Chapter 4

사회보험 (Social Insurance)

A. 개요

1. 사회보험 도입의 목적

- Social insurance, while pooling risk, has redistributive goals as well. It not only redistributes benefits/costs from the well to the ill, but also from the poor to the more affluent, from active workers to the elderly, from the community as a whole to children, and from the able-bodied to the disabled.

A. 개요

2. 사회보험의 역사

미국의 경우: Medicare and Medicaid

- 1965년도에 도입 amendments to the Social Security Act (Titles XVIII and XVIX respectively).
- Both are limited to certain categories of citizens and residents. Together they cover senior citizens, a segment of the poor, end-stage renal patients, and those with qualified disabilities. Coverage for the latter two categories was added in 1972 and 1973.
- Public insurance programs are also in place to cover children of low-income families, veterans, Native Americans on reservations, and members of Congress.

B. 메디케어(Medicare)

Medicare Part A

- A universal mandatory program for hospital benefits
- Citizens and legal residents are covered from age 65
- Requirement for eligibility: individual or spouse must have an employment record (about 95% of the elderly are covered)
- Not means tested: it transfers income from younger to older citizens, regardless of income

Hospital benefits (up to 150 days)

- After an initial deductible, no co-payment for 60 days
- Increasing co-insurance rates for days 61-150
- 60 additional lifetime days that can be used after the 150-day limit
- Some post-hospital services included (rehab or hospice)

B. 메디케어(Medicare)

Medicare Part B

- Covers non-hospital medical expenses and in-hospital services that are billed separately (surgeon, anesthesiologist, etc.)
- Not mandatory, but highly subsidized, so most seniors subscribe
- Premiums deducted from monthly Social Security retirement benefits (beginning in 2007, Part B premiums vary with income)
- After a deductible, pays 80% of approved fees for covered services
- Seniors may assign premiums to participating private insurers, including HMOs, in the Medical Advantage (MA) program

MA plans may charge additional monthly premiums, provide coverage for additional services, and limit coverage to services received from participating providers.

B. 메디케어(Medicare)

Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 took effect January, 2006.

- Like Part B, voluntary, requires a premium, and provides subsidy
- Complex drug coverage rules
- MA subscribers may enroll in plans of private insurers that compete with the Part D Prescription Drug Plan (PDP)

All plans must have cost-sharing averaging 25%, the same coverage limits, and are subject to the “donut” structure.

MA plans, but not PDP, may negotiate discounted prices from suppliers (Note: Different plans cover different drugs. Shopping among them is a difficult, and often confusing, task for seniors).

B. 메디케어(Medicare)

메디케어의 운용

- Financed by **payroll tax, Medicare FICA (currently 2.9% of earnings)** shared equally by employers and employees
- Contributions are put into the Medical Trust Fund
- A pay-as-you-go program: current employment taxes pay for current beneficiaries. In any given year, receipts may be greater or less than payouts.

The program's solvency is vulnerable to demographic shifts. Additional problems include the rising cost of medical care and increase in longevity.

In future years, benefits will have to be cut, payroll taxes raised, or financing radically reformed.

B. 메디케어(Medicare)

Reimbursement of Providers

Medicare is modeled on dominant private insurance of the1960s. Originally physicians and hospitals reimbursed on fee-for-service basis. Physicians can “accept assignment” and not bill any excess over Medicare price. In return, Medicare bills patients directly. Hospitals bill Medicare directly.

Cost-containment-based reforms in reimbursement

- Prospective payment to hospitals based on diagnosis: diagnostic related group (DRG) was instituted in 1983
- Agency for Health Policy Research (est.1989) set up a Resource-Based Relative Value Scale (RBRVS) for reimbursing physicians.

C. 메디케이드(Medicaid)

자격요건(Eligibility)

- Certain low-income families and individuals. Eligibility requires both low income and low wealth (personal property limit of $1,000)
- Children are largest group covered
- Poor-elderly and the disabled receive larger percentages of the budget
- A high proportion of Medicaid expenditure is to cover long-term in-patient nursing home care. Administered by states, programs vary by state
- All states are required to cover recipients for in- and out-patient hospital services, physician services, vaccines for infants and children, and prenatal care for pregnant women.

C. 메디케이드(Medicaid)

개정(Reforms)

Before 1996: all welfare recipients received Medicaid coverage for themselves and their children.

In 1996: welfare eligibility and Medicaid de-coupled.

- States receive federal bloc grants instead of payment per eligible recipient, allowing for more discretion.
- More low-income two-parent families, pregnant women and children are covered.
- Children born after 1983 with families below poverty level covered, whether or not their families qualify for public assistance.

More states now employ HMOs to service Medicaid clients. Some mandate HMO coverage for all non-elderly adult Medicaid recipients; others make it voluntary, or mandate on a county-by county basis. Most have excluded the disabled from these mandates.

C. 메디케이드(Medicaid)

메디케이드의 운용

- Jointly funded by Federal and state contributions
- Financed by federal income taxes and general tax revenues of states

State and Federal cost-sharing proportions are based on state average per-capita income, federal proportion varying between 50-80%. If a state cannot meet its required portion of funding in any given year, the federal allotment is also cut back.

Funding is vulnerable to cyclical shifts in the economy. This is especially true of the state component, since states are required to have annual balanced budgets.

C. 메디케이드(Medicaid)

Reimbursement of Providers

- Originally reimbursed physicians and hospitals on a fee-for-service basis, though at a rate lower than Medicare
- The federal government gives grants to states to pay hospitals that care for an unusually high proportion of Medicaid patients
- Hospitals now paid on a DRG basis, similar to Medicare
- Private physician practices paid on a reduced FFS basis; Medicaid HMOs reimbursed on a capitation basis

Physicians are not legally required to accept Medicaid reimbursements. Many do not. This may lead to Medicaid recipients having difficulties finding a physician.

Note: Results of report cards on Medicaid managed care are mixed. Medicaid HMOs may increase access to physicians.

D. 기타 사회보험

State Children Health Insurance Program (SCHIP)

The Balanced Budget Act of 1997 established a 10-year program of federal matching grants to states to cover uninsured children from low-income families. The program has been extended by legislation in December 2007.

SCHIP is not an entitlement. States can reduce size of the program or eliminate it at will. Eligibility is very flexible.

States have discretion to treat SCHIP as an expansion of Medicaid or administer the program separately.

Like Medicaid, this means-tested program, jointly funded by federal and state revenues, is vulnerable to fluctuations in the economy.

D. 기타 사회보험

The Veterans Administration (VA)

The VA has coordinated veterans' health services since 1930. All service-related medical problems are meant to be covered. Non service-related medical problems may be treated if veterans satisfy a means test and if treatment facilities are available.

The VA has maintained a number of hospitals over the years, but deficits in program financing (federal) have led to hospital closings.

A current high-profile problem is that veterans, particularly of recent conflicts, find difficulty in receiving treatment for service-related chronic conditions, particularly mental and emotional problems.

D. 기타 사회보험

Civilian Health and Medical Program for the Uniformed Services (CHAMPUS)

- Program largely limited to on-base facilities
- Retired members of the military and their dependents eligible for care through this program; the program receives less funding and serves fewer people than VA

Federal Health Program for Native Americans and Alaska Natives

- Programs administered by Indian Health Service of the U.S. Department of Health and Human Services
- Medical care provided on reservations plus a number of programs devoted to maternal health, integrated behavioral health (including alcoholism), and child health