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Introduction

Health care is a perennial topic on the public agenda. About 40 million Americans are uninsured, despite a decade of rapid economic growth. Medical expenditure growth has accelerated in recent years, followed by double-digit annual increases in commercial health insurance premiums. Meanwhile, public health remains an important challenge; people continue to drink and smoke, harming their own health and driving up costs for others. There is no shortage of health issues for governments to worry about.

Six years ago, the NBER launched an annual meeting and publication designed to expose the policy community to research on these policy issues. *Frontiers in Health Policy Research* is the result. The goal of the *Frontiers* volumes is to foster a dialogue between NBER researchers and the policy community. NBER researchers write papers on the economics of health policy, and these papers are discussed at a joint meeting of researchers and health care analysts. The papers in this book were presented at a conference in Washington, D.C., in May 2002.

As in the past, the chapters in this volume address a diverse set of topics of great current interest. Despite the apparent dissimilarity in subject matter, every chapter examines either a cause of cost growth or the effects of policies intended either to slow or to respond to cost growth.

In recent years, expenditures for pharmaceuticals have risen faster than for every other category of medical expenditures, rising 17.3 percent in 2000 alone. At the same time, direct-to-consumer advertising (DTCA) has become pervasive. Growth in DTCA was coincident with the FDA's easing of advertising regulations in 1997. According to the Henry J. Kaiser Family Foundation, DTCA expenditures more than tripled between 1996 and 2000. The growth in DTCA represents a break from tradition for pharmaceutical companies, which historically had

advertised primarily to doctors and other health professionals, not directly to patients. The new prominence of DTCA is controversial in part because of fears that uninformed consumers might be easily manipulated, but also because increased prescription drug use could increase health expenditures. The drugs that are advertised are usually monopoly products, and much of the cost is reimbursed by insurance. Thus, demand is often inelastic, and expenditures can be very high.

Despite ongoing public debate, little is known about the consequences of DTCA for the health care system. What effects does DTCA have on expenditures for the drug that is the principal object of the advertising? Do the advertisements promote the use of the individual drug, thereby increasing its share of the market, or do they mainly promote the entire class so that the main effect on expenditures for the drug in question is to share in the rise in sales for the entire drug class? Meredith B. Rosenthal and her colleagues answer these questions in the chapter entitled, "Demand Effects of Recent Changes in Prescription Drug Promotion." In this chapter the authors discuss what is known about the effects of DTCA and the ambiguities in the literature on this topic.

Rosenthal and her coauthors have assembled a unique data set from the late 1990s on DTCA matched with pharmaceutical sales for several drugs in six therapeutic classes. They use these data to examine the effect of advertising on class-level sales and sales of particular drugs within classes. They find that advertising substantially boosts sales of that therapeutic class. In classes of drugs that are advertised most heavily, pharmaceutical use increases the most. The link between advertising and sales of particular drugs within a class, however, is weaker. Rosenthal and her coauthors find inconsistent estimates of the drug-specific advertising effect. The coefficients vary across specifications and are not always statistically significant. They conclude that much of the impact of advertising might be of the "general foot-traffic" type, rather than the product-specific type. Advertising gets people to the doctor to talk about a particular medical problem but does not necessarily lead to the purchase of that prescription medication.

Rosenthal et al. estimate that between 9 and 22 percent of the recent growth in prescription drug spending is attributable to the effects of direct-to-consumer advertising. Although this figure indicates that advertising has a large effect, most of the growth in spending on medications reflects other phenomena, like the introduction of more expensive drugs or broader drug utilization generally.

It may seem self-evident that increases in medical care costs would lead to lower rates of coverage, but empirical evidence on this point has been mixed. Researchers have found it difficult to explore the relationship between cost growth and coverage rates because few databases contain both cost and coverage information. In his paper, "Employee Costs and the Decline in Health Insurance Coverage," David M. Cutler examines whether costs influence coverage. Cutler uses data from the Current Population Survey over the 1990s and the Kaiser Family Foundation/Health Education and Research Trust in 1999 to examine how coverage rates change in response to cost changes.

Cutler first shows that the decline in insurance coverage in the 1990s is largely a result of fewer people taking up coverage when it is offered, rather than fewer people being offered insurance. The share of workers offered health insurance was relatively constant over the 1990s, while take-up rates fell by several percentage points.

Cutler then relates the take-up rate to the employee cost for insurance. Using firm data in 1999, he shows that the rate of take-up is strongly related to the part of the premium borne by employees. When employee costs increase, take-up rates decline. The elasticity of take-up with respect to employee costs is relatively small. But the increase in employee costs over the 1990s was relatively large. As a result, Cutler finds that the bulk of the lower take-up rates over the 1990s can be explained by the increase in employee costs. This finding provides a warning that recent increases in medical care costs could lead to additional declines in insurance coverage if they translate into greater employee payments for insurance.

Insurance take-up is also the subject of Sherry Glied's paper, "Health Insurance Expansions and the Content of Coverage: Is Something Better Than Nothing?" Glied examines ways that health insurance policies could be designed to produce the greatest value for the currently uninsured. Most research focuses only on the price of insurance to the uninsured, building on the assumption that lower prices will result in higher take-up rates. But this conventional belief ignores the possibility that *value*, not price, determines take-up; value depends on both price and the content of coverage. Lower price leads to increased coverage if the content of the benefits package is held constant, but the benefits package is not necessarily valuable if its characteristics are also changing.

In her empirical work, Glied examines what features of insurance are most likely to maximize enrollment by the uninsured. She con-

cludes that the uninsured are likely to prefer front-end coverage with a low benefit maximum to catastrophic coverage, for two reasons. The first is that many of the uninsured are young and relatively healthy and so do not value catastrophic coverage highly. Second, the uninsured already have access to some catastrophic care through emergency rooms and other settings—that is, opportunities already exist to “free ride” for emergency services, while it is difficult or impossible to receive many of the lower-cost services, like physician office visits, without paying. Thus, the uninsured are less willing to pay for catastrophic coverage. Glied’s findings have important implications for the design of public insurance expansions.

The economy at large influences the price of care, the content of insurance, and insurance coverage—coverage rates rise in good times and fall when the economy declines. The magnitude of this link is important in determining how much insurance coverage fluctuates with the economy, a topic that John Cawley and Kosali I. Simon examine in their chapter, “The Impact of Macroeconomic Conditions on the Health Insurance Coverage of Americans.” They find that coverage declines substantially in response to increases in the state unemployment rate, but that the effects of national recession on coverage are small. In two-earner families, if the husband or wife loses health insurance, perhaps due to unemployment, the spouse can obtain insurance, lowering the risk that they will both lose coverage.

Although health policy discussions often emphasize the importance of health insurance, policy can influence health in many other ways. For example, behavior can be the target of policy, and behavioral choices have a large impact on health. Adverse behaviors are common and often occur together. Smokers are more likely to drink than are nonsmokers, and drinkers are more likely to smoke than are nondrinkers. Other behaviors might be substitutes. It is widely believed, and some empirical data suggest, that quitting smoking leads to weight gain. For public policy analysis, it is important to understand if the links among different behaviors reflect an underlying structure of complementarity and substitution, or whether they merely reflect individual heterogeneity. If quitting smoking is more likely to lead to alcohol reduction, for example, that result would increase the value of smoking cessation efforts. The opposite would be true if former smokers gained weight.

Gabriel Picone and Frank Sloan examine the complementarity and substitution of three behavioral factors—smoking, drinking, and

weight—in their chapter, “Smoking Cessation and Lifestyle Changes.” They use data from the first five waves (1992–2000) of the Health and Retirement Study (HRS) to examine the interrelationship among smoking cessation, changes in alcohol consumption, and changes in weight. Because their data are longitudinal, they can examine changes over time in these behaviors, and their techniques adjust for sample attrition over the time period examined.

They find that the interrelationships among the adverse health behaviors are complex and may differ between genders. Smoking cessation is negatively correlated with alcohol consumption and, as several studies have reported, positively correlated with weight gain. Thus, as the authors note, smoking cessation may create positive externalities by reducing alcohol consumption; the increase in weight is relatively small and is distributed primarily among smokers who are not obese.

The topics addressed by these studies are likely to remain relevant for many years. Although the studies do not lead directly to policy recommendations, they add to our understanding of the consequences of various policy options.

