Price elasticity of demand:

"10% ↑ in the price of care leads to 2% less spending on care."

(How is "care" measured?)

As for health outcomes, negative impact on low income people with chronic illness.

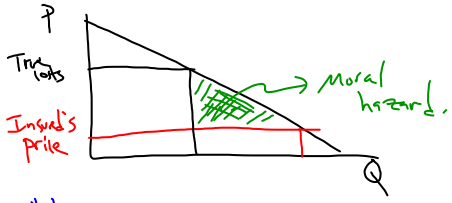
Otherwise, not much impact on health (from reductions in care or from increase in price?)

Optimal Health Insurance

- Do not have first dollar coverage
  little consumption smoothing benefit, significant moral hazard & admin. costs.
  ⇒ Deductibles good.
- Definitely want catastrophic care. And, want generous coverage for these low probability, devastating events.
  ⇒ No caps, limited co-pay, esp for chronic illness (may be still some moral hazard to manage)

  Reaction to cap it, charge people to cover costs is not sound policy, at least by consumption smoothing theory.

At this point, revisit the "moral hazard" D curve, argues why it's wrong.



Not so.

- Last time: "I have insurance so that I can pay low prices for care when I need it."
- Where does this D curve come from?

  U(c)? No.

  So far, just a theory of financial risk management.

  Need a broader theory.

- The right thing here is the same you'd have for homeowner's insurance. You get a new house (or expensive care) in low probability total loss events. No moral hazard there; an inefficiency if you are consuming health care in the bad state that you would not consume if you could get the money.

Supply Side

[Does supply/demand story really make sense here? Is it more of a bargaining model or some kind of collective decisionmaking model between doctors & patients that fits reality better?]

* Retrospective reimbursement

No incentive to treat "cost-effectively". Just "look back" and pay.

What does "cost effective" mean if doctor complying with law and medical ethics?

Could that really lead to spending with low private value, high social cost?

If doctor pushes a procedure and personally substitutes her tastes for yours (risk aversion, feelings about side effects), maybe. Oversells the treatment, manipulates info., for same reasons (what is best in own personal judgement).

Or, their desire to give hope & relief ⟹ ongoing care/treatments with little probability of much benefit.

Prospective Reimbursement

- Pay based on what treatments "should" cost, not actual cost.

- Capitation.
  May go too far the other way, too little incentive to treat.

Bottom line: Prospective payment systems and HMOs produced a 5-10 year period of level health spending increases, now back to increases in increases. Increasing faster than GDP increases, again.

Medicaid

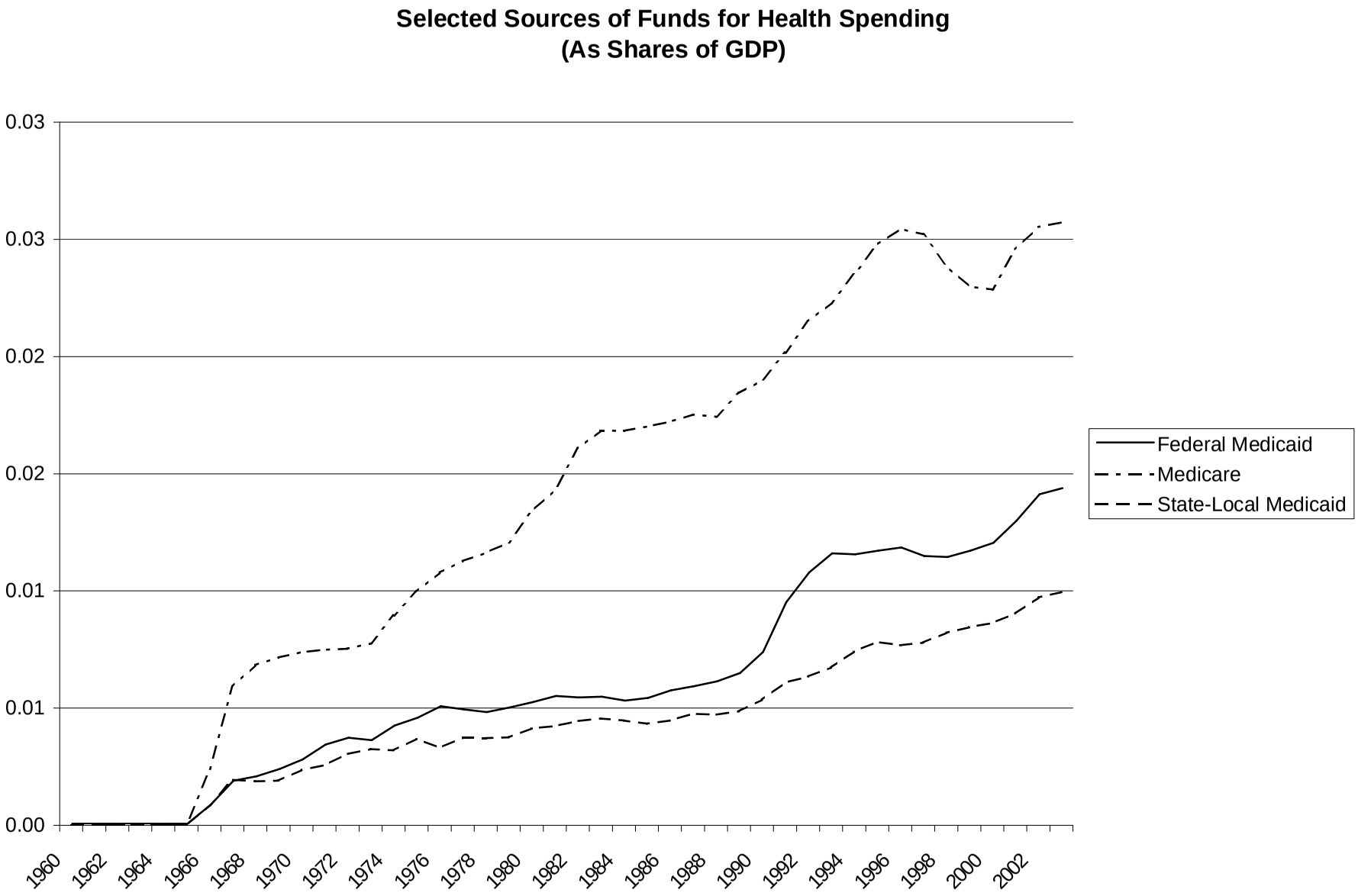
- "Poor" is necessary, but not sufficient.
- "Poor" means federal poverty line.

All that follows assumes poor.

* If you are in a household that is below the poverty line and you are a child or a pregnant woman, you are covered.
* " " talking care of the child, likely to be covered (but not necessarily).
* Disabled (total disability), covered.
* Elderly (nursing homes), covered.

- Federal government shares costs with states. Matching rate varies with state income.
- In order to be part of program, state <u>must</u> cover children, pregnant women, some others (?) and <u>must</u> cover basic physician and hospital care.
- All states provide some <u>additional</u> benefits and get federal match for those (if program is in compliance or gets a waiver).

  Prescription drugs, optometrist, some provide dental.


Selected Sources of Funds for Health Spending
(As Shares of GDP)
0.03
0.03
0.02
0.02
0.01
0.01
0.00
1960
1962
1964
1966
1968
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
Federal Medicaid
Medicare
State-Local Medicaid

Medicaid and health of poor

(Consumption smoothing not discussed; if on public assistance, get that regardless of state, with Medicaid you have smooth "C," non-health care consumption)

Increase eligibility: Program exists, now expand it.

Previously uninsured → Take-up (small)

Previously privately insured → Crowd-out (moderate)

New enrollment in Medicaid

↓ access

Utilization

↓

Outcomes

↓

Cost effectiveness: a cheaper way to get the outcomes?

Big success in reduced infant mortality. (Pregnant women & children.)

Look at other groups now eligible and the illness they get that pregnant women & children don't get, and see if outcomes are better. Esp. those dropping private insurance.

Issue: "Crowd out" from these expansions, but Medicaid is really offering better coverage. Does the crowd out not matter? Look at health outcomes.