Implications of Health Care Reform for Inequality and Welfare

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Brief summary

Question: How will the Affordable Care Act ("Obamacare") affect medical insurance coverage, savings, health status, and (the redistribution of) welfare in the U.S.?

- Looks at the combination of three policy elements aimed at increasing the coverage rate in the individual insurance market:
  1. *Community Rating and Guaranteed Issue*: Prohibits insurers from price-discriminating or rejecting based on health status.
  2. *Insurance Mandate*: Income-based penalties for those without insurance.
  3. *Insurance Exchanges*: Income-based insurance premium subsidies for low-income individuals.
- An important feature for the analysis is the provision of emergency care under limited liability for uninsured individuals in the U.S.

Brief summary, cont'd

Main findings:

- The reform substantially increases coverage in the individual insurance market – those who remain uninsured are wealth-rich with moderate income and good health (prefer self-insurance).
- It also substantially decreases the mark-up in medical services due to free-riding (limited liability for emergency care).
- Wealth inequality decreases slightly – the formerly uninsured poor who previously relied on free emergency care increase their savings, and the rich accumulate less precautionary savings.
- The reform generates significant average welfare gains for active participants in the private insurance market, as well as slight overall average welfare gains. While the wealth-poor experience welfare losses, the wealth-rich gain from the reform.

General remarks

What I really like about the paper:

- It deals with an important (also political) issue that obtained great (world-wide) attention.
- It goes straight at the most interesting question: Does the reform achieve the (welfare-)redistributional effects it claims to aim at?
- The analysis is based on a rich quantitative model setup that is carefully calibrated to relevant micro panel data (on income, wealth, insurance coverage, health status, medical expenditure).

As with all quantitative papers that tackle welfare and redistribution questions, I think there are some issues that should be dealt with (or at least discussed in detail in the paper)...

Comments: Overview

- Issues concerning the model
- Issues concerning the quantitative analysis
- Additional things to look at
- Some minor remarks

Comments: Issues concerning the model

- In the current setup, health status affects agents' utility only via the budget constraint (ie. consumption levels) by influencing
  - the realization of labor productivity z,
  - the realization of health expenditure shocks x,
  - the insurance premium p in the private insurance market,
  - and (indirectly through z) the eligibility for Medicaid m and the availability of employer-sponsored group insurance g.
- The only endogenous channel affecting health status is insurance coverage (idea of receiving primary care when insured).
  - This channel increases aggregate health when the policy reforms are implemented.

Comments: Issues concerning the model, cont'd

Dimensions of health care reform on agents' welfare that I am missing in the present setup:

- A direct effect of health status on (contemporaneous) utility.
- An indirect effect of health status on lifetime utility via influencing life expectancy.
- A more direct endogenous channel how agents can affect the evolution of their health status, e.g.:
  - Choice of incurring medical expenditure combined with an effect of medical expenditure on health status.
  - Separate dimension of investments in health maintenance (eg. the small expenditure shocks) that affect health status.

⇒ Adding these dimensions might change the welfare results significantly...

Comments: Issues concerning the quantitative analysis

- Related to the last comment, the exogenous calibration of different medical expenditure risk for insured and uninsured does not make much sense to me.

- The model fit to the pre-reform scenario seems somehow worrying with respect to:
  - Overestimating the fraction of active participants in the insurance market (and uninsured thereof) – do you overestimate the effects of the reform as a result?
  - Not matching the skewness of the wealth distribution among the uninsured – do you overestimate the relevant fraction of wealth-rich from which most of the welfare gains from the reform result?

Comments: Issues concerning the quantitative analysis, cont'd

- Currently there are only two realizations of health status: healthy={*excellent*,*very good*}, unhealthy={*good*,*fair*,*poor*}.
    - Given that, among the uninsured (income-)poor, there are probably many who have very bad health and cannot afford the extremely high pre-reform premia, you could in addition distinguish *poor* health status from the rest – those people should benefit a lot from the pooled-risk (and subsidies) parts of the reform.
- Given how crucial the risk aversion parameter γ is for your results, you should calculate and report (at least the overall) welfare effects of the reform for a range of values.
- It would be interesting to decompose the overall increase in post-reform output into the effects of increased labor productivity (health) and those of increased capital stock.

Comments: Additional things to look at

1. Decompose effects of the different policy elements on insurance coverage and welfare(-redistribution).
   - Apart from being interesting in its own right for a more differentiated evaluation of the reform, this would also shed more light on the mechanisms at work.

2. Compare predictions of the model about changes in insurance coverage with recent data on step-wise implementation of the policies to validate model framework (partial data should at least become available very soon).
   - For this, you would need to look at transition paths (which would be interesting regarding short-term welfare effects too).

3. Design a suggestion for a transfer system that would offset the (stationary-equilibrium) welfare losses of the poor.

Some minor remarks

- The results section in the paper could be expanded to include more detailed tables on distributional effects of the policies and illustrations of the mechanisms at work.
- Details on data sets and parts of the empirical analysis could be moved to an appendix.
- It would be good to include overview information on the dimensions of the "Obamacare" package and an implementation time-line (in an appendix).
- I could not figure out from the paper how reimbursements of medical expenditures in the public insurance system are financed...