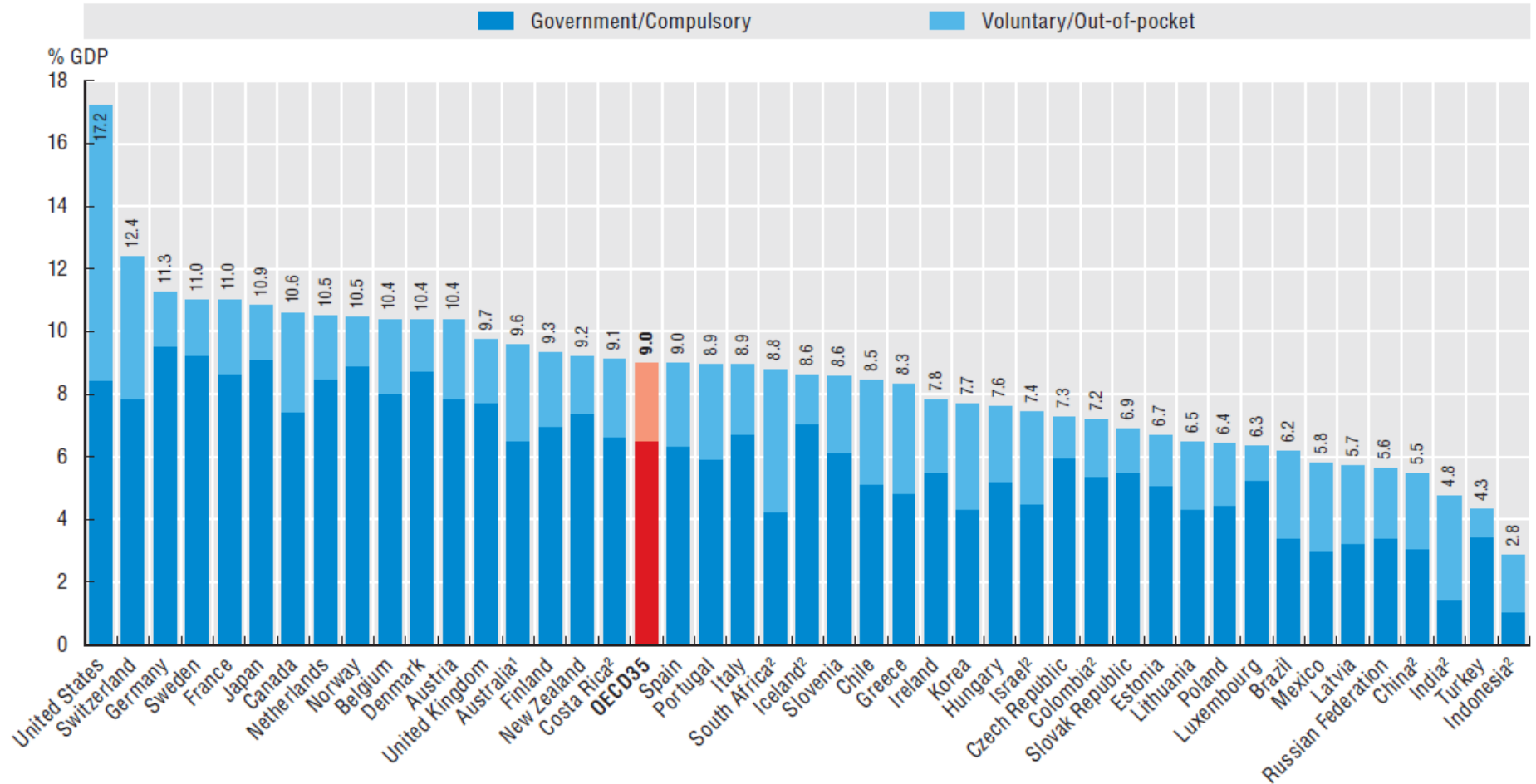


# Health spending was 9% of GDP on average in the OECD, ranging from 4.3% in Turkey to 17.2% in the United States

Health expenditure as a share of GDP, 2016 (or nearest year)



Note: Expenditure excludes investments, unless otherwise stated.

1. Australian expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services.

2. Includes investments.

Source: Health at a Glance 2017.

## 15.1

## Distribution of National Health Expenditures in the United States, 2010

Category	Share of Spending
Hospital care	31%
Physician, clinical care	20
Prescription drugs	10
Nursing home care	6
Other personal health care	15
Other health spending	16

## 15.1

# Americans' Source of Health Insurance Coverage, 2010

	People (millions)	Population %
<i>Private</i>	201.0	64.0
Employment-based	176.3	55.3
Direct purchase	26.8	9.8%
<i>Public</i>	87.4	31.0
Medicare	43	14.5
Medicaid	42.6	15.9
TRICARE/CHAMPVA	11.6	4.2
<i>Uninsured</i>	46.2	16.3

## 15.1

## Illustrating the Tax Subsidy

	<b>Jim</b>	<b>Peter</b>
Wage	30	30
Employer health insurance spending	0	5
Pre-tax wage	30	25
After-tax wage	20	16.67
Personal health spending	4	0
After-tax, after-health spending income	16	16.67

## 15.1

## Why Employers Provide Private Insurance, Part II: The Tax Subsidy

The subsidy to employer-provided health insurance is generally not well understood.

- Subsidy to *employees* not *employers*.
- Employer is indifferent between payments in wages and in health insurance (both are tax deductible).
- Worker prefers to be paid in health insurance rather than wages, the worker reduces her tax payments.
- To end the tax subsidy, don't increase the corporate tax paid by the firm; instead, include employer spending on health insurance as part of an employee's taxable income.

## 16.3

## The Medicare Program

The largest public health insurance program in the United States is Medicare.

■ TABLE 16-2

### Medicaid and Medicare

	Medicaid	Medicare
Eligibles	Families on welfare Low-income children, pregnant women Low-income elderly, disabled	Retirees and spouses 65 and older Certain disabled individuals under 65 People with kidney failure (requiring dialysis or transplant)
Premiums	None	Hospital coverage: none Physician coverage: \$66.60 per month Prescription drug coverage: Variable
Deductibles/copayments	None (or very small)	Hospital coverage: \$1,068 deductible for first 60 days Physician coverage: \$135 deductible, 20% coinsurance Prescription drug coverage: Variable
Services excluded	None (or very minor)	Prescription drugs (until 2006) Routine checkups, dental care, nursing home care, eyeglasses, hearing aids, immunization shots
Provider reimbursement	Very low	Moderate (but falling)

Medicaid provides health insurance for low-income individuals, covering a wide range of health services at little cost to those individuals. Medicare provides health insurance for those age 65 and over, covering many, though not all, health services at some cost to those individuals.

## 15.1

## An Overview of Health Care in the United States

### EMPIRICAL EVIDENCE

#### HEALTH INSURANCE AND MOBILITY

Is job lock an important problem in reality?

Initially, a large literature compared the mobility rate of those who have and do not have health insurance.

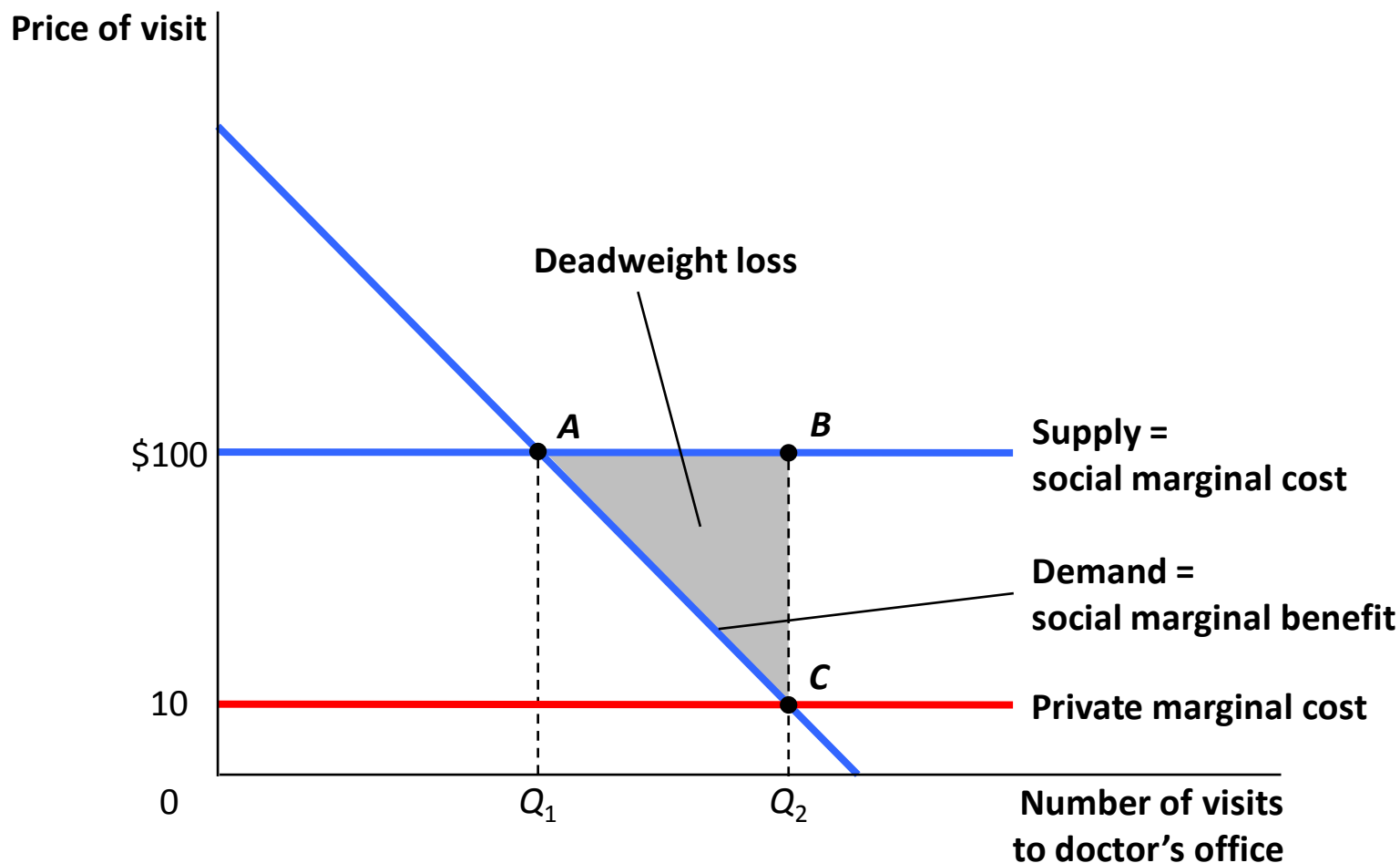
A more sophisticated literature in the 1990s surmounted this problem in two different ways:

- Studies used a difference-in-difference strategy that compared a treatment group of those who valued health insurance particularly highly with a control group of those who did not.
- Studies examined the impact of state laws that allowed workers to continue to purchase their employer-provided health insurance for some period of time after leaving their jobs.

The results from these studies support the notion that job lock is quantitatively important.

## 15.2

## Moral Hazard Costs of Health Insurance for Patients





**Table V: Health Care Utilization (Survey Data)**

	Extensive Margin (Any)				Total Utilization (Number)			
	Control Mean	ITT	LATE	p-values	Control Mean	ITT	LATE	p-values
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Prescription drugs currently	0.637 (0.481)	0.025 (0.0083)	0.088 (0.029)	[0.002] {0.005}	2.318 (2.878)	0.100 (0.051)	0.347 (0.176)	[0.049] {0.137}
Outpatient visits last six months	0.574 (0.494)	0.062 (0.0074)	0.212 (0.025)	[<0.0001] {<0.0001}	1.914 (3.087)	0.314 (0.054)	1.083 (0.182)	[<0.0001] {<0.0001}
ER visits last six months	0.261 (0.439)	0.0065 (0.0067)	0.022 (0.023)	[0.335] {0.547}	0.47 (1.037)	0.0074 (0.016)	0.026 (0.056)	[0.645] {0.643}
Inpatient Hospital admissions last six months	0.072 (0.259)	0.0022 (0.0040)	0.0077 (0.014)	[0.572] {0.570}	0.097 (0.4)	0.0062 (0.0062)	0.021 (0.021)	[0.311] {0.510}
<i>Standardized treatment effect</i>		0.050 (0.011)	0.173 (0.036)	[<0.0001]		0.040 (0.011)	0.137 (0.038)	[0.0003]
<i>Annual spending<sup>a</sup></i>					3,156	226 (108)	778 (371)	[0.037]

**Table VIII: Financial Strain (Survey Data)**

	Control Mean	ITT	LATE	p-values
	(1)	(2)	(3)	(4)
Any out of pocket medical expenses, last six months	0.555 (0.497)	-0.058 (0.0077)	-0.200 (0.026)	[<0.0001] {<0.0001}
Owe money for medical expenses currently	0.597 (0.491)	-0.052 (0.0076)	-0.180 (0.026)	[<0.0001] {<0.0001}
Borrowed money or skipped other bills to pay medical bills, last six	0.364 (0.481)	-0.045 (0.0073)	-0.154 (0.025)	[<0.0001] {<0.0001}
Refused treatment bc of medical debt, last six months	0.081 (0.273)	-0.011 (0.0041)	-0.036 (0.014)	[0.01] {0.01}
<i>Standardized treatment effect</i>		-0.089 (0.010)	-0.305 (0.035)	[<0.0001]

**Table IX: Health**

	Control Mean (1)	ITT (2)	LATE (3)	p-values (4)
<b>Panel A: Administrative data</b>				
Alive	0.992 (0.092)	0.00032 (0.00068)	0.0013 (0.0027)	[0.638]
<b>Panel B: Survey Data</b>				
Self reported health good / very good / excellent (not fair or poor)	0.548 (0.498)	0.039 (0.0076)	0.133 (0.026)	[<0.0001] {<0.0001}
Self reported health not poor (fair, good, very good, or excellent)	0.86 (0.347)	0.029 (0.0051)	0.099 (0.018)	[<0.0001] {<0.0001}
Health about the same or gotten better over last six months	0.714 (0.452)	0.033 (0.0067)	0.113 (0.023)	[<0.0001] {<0.0001}
# of days physical health good, past 30 days*	21.862 (10.384)	0.381 (0.162)	1.317 (0.563)	[0.019] {0.018}
# days poor physical or mental health did not impair usual activity, past 30 days*	20.329 (10.939)	0.459 (0.175)	1.585 (0.606)	[0.009] {0.015}
# of days mental health good, past 30 days*	18.738 (11.445)	0.603 (0.184)	2.082 (0.64)	[0.001] {0.003}
Did not screen positive for depression, last two weeks	0.671 (0.470)	0.023 (0.0071)	0.078 (0.025)	[0.001] {0.003}
<i>Standardized treatment effect</i>		0.059 (0.011)	0.203 (0.039)	[<0.0001]

Source: Finkelstein et al. 2012

**Table X: Potential Mechanisms for Improved Health (Survey Data)**

	Control Mean (1)	ITT (2)	LATE (3)	p-values (4)
<b>Panel A: Access to care</b>				
Have usual place of clinic-based care	0.499 (0.500)	0.099 (0.0080)	0.339 (0.027)	[<0.0001] {<0.0001}
Have personal doctor	0.490 (0.500)	0.081 (0.0077)	0.280 (0.026)	[<0.0001] {<0.0001}
Got all needed medical care, last six months	0.684 (0.465)	0.069 (0.0063)	0.239 (0.022)	[<0.0001] {<0.0001}
Got all needed drugs, last six months	0.765 (0.424)	0.056 (0.0055)	0.195 (0.019)	[<0.0001] {<0.0001}
Didn't use ER for non-emergency, last six months	0.916 (0.278)	-0.0011 (0.0043)	-0.0037 (0.015)	[0.804] {0.804}
<i>Standardized treatment effect</i>		0.128 (0.0084)	0.440 (0.029)	[<0.0001]

Source: Finkelstein et al. 2012

## 16.2

## EVIDENCE: Using State Medicaid Expansions to Estimate Program Effects

### Eligibility for all Children, by State

Year	Missouri Eligibility	Michigan Eligibility
1982	12%	20%
2000	76%	34%

### Eligibility for Children by age in Washington, D.C.

Year	Age 13	Age 0
1982	18%	48%
2000	59%	56%

Costs Per Life Saved of Various Regulations			
Regulation concerning ...	Year	Agency	Cost per life saved (\$ millions)
Childproof lighters	1993	CPSC	\$0.1
Food labeling	1993	FDA	0.4
Reflective devices for heavy trucks	1999	NHTSA	0.9
Medicaid pregnancy expansions	1996	Currie & Gruber	1.0
Children's sleepware flammability	1973	CPSC	2.2
Rear/up/should seatbelts in cars	1989	NHTSA	4.4
Asbestos	1972	OSHA	5.5
<b><i>Value of statistical life</i></b>			<b>7.0</b>
Benezene	1987	OSHA	22
Asbestos ban	1989	EPA	78
Cattle feed	1979	FDA	170
Solid waste disposal facilities	1991	EPA	100,000

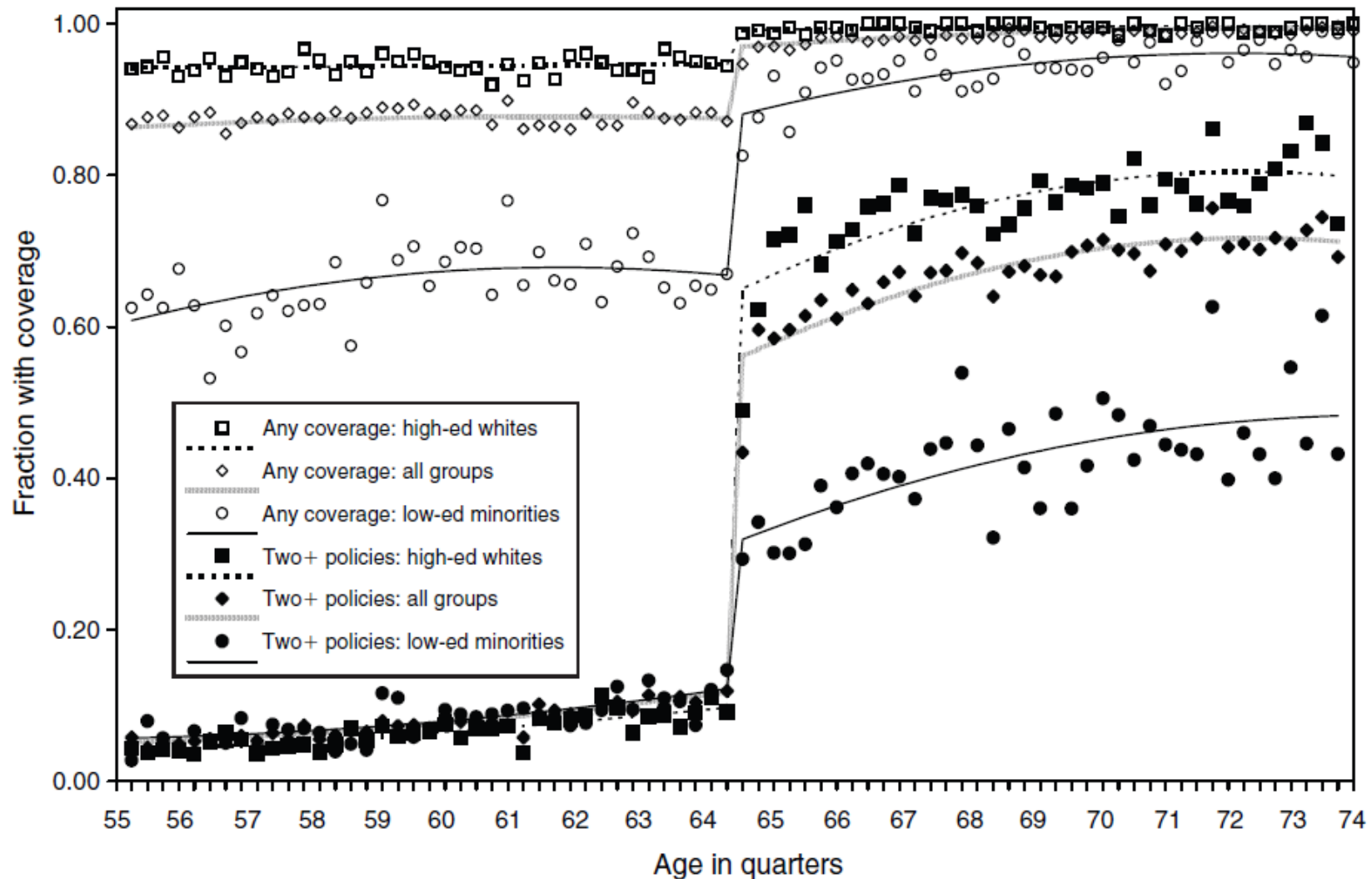


FIGURE 1. COVERAGE BY ANY INSURANCE AND BY TWO OR MORE POLICIES, BY AGE AND DEMOGRAPHIC GROUP

First stage: sharp increase in coverage; more for disadvantaged  
(From NHIS; age measured in quarters) FIGURE 1

## Hospital discharge data (CA, FL, NY 1992-2002), ages 60-70

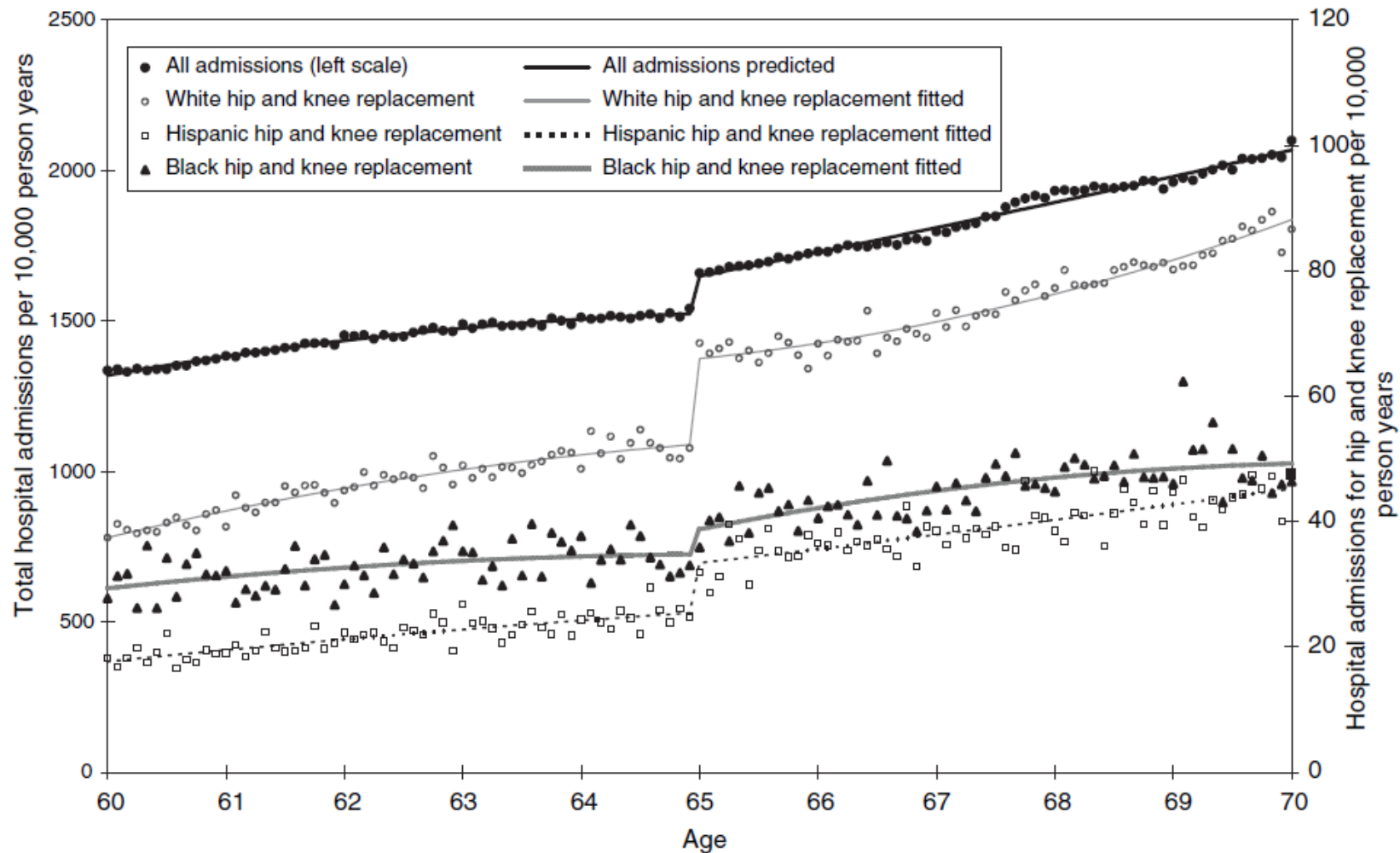


FIGURE 3. HOSPITAL ADMISSION RATES BY RACE/ETHNICITY

Increase is driven by discretionary medical care, diagnostic heart treatments.



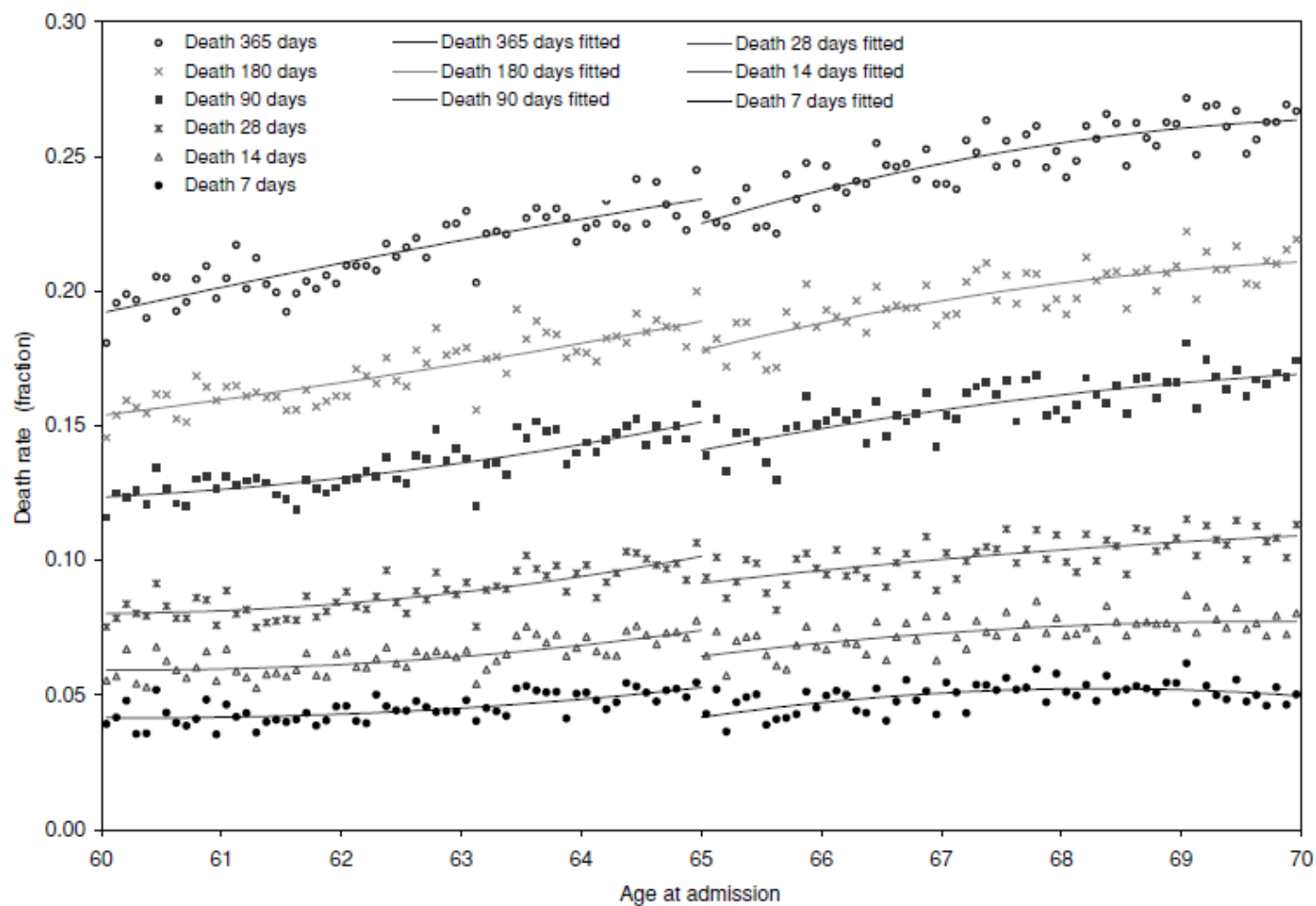
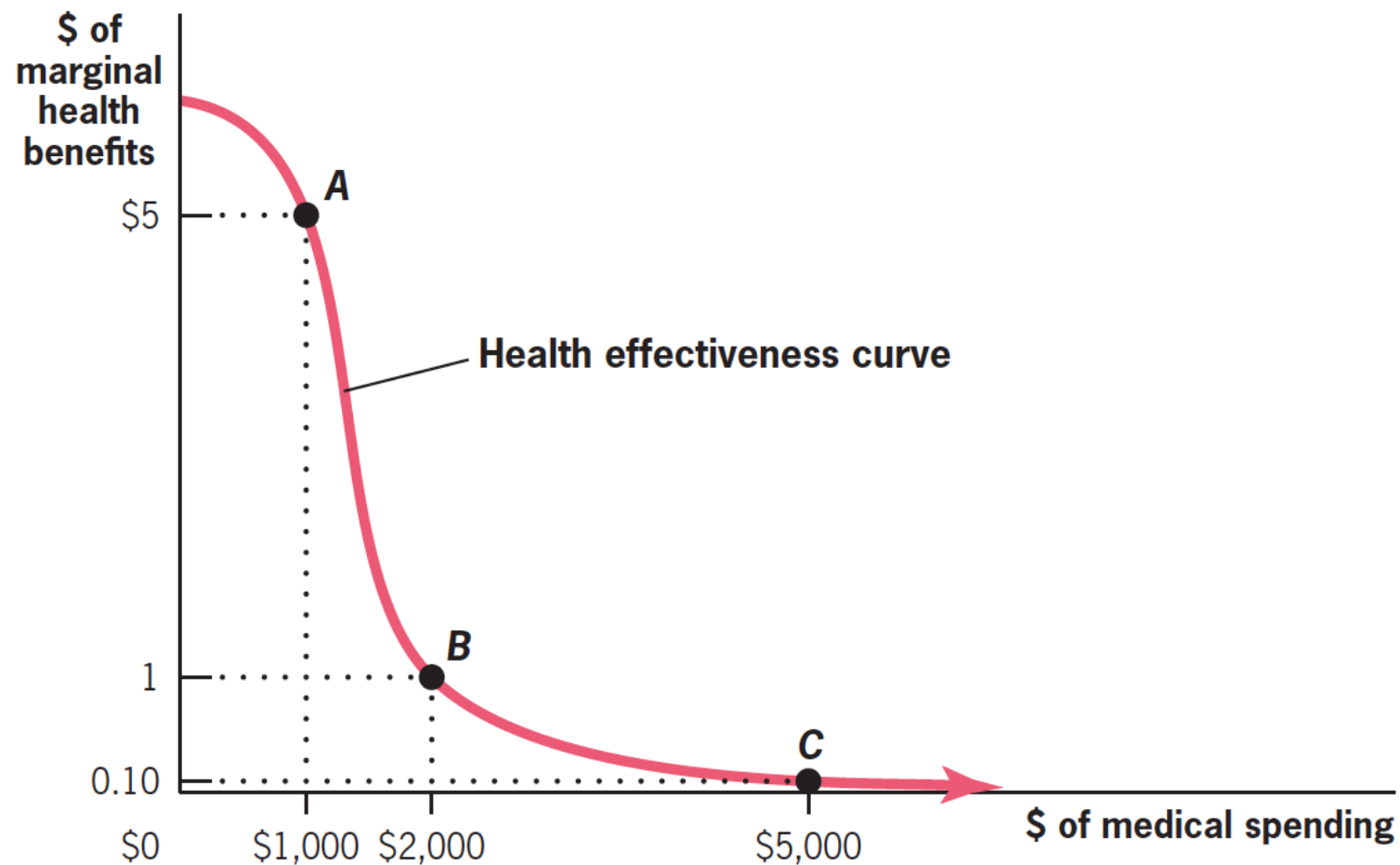


FIGURE VI  
Patient Mortality Rates over Different Follow-Up Intervals

Nontrivial decrease in mortality.

## 15.2

## The “Flat of the Curve”



## 16.6

## The Massachusetts Experiment with Incremental Universalism

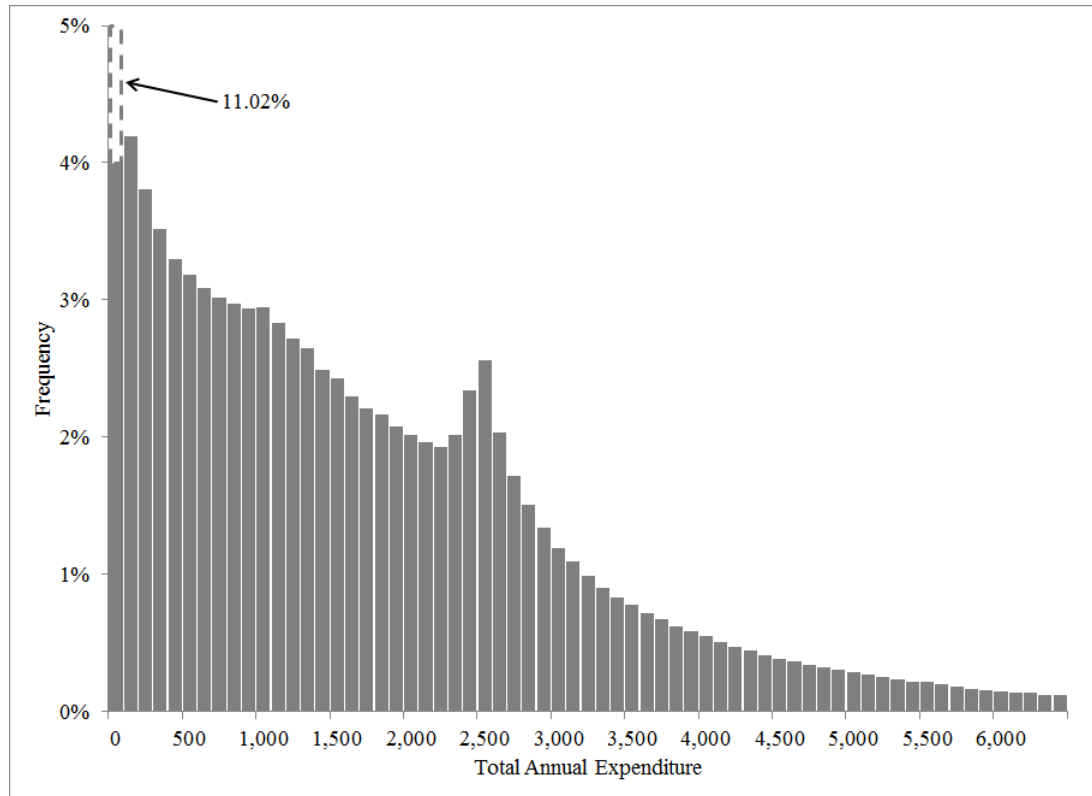
- In 2006, Massachusetts pushed to cover remaining 8% without insurance.
- “Three-legged stool” approach:
  - Ban pre-existing conditions exclusion, health-based pricing.
  - Individual mandate, avoiding adverse selection.
    - **Mandate:** A legal requirement for employers to offer insurance for individuals to obtain some type of insurance coverage.
  - Subsidized/free insurance for low-income families.

## 16.6

## The Massachusetts Experiment with Incremental Universalism

- Striking results:
  - MA uninsurance rate 3%, compared to 18% nationally.
  - Half of the increase in coverage from Medicaid or government subsidized plans.
  - Premiums in the non-group market have fallen by half relative national trends.
  - Costs of the reform roughly consistent with projections.

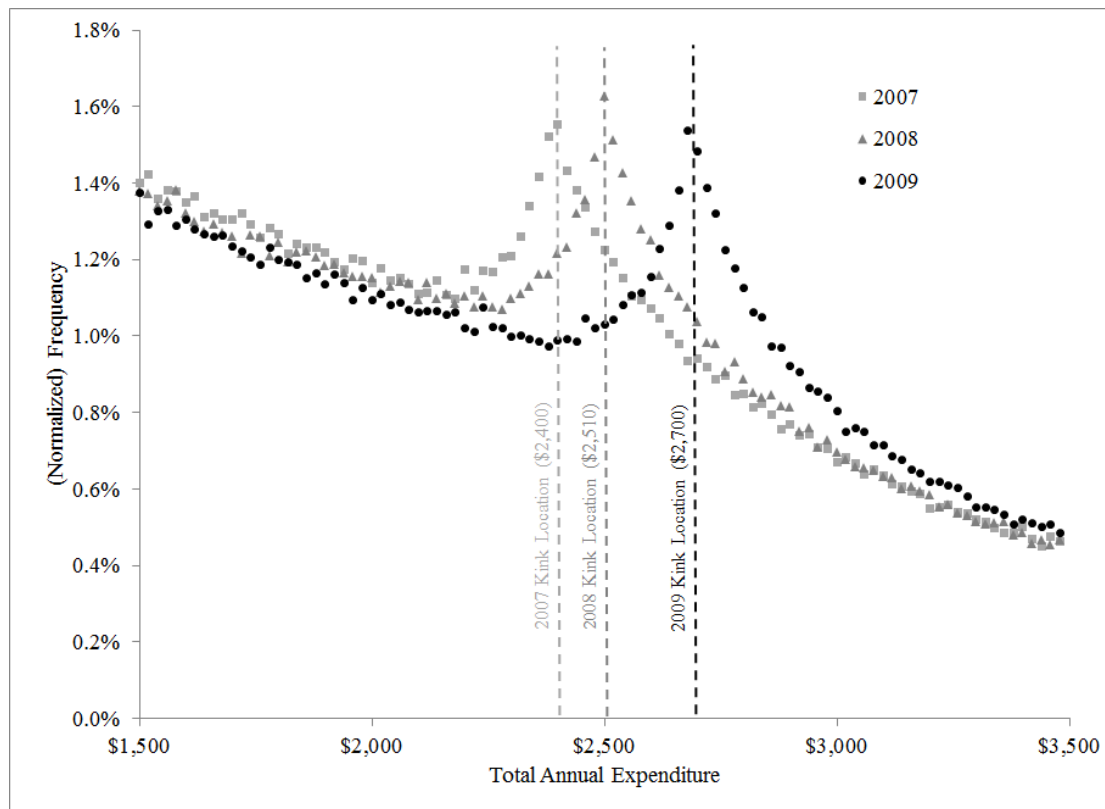
Figure 2: Annual spending distribution (in 2008)



The figure displays the distribution of total annual prescription drug spending in 2008 for our baseline sample. Each bar represents the set of people that spent up to \$100 above the value that is on the x-axis, so that the first bar represents individuals who spent less than \$100 during the year, the second bar represents \$100-200 spending, and so on. For visual clarity, we omit from the graph the 3% of the sample whose spending exceeds \$6,500. The kink location (in 2008) is at \$2,510.  $N = 1,251,969$ .

Source: Einav, Finkelstein, Schrimpf (2013)

Figure 3: Distribution of spending around the kink, by year

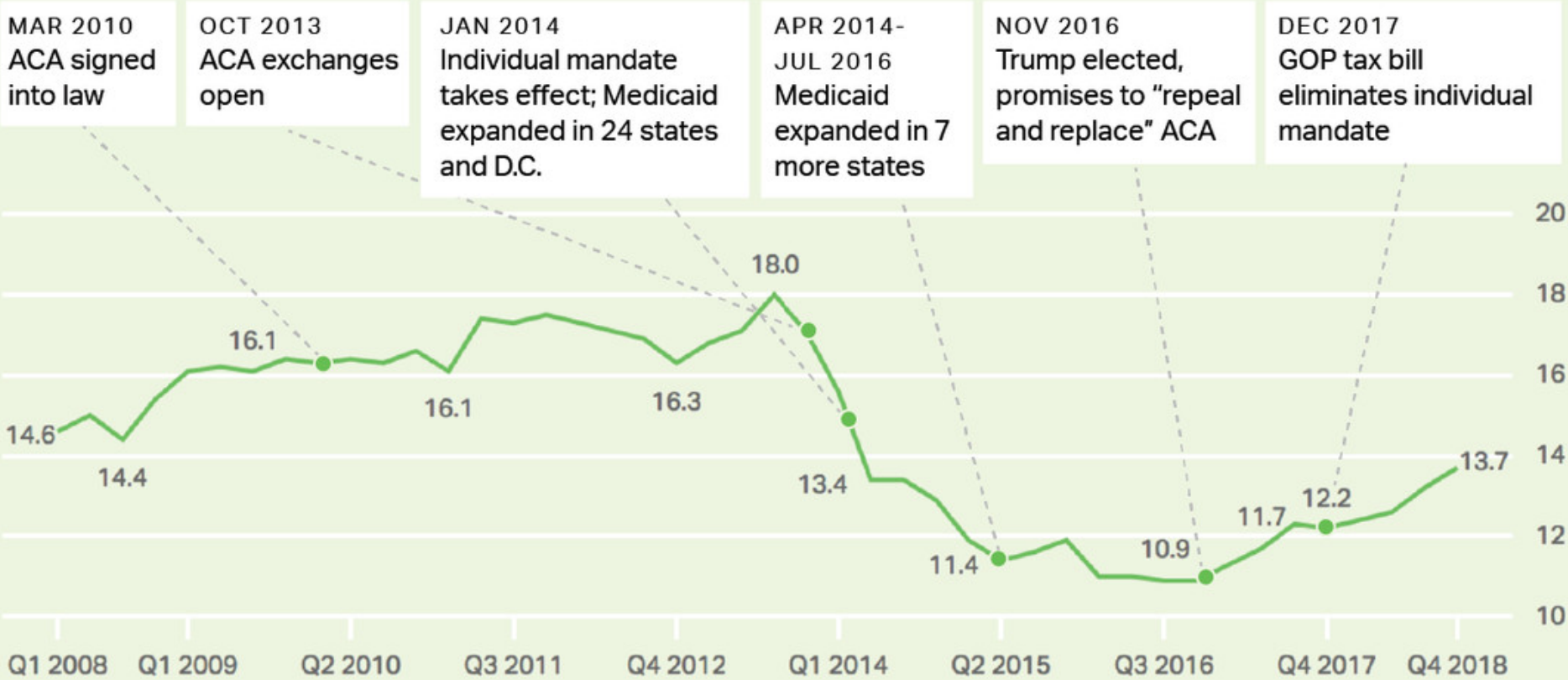


The figure displays the distribution of total annual prescription drug spending, separately by year, for individuals in our baseline sample whose annual spending in a given year was between \$1,500 and \$3,500 (N=1,332,733 overall; by year it is 447,006 (2007), 442,317 (2008), and 442,410 (2009)). Each point in the graph represents the set of people that spent up to \$20 above the value that is on the x-axis, so that the first point represents individuals who spent between \$1,500 and \$1,520, the second bar represents \$1,520-\$1,540 spending, and so on. We normalize the frequencies so that they add up to one for each series (year) shown.

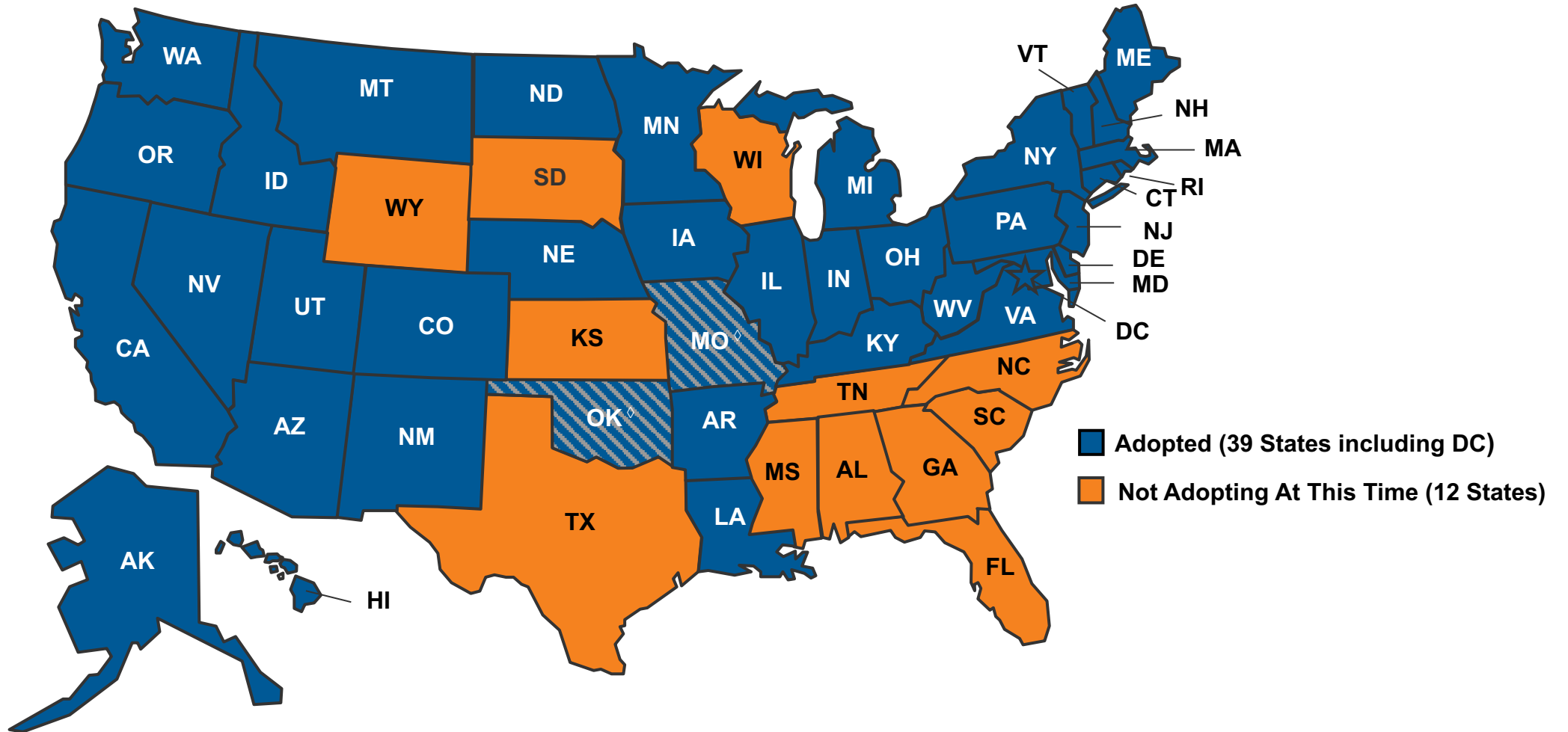
Source: Einav, Finkelstein, Schrimpf (2013)

# Percentage of U.S. Adults Without Health Insurance, 2008-2018

■ % Uninsured



# Status of State Medicaid Expansion Decisions

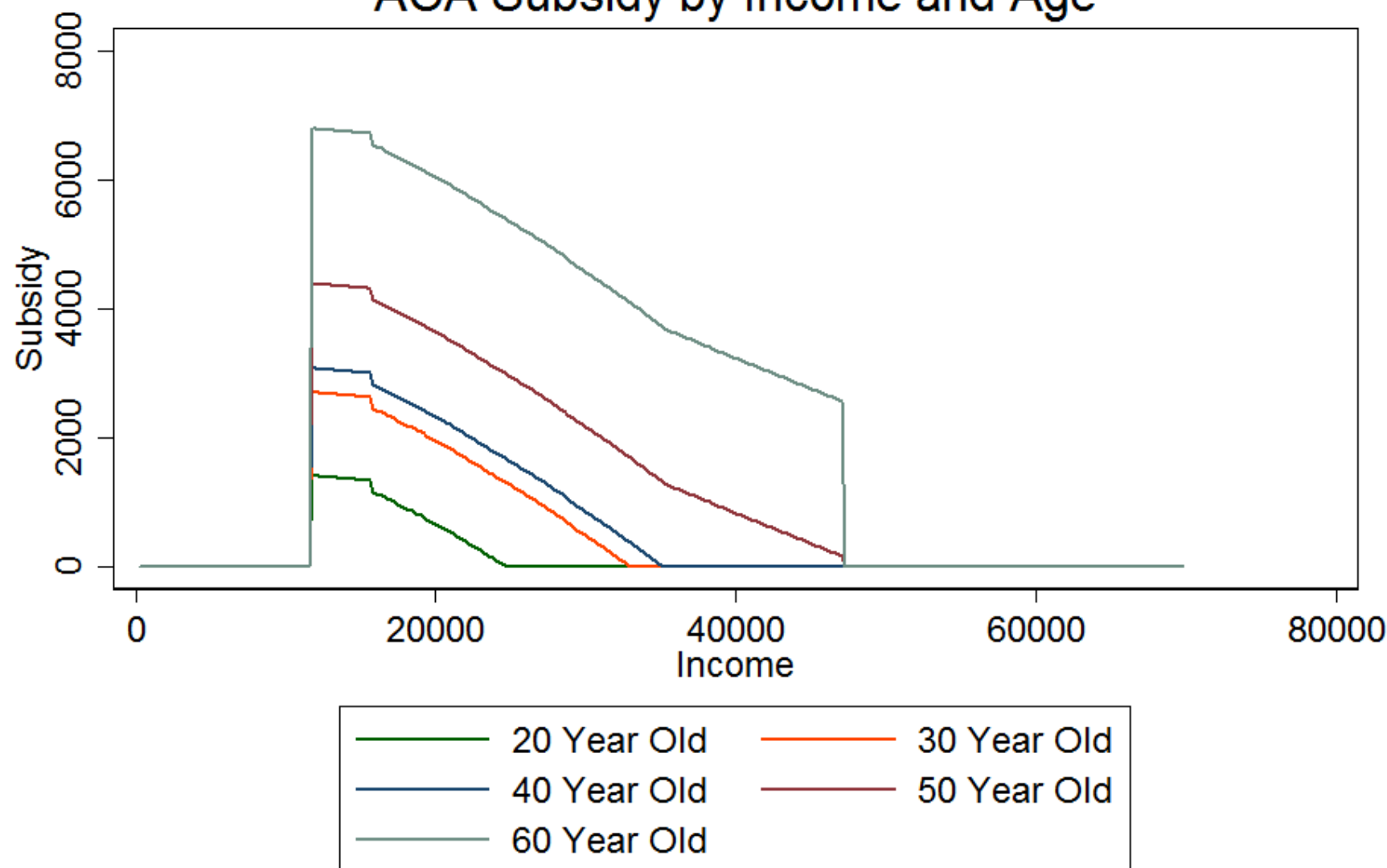


NOTES: Current status for each state is based on KFF tracking and analysis of state activity. ♦Expansion is adopted but not yet implemented in MO and OK. (See link below for additional state-specific notes).

SOURCE: “Status of State Action on the Medicaid Expansion Decision,” KFF State Health Facts, updated March 31, 2021. <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

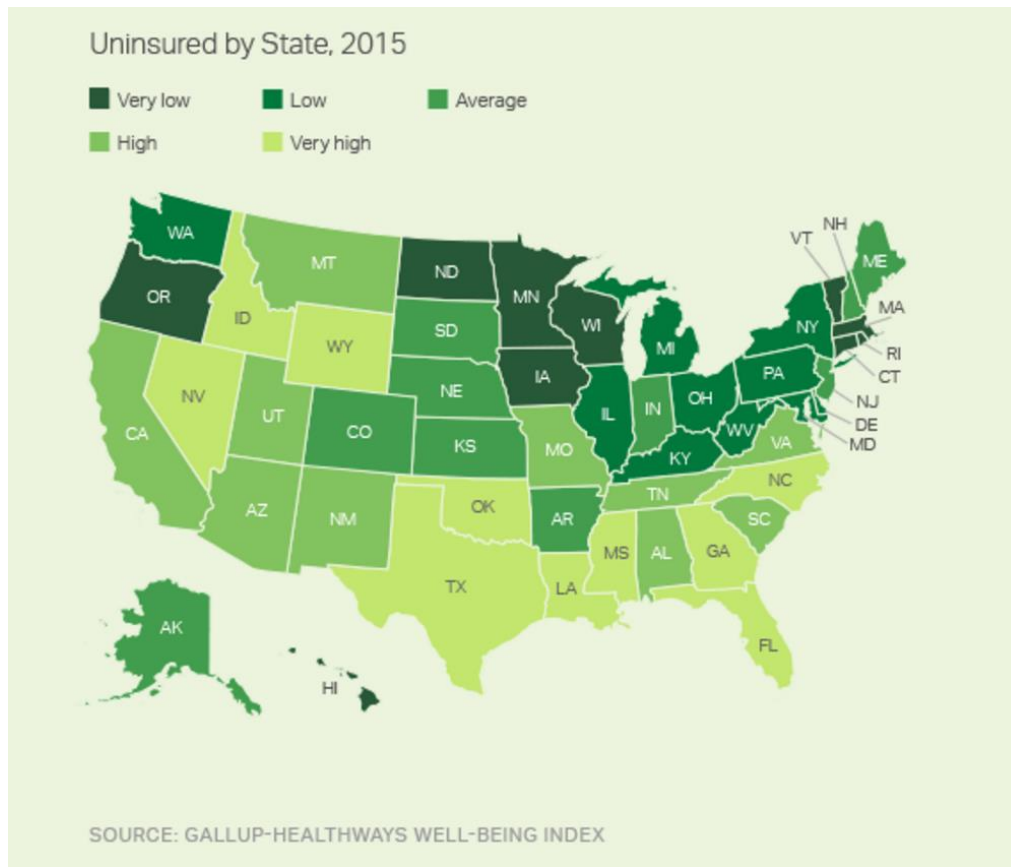


## ACA Subsidy by Income and Age

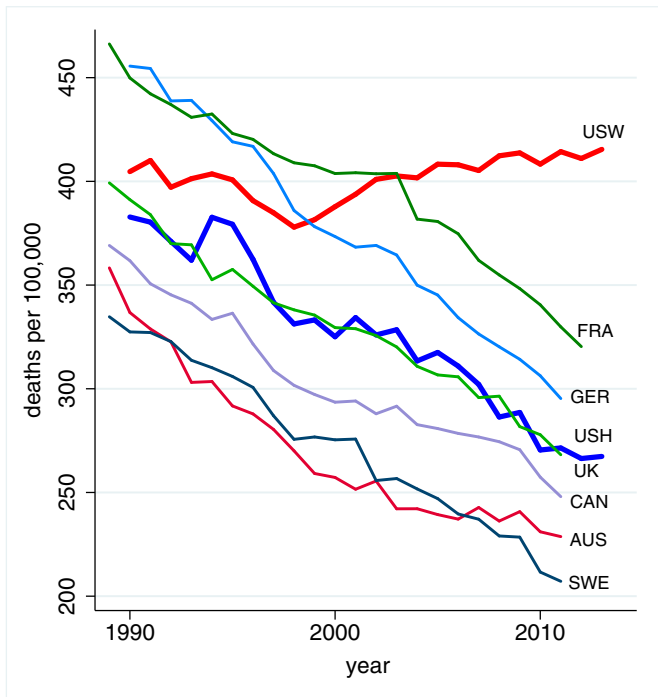


Note: Subsidy calculated for single person in 2015 for all scenarios.

# Coverage Gains Vary by State

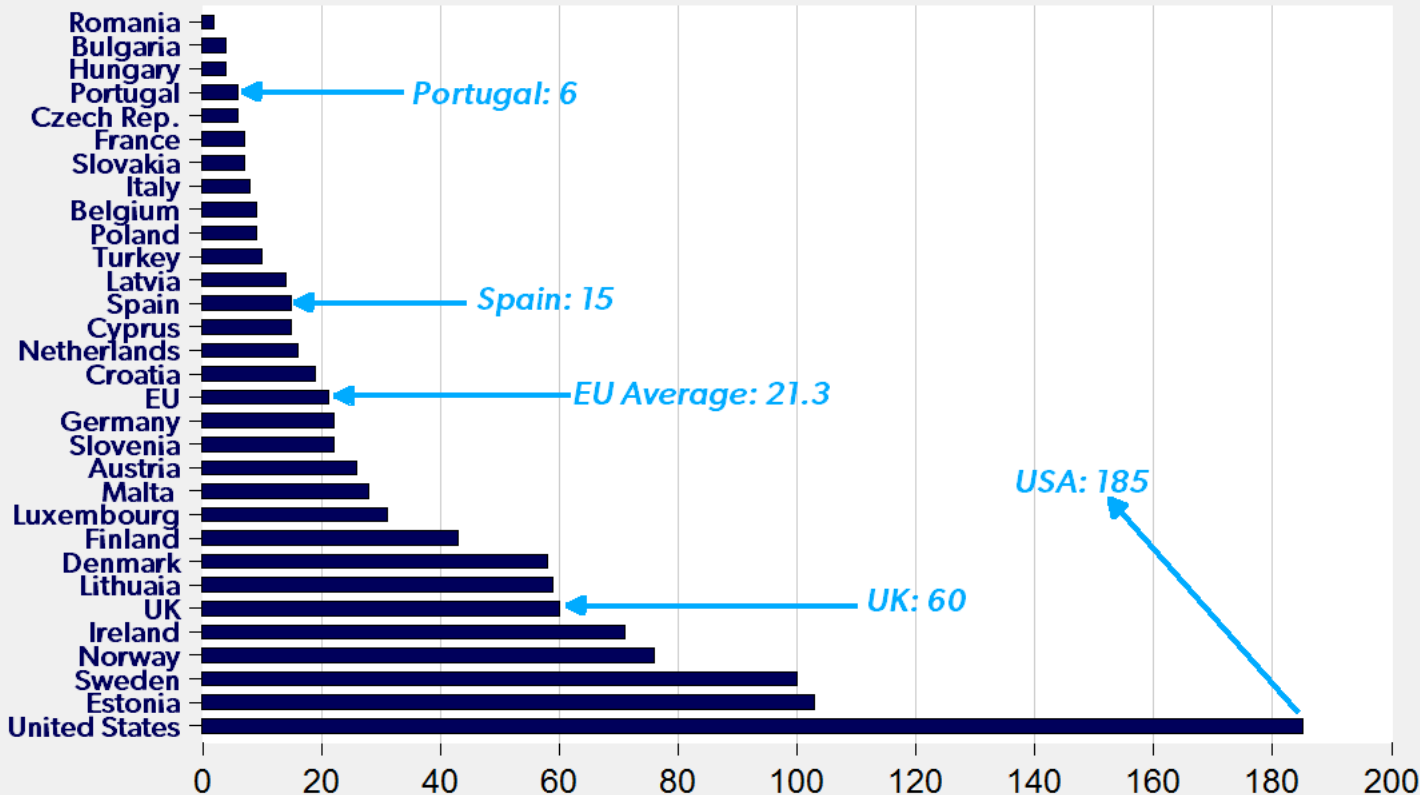


State	% Uninsured		Expanded Medicaid
	2013	2015	
California	21.6	11.8	Yes
Colorado	17.0	10.3	Yes
Florida	22.1	15.7	No
Illinois	15.5	8.7	Yes
Kentucky	20.4	7.5	Yes
Massachusetts	4.9	3.5	Yes
New York	12.6	8.6	Yes
Oregon	19.4	7.3	Yes
Texas	27.0	22.3	No
Virginia	13.3	12.6	No



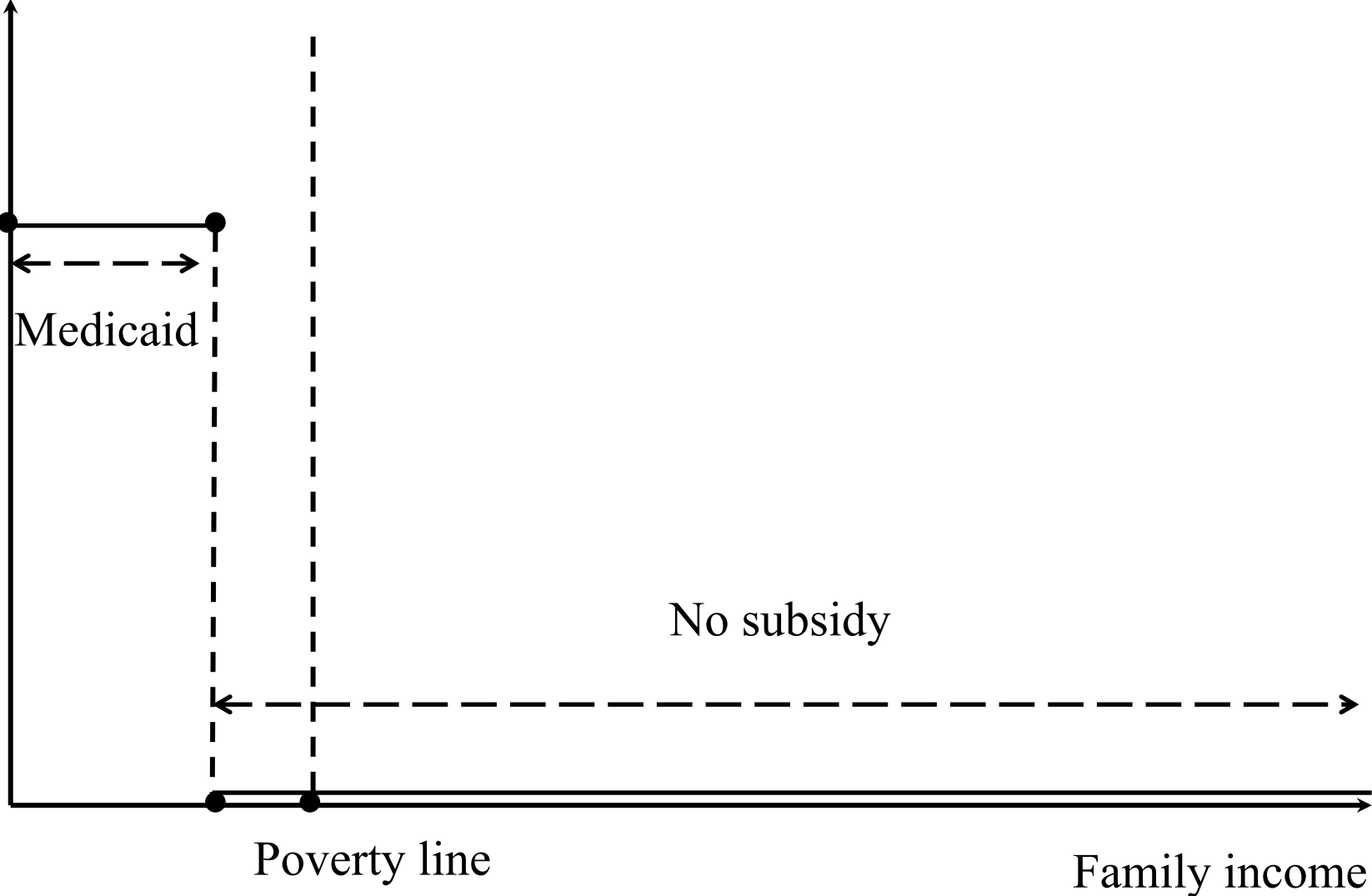
**Fig. 1.** All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). Source: Case and Deaton (2015)

## Drug Induced Deaths per Million Population, Ages 15-64

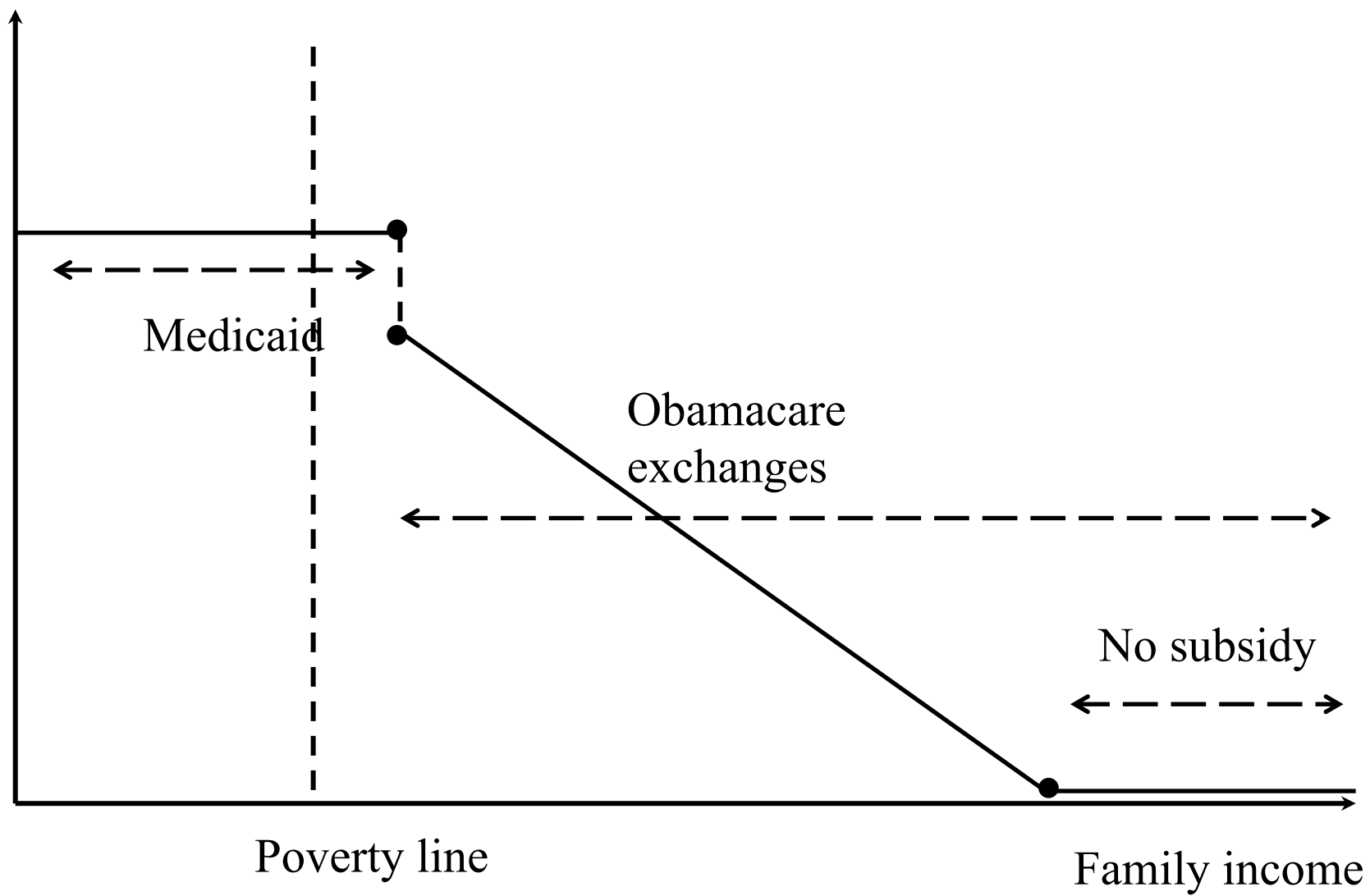


Sources: European Drug Report 2017 and New York Times

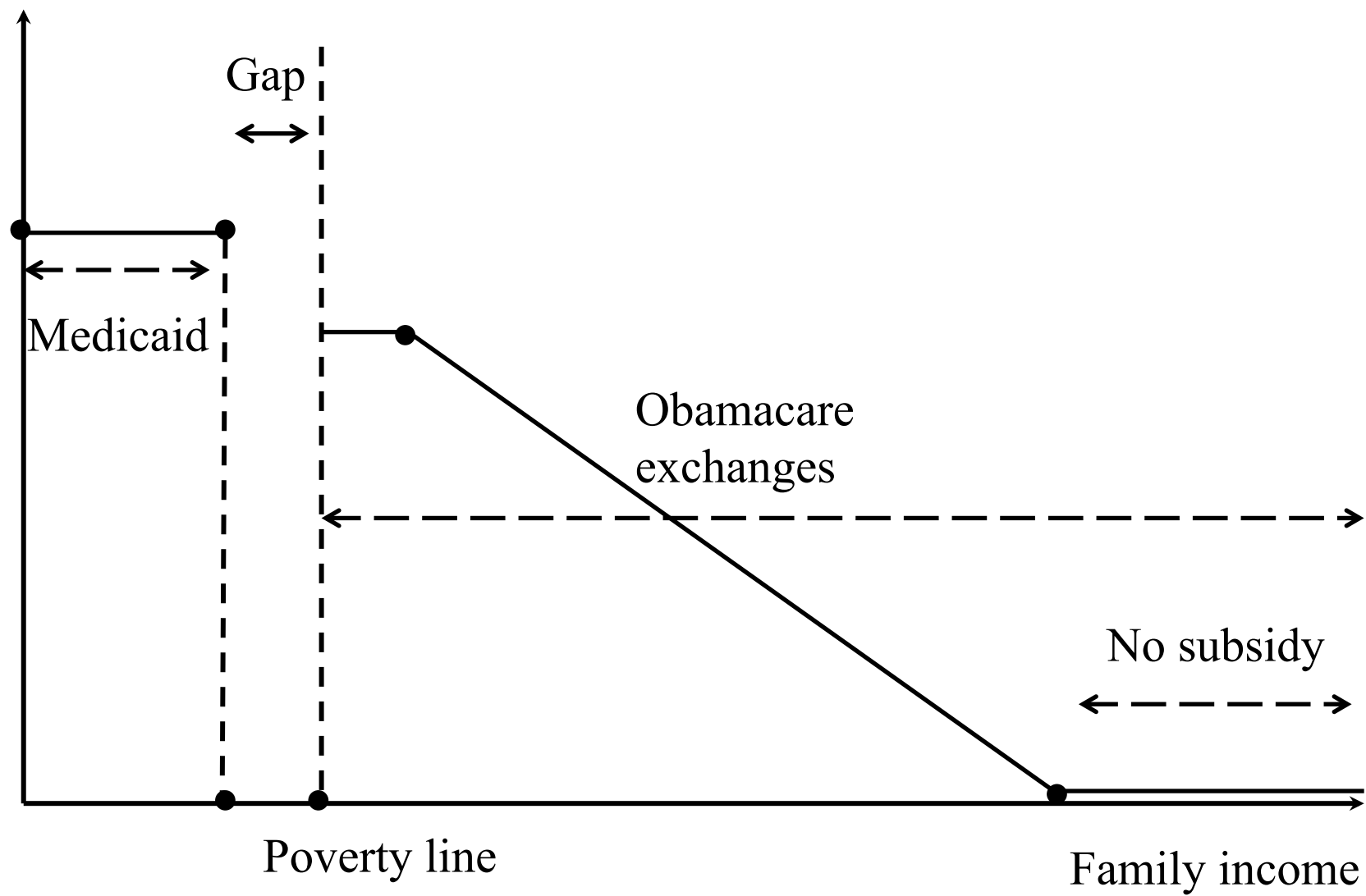
Health subsidy BEFORE Obamacare



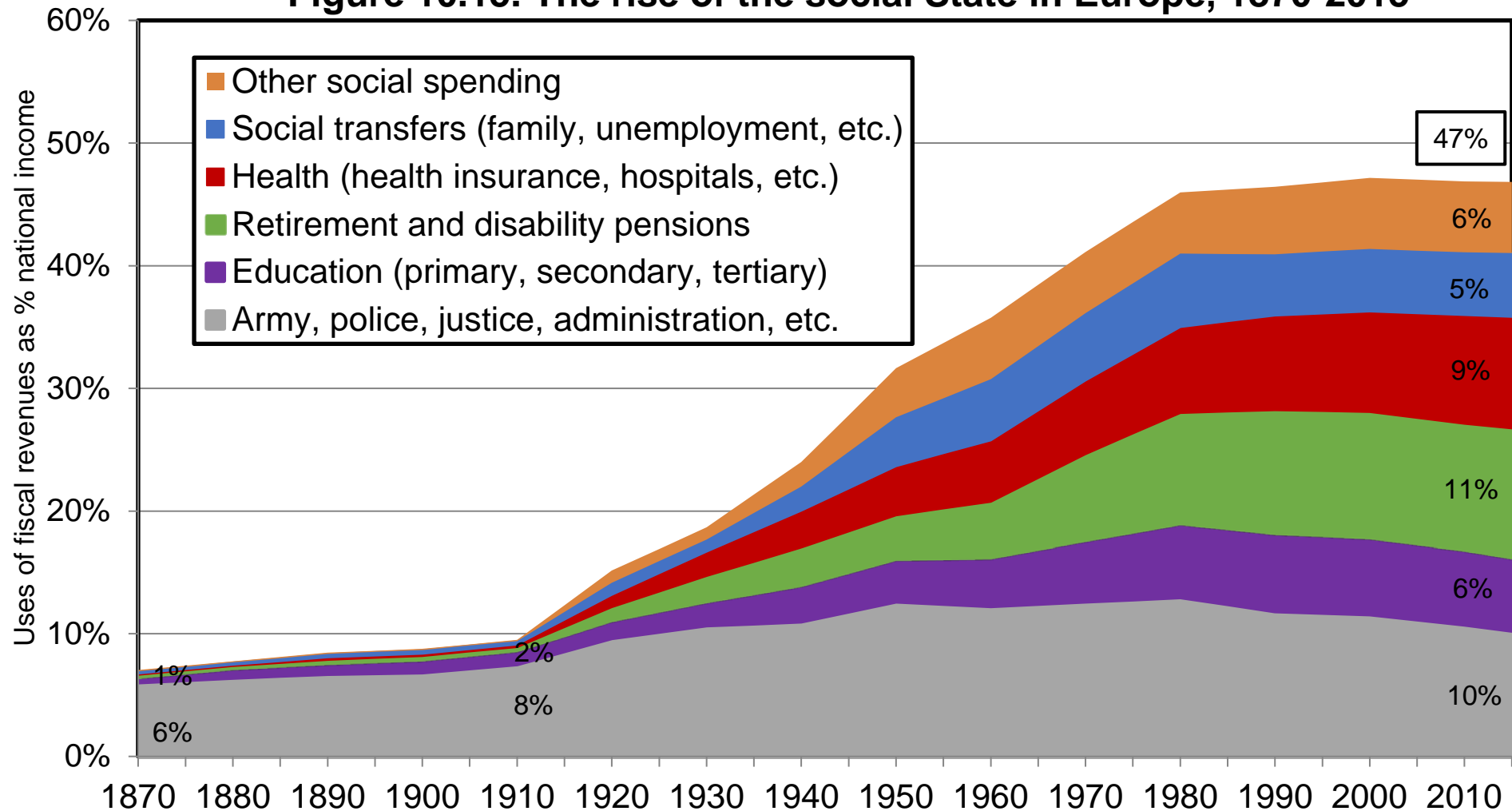
Health subsidy after Obamacare in Medicaid Expansion States



Health subsidy after Obamacare in non-expansion States



**Figure 10.15. The rise of the social State in Europe, 1870-2015**

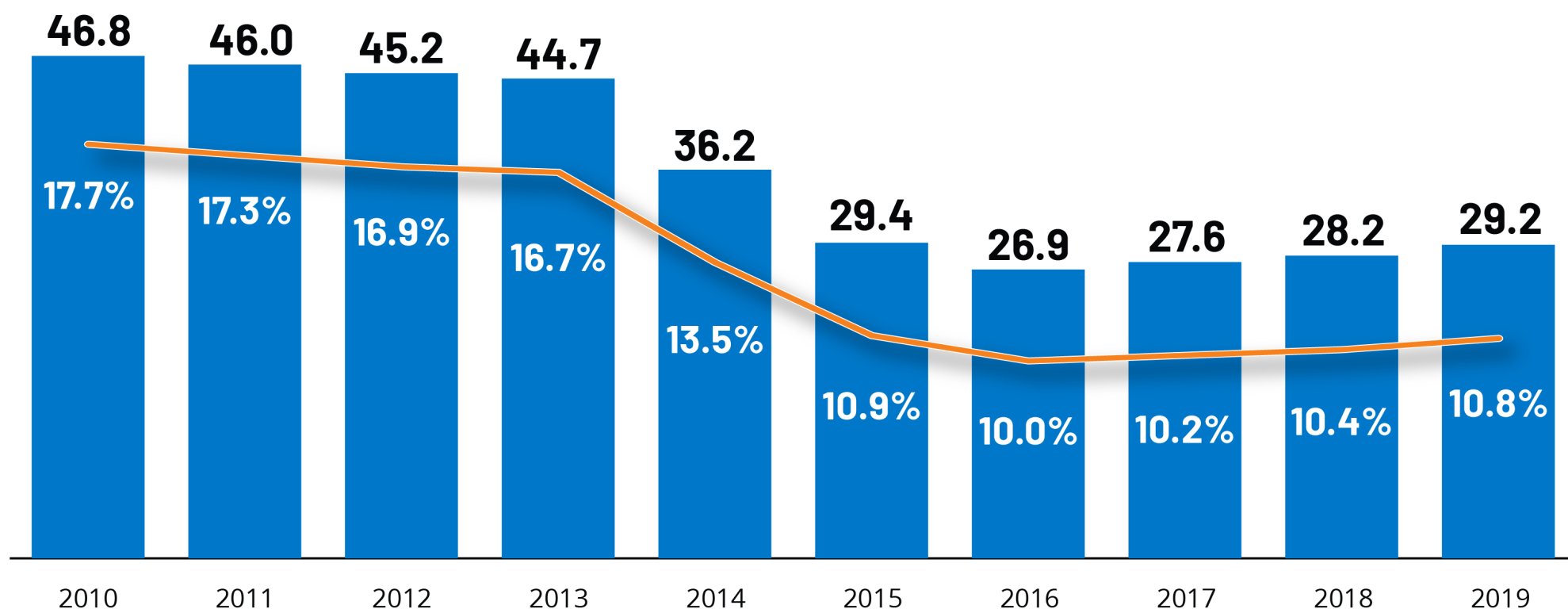


**Interpretation.** In 2015, fiscal revenues represented 47% of national income on average in Western Europe et were used as follows: 10% of national income for regalian expenditure (army, police, justice, general administration, basic infrastructure: roads, etc.); 6% for education; 11% for pensions; 9% for health; 5% for social transfers (other than pensions); 6% for other social spending (housing, etc.). Before 1914, regalian expenditure absorbed almost all fiscal revenues. **Note.** The evolution depicted here is the average of Germany, France, Britain and Sweden (see figure 10.14). Sources and séries: see [piketty.pse.ens.fr/ideology](http://piketty.pse.ens.fr/ideology).

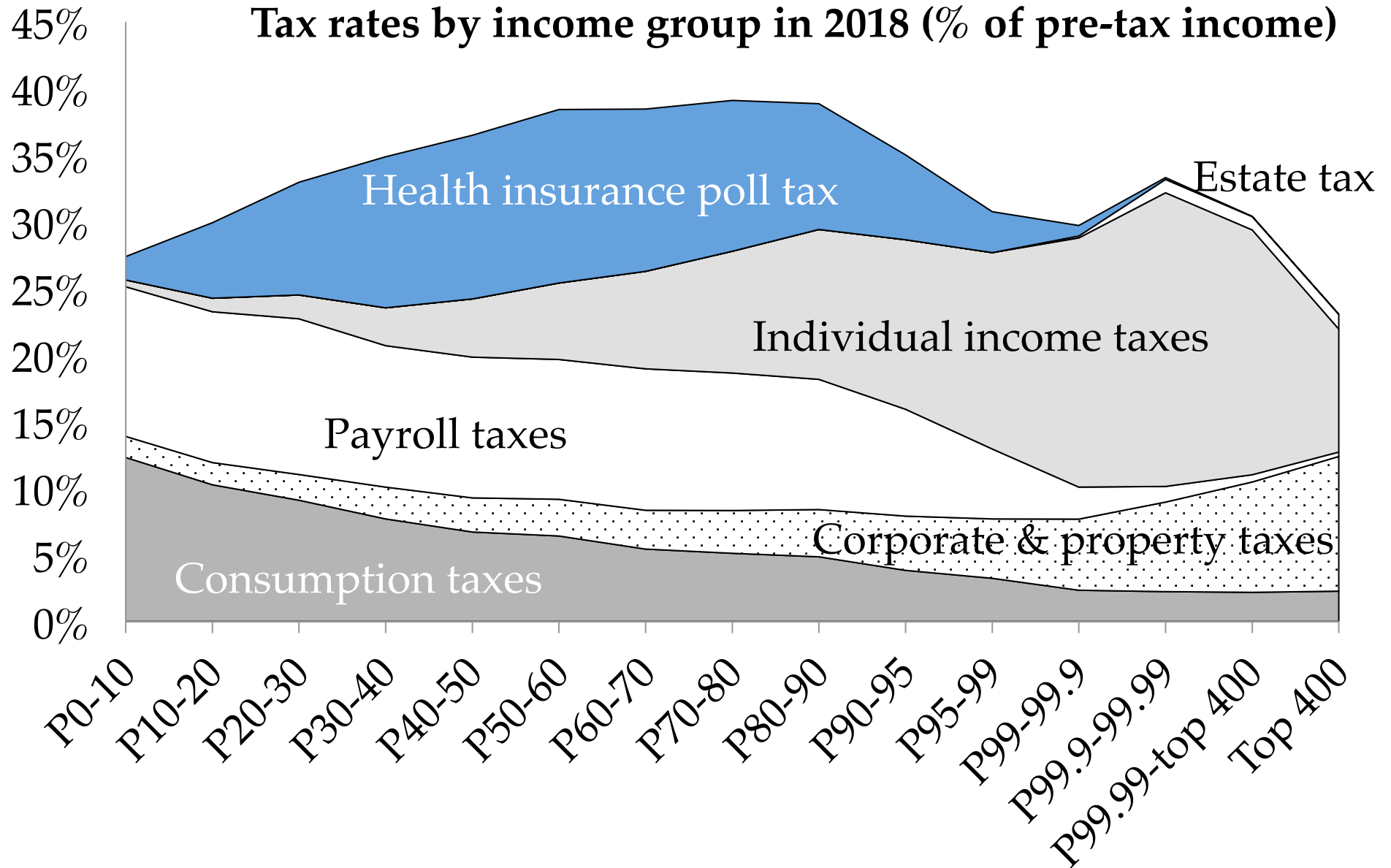


# Number of Uninsured and Uninsured Rate among the Nonelderly Population, 2010-2019

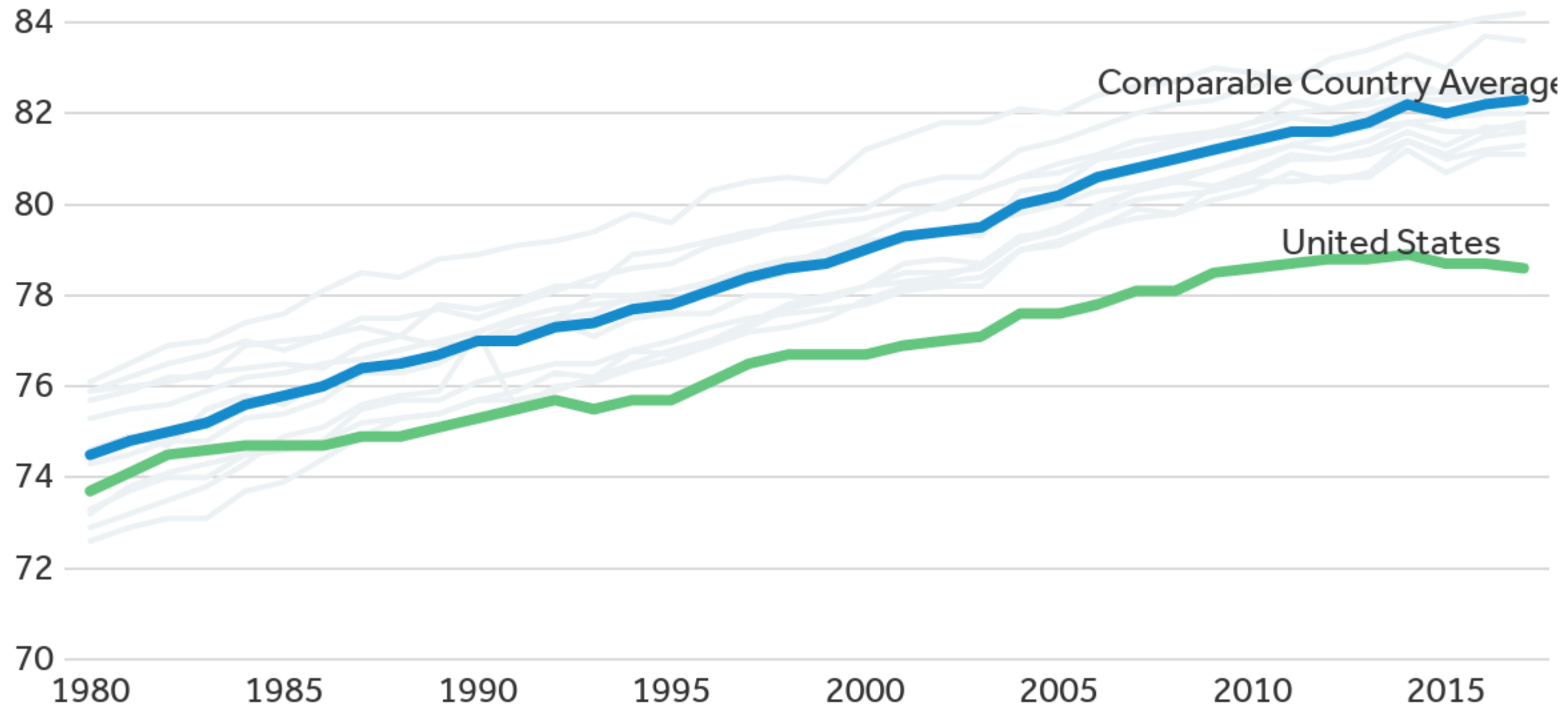
● Number of Uninsured in Millions



**Tax rates by income group in 2018 (% of pre-tax income)**



# Total life expectancy at birth in years, 1980-2017



Note: Break in series for Belgium and Switzerland in 2011, Germany in 1991, and Canada in 1982

Source: KFF analysis of OECD data

Peterson-KFF

**Health System Tracker**