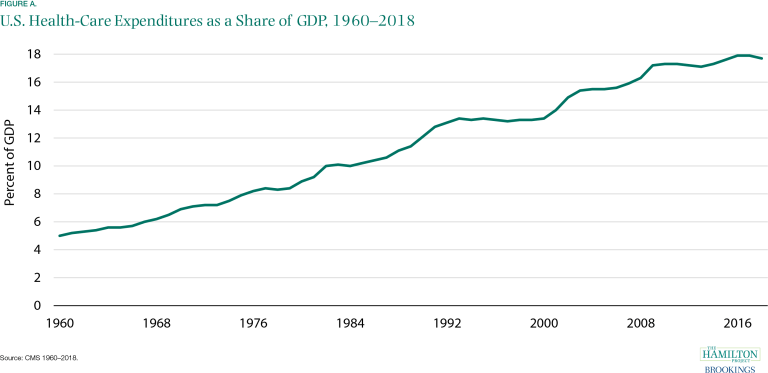
# RESEARCH TOPIC(S)

Health Insurance Facts & Spending Habits - Concept: Article with graphical elements to display how health coverage facts & spending habits in the U.S.

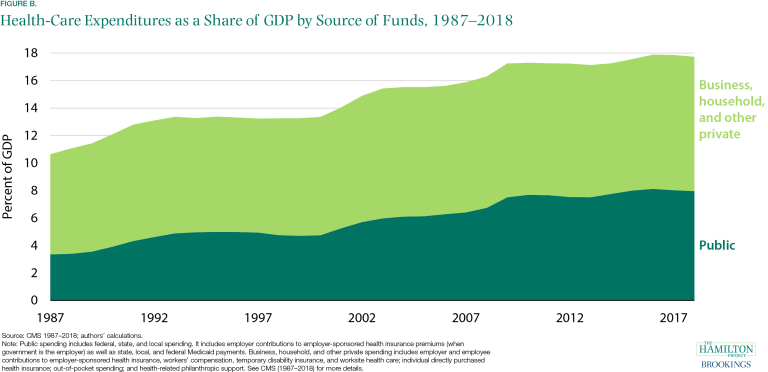
* The health-care sector is in many ways the most consequential part of the United States economy. It is a fundamental part of people’s lives, supporting their health and well-being. Moreover, it matters because of its economic size and budgetary implications.
* The health-care sector now employs 11 percent of American workers (Bureau of Labor Statistics [BLS] 1980–2019b and authors’ calculations) and accounts for 24 percent of government spending (Centers for Medicare & Medicaid Services [CMS] 1987–2018; Bureau of Economic Analysis 1987–2018; authors’ calculations).[1] Health insurance is the largest component (26 percent) of nonwage compensation (BLS 2019b) and health care is one of the largest categories of consumer spending (8.1 percent of consumer expenditures; BLS 2019a).
* A well-functioning health-care sector is therefore a prerequisite for a well-functioning economy. Unfortunately, the problems with U.S. health care are substantial. The United States spends more than other countries without obtaining better health outcomes (Papanicolas, Woskie, and Jha 2018). Health care is growing as a share of the economy and government budgets in ways that appear unsustainable (CMS 1960–2018; Organisation for Economic Co-operation and Development [OECD] 2015). This growth has slowed at times; health spending as a share of GDP was roughly flat in much of the 1990s, and growth has also slowed to some extent in recent years. But even if expenditures as a share of GDP plateaued at their current level, they would still represent a massive expenditure of resources. Sixty years ago, health care was 5 percent of the U.S. economy, as can be seen in figure A; at 17.7 percent in 2018, it was more than three times that.[[1]](#footnote-1)



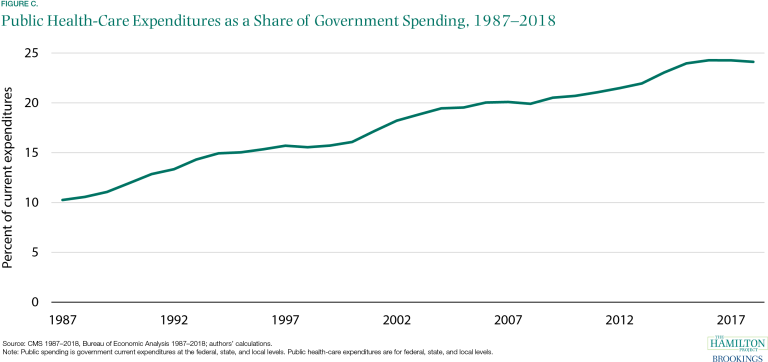
This growth represents a range of factors, from new health-care treatments and services to better coverage, higher utilization, and rising prices. Some of these changes are desirable: As a country gets richer, spending a higher share of income on health may be optimal (Hall and Jones 2007). Countries with a higher level of output per capita tend to have a higher level of health expenditures per capita (Sawyer and Cox 2018). In addition, as the population ages, health deteriorates and health-care spending naturally rises. Finally, if productivity advancements are more rapid in tradable goods like agriculture or manufacturing than in services like health care or education, the latter will tend to rise in relative price and as a share of GDP.

But some of the increase in health-care costs is undesirable (Cutler 2018). Rent-seeking, monopoly power, and other flaws in health-care markets sometimes result in unnecessary care or in elevated health-care prices. In several of the facts that follow, we describe these factors and how they are shaping health care.

Spending by private and public payers have both increased. The United States has a health-care system that largely consists of private providers and private insurance, but as health care has become a larger part of the economy, a higher share of health-care funding has been provided by government (figure B). As of 2018, 34 percent of Americans received their health care via government insurance or direct public provision (Berchick, Barnett, and Upton 2019).[[2]](#footnote-2)



As shown in figure C, health care has doubled as a share of total government expenditures in the last three decades, from 11.9 percent in 1990 to 24.1 percent in 2018. This increase comes from the rising shares of the population enrolled in Medicare, Medicaid, state Children’s Health Insurance Programs, and veterans’ health benefits. Policy changes like the introduction of the Medicare prescription drug benefit (Part D) in 2006 and a major expansion of Medicaid eligibility in 2014 played important roles. At the same time, spending on discretionary programs like education and research and development have decreased as a share of GDP (Congressional Budget Office 2020). If health expenditures continue to increase as a share of government spending, the increase will eventually necessitate either tax increases or reduced spending on other important government functions like public safety, infrastructure, research and development, and education.



Of course, health costs are also borne by the private sector. Firms and households in the United States spent 10 percent of GDP on health care in 2018. Despite widespread coverage—as of 2018, 91.5 percent of Americans had either private or government health insurance for all or part of the year (Berchick, Barnett, and Upton 2019)—many people still face large and variable out-of-pocket health-care costs. In 2017, more than 1 in 50 Americans who interact with the health-care system have out-of-pocket costs in excess of $5,000, and 1 in 200 have costs over $10,000. At the other end of the distribution, roughly one in seven have no out-of-pocket costs at all in a given year.

The upper end of the distribution of out-of-pocket costs dwarfs the liquid resources of many U.S. households, meaning that many people faced with a negative health shock may also find themselves in financial trouble. Negative health shocks tend to be associated with loss of income, thereby compounding the problem (Garcia-Gómez et al. 2013). Unexpected health costs can generate bankruptcies and ongoing financial hardship (Gross and Notowidigdo 2011).

**12 facts about the economics of U.S. healthcare, focusing largely on the private-payer system.**

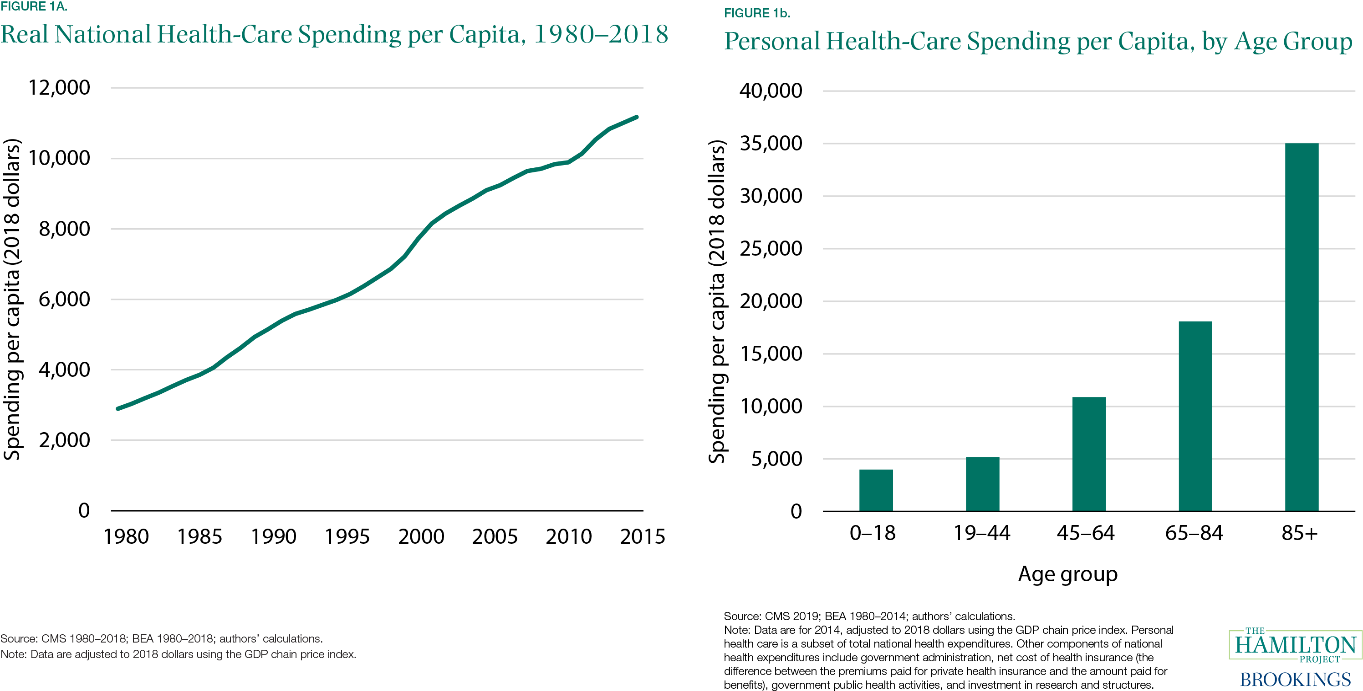
We highlight the surge in health-care expenditures and their current high level. We note the wide variation of expenditures across individuals—something that necessitates insurance. We document that the United States pays higher prices than most countries and that these prices vary widely across and within places. We show that a lack of competition and high administrative costs are especially important contributors to high expenditures, indicating the need for reforms to reduce costs in the United States. To keep the focus on these issues, we do not discuss questions of coverage or of how coverage is provided (publicly or via the market), but instead address the questions of why expenditures, costs, and prices are so high.

This analysis aims to promote The Hamilton Project’s mission to support broadly shared economic growth. Removing excess costs from the health-care system is both an economic imperative and a complement to policy efforts to improve health-care access and outcomes. In the following facts we provide context for understanding the landscape of policy options for reducing costs in the health-care system.[[3]](#footnote-3)

**Fact 1:  U.S. per capita health-care spending nearly quadrupled from 1980 to 2018.**

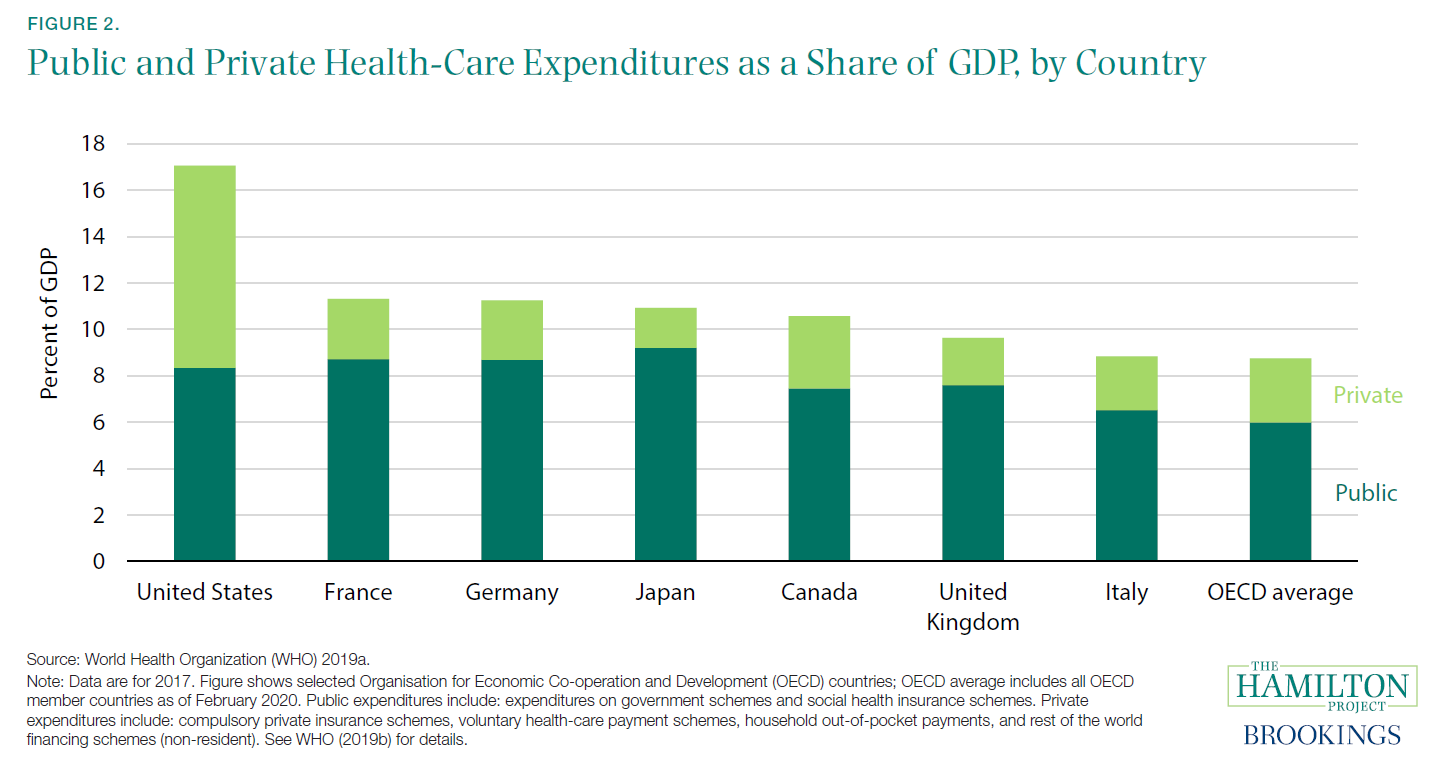
Spending on U.S. health care has grown steadily, rising from $2,900 per person in 1980 to $11,200 per person in 2018 (measured in 2018 dollars)—a 290 percent increase (figure 1a). That growth has slowed at times, as in the mid- to late 1990s and early 2010s, but since 1980 it amounts to annualized growth in real per capita spending of 3.6 percent. From 2005 to 2018, growth has been slower (2.0 percent per year).

* A small part of the reason for this growth is the aging of the U.S. population. As shown in figure 1b, the United States spends $18,100 on personal health care for an average person 65 to 84 years old and $35,000 on an average person 85 or older, while only spending $4,000 on an average person 18 or younger.[7] As the share of those 65 and older has risen, health-care spending per capita has increased accordingly. But this aging-related increase is only a small portion of the overall rise in spending: if the pattern of spending by age had remained constant at 2014 levels, the aging that took place from 1980 to 2014 would have led to a 34 percent rise in per capita spending—far below the 250 percent total increase over that same period.[8] In addition, as average age has increased, underlying health conditions like obesity have gotten worse over time, necessitating increased health-care expenditures (Paez, Zhao, and Hwang 2009; Cawley and Meyerhoefer 2012).
* Some of the increase simply reflects the growing spending that takes place as per capita income grows, and some comes from innovations that bring new health-care services and products. However, the phenomenon called Baumol’s cost disease describes how sectors with relatively low productivity growth (like health care) tend to experience rising costs (Baumol and Bowen 1965; Baumol 2012). But understanding why health care has had little productivity growth relative to the rest of the economy is important (Sheiner and Malinovskaya 2016). As we explore in subsequent facts, problems with health-care markets have contributed to rapidly rising costs in recent decades.[[4]](#footnote-4)



**Fact 2: U.S. health-care spending is almost twice as high as the OECD average.**

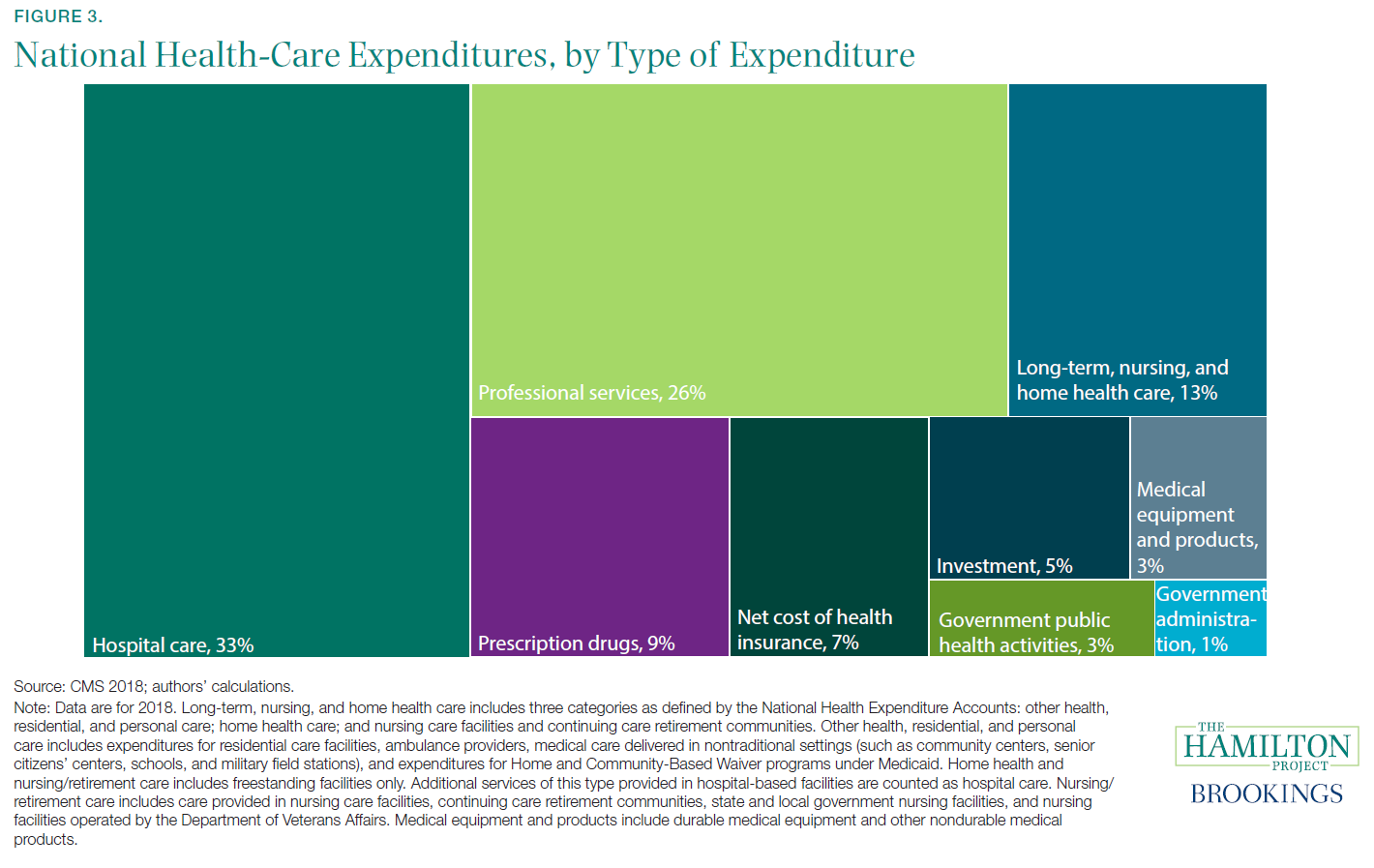
* The United States spends much more on health care as a share of the economy (17.1 percent of GDP in 2017, using data from the World Health Organization [WHO] than other large advanced economies like Germany (11.2 percent) and the United Kingdom (9.6 percent). Public spending by the United States (8.3 percent of GDP) is roughly similar to public spending by other countries; it is only when private spending is added that the United States far exceeds peer nations. However, public health insurance in the United States covers only 34 percent of the population, much less than the universal coverage in countries like Canada and the United Kingdom (Berchick, Barnett, and Upton 2019; OECD 2020b), indicating that it costs far more to provide coverage in the U.S. system than around the world.
* Figure 2 distinguishes spending on the basis of the ultimate payer, such that government payments to private providers are counted as public spending. Almost all U.S. health care is privately provided, and 51 percent of spending is paid for by families, nonprofits, and businesses. This is in contrast to those countries that also rely largely on private providers but have the government as the payer (e.g., Canada) and those countries that rely both on public health-care providers and public funding (e.g., the United Kingdom). Note that the countries shown in figure 2 are high-income, advanced nations with near-universal health coverage, meaning that the gap in spending is not primarily explained by differences in coverage rates or income levels, but rather by differences in health-care institutions and policy.
* What do Americans get for their additional health-care spending? In the United States, life expectancy at birth is the lowest of the countries; maternal and infant mortality are the highest (Papanicolas, Woskie, and Jha 2018). Certainly, other non-health-care factors contribute to these outcomes, but poor U.S. performance stands in striking contrast to its high spending on health care (Garber and Skinner 2008).

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**Fact 3:  Most health-care spending is on hospitals and professional services.**

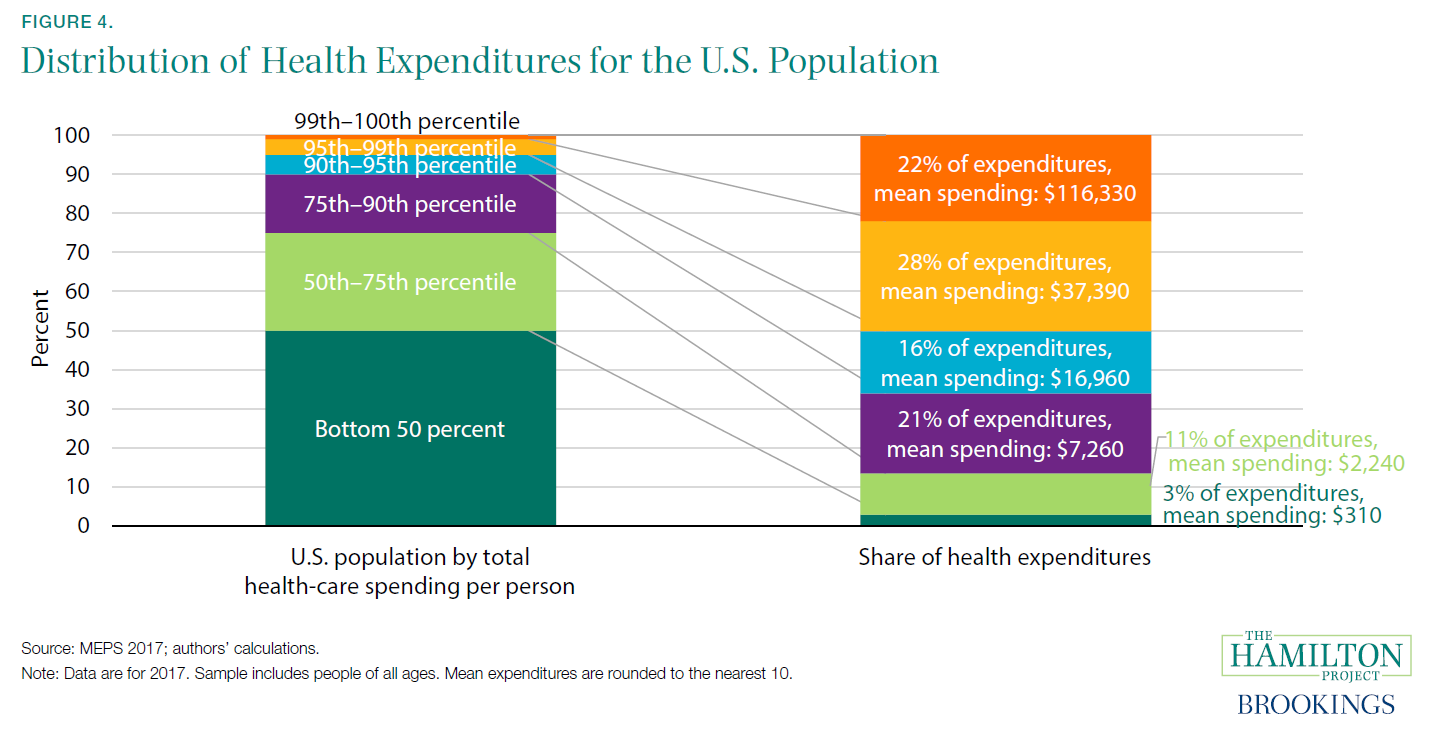
U.S. health-care spending is high and has increased dramatically in recent decades. But what does the United States purchase with all this spending?

* Roughly a third of all health-care spending goes to hospital care (figure 3), making clear that the functioning of the U.S. hospital system is crucially important when health-care expenditures are considered. Professional services make up roughly a quarter of spending. (Professional services are those provided by physicians and nonphysicians outside of a hospital setting, including dental services.) The combination of long-term care, nursing care facilities, and home health care account for 13 percent of total health expenditures. Prescription drugs are next at 9 percent, and net health insurance costs (i.e., premiums earned less benefits paid) account for 7 percent of total spending.
* Insurance covers these different expenditures to varying degrees. Consequently, out-of-pocket spending looks somewhat different than overall spending: the largest shares of out-of-pocket spending go to professional services (38 percent of total out-of-pocket spending) and prescription drugs (13 percent) (CMS 2018 and authors’ calculations).[11] Because prescription drugs are an ongoing expense for many, and given the immediate and direct health impact that often results from a lack of access, the costs of prescription drugs can dominate health-care cost discussions. However, for individuals (and especially for the system as a whole), the expense of professional services is much larger.
* Much health spending consists of labor costs, rather than capital investment. One study of physicians’ offices, hospitals, and outpatient care found that labor compensation accounted for 49.8 percent of 2012 health-care revenues (Glied, Ma, and Solis-Roman 2016). Lowering these labor costs requires some combination of increased labor supply, (e.g., more health-care professionals), fewer restrictions on what nonphysicians are permitted to do (Adams and Markowitz 2018), and reductions in unnecessary services.



**Fact 4: Five percent of Americans accounted for half of all U.S. health-care spending in 2017.**

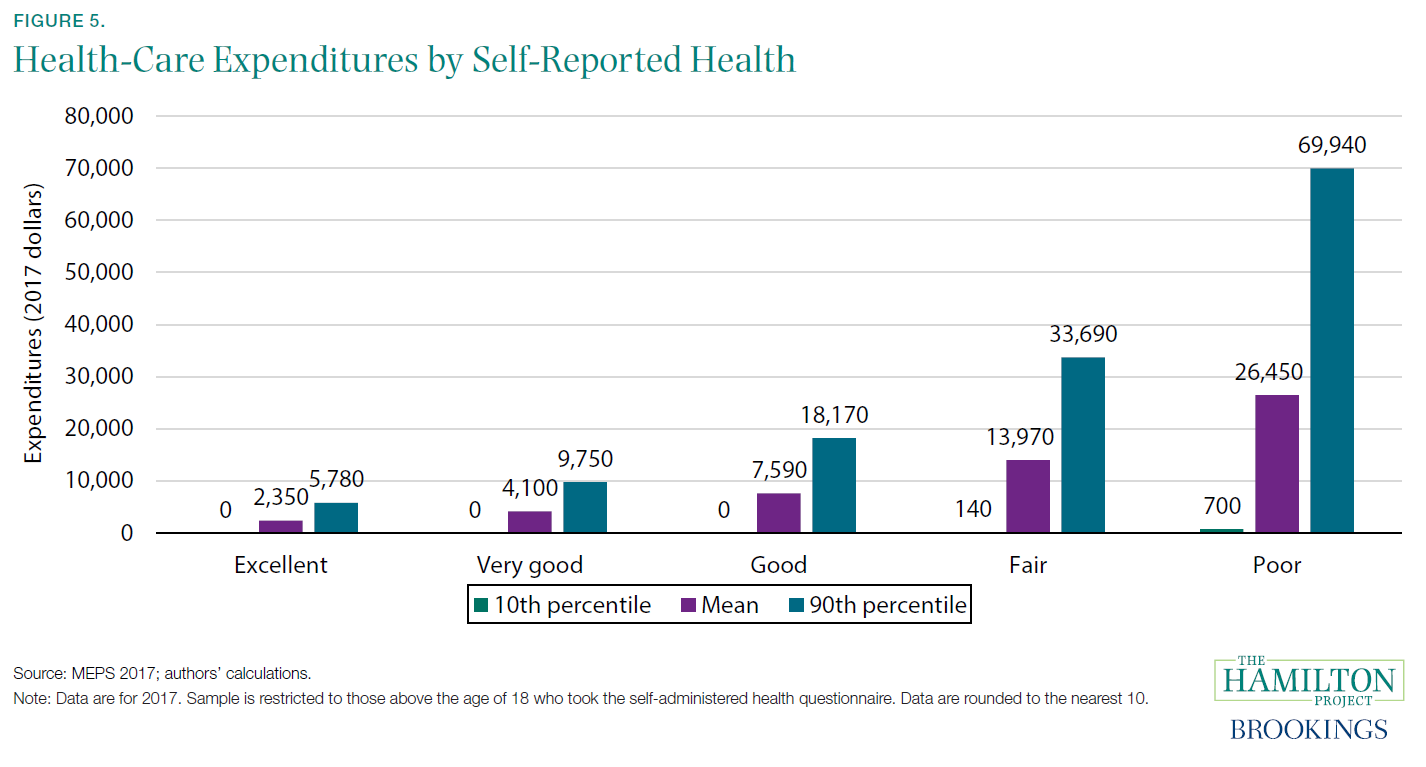
* Health-care spending in any given year is distributed very unequally. The half of the population using the least health care accounts for only 3 percent of total (not just out-of-pocket) expenditures (excluding long-term care and some other components of spending),while the top 1 percent accounts for 22 percent.
* One reason for this is that health misfortunes can strike at random, causing one-year expenditures to spike. In any given year the distribution can be very unequal, but only some of those with the highest spending will continue to have high spending in subsequent years (Cohen and Yu 2012). The bottom half of health-care users are disproportionately young and consequently less likely to need expensive health care (but apt to need it later in life). Many people will incur high end-of-life expenditures—such costs accounted for 13 percent of personal health-care costs in 2011 (Aldridge and Kelley 2015)—but in any given year most people do not incur these costs. Also, at 13 percent, end-of-life care is important but not a dominant part of U.S. health-care costs.[
* When individuals incur high costs, insurance is usually necessary to prevent extreme financial hardship. The top 1 percent have mean health-care expenditures of over $100,000, and the next 4 percent have an average of $37,000—expenses that are well beyond ability to pay for many families. At the same time, the existence of insurance means that patients bear less financial responsibility for the cost of their care and have less incentive to control costs. In other cases—such as emergencies—patients are often unable to compare costs or weigh prices. Both of these features mean that normal downward pressures on prices may not operate in the standard way in a health-care market.[[5]](#footnote-5)



**Fact 5: Expenditures are high and variable for those with the poorest health.**

Self-reported health is a well-established summary measure of a person’s health that reliably correlates with objective health measures like laboratory biomarkers (Schanzenbach et al. 2016). We use it to explore how the level and variation in health-care expenditures (total, rather than out-of-pocket) differ across people of varying health conditions.

* People enjoying good health are, unsurprisingly, not a major driver of health-care expenditures. Among those who report excellent health, even those at the 90th percentile of expenditures incur only $5,780 in annual spending, not far above the average of $2,350 for that group. On the other end of the spectrum, people who report being in poor health have average health-care expenditures of $26,450.
* More striking is the dramatically higher range of expenditure levels for those in poor health. People at the 90th percentile of expenditures (for those in poor health) have nearly $70,000 spent on their behalf. Conversely, the 10th percentile of those in poor health have just $700 in expenditures, or 100 times less than the 90th percentile.
* The group of people who report poor health as well as low health-care expenditures may have health problems that are not resolvable through expensive medical services, but they may also be medically underserved, whether because of a lack of insurance or other reasons (Cunningham 2018). Regardless, health status alone may not always be a good guide to expected expenditures in a given year.



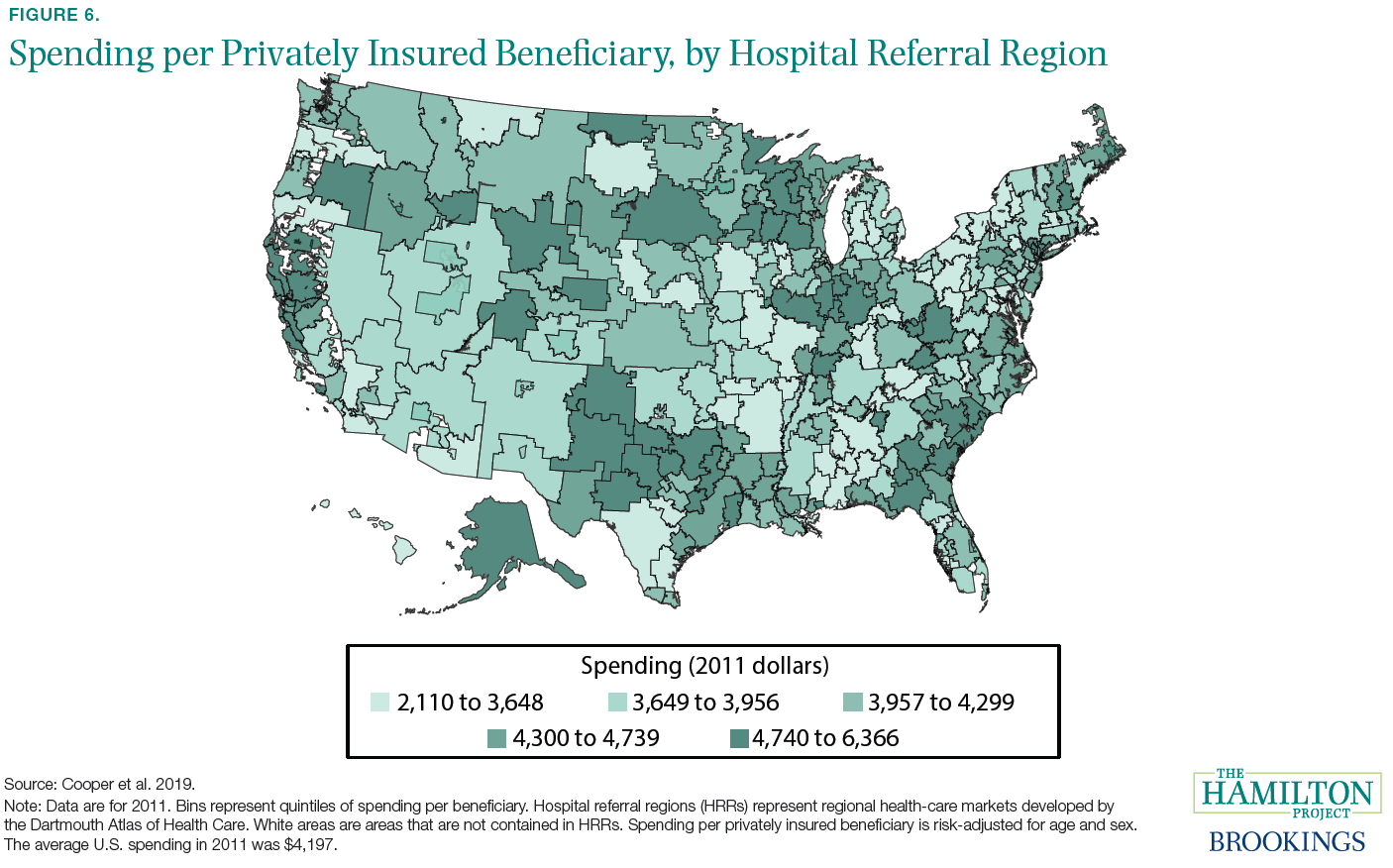
**Fact 6: Health-care spending per privately insured person is three times higher in some parts of the country than in others.**

Some places in the United States have considerably higher health-care spending than others. This is not primarily a matter of elderly people being disproportionately represented in certain areas. Figure 6 shows spending per privately insured beneficiary after adjusting for differences across places in age and sex (Cooper et al. 2019). The upper Midwest, much of the east coast, and northern California are all notable as places with especially high spending.

* In a comparison of so-called hospital referral regions (i.e., regional health care markets), spending per privately insured beneficiary is about three times higher in the highest-spending region ($6,366 in Anchorage, Alaska) than in the lowest-spending region ($2,110 in Honolulu, Hawaii). Roughly half of the overall variation is associated with differences in prices across regions, with the other half due to differences in the quantity of health care consumed. Surprisingly, a significant amount of the national variation in prices occurs within hospitals (Cooper et al. 2019).
* Medicare spending is somewhat different: prices are set administratively rather than through decentralized negotiations between payers and providers. Most of the geographic variation in Medicare spending is accounted for by differences in health-care utilization across places—especially in post-acute care—rather than by prices (Cooper et al. 2019). Further, about half of the variation in utilization is driven by demand-side factors like health and preferences, but differences in supply across places are also important (Finkelstein, Gentzkow, and Williams 2016).

**Is this spending variation evidence of a problem that policy should address?**

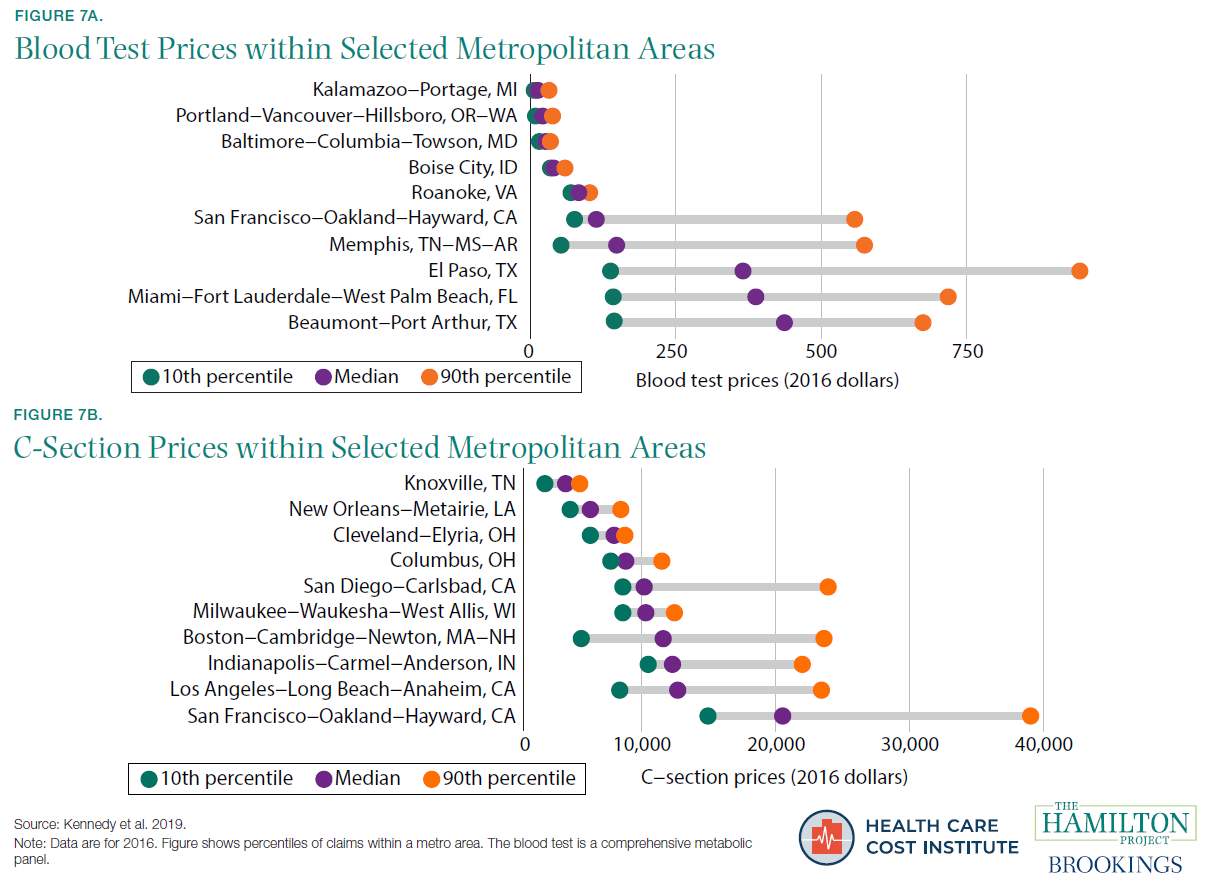
The answer (and the policy response, if one is called for) depends on whether spending is especially high in some places because of insufficient competition and related market failures (Cooper et al. 2019), differences in physician behavior (Cutler et al. 2019), a larger share of people with expensive health conditions (Rosenthal 2012), or a higher cost of living and other factors not directly related to the functioning of health markets.



**Fact 7: In many cities, health-care prices vary widely for the same service.**

In a well-functioning competitive market, prices for the same service will not vary widely within a given place: consumers will avoid a business that charges much higher prices than its competitors. However, many health-care markets dramatically violate this expectation. Figure 7 focuses on health-care price variation within selected metro areas, showing that some metropolitan statistical areas feature much more price variation than others.

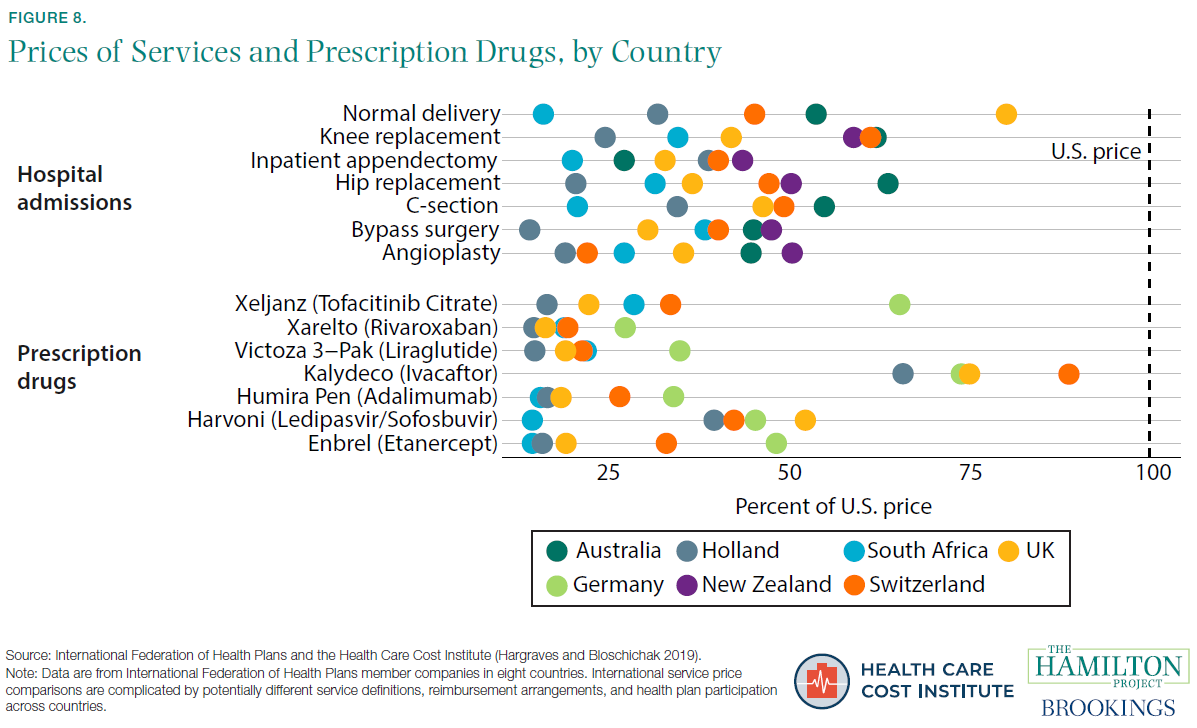
* For example, estimates from the Health Care Cost Institute show that the price for a blood test ranges from $22 (10th percentile) to $37 (90th percentile) in Baltimore, Maryland, but in El Paso, Texas, the same range is $144 to $952. For a C-section delivery, prices vary widely both across and within markets: the 10th to 90th percentile range is 9.3 times larger in the San Francisco, California, metro area than in the Knoxville, Tennessee, metropolitan area.
* Some variation in prices is due to differences in quality and amenities: one medical practice might take more time with patients, have nicer facilities, or employ more experienced medical teams, allowing it to charge correspondingly higher prices. But much of the variation is likely related to market imperfections that limit the ability and incentive for patients to shop for the lowest price (Chernew, Dafny, and Pany 2020; Tu and Lauer 2009; Mehrotra et al. 2017).
* A Hamilton Project proposal by Michael Chernew, Leemore Dafny, and Maximilian Pany (2020) would address this type of health-care price dispersion with regulatory interventions directed at the most egregious price growth.[[6]](#footnote-6)



**Fact 8: The United States pays more for health-care services than other advanced economies.**

The United States has dramatically higher health-care prices than other advanced economies. This is the case for surgical procedures, diagnostic tests, prescription drugs, and almost any other type of health-care service. Figure 8 shows seven other countries’ prices, as a percentage of the U.S. price, for selected health-care services (Hargraves and Bloschichak 2019). For example, a Humira Pen costs between 16 percent (South Africa) and 35 percent (Germany) of the U.S. average price.

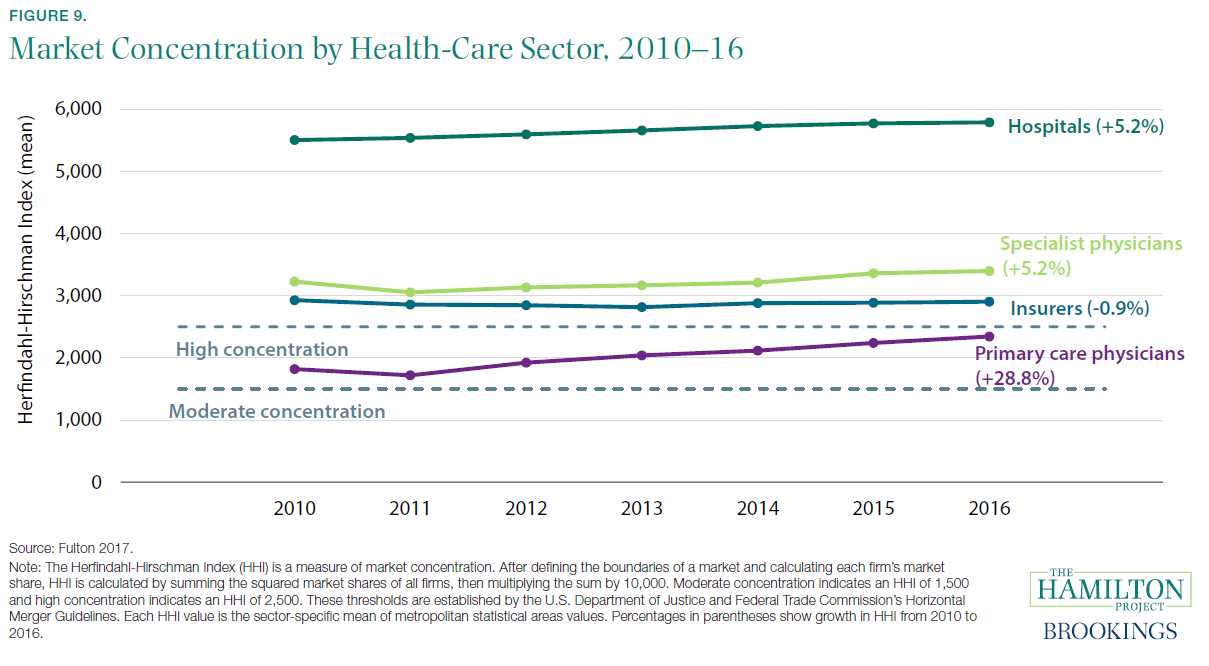
* Relatively high U.S. prices are not just about higher prescription drug prices (the bottom panel of figure 8) and the implicit subsidies that the United States provides to the rest of the world (much of which imposes price controls on prescription drugs) by paying the fixed costs of drug research and development (Wagner and McCarthy 2004). The United States also has higher prices for outpatient procedures like colonoscopies, MRIs, and cardiac catheterization, and hospital procedures like C-sections and bypass surgeries (Hargraves and Bloschichak 2019). For example, a hip replacement surgery costs between 21 percent (Holland) and 64 percent (Australia) of the average price in the United States. These patterns are consistent with research showing that high U.S. prices are an important part of high U.S. spending on health care (Papanicolas, Woskie, and Jha 2018).
* High prices indicate underlying concerns that are different than those indicated by high use of health care. In particular, prices so far above those in other countries can reflect rents (i.e., payments to the health-care system beyond what is necessary for a normal rate of profit). These rents are driven by market imperfections including provider market power and the difficulty that health-care patients and other payers have in assessing prices and quality (Chernew, Dafny, and Pany 2020). In addition, excess administrative costs (see fact 10) and generally higher wages for highly educated workers in the United States contribute to relatively high U.S. prices.



**Fact 9: Market concentration is high for specialist physicians, insurers, and especially hospitals.**

One reason for high prices and high health-care costs is that competition is unusually weak in the health-care system. Consolidation of medical providers, barriers to market entry, and the closing of some hospitals have led to high and rising market concentration, which allows providers to set higher prices without losing patients.

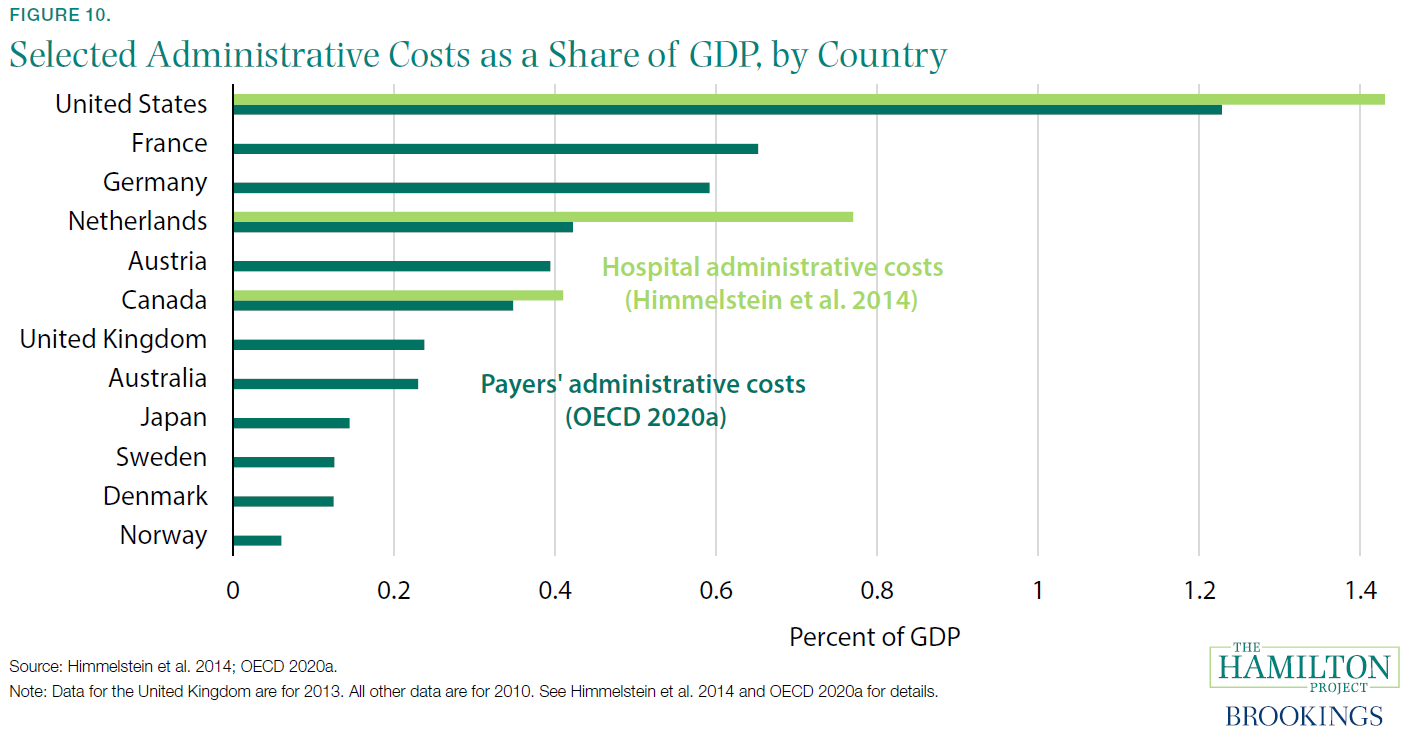
* Figure 9 describes this situation in terms of a commonly used concentration metric called the Herfindahl-Hirschman Index (HHI). This index captures the degree to which market share is concentrated in a few organizations, and it is an important assessment tool for antitrust policy. Under the Department of Justice/Federal Trade Commission Merger Guidelines, an HHI of 1,500 indicates a moderately concerning concentration level, and an HHI of 2,500 indicates high concentration. As shown in the figure, insurers, specialist physicians, and hospitals are all above this latter threshold, with hospital concentration especially high (with an HHI of 5,790 in 2016). Primary care physicians are between the moderate and high concentration levels, but they have experienced a rapid increase in HHI as private practices have been acquired (Capps, Dranove, and Ody 2017; Capps, Dranove, and Ody 2018; Fulton 2017).
* Figure 9 shows mean HHI across metropolitan areas, rather than the national level. It therefore does not increase when a hospital in New York merges with a hospital in California, for example. While this is appropriate for understanding the range of choices available to a patient, it does not capture the deleterious effects of consolidations across geographic areas (Dafny, Ho, and Lee 2019; Lewis and Pflum 2017). As explained in Gaynor (2020), hospitals that consolidate across areas gain leverage in negotiations with insurers, who prefer to offer large employers a health plan that includes many provider options throughout the United States.
* Reversing consolidation that has already occurred is likely to be difficult. But policymakers can take steps to prevent additional consolidation—and promote competition in other ways—as described in a Hamilton Project proposal by Martin Gaynor (2020).



**Fact 10: U.S. health-care administrative costs are the highest of all advanced economies.**

Administrative health-care costs are higher as a share of GDP in the United States than in other countries. These administrative (i.e., nonclinical) costs take several forms: claims processing and payment, prior authorization and eligibility determinations, and quality measurement, among others. While a certain amount of this administrative expense is inevitable and necessary for a well-functioning system, public or private, the excess of U.S. costs over those of other advanced economies is part of the explanation for high U.S. health-care costs overall (Cutler and Ly 2011).

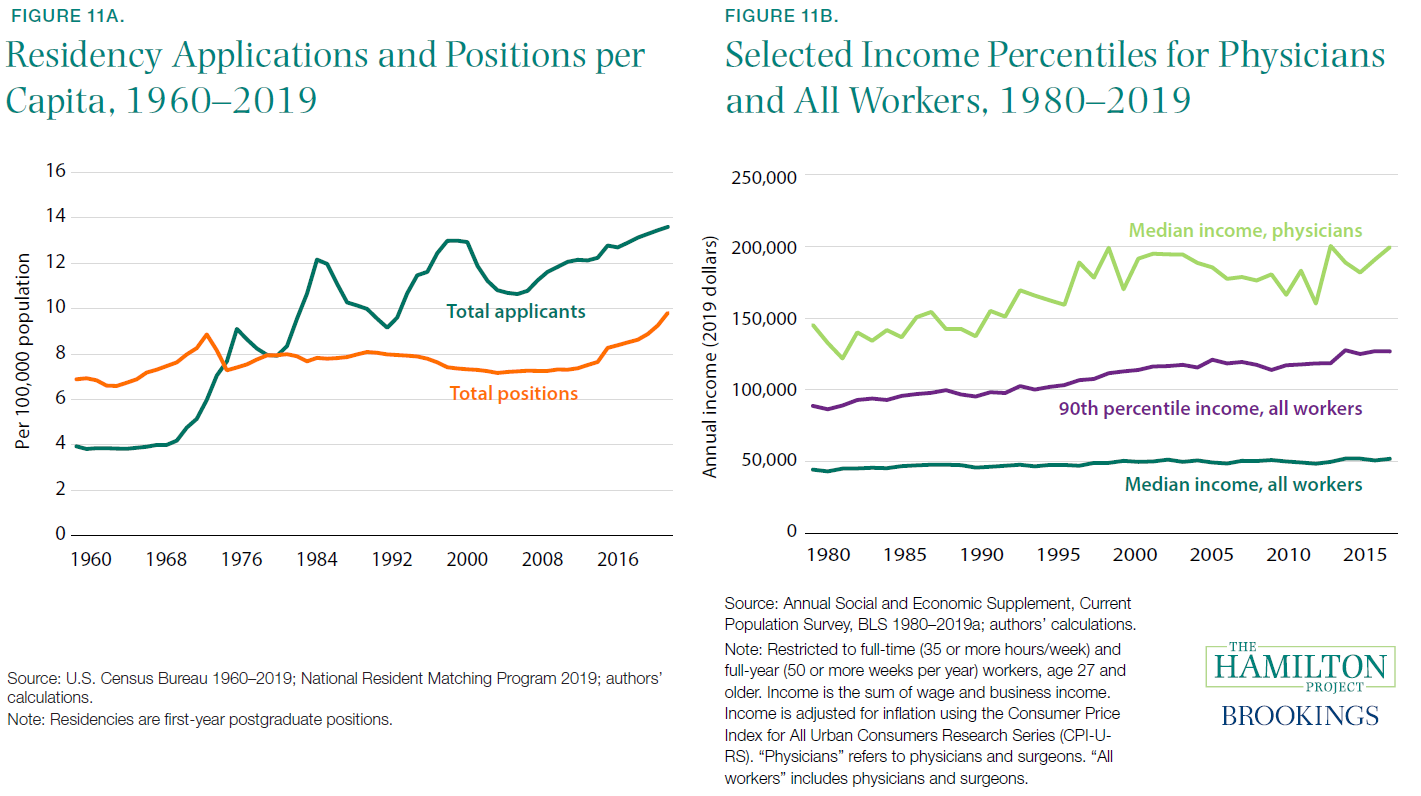
* Figure 10 shows two different estimates of administrative costs in the health-care systems of the United States and several other countries. The OECD estimates include only payers’ costs to administer health benefits and coverage, while the estimates by Himmelstein and coauthors include only administrative costs to hospitals (OECD 2020a; Himmelstein et al. 2014). The differences between the United States and other countries are notable.
* The United States spent 1.4 percent of GDP on hospital administrative costs in 2010, compared with 0.8 percent in the Netherlands and just 0.4 percent in Canada. On the payers’ side the United States is also an outlier, spending 1.2 percent of GDP on payers’ administrative costs, compared with just 0.2 percent in the United Kingdom.
* One reason for administrative costs is to reduce non-administrative costs related to excess use of health-care services. For example, prior-authorization requirements can reduce costs and limit use of the most expensive drug options (Soumerai 2004). However, these requirements impose costs on patients and providers that must be taken into account, and in some cases they may simply reflect a battle over who pays for necessary procedures.
* Administrative costs cannot and should not be completely eliminated, even in a public system like the United Kingdom’s, but they can be affected by policies and practices. In a Hamilton Project proposal, David Cutler (2020) describes reforms that would reduce administrative costs without impairing important functions of the health-care system.



**Fact 11: U.S. physician labor supply is tightly restricted.**

Health-care providers have become a larger share of the labor force, rising from 5.0 percent of employment in 1980 to 8.5 percent in 2019 (BLS 1980–2019b and authors’ calculations).[17] However, labor supply has been limited in important ways. In figure 11a, we show the rate of medical residency positions per 100,000 U.S. residents that were available over the last 60 years. These positions are a necessary part of physician training, required just after medical school. Historically the federal government has heavily subsidized a certain number of residency positions (Heisler et al. 2018); hospitals have been reluctant to provide many residencies without subsidy.

* From 1960 through 2010, per capita medical residency positions increased only slightly, rising from 6.9 to 7.4 per 100,000 people. A more rapid increase occurred since 2010 as a number of osteopathic programs entered the data, bringing the rate to 9.8 in 2019 (about 32,000 total positions), but still below the application rate.[18]The flat rate—contrasted with rising expenditures and health-care needs for an aging and richer population—suggests that limited supply has been a problem.
* In health-care occupations generally, training requirements have steadily risen. In 2000, for example, physical therapists were required to have either a four-year degree or a master’s degree in every state. By 2015, 43 states required that they obtain a doctorate degree to be legally permitted to practice (Cai and Kleiner 2016).
* Limited labor supply contributes to high wages, which in turn contribute to high health-care prices in the United States[20] As shown in figure 11b, the median annual income of U.S. physicians is $199,500, well above the 90th percentile of overall income ($126,900).  In 1980 the typical physician earned 3.27 times the median wage for all workers, compared with 3.84 times today. Growth in physicians’ salaries has coincided with the general rise in inequality at the top of the earnings distribution. In comparison with other advanced economies, U.S. physicians earn considerably higher salaries than their counterparts (Kane et al. 2019; Peterson and Burton 2007).

[[7]](#footnote-7)

## DELIVERABLE

Pick out the most interesting data & facts.

The U.S. spends more per person on healthcare than any other country in the world. According to the Centers for Medicare & Medicaid Services, this spending came to the tune of [$3.5 trillion](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf), or $10,739 per person, in 2017.

The worst part is that everyone from patients to providers don’t fully understand medical debt and the detrimental effect it has on patients and the healthcare industry as a whole. Check out these four surprising facts about healthcare debt:

1. More than 60 percent of Americans deplete their savings to pay off medical debt

Nearly all of us have had to dip into our savings to pay off a bill or an unexpected expense. However, according to a Kaiser Family Foundation and New York Times survey, [60 percent](https://www.kff.org/health-costs/press-release/new-kaisernew-york-times-survey-finds-one-in-five-working-age-americans-with-health-insurance-report-problems-paying-medical-bills/) Americans have completely drained their savings in order to pay off their medical debt.

What many will find surprising is that this statistic includes those who have health insurance. In today’s healthcare landscape, even those with health insurance are struggling to pay increasing out-of-pocket expenses. In fact, of the population with health insurance, [42 percent](https://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html) pick up extra jobs and 37 percent have admitted to borrowing money from family members to pay their medical bills. With that in mind, it’s important that providers identify these patients early on and take action to prevent debt from getting this far.

2. Health insurance has continued to become less affordable since 2015

While recent laws have actually made insurance itself more affordable, the barriers to entry have continued to rise along with deductibles. When people cannot pay their deductible, more debt is created, leading to prices rising even more. It’s a vicious cycle that has forced millions to [stop taking their medications](https://www.health.harvard.edu/blog/millions-skip-medications-due-to-their-high-cost-201501307673). Many insurance policies follow an 80/20 coinsurance model; however, even after 80 percent of an expense is covered by insurance, the remaining 20 percent can still be impossible to pay for some patients.

3. Approximately 1 in 10 adults delay medical care due to cost

Medical treatment is starting to take a back seat in family budgets. Currently, the average [cost of a primary care visit](https://www.jhsph.edu/news/news-releases/2015/primary-care-visits-available-to-most-uninsured-but-at-a-high-price.html) is $200, and the [average cost of a hospital stay](https://www.debt.org/medical/hospital-surgery-costs/) sits at $15,734. With looming costs like that, many patients delay medical care, which can result in life-threatening conditions being discovered too late to receive effective treatments. Once again, this statistic includes those who are medically insured. To combat this alarming issue, providers need to be transparent when discussing costs with patients and proactively help in setting up payment plans and options.

4. Debt creates rising medical care prices

According to a 2012 report, [h](https://www.forbes.com/sites/toddhixon/2012/02/09/the-u-s-does-not-have-a-debt-problem-it-has-a-health-care-cost-problem/#66f9356c6eb7)[ealthcare spending](https://www.forbes.com/sites/toddhixon/2012/02/09/the-u-s-does-not-have-a-debt-problem-it-has-a-health-care-cost-problem/#66f9356c6eb7) is growing at 1.5x the rate of growth of GDP and is already close to 20 percent of the economy. What does this mean for prices? Well, the cycle continues since this debt forces the industry to raise prices in order to compensate for the difference, ultimately creating more debt for everyone.

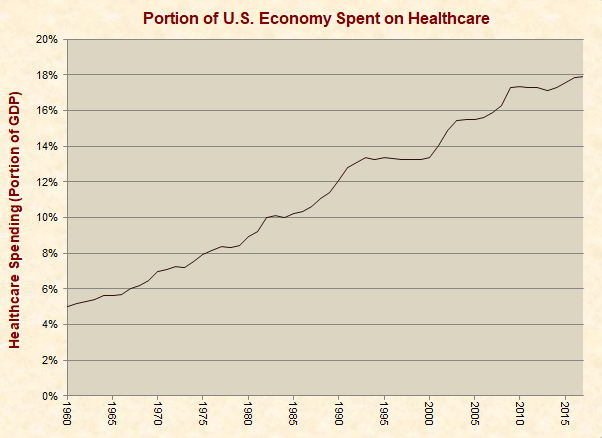
For example, 20 percent of Americans would have to charge an unexpected $500 medical bill to a credit card and pay it off over time. With the average credit card [interest](https://www.creditkarma.com/credit-cards/i/average-apr-on-credit-card/) rate at nearly 16 percent, it becomes incredibly difficult to catch up and pay off the charge. [[8]](#footnote-8)

**The facts below differentiate between healthcare spending, prices, and costs based upon the following definitions:**

* Spending refers to what is spent on healthcare in general. Thus, if people use more healthcare services, this causes spending to increase even if prices remain the same.
* Prices refer to what healthcare providers charge for particular services and products.
* Costs refer to what healthcare providers spend in order to provide services and products to patients. This is equivalent to prices minus profits or losses.

\* From 1960 to 2017, healthcare spending in the United States increased:

* from an average of $151/person per year to $10,731 (by 71 times).
* from an inflation-adjusted average of $1,278/person per year to $10,993 (by 8.6 times).
* from 5.0% of the nation’s economy (gross domestic product) to 17.9% (by 3.6 times).[[1]](https://www.justfacts.com/healthcare.asp#_ftn1)

[](http://www.justfacts.com/images/healthcare/economy_spending-full.png)

[[2]](https://www.justfacts.com/healthcare.asp#_ftn2)

\* In 1942, the price for a maternity room at Christ Hospital in Jersey City, NJ was $7.00 per day.[[3]](https://www.justfacts.com/healthcare.asp#_ftn3) Adjusting for inflation, this amounts to $97.29 in 2011 dollars.[[4]](https://www.justfacts.com/healthcare.asp#_ftn4) In 2011, the price for a maternity room at the same hospital was $1,360 per day.[[5]](https://www.justfacts.com/healthcare.asp#_ftn5)

\* A 2019 survey of 15 hospitals in Ohio (where state law requires hospitals to publish their prices)[[6]](https://www.justfacts.com/healthcare.asp#_ftn6) found that the daily price of a typical hospital room ranged from $1,010 to $3,464, with an average of $2,125 and a median of $2,040.[[7]](https://www.justfacts.com/healthcare.asp#_ftn7)

\* In 1980, the average price for a typical hospital room in the U.S. was $127 per day.[[8]](https://www.justfacts.com/healthcare.asp#_ftn8) Adjusting for inflation, this amounts to $413 in 2019 dollars.[[9]](https://www.justfacts.com/healthcare.asp#_ftn9)

\* In 1988, Mutual of Omaha insurance company paid an average of $270 per day for all types of hospital rooms (such as medical/surgical, intensive care, maternity, etc.).[[10]](https://www.justfacts.com/healthcare.asp#_ftn10) [[11]](https://www.justfacts.com/healthcare.asp#_ftn11) Adjusting for inflation, this amounts to $590 in 2019 dollars.[[12]](https://www.justfacts.com/healthcare.asp#_ftn12)

\* In 2002, Mutual of Omaha paid an average of $748 per day for all types of hospital rooms.[[13]](https://www.justfacts.com/healthcare.asp#_ftn13) Adjusting for inflation, this amounts to $1,068 in 2019 dollars.[[14]](https://www.justfacts.com/healthcare.asp#_ftn14)

Third-Party Payments

\* Third-party payments are healthcare expenses that are not directly paid by consumers but by other entities such as governments and insurance companies. Such entities are called “third-parties” because they do not deliver or receive healthcare. In other words, they are not patients or caregivers.[[15]](https://www.justfacts.com/healthcare.asp#_ftn15)

\* From 1960 to 2017, the portion of U.S. healthcare expenses paid:

* directly by consumers decreased from 48% to 10%.
* by private insurance increased from 21% to 34%.
* by government increased from 24% to 49%.[[16]](https://www.justfacts.com/healthcare.asp#_ftn16)

\* A scientific, nationally representative survey commissioned in 2018 by Just Facts found that 40% of voters believe the government now pays a smaller portion of all U.S. healthcare costs than it did in 1960.[[17]](https://www.justfacts.com/healthcare.asp#_ftn17) [[18]](https://www.justfacts.com/healthcare.asp#_ftn18) [[19]](https://www.justfacts.com/healthcare.asp#_ftn19)

\* **Per the Encyclopedia of Health Care Management:**

[B]ecause most medical care is delivered with third-party payments, and the purchaser is in dire need of the services, the typical patient has little interest in price.[[20]](https://www.justfacts.com/healthcare.asp#_ftn20) [[21]](https://www.justfacts.com/healthcare.asp#_ftn21) [[22]](https://www.justfacts.com/healthcare.asp#_ftn22)

\* A Rand Corporation study tracked the healthcare spending of 2,756 families over periods of either three or five years during 1974–1982. The families were given insurance plans that covered all healthcare expenses above $1,000 per year or a reduced amount for lower-income families so that healthcare expenses could never exceed certain portions of their income.[[23]](https://www.justfacts.com/healthcare.asp#_ftn23) (Accounting for inflation, $1,000 during the timeframe of this study equates to about $4,000 in 2019 dollars.[[24]](https://www.justfacts.com/healthcare.asp#_ftn24))

\* The families in the study were then randomly assigned to plans that covered their healthcare expenses below $1,000 per year, covering either 5%, 50%, 75%, or 100% of this spending. For example, families with 75% coverage paid 25% of their healthcare spending up to $1,000 per year (a maximum of $250 out-of-pocket), and insurance paid for everything else. The results were as follows:

* Families with 100% coverage spent an average of 16% more on healthcare than families with 75% coverage, 22% more than families with 50% coverage, and 58% more than families with 5% coverage.
* Using mathematical “techniques better suited to such data,” families with 100% coverage were predicted to spend 24% more than families with 75% coverage, 49% more than families with 50% coverage, and 45% more than families with 5% coverage.[[25]](https://www.justfacts.com/healthcare.asp#_ftn25)
* The increased spending that occurred under the plans with higher coverage had “little or no” effect on health outcomes except for the poorest 6% of the population.[[26]](https://www.justfacts.com/healthcare.asp#_ftn26)
* In hospital settings (where costs typically exceeded the maximum out-of-pocket costs that the patients had to pay), the plans had no effect on spending. Per the study:
* Complete or nearly complete coverage for additional inpatient services is common in this country. Moreover, the additional expense that comes from being admitted to a relatively costly hospital is also fully insured, or nearly so. Thus, neither patients nor physicians have much incentive to choose an economically efficient rather than an inefficient hospital, or to economize on services once a patient is admitted….[[27]](https://www.justfacts.com/healthcare.asp#_ftn27)

\* A 2001 study published in the American Journal of Public Health analyzed insurance coverage levels and health outcomes of “an older, chronically ill population” with conditions such as “diabetes, hypertension, coronary artery disease, congestive heart failure, or depression.” The study grouped “individuals into 3 cost-sharing categories: no copay (insurance pays all), low copay (insurance pays more than half but not all), and high copay (insurance pays half or less).” Per the study:

We found no association between cost sharing and health status at baseline or follow-up. Other studies of cost sharing examining acutely ill individuals have also failed to observe any negative health effect from cost sharing.[[28]](https://www.justfacts.com/healthcare.asp#_ftn28) [Click on the footnote for some limitations of the study.]

\* **U.S. law has incentivized and subsidized third-party healthcare payments by:**

* making employer-provided health insurance generally exempt from federal taxes but not medical expenses paid directly by consumers unless they exceed 10% of their adjusted gross income.[[29]](https://www.justfacts.com/healthcare.asp#_ftn29) [[30]](https://www.justfacts.com/healthcare.asp#_ftn30) [[31]](https://www.justfacts.com/healthcare.asp#_ftn31)
* providing health insurance through [Medicare](https://www.justfacts.com/healthcare.asp#government-medicare) for almost all Americans aged 65 and older and for younger people who are permanently disabled (60 million people in 2018, or 18% of the population).[[32]](https://www.justfacts.com/healthcare.asp#_ftn32) [[33]](https://www.justfacts.com/healthcare.asp#_ftn33)
* providing health insurance through [Medicaid](https://www.justfacts.com/healthcare.asp#government-medicaid) for people with family incomes up to 138% of federal [poverty guidelines](https://www.justfacts.com/income_wealth_poverty#poverty_measures) and unlimited financial assets (an average of 72 million people in 2016, or 22% of the population).[[34]](https://www.justfacts.com/healthcare.asp#_ftn34) [[35]](https://www.justfacts.com/healthcare.asp#_ftn35) [[36]](https://www.justfacts.com/healthcare.asp#_ftn36) [[37]](https://www.justfacts.com/healthcare.asp#_ftn37)
* subsidizing health insurance through the [Children’s Health Insurance Program](https://www.justfacts.com/healthcare.asp#government-chip) for children in families with incomes as high as 400% of federal [poverty guidelines](https://www.justfacts.com/income_wealth_poverty#poverty_measures) and unlimited financial assets (9.6 million people in 2018, or 3% of the population).[[38]](https://www.justfacts.com/healthcare.asp#_ftn38) [[39]](https://www.justfacts.com/healthcare.asp#_ftn39) [[40]](https://www.justfacts.com/healthcare.asp#_ftn40) [[41]](https://www.justfacts.com/healthcare.asp#_ftn41)
* subsidizing certain health insurance plans for individuals with incomes up to 400% of federal [poverty guidelines](https://www.justfacts.com/income_wealth_poverty#poverty_measures) (9.2 million people in 2019, or 3% of the population).[[42]](https://www.justfacts.com/healthcare.asp#_ftn42) [[43]](https://www.justfacts.com/healthcare.asp#_ftn43)
* subsidizing certain health insurance plans for certain small businesses.[[44]](https://www.justfacts.com/healthcare.asp#_ftn44) [[45]](https://www.justfacts.com/healthcare.asp#_ftn45)

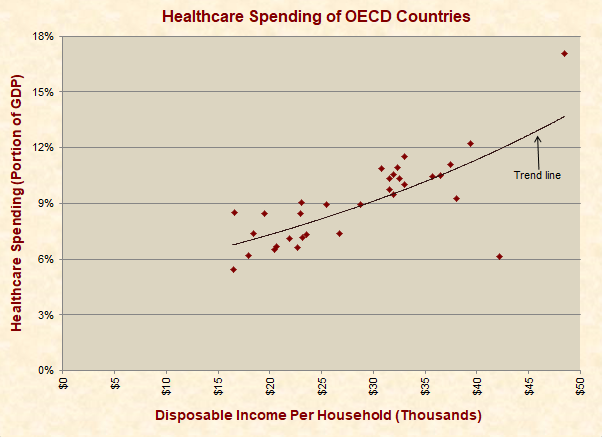
**Wealth**

\* Two common measures of nations’ wealth are:

* [gross domestic product](https://www.justfacts.com/income_wealth_poverty#international_gdp) (GDP), or the amount of the goods and services produced by an economy.[[46]](https://www.justfacts.com/healthcare.asp#_ftn46) [[47]](https://www.justfacts.com/healthcare.asp#_ftn47) [[48]](https://www.justfacts.com/healthcare.asp#_ftn48)
* [disposable income](https://www.justfacts.com/income_wealth_poverty#international_disposable), or household income minus taxes.[[49]](https://www.justfacts.com/healthcare.asp#_ftn49) [[50]](https://www.justfacts.com/healthcare.asp#_ftn50)

The Organization for Economic Cooperation and Development (OECD) is a group of 36 mostly developed nations such as Australia, Canada, Germany, Japan, and the United States.[[51]](https://www.justfacts.com/healthcare.asp#_ftn51) [[52]](https://www.justfacts.com/healthcare.asp#_ftn52)

Among OECD nations, higher disposable income is generally associated with a greater portion of GDP spent on healthcare:

[](http://www.justfacts.com/images/healthcare/oecd-full.png)

[[53]](https://www.justfacts.com/healthcare.asp#_ftn53) [[54]](https://www.justfacts.com/healthcare.asp#_ftn54) [[55]](https://www.justfacts.com/healthcare.asp#_ftn55) [[56]](https://www.justfacts.com/healthcare.asp#_ftn56)

\* Per the Handbook of Health Economics, “results obtained with international comparisons should be treated with considerable caution,” but a “common and extremely robust result of international comparisons is that the effect of per capita GDP (income) on [healthcare] expenditures is clearly positive and significant….”[[57]](https://www.justfacts.com/healthcare.asp#_ftn57) [[58]](https://www.justfacts.com/healthcare.asp#_ftn58)

**Age**

\* Personal healthcare expenditures consist of monies directly spent to “treat individuals with specific medical conditions.”[[59]](https://www.justfacts.com/healthcare.asp#_ftn59)

\* In the U.S. during 2014, the average annual healthcare spending per person for 65–84-year-olds was 3.5 times higher than that of 19–44 year-olds:

|  |  |
| --- | --- |
| Age Group (Years) | Annual Personal Healthcare  Spending Per Person |
| 0–18 | $3,749 |
| 19–44 | $4,856 |
| 45–64 | $10,212 |
| 65–84 | $16,977 |
| 85+ | $32,903 |
| All ages | $8,054 |

[[60]](https://www.justfacts.com/healthcare.asp#_ftn60)

\* When the first wave of baby boomers reached the age of 65 in 2011, there were 4.5 Americans aged 20–64 for every American aged 65 or older. As the baby-boom generation ages and projected life expectancy increases, the Social Security Administration projects that this ratio will drop to 3.5 to 1 by 2020 and to 2.8 to 1 by 2030.[[61]](https://www.justfacts.com/healthcare.asp#_ftn61) [[62]](https://www.justfacts.com/healthcare.asp#_ftn62) [[63]](https://www.justfacts.com/healthcare.asp#_ftn63)[[9]](#footnote-9)

**Preventative Care**

\* Cancer, cardiovascular disease, and diabetes are responsible for the majority of deaths and healthcare costs in the United States.[[64]](https://www.justfacts.com/healthcare.asp#_ftn64)

\* In 2008, the journal of the American Heart Association published a study entitled “The Impact of Prevention on Reducing the Burden of Cardiovascular Disease.” The authors found that:

* about 78% of U.S. adults aged 20–80 years are “candidates for at least one prevention activity” that would reduce the risk of cardiovascular disease, such as taking aspirin, drugs that reduce LDL cholesterol, and drugs that decrease blood pressure.
* “aggressive” but “feasible” implementation of such prevention strategies would reduce the number of heart attacks by 36% and the number of strokes by 20%, thereby increasing the average life expectancy of all adults by 1.3 years.
* “if all the recommended prevention activities were applied with 100% success,” the costs of implementing these measures would be ten times greater than the savings of not treating the illnesses prevented.[[65]](https://www.justfacts.com/healthcare.asp#_ftn65)

## DELIVERABLE

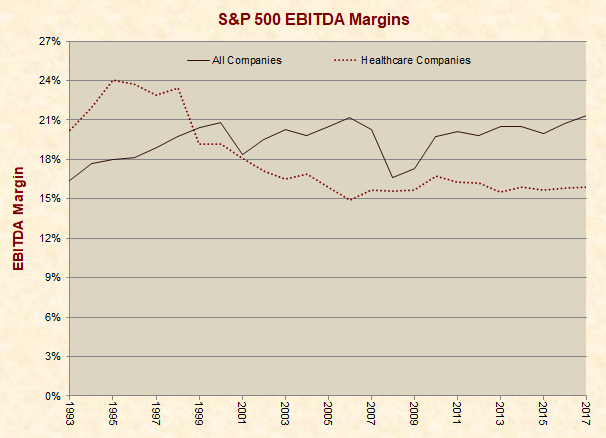
Some incredible sources & ideas we could include:

* How has Government spending on health changed over time? Some very insightful data.  
  US Census Health Insurance in the U.S. 2018

**Profits & Salaries**

\* EBITDA or “earnings before interest, taxes, depreciation and amortization,” is “an important standard measure” of company and industry profitability.[[70]](https://www.justfacts.com/healthcare.asp#_ftn70) [[71]](https://www.justfacts.com/healthcare.asp#_ftn71)

\* From 1993 to 2017, the average EBITDA margin for all companies in the S&P 500 was 20%. For healthcare companies in the S&P 500, it was 18%:

[](http://www.justfacts.com/images/healthcare/ebitda_sandp-full.png)

[[72]](https://www.justfacts.com/healthcare.asp#_ftn72) [[73]](https://www.justfacts.com/healthcare.asp#_ftn73)

\* As of August 2015, the net profit margins (after taxes)[[74]](https://www.justfacts.com/healthcare.asp#_ftn74) for various industries within the healthcare sector were as follows:[[10]](#footnote-10)

|  |  |
| --- | --- |
| **Industry** | **Net Profit Margin** |
| Medical Practitioners | –11.5% |
| Generic Drugs | –4.4% |
| Long-Term Care Facilities | –2% |
| Home Healthcare | –0.5% |
| Drug-Related Products | 1.7% |
| Healthcare Plans | 3.2% |
| Hospitals | 4.1% |
| Specialized Health Services | 6.2% |
| Medical Laboratories & Research | 6.4% |
| Drug Delivery | 8.2% |
| Medical Appliances & Equipment | 10.2% |
| Medical Instruments & Supplies | 10.5% |
| Diagnostic Substances | 11.4% |
| Non-Major Drug Manufacturers | 17.6% |
| Biotechnology | 19.5% |
| Major Drug Manufacturers | 21.6% |

**Data with the latest up to date information.**

The National Health Expenditure Accounts (NHEA) are the official estimates of total health care spending in the United States. Dating back to 1960, the NHEA measures annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care. The data are presented by type of service, sources of funding, and type of sponsor.

U.S. health care spending grew 4.6 percent in 2018, reaching $3.6 trillion or $11,172 per person.  As a share of the nation's Gross Domestic Product, health spending accounted for 17.7 percent.

US health care spending increased 4.6 percent to reach $3.6 trillion in 2018, a faster growth rate than the rate of 4.2 percent in 2017 but the same rate as in 2016. The share of the economy devoted to health care spending declined to 17.7 percent in 2018, compared to 17.9 percent in 2017.

The 0.4-percentage-point acceleration in overall growth in 2018 was driven by faster growth in both private health insurance and Medicare, which were influenced by the reinstatement of the health insurance tax.

* For personal health care spending (which accounted for 84 percent of national health care spending), growth in 2018 remained unchanged from 2017 at 4.1 percent.
* The total number of uninsured people increased by 1.0 million for the second year in a row, to reach 30.7 million in 2018.
* US health spending reached $3.5 trillion in 2017, or $10,739 per capita, and accounted for 17.9% of gross domestic product (GDP).
* National health spending grew 3.9% in 2017, its slowest pace since 2013.
* Health spending and the economy grew at similar rates in 2017.
* Looking ahead, health spending is projected to grow at an average rate of 5.5% per year between 2018 and 2027, faster than the economy’s 4.7% growth.
* By 2027, health care spending is expected to total $6.0 trillion and account for nearly one-fifth of GDP.

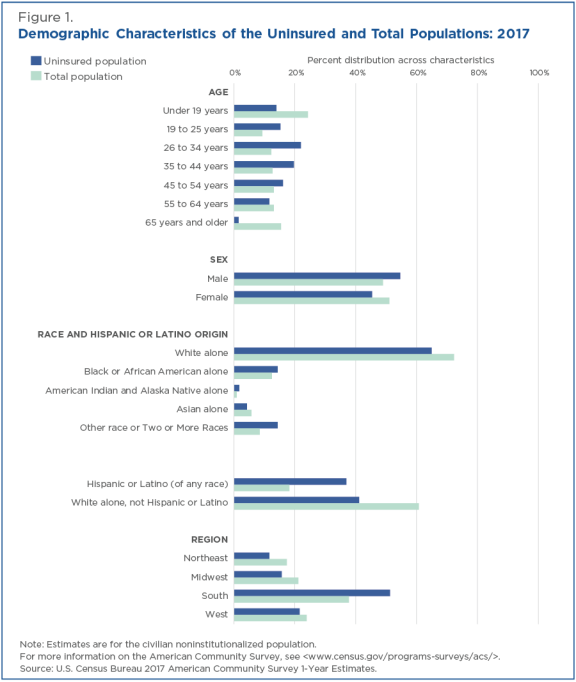
**KEY FINDINGS INCLUDE:**

* The slowdown in 2017 health spending was attributable to slower growth in spending for hospital care, physician services, and prescription drugs.
* Prescription drug spending, which totaled $333 billion in 2017, grew 0.4% in 2017, its lowest rate since 2012. The 2017 slowdown was driven largely by changes in the use and mix of drugs prescribed.
* Per capita health spending increased 3.2%.
* Households and the federal government each accounted for 28% of health spending in 2017. Private business accounted for 20%.
* Federal subsidies for ACA marketplace (individual coverage) premiums and cost sharing totaled $41 billion, accounting for 4% of federal health spending.
* Household spending on direct purchase insurance declined by 6.7%, driven by declining enrollment in unsubsidized individual insurance.
* Public health insurance, including Medicare and Medicaid, paid the largest share of spending (41%). Private health insurance paid for 34% of health spending, and consumers’ out-of-pocket spending accounted for 10%.[[11]](#footnote-11)

DELIVERABLE  
How many people have insurance now vs 10 years ago etc.

In 2017, the number of people without health insurance increased to 28.0 million, up from 27.3 million the year before, according to the latest American Community Survey data released today.[[12]](#footnote-12)

* Working-age adults made up a much larger share of the uninsured population than any other age group. In fact, most uninsured people (84.6 percent) were 19- to 64-year-olds.
* The two largest groups in that age range are 26- to 34-year-olds and 35- to 44-year-olds. About 1 in 4 uninsured people were 26 to 34 years old, and about 1 in 5 people ages 34 to 44.
* Over half of all people without health insurance coverage were male (54.6 percent), even though the U.S. population has more women than men.
* About 4 in 10 uninsured people were non-Hispanic white, while nearly 6 in 10 people in the United States were non-Hispanic white.
* Other races and ethnic groups made up the majority of the uninsured population but less than half (39.3 percent) of the total population.
* The uninsured were disproportionately concentrated in the South.

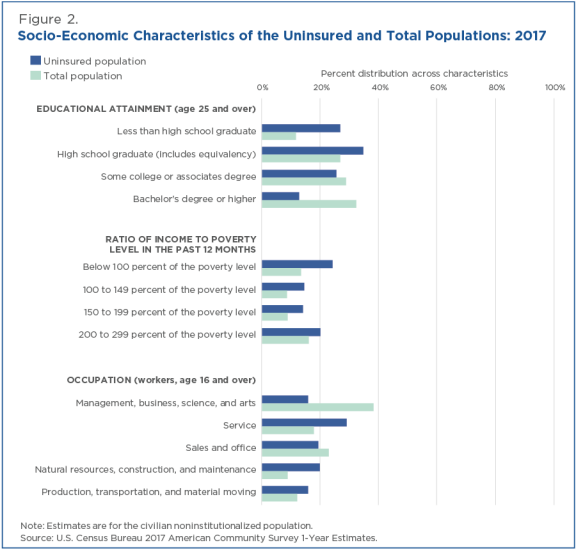


The new data also show that 14.0 percent of those without health insurance are under 19 years old. That number may seem a bit high but it is relatively low considering that children were almost one-quarter of the U.S. population last year.  
  
By contrast, only a small fraction of the uninsured — just 1.4 percent — were age 65 and over.

**Social and Economic Factors**

Most people without health insurance coverage had a high school education or less. People who did not complete high school made up a much larger part of the uninsured population (26.9 percent) than the overall population (11.8 percent).

The uninsured population was also disproportionately more likely to live in poverty. About 1 in 3 uninsured workers were in service occupations, compared with about 1 in 5 workers in the U.S. overall.



**Profile of the Uninsured**

So who were the uninsured? They tended to be 19 to 64 years old, male, have less than a high school education and/or have lower incomes. This profile is fairly different from the profile of the overall U.S. population.

The large sample size of the American Community Survey provides a detailed look at the characteristics of populations such as the uninsured.

To find out more about the uninsured population, such as employment characteristics, disability status, nativity and residence, or about the uninsured population in smaller geographic areas (states, counties and zip codes), see [Table S2702 in American FactFinder](https://factfinder.census.gov/bkmk/table/1.0/en/ACS/16_5YR/S2702/0100000US). (“Selected Characteristics of the Uninsured in the United States”).[[13]](#footnote-13)

For the first time in a decade, the number of Americans without health insurance has risen — by about 2 million people in 2018 — according to the annual [U.S. Census Bureau report](https://www.census.gov/content/dam/Census/newsroom/press-kits/2019/iphi/presentation-iphi-overview.pdf) released Tuesday.

* The Census found that 8.5% of the U.S. population went without medical insurance for all of 2018, up from 7.9% in 2017. By contrast, in 2013, before the Affordable Care Act took full effect, 13.3% were uninsured. It was the first year-to-year increase since 2008-09, Census officials said.
* Census officials said most of drop in health coverage was related to a 0.7% decline in Medicaid participants. The number of people with private insurance remained steady and there was a 0.4% increase in those on Medicare.
* Many of those losing coverage were non-citizens, a possible fallout from the Trump administration’s tough immigration policies and rhetoric. About 574,000 non-citizens lost coverage in 2018, a drop of about 2.3%, the report found.
* The increase in the number of uninsured people in 2018 was remarkable because [uninsured rates typically fall or hold steady](http://www.ncsl.org/research/labor-and-employment/national-employment-monthly-update.aspx) when unemployment rates drop. The U.S. unemployment rate fell slightly from about 4.3% in 2017 to 4% in 2018.

**The uninsured rate continued to vary by poverty status and whether a state expanded its Medicaid program under Obamacare. Texas (17.7%), Oklahoma (14.2%), Georgia (13.7%) and Florida (13%) had the highest uninsured rates in 2018, according to the report. None of those states have expanded Medicaid under Obamacare.**

The percentage of uninsured children under the age of 19 increased by 0.6 percentage points from 2017 to 2018, to 5.5%.[[14]](#footnote-14)

The number of Americans without health insurance edged up in 2018 — the first evidence from the government that coverage gains from President Barack Obama's health care plan might be eroding under President Donald Trump.

* The Census Bureau also said in an annual report Tuesday that household income rose last year at its slowest pace in four years and finally matched its previous peak set in 1999. Median household income rose 0.9% in 2018 to an inflation-adjusted $63,179, from $62,626 in 2017.
* The data suggest that the economic expansion, now the longest on record at more than 10 years, is still struggling to provide widespread benefits to the U.S. population. Solid gains in household incomes in the past four years have returned the median only to where it was two decades ago. And despite strong growth last year in the number of Americans working full time and year-round, the number of people with private health insurance remained flat.
* One bright spot in the report was that the poverty rate fell for a fourth straight year to 11.8%, its lowest point since 2001. The proportion of households led by women that were poor fell to a record low.
* Though income inequality narrowed last year, it remains near record levels reached in 2017. Last year, the richest 5% of the U.S. population captured 23% of household income.
* An estimated 27.5 million people, 8.5% of the population, went without health insurance in 2018. That was an increase of 1.9 million uninsured people, or 0.5 percentage point.
* More people were covered by Medicare, reflecting the aging of the baby boomers. But Medicaid coverage declined. The number of uninsured children also rose, and there were more uninsured adults ages 35-64.
* Though the increase in the number of uninsured Americans last year was modest, it could be a turning point, the first real sign that coverage gains under Obama could be at least partly reversed. This year, the number of uninsured could rise again because a previous Republican-led Congress repealed fines under the Affordable Care Act for people who remain uninsured if they can afford coverage.
* Yet ACA enrollment has held fairly steady, with about 20 million people covered by its mix of subsidized private plans and a Medicaid expansion for low-income individuals. The Census report found that Medicaid coverage declined by 0.7 percent from 2017.[[15]](#footnote-15)

1. <https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/> [↑](#footnote-ref-1)
2. Centers for Medicare and Medicaid Services (CMS) used elsewhere in this document. These excluded expenditures could be distributed unevenly across the population and can therefore affect the patterns shown in figures based on MEPS data. For more on a comparison of the types of spending covered in the MEPS and spending covered in the NHEA, which is used in other figures in this document, see Bernard et al. (2012). [↑](#footnote-ref-2)
3. Plans seem to lead patients to reduce their spending indiscriminately, cutting valuable and less-valuable care alike (Brot-Goldberg et al. 2017). [↑](#footnote-ref-3)
4. Recent research suggests that hospitalizations of uninsured adults generate only about 6 percent of bankruptcies for that group (Dobkin et al. 2018). [↑](#footnote-ref-4)
5. Estimates includes administrative costs to providers. Thus, these calculations embody a different accounting of administrative costs than is cited in Cutler (2020), and the estimated fractions of health-care expenditures are substantially lower. [↑](#footnote-ref-5)
6. Increase in opportunity reflects the growth in the number of osteopathic programs joining the Main Residency Match as a result of the ongoing transition to a single accreditation system for graduate medical education (GME) programs” (Murphy 2019) [↑](#footnote-ref-6)
7. U.S. hospital service prices are only 30 percent higher than the OECD average and just slightly above those of countries like Canada and Austria (Lorenzoni and Koechlin 2017) [↑](#footnote-ref-7)
8. <https://www.medicaleconomics.com/money/4-surprising-facts-you-didnt-know-about-healthcare-debt> [↑](#footnote-ref-8)
9. <https://www.justfacts.com/healthcare.asp> [↑](#footnote-ref-9)
10. <https://www.justfacts.com/healthcare.asp> [↑](#footnote-ref-10)
11. <https://fortune.com/2019/02/21/us-health-care-costs-2/> [↑](#footnote-ref-11)
12. <https://www.census.gov/library/stories/2018/09/who-are-the-uninsured.html> [↑](#footnote-ref-12)
13. ibid [↑](#footnote-ref-13)
14. <https://khn.org/news/number-of-americans-without-insurance-rises-in-2018/> [↑](#footnote-ref-14)
15. <https://www.nbcnews.com/politics/politics-news/number-americans-without-health-insurance-rises-1st-time-decade-n1052016> [↑](#footnote-ref-15)