered health insurance. If these young adults could not find jobs but loan payments began to pile up and they got ill how would they pay their medical expenses? Thanks to the Affordable Care Act 3.1 million young adult who were uninsured have gained coverage by being able to stay on their parents health plan (Health Insurance). Large employers received larger discounts on medical plans for employees making it nearly impossible for small businesses to insure employees. Small businesses now receive up to 18% more tax credits than larger employers thanks to the Affordable Care Act (Health Insurance).

The National Association of Public Hospitals and Health Systems claim, “the simple fact of having coverage reduces health care disparities and improves health care outcomes. For some people, it is literally the difference between life and death”(Siegel, Bruce). This statement was

asserted in response to the Affordable Care Act and their support of the expansion of Medicaid eligibility.

All systems, whether public or private, are prone to corruption. Private insurance agencies can be as easily corrupt as government funded projects. Without government regulation, there is little to prevent a private insurer from raising prices. If it weren't for government regulating the insurance companies and subsidizing it for those in need then people and employers would be paying more, dropping coverage for those who are sick, billing people into bankruptcy because of an annual or lifetime limit, or discriminating those with pre-existing conditions.

Although the aid provided by these programs is a great assistance to those in need of healthcare coverage, the structures of both Medicare and Medicaid have numerous negative aspects respectively. We will focus specifically on the abuse of both systems, lack of doctors who accept Medicare and Medicaid, quality of services, ability to control costs and the possible bankruptcy of the programs.

A major issue with Medicaid and Medicare is the abuse of both systems. Due to the size of these programs regulation and control are increasingly difficult to manage. The fraud in these programs is entirely out of control, ultimately putting the burden on the less than pleased taxpayers. "The Government Accountability Office estimates that there are about \$17 billion of improper Medicare payments each year, including fraudulent and erroneous overpayments to health care providers" (Edwards and DeHaven). This statistic comes with no surprise as most claims are processed without any human interaction due to computerized systems. There have been many cases of abuse of these systems in the news. For example the *New York Times* reported about a dentist in New York making claims for "fictitious patients and

procedures...[totaling] 991 procedures supposedly performed in a single day” (Edwards and DeHaven). It seems that something so obviously unrealistic would gain attention and be investigated, however, there is even a disincentive for states to be concerned about fraud when they too are able to abuse the systems. Due to the matching program, which provides government funds to states as reimbursement, the states also benefit from fraudulent behavior by increasing their receipts of federal matching dollars to make a profit.

The balance between regulation and organizational structure suggests another area of concern, specifically the balance of costs that would provide the proper control. It is nearly impossible to assess how many paid employees would justify the abuse of the system and provide actual regulation and control of the fraud. However, the National Association of Medicaid Fraud Control Units reports a staff totaling only 1,900 employees nationwide (MFCU). The units have limited funding; yet need to provide supervision of the program with the employment of government employees. Wyoming for example, has a staff of only four, while New York has upwards of three hundred (MFCU). A balance needs to be attained to control fraud at a cost that makes sense to control the costs of the program while maintaining the integrity of the system.

Equally as unethical is the steps some may take to qualify for Medicaid. For example, since applicants have to qualify for Medicaid before the program will start paying for medical expenses, “oftentimes, adult children with power of attorney try to hasten the point at which Medicaid pays their parents’ medical expenses by draining the wealth of their parents by making gifts of it to themselves and their own children” (Guell, 264). As inconceivable as it may be, this is actually legal to an extent. However to the taxpayers that suffer from this behavior it can certainly be considered abuse. There are also financial consultants that assist seniors in hiding

their assets in order to become eligible for the benefits. There are also countless instances of fraud within medical offices, even reimbursements or “kickbacks” for medical equipment subsidies, like motorized wheelchairs that patients may not necessarily need. Medical equipment fraud is of increasing concern, as a “report by Senate investigators found that 30 percent of medical equipment reimbursements that they examined appeared to be fraudulent (Edwards and DeHaven). Most abuse of these systems is due to faults in the programs that leave many with no other options, for example, the lack of doctors and Medicaid acceptance.

The lack of doctors for these patients raises problems of its own, specifically, “the use of HMOs has stemmed the unfortunate practice of Medicaid patient’s use of emergency room treatments for basic care” (Guell, 265). When these patients are unable to easily access a doctor they will simply use an emergency room where taxpayers are essentially charged a premium for services that should have been performed at a lower cost. Therefore, “states must set reimbursement rates high enough that there are enough physicians and hospitals in all areas to treat Medicaid patients adequately” (Guell, 263). Since physicians are able to deny service to Medicaid patients it leaves many with limited access to healthcare. Likewise, physicians cannot operate their practices without proper reimbursement for their services. Reimbursement rates differ by state; Kentucky for example, has not raised its rates since 1993, however medical treatments and costs have substantially increased (Jasper and Hunt). Unfortunately the restrictions and low reimbursement rates on Medicaid leave many physicians with no option but to deny their services, those who accept this “all-or-nothing” proposition however, are faced with different challenges.

Physicians that serve Medicaid and Medicare patients are faced with tight budgets due to limited funding. These constraints provide incentives for doctors to cut costs and oftentimes lead



to improper treatment. Since doctors are already putting themselves in a financial bind simply by accepting the patients they are under constant pressure to cut costs and ensure that their business is profitable. Medicare pays the hospital a specific predetermined amount depending on the patients' diagnosis, this system provides yet another incentive to keep costs down, however, "the current system also provides an incentive for hospitals to discharge patients as soon as possible," and often too soon for recovery purposes (Guell, 267). Even President Obama is not in favor of the current reimbursement system. He, "derogatorily labels this prospective payment system as paying hospitals based on what the patients have when they walk in the door not for what the hospitals do to make the patients better, or even by what services they perform" (Guell, 267). Unfortunately, this payment system was designed to control costs and has managed to damage the integrity of healthcare in the process. Controlling costs is a focal point for both physicians and government, alike.

A significant factor to the difficulty of controlling costs of Medicare and Medicaid is the rising healthcare costs. The sophistication of medical care has led to longer lifespans which allow the elderly to use Medicare's resources even longer, "as treatments for health problems continue to become more effective and life expectancies increase, we will see a continued escalation of Medicare spending" (Guell, 266). Although this can be both a negative and positive aspect, this change was not adequately accounted for, therefore depleting the funds faster than anticipated. The Republican Study Committee reported that, "states now spend more on Medicaid than anything else, including K-12 education programs" (Medicaid & CHIP). This fact emphasizes the need to control and consider cutting costs of the program.

It is also important to understand who pays for Medicare. "Three-quarters of the total expenses are paid out of tax dollars and only about a quarter by its beneficiaries" (Guell, 266).

When a third party is footing the bill multiple problems arise. A primary factor is over-consumption. When the patients are not required to contribute to the cost they will make a trip to the doctor for any and all insignificant health problems, since it is essentially free. However, we know in economics, nothing is actually free, and in this case the opportunity cost is collected through taxes and the burden is put on healthcare providers. Another problem is that, “by ensuring consumers and thereby insulating them from the costs, neither consumers nor producers have incentives for holding down costs” (Guell, 266). To control these costs and avoid bankruptcy, taxes may have to be raised substantially.

There are many predictions about Medicaid bankruptcy, however there is one undoubtable truth, funds are depleting rapidly. Medicaid is currently underfunded by \$4 trillion (Guell, 184). This may partially be due to the fact that the program began on many assumptions, many of which are flawed, for example, the assumption that the current employees could pay for current retirees. In Medicare’s first year in 1967, “the cost of its benefits totaled \$2.7 billion; by 2011 it cost 502 billion” (Guell, 262). Since the costs of healthcare are rapidly increasing and the states have been cutting Medicaid budgets, many states have been removing any additional coverage, eyeglasses for example, and only providing coverage for basic health needs. Fortunately, there are many options to prevent or delay the bankruptcy of these programs as well as improve the services of both Medicare and Medicaid. After all, these programs were meant to be the solution, not the problem.

There are many different types of healthcare comprises that countries have put in place to decrease the health care systems from getting taken advantage of along with increasing the quality of care and amount of people that are able to be covered under the plan. The United States use Medicare, Medicaid and private sector system. Another form of health care is the

universal, tax-funded system used by the United Kingdom. This system is public sector funded by taxation and national insurance contributions. Health care is free but citizens are charged for prescription drugs, ophthalmic services and dental. France uses a social insurance system. All citizens are covered; the health care is funded by compulsory social health insurance contributions by employers and employees who are not able to opt out. Singapore uses Dual system healthcare, with it being funded by both private and public sectors which is financed by taxes, employee benefits, savings called Medisave, insurance and out of the pocket payments. The government expects the patients to pay for part of their medical bills.

With all the different types of healthcare systems that can be used, is there a right system that will maximize benefits and minimize risk and economic cost? Other nations use a variety of different systems that have both positives and negative that other nation's health care systems do not. A healthcare system has to meet certain needs in order to be successful. Health Care must be available to everyone even those who cannot afford it. It must fit into a budget that will not bankrupt the country or company providing it. Also it needs to be affordable on the average citizen's salary. And it must minimize the potential for it to be abused.

A solution for the health care system would have the consumer pay for ordinary medical procedures such as check ups, other minor procedures, and for a percent of medicine costs lower than a reasonable amount based on income. Other major operations and medical expenses would be covered all but a deductible by the insurance companies. For consumers that cannot afford even minimal health care coverage a government savings plan such as the one used by Singapore (Medisave) would be created with a certain allowance for the year and for the lifetime of the savings account. This account would be funded by taxes. To apply for the government provided medical plan consumers will have to go through a screening process to check that they are

unemployed or making below a certain income, and do not have any major assets. Along with this they will have to state their current health conditions. All this information will be taken into account when determining the amount that will be put into their savings plan and how much they would be allowed to spend each year. Applicants will be able to re file if a medical condition were to come up in later years.

This government savings plan will encourage consumers to not overuse the medical insurance for insignificant health issues such as the common cold. The healthcare plan would also hold them accountable for paying for some part of the cost, which in the end would help keep prices reasonable. The government medical plan will reduce the abuse of healthcare paid for by the government. The consumer would still be able to go to the doctor when needed, while reducing the expenses endured by the insurance companies and government for consumers over using and in the end this will lower premium rates in general. The lower premium rates would make health insurance more affordable for employers and the government. The employers would then not mind keeping their insurance policies especially with the declining cost in health insurance they will be able to hire more full time employees. The lower and middle class incomes would also benefit from this because the employer would once again help them pay for insurance and the premium rates in the individual market would be lower. This would help the resources be better allocated to other more productive industries and items in the government budget where it is more needed, making the use of resources more efficiently.

Medicaid and Medicare in theory are great ways to help low or no income household's pay for medical expenses, helping millions of Americans. The problem lies in that these systems get abused to the point where it cost the government more than the funding available. To make up for this gap the bill is then placed on the taxpayers. The key is to come up with a solution that

will reduce the abuse of the system lowering the cost on the government and taxpayers. This problem has been present in all countries which use a variety of different systems to try and accomplish this issue. The proposed solution will do exactly that. This plan will keep the health care from getting over used while still providing healthcare to those that cannot afford it. In the end this will lower the burden on the taxpayers and make healthcare affordable for the government budget.

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