# Chapter 20 Social Insurance

## Key Ideas

- Social insurance and private insurance are different. Private insurance develops to protect its purchasers against risk. Social insurance, provided through taxes or regulations, addresses the particular needs of those who may require resources due to poverty, old age, disability, health problems, or unemployment.
- Comprehensive health insurance programs started in Western Europe in the late nineteenth century. Medicare and Medicaid began in the United States in the 1960s. Medicare relates fundamentally to health care for the elderly, whereas Medicaid focuses on health care for the poor.
- Medicare and Medicaid have accompanied improvements in access to care by the lower-income population, as evidenced by higher utilization rates, both absolutely and relative to higher income groups.
- The Affordable Care Act, passed in 2010, is one of the signal pieces of health care legislation in US history. It has provided insurance to millions who were previously uninsured.

## Teaching Tips

- This is another good place to introduce students to important websites regarding social insurance. The Centers for Medicare and Medicaid Services website is www.cms.gov. The Social Security Administration web site is www.ssa.gov. Both of them provide up-to-date information on the programs, including program features (benefits and expenditure limits), as well as research on the systems.

- Policymakers in the United States have debated the appropriateness of privatizing at least part of the system through individual investments. Discussing this in class may clarify the distinction between social insurance and investments.
- Figure 20.4 in the textbook looks at the economics of state participation in Medicaid. It shows how social programs may be desirable even if they constrain individuals or governments to purchase more of the good than they might have otherwise preferred.
- Figure 20.5 in the textbook shows how there are many steps in the enactment of an intervention meant to provide improved health. Although many students may not be aware of their own health insurance, others may have experienced issues of access, or stigma, that have influenced their health care decisions.
- Figure 20.6 in the textbook looks at the economics of "crowd-out." It is a subtle application using indifference curves with nonlinear budget constraints and "corner solutions." Instructors may want to work through it carefully with less sophisticated students.

## Chapter 20 Multiple-Choice Questions

1. Social insurance originated in ____, focusing on the _____.

    a. the United States; elderly.
    b. Germany; unemployed*
    c. Egypt; poor
    d. France; disabled

2. Under the Affordable Care Act, passed in 2010:

    a. all residents were to get health insurance by 2013.
    b. all residents were to get health insurance by 2016.
    c. about 32 million of the 50 million uninsured (in 2010–2011) will get health insurance by 2020.*
    d. there is no firm timetable for universal health insurance.

3. The Affordable Care Act, passed in 2010 requires:

    a. that employers provide health insurance to their employees.
    b. most US citizens and legal residents to have health insurance.
    c. states to provide health insurance for their residents.
    d. families to pay up to $5,000 out-of-pocket for their health insurance.

4. The Affordable Care Act, passed in 2010, requires:

    a. all states to create Health Benefit exchanges .
    b. all states to expand their Medicaid programs.
    c. all health insurers to provide a package of essential benefits.*
    d. Answers (a), (b), and (c) are all correct.

5. Among social insurance programs in the United States, Medicare refers most often to the _____ and Medicaid to the ____.

    a. elderly; poor*
    b. poor; elderly
    c. disabled; homeless
    d. disabled; elderly

6. Between 1965 and 2014, the number of Medicare beneficiaries:

    a. almost tripled.*
    b. almost doubled.
    c. increased by a factor of ten.
    d. remained constant.

7. Figure 20.9 in the textbook shows that between 1987 and 2014 (in constant dollars), Medicare expenditures per enrollee grew by about ____ while Medicaid outlays grew by about ____.

    a. 10 percent; 20 percent
    b. 50 percent; 25 percent
    c. 100 percent; 50 percent*
    d. 200 percent; 100 percent

8. The elderly often buy "Medigap" insurance because:

    a. Medicaid does not pay all of their expenses.
    b. Medicare is not available to all of those in the Social Security system.
    c. Medicare Parts A and B do not pay all of their expenses.*
    d. Answers (a) and (b) are correct.

9. Medicare Advantage Programs refer fundamentally to _____ programs.

    a. poverty-related
    b. pharmaceutical
    c. chronic illness
    d. managed care*

10. Medicare Part D provides improved coverage focusing on _____.

    a. nursing home care
    b. pharmaceutical expenditures*
    c. chronic illness
    d. managed care

11. Medicare Part D helps the elderly by:

    a. covering all pharmaceutical expenditures with a constant copayment.
    b. negotiating lower payments with the pharmaceutical manufacturers.
    c. providing extensive coverage at low levels and high levels of drug expenditures.*
    d. Answers (a) and (b) are correct.

12. The Medicare Part D "doughnut hole" means that:

    a. diet plans are not covered.
    b. at a specified level of expenditures, the consumers' incremental share jumps to near 100 percent.*
    c. the costs will put the system in financial jeopardy.
    d. Answers (a) and (b) are correct.

13. Kaestner and Kahn's 2012 research on Medicare Part D found that the program:

    a. increased socioeconomic and geographic disparities in elderly drug insurance.
    b. increased the use of outpatient and inpatient services.
    c. increased prescription drug expenditures by 40 percent. *
    d. increased life expectancy by 1.1 years.

14. Medicaid programs:

    a. are uniformly administered across all of the states.
    b. vary in eligibility standards among the states.*
    c. represent entitlements, available to all who qualify.
    d. Answers (a) and (b) are correct.

15. Medicaid can be very attractive to the states because:

    a. it provides additional funds for the purchase of services for the poor.
    b. it effectively lowers the price per unit of medical care to the poor.
    c. it increases the size of state governments.
    d. Answers (a) and (b) are correct.*

16. Figure 20.4 in the textbook shows that one way that Medicaid may be less attractive to the states than a simple monetary block grant is that:

    a. it forces them to help pay for those who are dually enrolled in Medicare.
    b. it forces them to provide more services per person than they might otherwise choose.*
    c. it increases the sizes of state bureaucracies.
    d. it limits the reimbursement to physicians.

17. In 2010 and 2011, some states scaled back their Medicaid programs, or considered withdrawing because:

    a. they found widespread fraud in the programs.
    b. physicians were refusing Medicaid clients.
    c. they found nursing home payments to be onerous.
    d. budget troubles made it difficult for them to pay their match.*

18. Following the passage of the Affordable Care Act, many states have refused to expand their Medicaid plans, arguing that they:

    a. do not wish to cover poor people.
    b. will be unable to pay their matches, once the generous federal subsidies end after 2020. *
    c. will expand their health insurance in other ways.
    d. find it unfair to crowd out private insurance plans.

19. Within the past 30 years, Medicaid has increasingly become the source of payment for:

    a. pharmaceuticals.
    b. children.
    c. long-term nursing home care.
    d. Answers (b) and (c) are correct.*

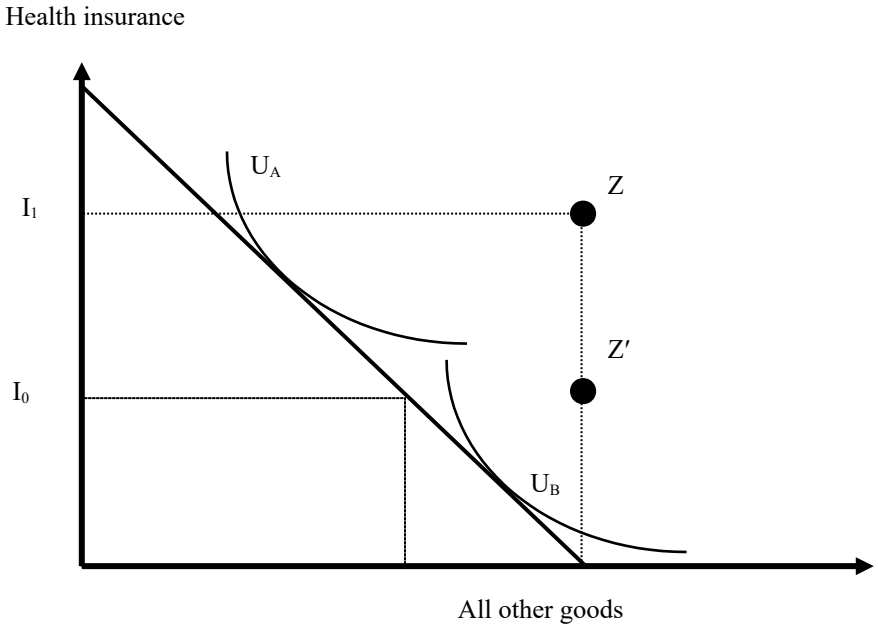
20. "Crowd-out" refers to a situation in which program benefits:

    a. lead recipients to replace private insurance with public insurance.*
    b. lead recipients to replace public insurance with private insurance.
    c. cause long waiting lines for services
    d. Answers (b) and (c) are correct.

21. "Take-up" refers to a situation in which:

    a. previously insured households drop their insurance.
    b. additional households move to a location to take advantage of a program.
    c. previously uninsured households become insured.*
    d. households stop working in order to qualify for benefits.

Figure E20.1



22. Referring to Figure E20.1, suppose that $U_A$ and $U_B$ represent the preferences of Persons A and B for health insurance and all other goods. If $I_0$ represents the minimum coverage available:

    a. both will buy the minimum insurance.
    b. Person A will buy more than $I_0$ and Person B will be uninsured.*
    c. Person A and Person B will both buy health insurance.
    d. Person A will buy the minimum insurance and Person B will be uninsured.

23. Referring to Figure E20.1, suppose that $U_A$ and $U_B$ represent the preferences of Persons A and B for health insurance and all other goods. If Medicare offers insurance package Z:

    a. both will buy package Z.
    b. Person A will be crowded out of private insurance and Person B will take up the Medicaid.
    c. both will be crowded out of private insurance.
    d. Answers (a) and (b) are correct.*

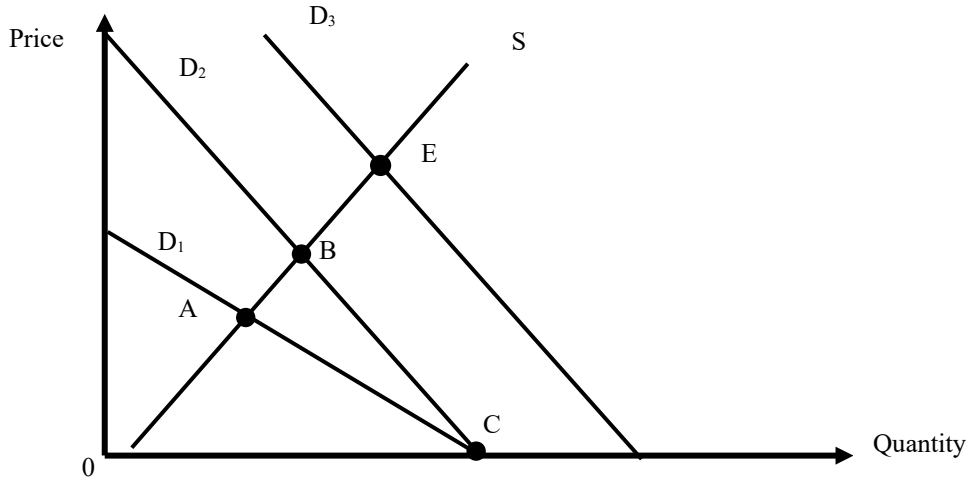
24. Referring to Figure E20.1, suppose that $U_A$ and $U_B$ represent the preferences of Persons A and B for health insurance and all other goods. If Medicare reduces its policy size from Z to Z′:

    a. both will buy package Z′.
    b. Person A will choose private insurance (instead) and Person B will continue to use Medicaid.*
    c. both will buy private insurance.
    d. both will choose to be uninsured.

25. Referring to Figure E20.2, increased insurance coverage (more recipients) and more generous coinsurance leads to a shift from:

    a. point A to point B and a decrease in health expenditures.
    b. point A to point B and an increase in health expenditures.
    c. point B to point C and an increase in health expenditures.
    d. point A to point E, and an increase in health expenditures.*

Figure E20.2




26. Referring to Figure E20.2, more generous coinsurance with the same number of recipients leads to a shift from:

    a. point A to point B and a decrease in health expenditures.
    b. point A to point B and an increase in health expenditures.*
    c. point B to point C and an increase in health expenditures.
    d. point A to point E and a decrease in health expenditures.

27. Analysts who have studied universal health care have determined that the incremental costs may not always be as high as people would expect. This is because:

    a. most people will not use the care provided in universal health care plans.
    b. many who do not have health insurance already consume health care.*
    c. universal health insurance plans would not cover all of the poor.
    d. Answers (a) and (b) are correct.

28. Many expect Medicare costs to rise as a proportion of GDP because:

    a. the costs of health care services are expected to rise.
    b. an increasing portion of the population will be in the Medicare program.
    c. new technologies are expensive.
    d. Answers (a), (b), and (c) are correct.*

29. Currie and Gruber have found that Medicaid programs often lead to improvements in measures of health such as infant mortality rates. They tend to be expensive, however, leading to questions of program viability as measured by:

    a. cost-benefit ratios.
    b. economic efficiency.
    c. cost-utility analysis
    d. cost-effectiveness.*

30. Analysts expect the total number of Medicare beneficiaries to rise between the years 2010 and 2040, by approximately _____ million people.

    a. 14
    b. 21
    c. 40
    d. 50*

31. By 2040, the expected number of Medicare beneficiaries will likely be about:

    a. as large as it was in 2000.
    b. twice as large as it was in 2000.*
    c. four times as large as it was in 2000.
    d. ten times as large as it was in 2000.

32. By 2050, Medicare is projected to equal _____ percent of the GDP

    a. between 2 and 3
    b. between 4 and 5
    c. between 6 and 7*
    d. between 9 and 10

33. Analysts believe that Medicare's share of GDP will rise because of:

    a. increased numbers of beneficiaries.
    b. increased costs per beneficiary.
    c. fraud in the Mediare system.
    d. Answers (a) and (b) are correct.*

34. Analysts believe that in the economic downturn of 2000–2003:

    a. the number of uninsured did not change much because people bought more private insurance.
    b. the number of uninsured did not rise much because employers provided more health insurance.
    c. Medicaid take-up provided insurance for many who would have otherwise gone without insurance.*
    d. many households voluntarily reduced their health insurance.

35. Finkelstein and McKnight (2008) remind us that:

    a. in evaluating Medicare programs, direct insurance benefits should be added to the benefits of better health.
    b. reduction of risk exposure from Medicare is valuable, and may justify about one-quarter of the Medicare program costs.
    c. reduction of risk exposure from Medicare is valuable and may justify between 50 and 75 percent of program costs.
    d. Answers (a) and (c) are correct.*