IIB. ECONOMIC ISSUES IN THE PRESIDENTIAL CAMPAIGN

Topics I have identified include health care, international trade (“the global economy”), agricultural policy, and taxes, as well as social security and global warming. We have already reviewed issues for social security, so we can give just a brief review of presidential candidates’ stated positions. We will spend about 2 weeks on global warming in part IIC of the syllabus, and will briefly review the candidates’ stated positions as part of that material. If you have identified other economic issues in the campaign that you think we should include, please let me know.

0. SOCIAL SECURITY ADDENDUM

- Where do the candidates stand on Social Security? (John Ydstie, NPR)
  - Obama, Edwards have both argued for extending social security taxes to those earning over $200,000 to close the funding gap. A reporter claims that he overheard Clinton saying that would be acceptable, in a private conversation with a voter. However Clinton’s public position is that the question should be referred to a new bipartisan commission to make recommendations.
    ⇒ Edwards has said that we should skip over those who earn between $97,500 and $200,000. Obama claims that the Congressional Research Service has said that taxing all salaries with no cap would cure the Social Security financing problem for the next 75 years; I have not seen that study.
  - All democratic candidates appear to reject diverting any funds to private accounts, though Gravel has supported investing part of the Social Security Trust Fund in securities, to improve yield. Most Republicans support Bush plan to do so. Romney, like Clinton, wants bipartisan discussion, but by “statesmen” behind closed doors, rather than by a commission; Hunter wants to consider all options; Paul prefers to cut payroll taxes and let workers invest the funds themselves; Thompson wants to divert “budget surplus funds” [where are they?] to finance a private savings account program to supplement social security. Source: http://www.cnn.com/ELECTION/2008/issues/issues.socialsecurity.html

1. HEALTH CARE

a. The big picture

- 2005, $2 trillion: 16% of GDP, $6,697 per capita. (1980 total was under 9% of GDP).

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1 In addition to assigned readings I have drawn on the following in preparing these lecture notes:
Stiglitz, Economics of the Public Sector (W. W. Norton, 2000, 3d Ed.)
These readings are not assigned for the course.
• Federal government pays about 25% – 25% of all Federal spending

• State and local governments pay about 10%; National Governors’ Association says 31% of state spending goes to health are, with 22% going to Medicaid.

• 15% of Americans uninsured; 9% of children under 18 are uninsured (2006):

18% of non-elderly adults uninsured, 62% covered under employer plans, 5% have individual coverage, 15% covered by Medicaid and other public plans (e.g., VA).

• For employer –covered plans, total premium for an individual averages $3,700 of which employee contributes $600; total premium for employee and family averages $10,000 of which employee contributes $2,700.

b. Background on insurance (review)

• Insurance is an important social solution to deal with idiosyncratic (i.e., individual) risk.
  ➢ Doesn’t help deal with aggregate risk
  ➢ (What about unemployment insurance: Does that help to resolve aggregate risk?)

• Two terms to remember:
  ➢ Adverse selection: tendency for those who are most likely to need the insurance to buy it.
    ⇒ Requires that purchaser knows something that the insurer does not know: imperfect information.
    ⇒ Can lead to dynamic change in which the least likely to need the insurance drop out of the market, driving up price for others, so that more drop out of the market ….
  ➢ Moral hazard: tendency to reduce effort to avoid the event insured against.
⇒ This is not necessarily a problem of morals, as in torching a worn-out building to get the insurance. More generally, a problem of incentives.

⇒ Another example of imperfect information

⇒ Requires that purchaser be able to influence the probability of occurrence of the event insured against.

- Social insurance, rather than private insurance, can help with adverse selection but not with moral hazard.

c. **Why should government be involved in health care?**

- Does it meet the normal criteria? Which of following reasons would justify government intervention in the market?
  
  ➢ Public good
  ➢ Market failure
  ➢ (as special case) imperfect information
     ⇒ Licensing of physicians
     ⇒ How much care do I need?
     ⇒ Who is competent to provide it?
  ➢ External benefits or cost
  ➢ Monopoly
     ⇒ Complexity of prices makes it hard to compare (more imperfect information)
     ⇒ Limited choices, especially in small towns.
  ➢ Equity (distribution of income)
  ➢ Protect children
  ➢ Other reasons?

- Ways government could be involved
  
  ➢ Regulation
  ➢ Public financing
  ➢ Public provision of services

- Level of government that regulates or finances or provides services
  
  ➢ Local
  ➢ State
  ➢ Federal
d. Particular problems in health insurance

- Ambiguity in defining appropriate level of treatment
- Conflicting incentives of patient, physician, and insurer (third party payers, who pay for 80% of all health care costs)
  - Physicians are interested in protecting against malpractice (“defensive medicine”), in maximizing income, and perhaps in providing best possible service.
  - With full coverage, patients are not interested in saving money.
    - Most health insurance now requires co-pay, or deductible.
    - Cheapest health insurance, and most legitimate as covering unforeseen risk, is major medical insurance, which covers costs above (e.g.) $2,000 per year.
    - Insurers are most interested in holding cost down.
    - Has led to HMOs as alternative to fee for service plans.
    - This reduces physicians’ ability to perform more work than needed.
    - Also gives buyers some monopsony power.

- Cost shifting
  - Uninsured who can’t pay still get (some) treatment. Others have to pay for it.
  - Biggest clients (Federal government, state governments, biggest employer groups) demand discounts, so others have to pay more.

e. Federal government role

- Medicare: for those over 65
  - Part A: hospitalization, paid by 2.9% tax on wages and salaries (39% of benefits)
  - Part B: Supplementary medical insurance (32% of benefit payments)
  - Part C: Medicare advantage (private health care plans -15% of benefit payments)
  - Part D: Prescription drugs (9% of benefits)

- Medicaid:
  - For poor only: families with children, aged (expense not covered by Medicare), disabled, and blind.
  - Administered by states, with Federal government paying from 50% to 80% of fees and 50% of administrative cost.

- Public health
- Veterans’ Administration hospitals
• Support medical research (NIH, universities) and teaching future health care professionals ($20 billion)
• Tax “expenditures” through income tax deductions for expenses in excess of 7.5% of income ($4 to $5 billion) and through pre-tax expenditures on health insurance and health expenditure accounts (value?)

**Reforming health care**

• Eliminate tax incentives
• Expand use of managed care
• Extend insurance coverage

f. **Medicare**

i. **The big picture**

(See slides for material from Kaiser Family Foundation Fact Sheet)

• Without Medicare, there’s a big problem of adverse selection among retired, so private market doesn’t work well.
  - No longer in group health plan
  - So individual families are deciding whether or not to take out health insurance. Healthy get priced out of market.
  - That’s the problem Medicare was intended to solve
  - (Plus fact that in late 50’s, early 60’s, about 1/3 of people over 65 were in poverty).

• Now Medicare is 12% of all Federal spending, growing 6%/year in real terms.

• Cost of medical care in general has risen faster than CPI.
  - Incentive problems
  - New technologies that have raised quality of medical care

• For general population, some successful attempts to limit rise of prices
  - Managed care
    ⇒ Creates competition among providers
    ⇒ Use monopsony power with suppliers
    ⇒ Co-pay, or deductible
    ⇒ Direct controls on physician decisions

• For over 65 population, hasn’t been easy to follow that example
Medicare (and Medicaid) led to huge increase in demand for medical services, starting in 1966.

Started with administered prices; for many medical problems of aged, there is no “market price” because Medicare is the only payer.

Devising a scheme in which competing service providers will compete to attract patients is tough.

- Patients don’t pay, so they care only about level of service.
- Suppliers have incentive to practice “cream-skimming” or “cherry-picking.”

Medicare has moved to lump-sum payments to treat specific illnesses, and to “risk contracts” that pay 95% of average Medicare cost in county per enrollee.

- That gives good incentive to supplier to cut costs, but also to cut quality of service, since all savings are pure profit

Also have moved toward “risk contracts” that pay 95% of average Medicare cost in county per enrollee.

- “cream-skimming” is the big problem.

Conclusions:

- Both hospitals and patients respond to incentives
- Tricks that have worked (more or less) to control costs for population under 65 are hard to apply to Medicare.

**Medicaid**

i. The big picture

- Rise in cost of medical care has led many employers to drop health insurance as fringe benefit.
- Shift from manufacturing to service has also meant shift of jobs from big unionized firms to small, non-unionized firms, less likely to offer health insurance fringe.
- Medicaid expanded care for those under 65 from AFDC only to pregnant women and children in families under some multiple of poverty level of income (133% mandated)

Three big issues

- Large number of those eligible don’t use the service
- Others who have private insurance drop it to let Medicaid pay instead.
- Equity issues: equally poor people have differential access to health care.