

DISCUSSION – Session IV:

ILISE FEITSHANS: I am here today for the *Institute for Elimination of Health Disparities* from Rutgers University. Firstly I want to commend you for this. I think this is a very important discussion in a very important definitional question and itself the process of doing that is very important. I was listening to Dr. Burtless and also to Dr. O'Hara and I think it may have been implied --I am not sure it was directly said-- that this is almost sort of a dichotomy's situation of being poor or not poor; and as a lawyer I find that definition very important if you are just talking about sort of various cut-offs you are debating where to put the cut-off or if in fact this isn't a static population and I would like to know if any of the models --I guess if you listen to the first paper it's three models are being suggested-- I would like to know if any of these models actually anticipates or takes into account movement across this set of categories of poor and non poor. I am specifically thinking of wage earners who are the primary wage earner who are injured on the job and specially in cases where that work-related injury has consequences either for possible loss of insurance or for loss of income, even if they do eventually obtain workers compensation. I am imagining --and again, I am going to say this as a lawyer, not as an economist-- I imagine that in such cases the MOOP would go up and the income would go down and a family would actually move from one category to another and I would like to know whether any or all these models take that kind of fluctuation into account and if so, how.

JUAN RAFAEL VARGAS: I am an economist myself, so I am going to get all to the other end. This is kind of ex-ante. There are two things that I see are missing in the discussion; one is the informational asymmetries of health expenditures, I mean the doctor says what I should take so my decision is very limited; and the other is price elasticities although the first argument goes against it, because if I am told as a child by the teacher or by the mother you do this, then price elasticity should not count, but on the other hand they count.

Our research has been showing for people with permanent illnesses, price elasticity count but in not so much for people that get sick and then get well, so I would like to see something of that which either I missed or was not reflected or perhaps I am out of order. Thank you.

JESSICA BANTHIN: I'll respond if I can ask a question at the end. In response to your question, the way we calculate the measures is just a cut-off and then it is estimated every year to see what percentage people, how the population changes. What I found really interesting about Brett O'Hara's paper is that one of the important factors of people who became impoverished was not having a full year job, so if you look closely, the people you are concerned about, those who have been injured on the job are probably turning up there and that's what he is finding in his results and the insurance coverage doesn't necessarily protect you, sometimes. I think that's a very interesting result.

Regarding price elasticities, I have done one paper that calculated take up elasticities; and you are right, in the U.S. actually the general trend in looking at workers who take up insurance --this is insurance/price elasticities--, it's the healthy low income young people who are most responsive to prices and who turn down insurance when it's too expensive; whereas those who are chronically ill will turn to take up and are less responsive to the price of insurance. I mean, that's a general pattern.

Then, my question was to Gary Burtless. I did read your paper and I found that it didn't make a difference --does make a difference to certain segments of the population- - how you incorporate MOOP, and in your tables you don't break out the uninsured as a separate group and to them, of course it does matter given the method that Dave Betson used which in your methods; and I will talk about that more, tomorrow morning when I present my paper but it matters a little bit in your tables to Hispanics and Blacks and people who aren't working and that's probably because segments of those groups are uninsured. So it makes a difference how you incorporate MOOP into thresholds or whether you use thresholds or whether you subtract it, depending on your methods. What do you think about that?

GARY BURTLESS: I think that the differences are relatively subtle. They didn't overwhelm me compared with the differences between the official measure, on the one hand, and either of the alternatives, on the other. One reason that Sarah Siegel and I mentioned for the difference in poverty under the two alternatives -the one proposed by the NAS and one where you add some measure of expected spending on the thresholds- is that when you add expected medical spending to the threshold, you are

adding a relatively big number to everyone's threshold. In contrast, under the National Academy of Sciences approach you are adding a number [for medical spending] that may vary widely. Given the very skewed distribution of actual medical outlays, that means for a very large proportion of almost all the people in various cells you are adding very modest amounts and for some people you are adding very big amounts. Actual medical spending is just a very skewed distribution. In light of these major differences in approach I was surprised that you could still hit almost the same poverty rates, regardless of the way you implement the procedures to add some estimate of reasonable spending to the thresholds.

While I agree with your point -- there are differences -- I just think that they are pretty subtle. The differences are certainly at a level that very few people in the general public would care terribly much about, I think.

There is a tendency in American politics -- it is a very strange one, I think -- to believe that any change you make in the poverty measure that makes your favorite group look like it has less poverty is somehow very pernicious. An attempt to implement the proposed change in poverty measurement then represents an evil conspiracy: The resulting drop in measured poverty must be intended to reduce the public's demand for spending on that group. So anything you do that makes child poverty look lower or African-American poverty look lower or Hispanic-American poverty look relatively lower must represent an evil conspiracy to reduce public spending on that favored group. As a social scientist I find this a very questionable assumption on the part of these interest groups, I find it particularly puzzling to think that people in Kansas must believe that anything that makes their State look less poor compared with the rest of the country must represent an evil innovation in poverty measurement.

DAVID BETSON: Gary, you are absolutely right. When the panel showed that by their proposed poverty measure there would be slightly less blacks, slightly less children in poverty, the Children's Defense Fund attacked us as pernicious by trying to undermine their cause.

But the question I have has to do with the elderly. Gary, the question pertains to a comment you made that I wish you elaborate just a little bit more. You said -correct me

if I am paraphrasing you incorrectly- that you just couldn't understand how any realistic poverty measure could show the elderly over time coming poorer. Especially given their increased life expectancy and improved quality of health. How can they really be poor? Is that a fair characterization?

If that is a fair characterization here is my question: Is your wonderment over increasing poverty among the elderly because you misinterpreted the intentions of the panel? The panel was trying to construct a poverty measure that would reflect of the ability to meet their non medical expenses. Isn't it fair to say that it could be true that health and life expectancy of the elderly have greatly improved through the advances in medical technology, yet at the same time they are finding themselves harder and harder to meet their non medical expenses? In other words there are two dimensions of poverty. The panel stated very clearly that we shouldn't try to put them together. However, you implicitly want to do that.

GARY BURTLESS: I think running through the National Academy's proposal is a view that we should be regularly and rapidly updating our assessment of the spending needs necessary to escape poverty. That view is just fundamental. The way the NAS panel proposed to update the standard for how much is necessary to buy a minimally adequate allotment of food, shelter, clothing and something a little bit extra is basically a lagged average of what the consumer expenditure survey tells us people are actually spending on those items in the United States. Consistent with that view is this point that David just made, namely, if the aged are spending more and more money on medical care then we can take it for granted that the increased level of actual spending is what a minimal spending allotment must be. But that really is very different from another perspective of poverty which emphasizes an absolute standard of need. Bear in mind the United States poverty threshold has always been absolute; it has never been relative. There has always been a fixed absolute threshold. So it strikes me that there is a tension between doing a lot of updating for what we think is required to escape poverty (which is really the spirit of the National Academy of Sciences proposal) and this more traditional idea that if there are improvements in absolute living standards amongst people in the bottom one-third of the income distribution, those improvements should be reflected in lower rates of poverty in the bottom one-third of the income distribution. In other words, absolute improvements in the consumption of people on the bottom one-

third of the income distribution should produce reduced levels of destitution; that was the clear implication of the old poverty thresholds.

Now think about this from the point of view of medical spending. Medical consumption in the United States has risen, and for no subgroup in the population has that increased spending been more important than it has been for the aged. Furthermore, compared with the early 1960s, when the poverty thresholds were first developed, someone else is paying for a vastly bigger share of older Americans' medical spending. More of the consumption that they obtain every year in the form of medical services is being paid by someone else – primarily the federal government -- so the price of obtaining really magnificent care has in some sense fallen a long way. If the aged in 2003 were willing to buy the medical services that were available to people back when the poverty standards were developed, the costs they would face for medical care wouldn't have risen very much. For example, you can buy a lot of those 1960 drugs at cheaper prices nowadays than you could buy them back in 1960. The drugs aren't more expensive, they are cheaper.

There have been real improvements in absolute standards of comfort, medical care and so forth that have been brought about by all of the additional medical spending. Yet the implication of the NAS panel's proposal is that relative poverty amongst the aged has gotten worse over time as more of elderly households' budgets have been consumed paying for vastly improved medical care. How can this possibly be true?

It strikes me that in a democratic society you must persuade a lot of ordinary citizens that this important measure -- the poverty rate -- actually makes some sense. Will the poverty rate make sense if it tells people that tax payers are spending 10 times as much, 20 times as much to improve the circumstances of the aged through government-provided health insurance, and yet it is precisely as a result of the health care system that the well-being of the elderly is declining? According to the NAS panel's proposal, trends in health care spending are driving up the incidence of poverty amongst America's aged. I think it is going to be very difficult to explain this paradox to ordinary citizens. How come we have made old people so much worse off after devoting so much of national income to subsidizing precisely this kind of consumption for them. I am not saying that the NAS proposal is wrong, and incidentally I would agree with David

when he said either the National Academy of Science's approach or the alternative approach proposed by Richard Bavier would represent a considerable improvement over the official poverty statistics. Rather, I am trying to explain why the particular proposal of the National Academy of Sciences is controversial amongst people who pay a lot of attention to poverty and health care consumption. I think one of the reasons is this implication of the NAS recommendations.

DAVID GORDON: My question is on the causality? A lot of the discussion has been on how sickness makes you poor, but of course, poverty can also make you sick. There have been longitudinal studies in the U.K. which have shown that if you look at the group of the sick and poor 90% of them were poor before they became sick whereas only 10% were sick before they became poor. Of course it varies with household circumstances and the time horizon you use. Do you have any ballpark estimates on the scale of causality? It is poverty more likely to make you sick or the sickness more likely to make you poor?

MICHAEL HATFIELD: I can actually speak to that based on not the research that we have talked about today but some other research that we have been doing in the group that I work in on what we call *persistent* poverty, I think the European Union call it *permanent* poverty using their panel surveys. We have identified five particular groups in our society that are by orders of magnitude to four and five times more subject to persistent low income using the after tax LICO measure than the rest of society. Of course one of those groups are people who report what we call a work claim of disability, that is a disability that either limits the kind of work they can do or the amount of work they can do. What we have found is that the people most likely to be in that category are people not necessarily who are poor before, but we haven't gotten that particular point, that certainly people who looking at their characteristics you would think would be more likely to be poor. That is for instance, if you have a low level of education before you became disable it will encourage your disability, you are much likely to have a disability, so I suspect that it is true, although I don't think it would be just trying to recall the data that we were working with, it wouldn't be as stark as numbers that you have indicated. I think it would be the case that a majority of people who become disabled or poor before they were disabled, rather than the other way around, they became poor. Now the reason they become persistently poor though probably it is related to disabilities.

GARY BURTLESS: I don't have any answer, but if I were going to obtain an answer, I would call up first Angus Deaton at Princeton and second Jim Smith at Rand. I think that they have thought very hard about the problem, and I think they are both very sensible. I would trust what they say about that question.

GISELLE KAMANOU: I am here for the United Nations Statistic Division and I coordinate the world program on public statistics. I had a question for Mr. Burtless. At the end of your presentation you suggested that we can go about calculating health needs by trying to have a cost of health plan that would be calculated by locality or something similarly of that. I am wondering if you talked about its implications on national poverty line or whether does it mean the national poverty line will not be available no more.

GARY BURTLESS: It is certainly true that in some sense the thresholds I have in mind are much more complicated than the current measure because there isn't a single threshold. For each family the calculations that you must perform to determine whether the family is poor are more complicated than under the existing definition in the United States. I guess I don't see any way around that problem, really. My proposal and one that I made jointly with Henry Aaron about measuring poverty in this way is a little bit more practical than most other proposals for including medical spending in the poverty definition. Under our proposal every year some statisticians in the Department of Health and Human Services would be responsible for determining the cost of an "adequate" health insurance policy in different places in the United States. First of all, what constitutes an adequate insurance plan? That is question number 1. Number 2, what is the price of that insurance plan in different parts of the United States? Many states do have some back up insurance plan. The "minimally adequate" insurance policy may have an extremely high price tag for people who are in some kinds of circumstances, but in most states there is almost always some adequate policy available at some price. That at least gives a set of numbers which then anyone in the United States if they wanted to perform their own analysis can download. Users outside the U.S. government can use the information.

I don't see any way around the problem of deriving different poverty thresholds

for people in different circumstances (circumstances determined by their age, their coverage under an employer-sponsored or government-subsidized health plan, and possibly their health status). I see no way around this complicated and demanding set of calculations for a country that has as complicated an insurance system as the United States.