Healthcare Policies Reforms In The United States

Posted on May 12, 2020

Healthcare Reform and the Complexity of Insurance Markets

Healthcare policies have been reformed, and several analyses and issues regarding those policies are being debated. The United States has one of the most robust health systems in the world, as it provides better options for health and healthcare facilities. However, the article in the New York Times newspaper, “Why Healthcare Care Policy is so Hard” (Mankiw, 2017), is insightful as it provides an outline of why it is difficult to have a good healthcare policy. The article started off with the idea that healthcare is a complicated concept, and it is different from other services and goods in the market. The author has highlighted five aspects of why healthcare and healthcare policy are complex services or products. The first and foremost point is that bystanders, or what economists call externality, affect healthcare service. The two examples quoted are the vaccine and research. For example, if the vaccine is not free someone will not get vaccinated if they are not getting it free. At that point, the government needs to intervene and provide free vaccination programs. The next point that the author has pointed out is the consumer is unaware of the type of goods they need.

If one person goes to an open market, they already know and have planned on what they need from the particular market. However, in the healthcare industry, people are often uninformed about the type of service or the products they need with regard to treatment and medications. At that point, other than the buyer and seller third party, which is a physician or medical specialist, uses their best knowledge to understand the requirements of the individuals or the patients. Because consumers of this industry are not able to understand their products, the Food and Drug Administration (FDA) plays a role in ensuring licensing, rules, and regulation. Health is one of the aspects of human life that is unpredictable because you cannot know when someone will have health issues. The planning of other things like housing, transport, and education can be carried out, but healthcare finances are unseen and can have a significant impact on the financial budgets of families. In this case, health insurance companies do play a role in the provision of timely healthcare finances to individuals. However, the article has pointed out that people are misusing the insurance facility.

Adverse Selection, Coverage Decisions, and Policy

Counterarguments

One of the examples cited in the article is that people tend to overconsume the facilities that are being provided for free. If one person is insured, then for even minor issues, they will visit the doctor, whereas those who are not insured are more likely to visit the doctor only when they have severe health issues. To cater to this problem, many insurance companies also have high premiums, deductibles, and limited access to health services. A problem that arises in the insurance markets in the cases of health is adverse selection. Adverse selection is a strategic behavior where insurance companies have more information about the buyers of schemes than the buyers themselves. It happens when people who are sicker and are at risk of becoming more sick buy comprehensive insurance schemes as compared to the people who are healthy (Handel, 2013). However, the author of the New York Times article has suggested that adverse selection can result in a death spiral where insurance companies impose the same insurance premium for all people.

This will lead to healthy people being less likely to buy health insurance and will ultimately lead to rising in insurance costs for sicker people. The Affordable Care Act did not introduce employer-sponsored health insurance. Its employer shared-responsibility rules apply to applicable large employers that averaged at least 50 full-time employees, including full-time-equivalent employees, in the preceding year. Such employers must offer qualifying coverage to their full-time employees and dependents or may owe a payment if at least one full-time employee receives a Marketplace premium tax credit. The law does not simply require every company with more than 50 employees to buy insurance for all employees, and the original causal claim about employers reducing staff is not established by the cited passage.

There are several counterarguments to the article, such as the point of overconsumption can be rebuttable. The idea is that people who get free access to health insurance can overconsume but it is important to understand that people will only go to the hospital and visit the doctors when they are solely in need. In this rapidly developing world, people often find no time to go to the hospital for the slightest twinge. Another point that consumers are unaware of has some fallacies because one of the most important concerns in medical ethics is informed consent, and it does not only apply to research but to avail the treatment at all levels. While making decisions, insurance companies, physicians, and the consumers (patients) decide and approve the treatment to avoid any malfunctions during the treatment. This means that consumers are also part of decision-making and are not the uninformed parties who are just receiving the end product.

Regulation, Insurer Incentives, and the Future of Health Policy

In my opinion, there are other factors that also make policy complicated and are real-life issues such as political influences, issues of health insurance companies, and views of hospital managers, doctors,

and practitioners. The political parties and their agendas regarding healthcare are what make healthcare policy law (Bambra, Fox, & Scott-Samuel, 2005). For instance, if access to healthcare is the primary point during the campaign, then the work on health will be more, and in this also, profit and revenue will be the utmost priority. It is also essential to know that many healthcare and insurance companies invest in the campaigns of political parties; therefore, upon selection, the investors will influence while devising the policies. In other words, while designing a policy, the priority is corporate profits, lowering the tax rates comes second on the priority list, and providing affordable healthcare is the least of concern for the policymakers, which makes the policy complicated and hard. Therefore, it can be easy to say that health is political because not only are healthcare services politically dependent and require government intervention (Bambra et al., 2005), but also policies can be turned into law only when it is on the agenda of political parties.

As far as insurance companies are concerned, if the insurance companies are offering expensive health insurance, most people have the option not to buy the insurance scheme. But if you are lying in an ambulance, the power is not in your hands to decide whether to buy it or not; instead, you have to buy it regardless of the cost. Also, not everyone can afford health insurance. For example, can a server afford to buy or contribute to a health insurance plan, or can the bartender buy health insurance from the minimal salary they acquire? Health insurance can also be considered a luxury for most people. Health insurance is also a complex phenomenon because there are also several stakeholders and cooperative beneficiaries involved in the health insurance industry and for them, the profit is above the health services provided. Another important factor is raising awareness and understanding that health is a basic need and right so considering it as a profitable sector will make the health policy hard and will further have issues with the provision of health services.

In conclusion, the article has presented some insights into why health policy is a complex phenomenon, but there are some concerns regarding policymaking and health insurance companies that were not taken into consideration in the article. Healthcare policy is complicated and hard because every citizen needs health services and health insurance, but not all people can pay for the services, and the bigger chunk is left for the government to handle. Health is a basic right, but not everyone can afford health services, so government interventions are required, which are also influenced by stakeholders and primarily focus on revenue generation. Healthcare policies are business-driven, which makes it difficult to devise a policy that benefits the people who cannot afford health services. ACA Act might have benefited the community, but it has put more pressure on employers. The government needs to subsidize or provide health insurance, and rich people can be a helping hand in assisting government agencies in the provision of health insurance to those who cannot afford it.

References

Bambra, C., Fox, D., & Scott-Samuel, A. (2005). Towards a politics of health. *Health Promotion International*, *20*(2), 187–193.

Belliveau, J. (2016, August 18). How the Affordable Care Act Impacted Healthcare Revenue Cycle. Retrieved February 17, 2018, from https://revcycleintelligence.com/news/how-the-affordable-care-act-impacted-healthcare-revenue-cycle

Handel, B. R. (2013). Adverse selection and inertia in health insurance markets: When nudging hurts. *American Economic Review*, *103*(7), 2643–82.

Herrick, D. (2014, June). The Effects of the Affordable Care Act on Small Business. Retrieved February 18, 2017, from https://www.ncpa.org/pub/st356

Mankiw, N. G. (2017, July 28). Why Health Care Policy Is So Hard. *The New York Times*. Retrieved from https://www.nytimes.com/2017/07/28/upshot/why-health-care-policy-is-so-hard.html