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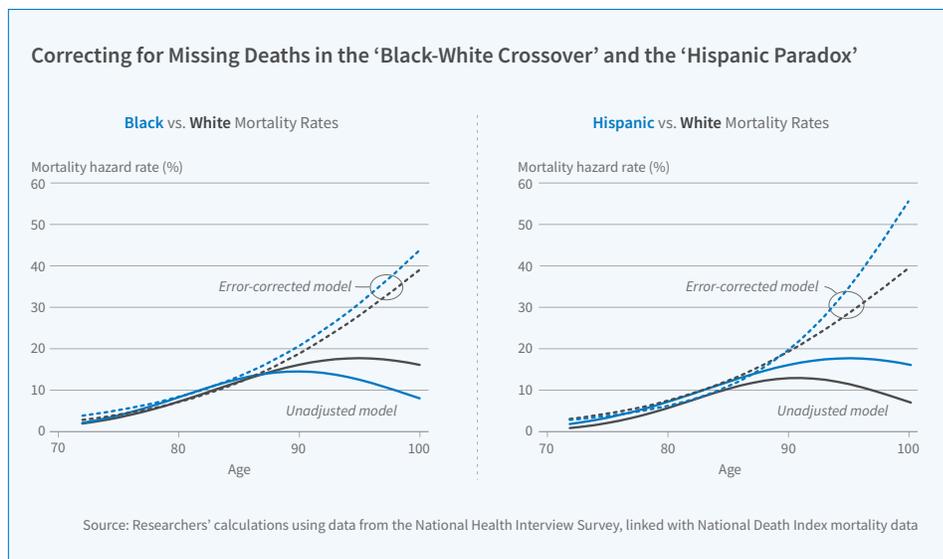
## Bulletin on Aging and Health

NATIONAL BUREAU OF ECONOMIC RESEARCH

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### Unreported Deaths Affect the ‘Hispanic Paradox’ and the ‘Black-White Mortality Crossover’

The “Hispanic paradox” and the “black-white mortality crossover” are phenomena related to racial and ethnic differences in mortality that have generated substantial interest beyond the scientific community. The former refers to the empirical generalization that Hispanic and Latino Americans have mortality rates that are similar to or lower than those of their non-Hispanic white counterparts, an outcome that is seen as paradoxical given the socioeconomic differences between the two groups. The latter concerns the finding that although blacks have higher mortality rates than whites at younger ages — an unsurprising



result given racial differences in socioeconomic factors — this pattern reverses at older ages.

Numerous theories have been advanced to explain these anomalous findings, including

the possibility that they are primarily due to bad data. After decades of work to identify and correct data issues, demographers have largely concluded that careful data (continued on page 2)



### NBER Profile: Alex Gelber

Alex Gelber is a tenured Associate Professor at the University of California, Berkeley Goldman School of Public Policy. He is a research associate in the NBER’s aging and public economics programs. Beginning in July 2018, he will be a tenured Associate Professor in the University of California, San Diego Economics Department and School of Global Policy and Strategy.

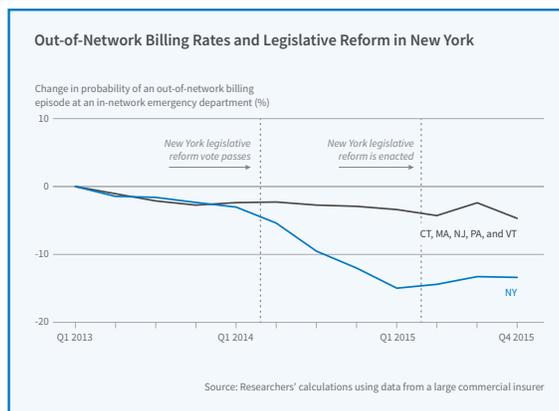
Dr. Gelber’s research concerns public finance, particularly issues relating to taxation and social insurance. Some of his recent projects have explored the

effect of Social Security Disability Insurance benefits on recipients’ earnings and mortality, as well as the labor supply effects of Social Security. He has also worked on estimating the effects of tax and other public programs on the labor market. Much of his work uses large, government administrative datasets to address these issues.

During 2012 to 2013, Gelber served as Deputy Assistant Secretary for Economic Policy at the U.S. Treasury Department, and in 2013 he served as Acting Assistant Secretary for (continued on page 2)

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- NBER Affiliates’ Work Appearing in Medical Journals
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### Profile (from page 1)

Economic Policy and Acting Chief Economist at the Treasury. He was awarded the U.S. Treasury's Meritorious Service Award for his work on a wide spectrum of issues facing the U.S. economy.

Professor Gelber is a coeditor at the *Journal of Public Economics* and an associate editor at the *Journal of the European Economic Association*. His work has been supported by external grants from the National Institutes of Health, National Institute on Aging, and the Social Security Administration, among others. He is a recipient of the National Tax Association Musgrave Prize.

Gelber earned an A.B. and a Ph.D. in economics, both from Harvard University. Prior to joining the faculty at the University of California at Berkeley, Gelber was an assistant professor at the Wharton School of the University of Pennsylvania. He completed a post-doctoral fellowship in aging and health at the National Bureau of Economic Research.

In his free time, Gelber enjoys spending time with his wife and two children, jogging, playing the piano, and hiking. He is attempting to learn how to surf, mostly unsuccessfully.

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### Mortality (from page 1)

correction mitigates, but does not eliminate, these findings.

In “**The Methuselah Effect: The Pernicious Impact of Unreported Deaths on Old Age Mortality Estimates**” (NBER Working Paper No. 23574), researchers **Dan Black, Yu-Chieh Hsu, Seth Sanders, Lynne Schofield, and Lowell Taylor** offer a fresh perspective on this issue. The researchers focus on a particular data problem — which they denote the “Methuselah effect” — and explain how it can bias inferences about old age mortality.

The intuition of the Methuselah effect is straightforward. Suppose that in a sample of respondents that is being tracked over time and used to calculate mortality rates, a respondent dies at a particular age but the death is not matched to the original sample respondent. At all future ages, the estimated mortality rate (calculated as the number of deaths among people of a given age relative to the number of people who reached that age alive) will be an underestimate of the true rate because the number of people alive is smaller than measured. Mortality estimates will become progressively more downward-biased at older ages, as the effect of missing deaths cumulates with age. Crucially, if the failure-to-match rate varies by group characteristics such as race or ethnicity, the measurement error will affect cross-group comparisons of mortality rates.

To explore the empirical relevance of this issue, the researchers use the National Longitudinal Survey of Older Men (NLS-OM), a survey of men born between 1906 and 1921 that ran from 1966 through 1990. There are multiple sources of information on deaths of NLS-OM participants, including the 1990 survey data, a hand match to Vital Statistics (VS) death records in 1990, an electronic match to VS records in 2008, and a match to the Social Security Administration (SSA) Death Index file. The number of reported deaths through 1990 is dramatically different across the four sources. Among respondents reported dead in the 1990 survey, the hand match of VS data failed to identify the death in 28 percent of cases for blacks, 30 percent for non-black Hispanics, and 19 percent for non-Hispanic whites. The rates of missing death data were 21, 15, and 11 percent for the three groups, respectively, in the SSA data. The lowest rates of measurement error were in the electronic match to VS records, which nonetheless missed 4.2 percent of deaths among blacks and 1.8 percent among non-Hispanic whites

(there were no missing deaths among the sample's 82 non-black Hispanic respondents).

The researchers also explore this issue using the National Health Interview Survey (NHIS), an annual cross-sectional survey that is linked to the National Death Index (NDI), a centralized database of death records from state vital statistics offices. The researchers focus on some 3,700 NHIS respondents who were ages 85 and above when sampled in the late 1980s. The number of these individuals that is expected to be alive more than two decades later in 2011 is extremely small — just 0.7 blacks, 0.1 non-black Hispanics, and 5.3 non-Hispanic whites, based on SSA life tables. In fact, there are 45 black, 15 non-black Hispanic, and 216 non-Hispanic white respondents that are not in the NDI. It is clear that virtually all of these individuals are deceased, despite their lack of a death record. As in the NLS-OM, blacks and non-black Hispanics experience higher rates of unreported deaths than non-Hispanic whites.

Finally, the researchers estimate how correcting for Methuselah error affects mortality rates. A “naive” model that ignores unreported deaths generates the familiar black-white crossover and Hispanic paradox phenomena. In the error-corrected model, the mortality rate for blacks is above that for whites at every age, while the mortality rates for Hispanics and whites are initially similar and then higher for Hispanics after age 90. As the researchers note, “it appears that in these data both the black-white crossover and the Hispanic paradox are due entirely to the Methuselah effect.” The apparent deceleration in mortality rates at higher ages — another phenomenon that has drawn scrutiny from demographers — also disappears in the error-corrected model.

In sum, there are non-negligible errors in the reporting of deaths in survey data and the magnitude of the problem differs by race and ethnicity. “Failure to recognize the error, and correct for it, could lead us to believe in mortality rate deceleration, the black-white mortality crossover, and the Hispanic paradox. Correction for the error reverses all of these inferences.” The researchers note that there may be other cross-group differences in error rates that could be incorporated in mortality models to further improve them and also that the possible misreporting of age in surveys merits further attention. They conclude “a great deal more work lies ahead for demographers interested in the accurate assessment of mortality at older ages.”

## The Multi-Generational Impacts of Medicaid

In recent years, increasing attention has been paid to socioeconomic differences in health outcomes and to the role that the early life health environment may play in such differences. The Medicaid program has provided health insurance to many low-income pregnant women and children, particularly since eligibility for the program was expanded in the 1980s and 1990s. Using variation in the timing and extent of expansion across states, past research has established that making women eligible for prenatal Medicaid coverage leads to better adult health and economic outcomes for their babies.

Less well understood, however, are the possible “echo” benefits of Medicaid for the descendants of this generation. Multi-generational effects are plausible, given the known links between maternal health or socioeconomic status and infant health, as well as animal studies that have found that early life environmental impacts can be translated to later generations. Yet while many studies by social scientists document the persistence of health and economic status across multiple generations, there is a dearth of evidence establishing a causal relationship between the early life health environment and the outcomes of future generations.

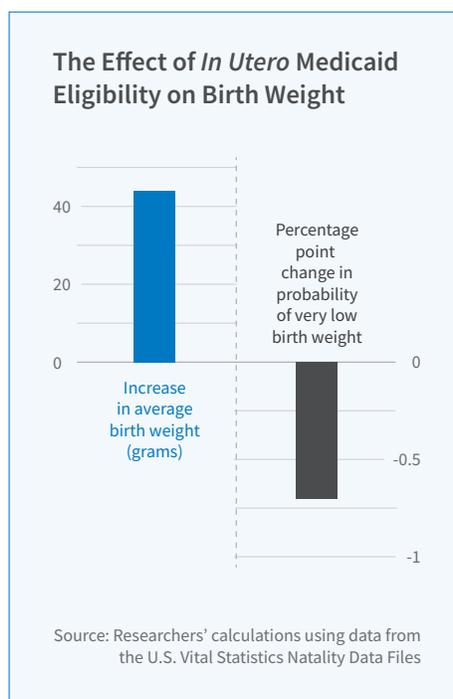
In “Multi-generational Impacts of Childhood Access to the Safety Net: Early Life Exposure to Medicaid and the Next Generation’s Health” (NBER Working Paper No. 23810), researchers [Chloe East](#), [Sarah Miller](#), [Marianne Page](#), and [Laura Wherry](#) step into this void by examining Medicaid’s impacts on the second generation’s birth outcomes.

The researchers use data from a restricted access version of the 1994–2015 Vital Statistics Natality files that contains information on the mother’s state and date of birth. Following the past literature, they exploit the staggered nature of Medicaid expansions in the 1980s, which made pregnant women in certain states and years more likely to be eligible for Medicaid than similar women in other states and years.

The researchers focus on the children of mothers who were born between 1979 and 1986, when the most dramatic increases in prenatal Medicaid coverage occurred. They look at birth outcomes for the second generation including birth weight and gesta-

tional length, which are known to be affected by aspects of maternal health (such as high blood pressure and metabolic syndrome) that improve with early life access to Medicaid. These birth outcomes are also predictive of later life health and economic outcomes.

Turning to the results, the researchers find that mothers’ own *in utero* Medicaid eligibility has a substantial, positive impact on their children’s health at birth. Increasing the share of mothers with *in utero* coverage from zero to one is associated with a 44-gram increase in the second generation’s



average birth weight and a 0.7 percentage point decrease in the incidence of very low birth weight (less than 1500 grams). *In utero* Medicaid eligibility also reduces the probability that a second generation baby is born under 28 weeks of gestation; interestingly, there is no change in the probability the baby is small for its gestational age. Taken as a whole, the results suggest that the improvements in infant health are generated by underlying health processes that increase gestational length. By contrast, later childhood exposure to Medicaid does not lead to persistent health effects across generations.

In comparing how the “spillover” effects of *in utero* Medicaid access on the second generation’s health compare to the direct

effect on the first generation, the researchers note that their low birth weight estimate is approximately half the size of the effect of Medicaid eligibility on the first generation’s birth weight, as estimated in earlier research. The presence of significant benefits beyond the first generation indicates that “benefit to cost ratios based only on cohorts immediately affected by Medicaid generate underestimates of the program’s overall efficacy,” as the researchers observe.

Exploring the possible mechanisms for these effects, the researchers note that Medicaid access could affect the fertility patterns of women exposed to the program while *in utero*, changing the composition of women who choose to give birth or the timing of births in a way that affects health. They find that these changes explain at most 6 to 17 percent of the overall changes in second-generation infant health. The researchers also use estimates from existing research regarding the effect of Medicaid access on earnings to project how much of the second-generation’s health gains might result from Medicaid-induced increases in the first generation’s income. Although the estimates are imprecise, the researchers conclude that income likely plays an important role in the transmission process.

In concluding, the researchers note “generational persistence in the impacts of early life environments suggest that historical differences in fetal health conditions between advantaged and disadvantaged groups may undermine contemporaneous efforts to close health and economic gaps. At the same time, our results indicate that early life health investments have payoffs that extend well beyond those that social policy makers usually consider. Investigating a more complete range of program benefits to later generations is an important goal of future work, and is critical in light of increasing debates about the efficacy of the U.S. safety net.”

*This project was supported by funding from the National Science Foundation (Grant #1327768), the University of California Davis Interdisciplinary Frontiers in the Humanities and Arts Grant, and the U.S. Department of Health and Human Services. Wherry also benefited from facilities which receive core support (R24-HD041022) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development.*

## Surprise Charges for Emergency Care

Patients who visit a hospital in their insurer’s network may be surprised to receive a bill for services from an out-of-network provider who treated them during their stay. This surprise is particularly troubling when the visit is to the emergency department (ED), since patients in the ED are in medical distress and not in a position to choose their provider.

Hospitals and physicians negotiate contracts separately with insurers, so a hospital in the patient’s network may be staffed by physicians that do not have a contract with the patient’s insurer. Physician charges on out-of-network bills are not set through a competitive process and may be significantly higher than in-network or Medicare rates for the same services. When a patient receives an out-of-network bill, their insurer may choose to reimburse the billed amount, though the patient may still face substantial cost sharing. Alternatively, the insurer may pay the physician only the usual and customary rate, leaving the physician free to “balance bill”

the patient for the remainder of the charge, or may not reimburse at all. In any case, the patient can be liable for a large bill.

In **“Surprise! Out-of-Network Billing for Emergency Care in the United States”** (NBER Working Paper No. 23623), researchers [Zack Cooper](#), [Fiona Scott Morton](#), and [Nathan Shekita](#) explore the scope of this phenomenon and analyze the effect of a New York state law designed to protect consumers from surprise bills.

Over the past several decades, ED care has accounted for a growing share of hospitals’ inpatient admissions. There has been rapid growth in the share of hospitals that outsource the management, staffing, and billing of their EDs in an attempt to run these important departments more effi-

ciently. At present, 65 percent of the physician ED workforce is outsourced, with two firms — EmCare and TeamHealth — collectively accounting for 30 percent of the outsourced physician market.

For the analysis, the researchers use claims data from a large commercial insurer to construct a sample of 9 million ED visits over the period 2011–15, representing \$28 billion in spending. The data include the ED physician charge, the amount reimbursed by the insurer, and the amount paid by the patient as a copayment or towards

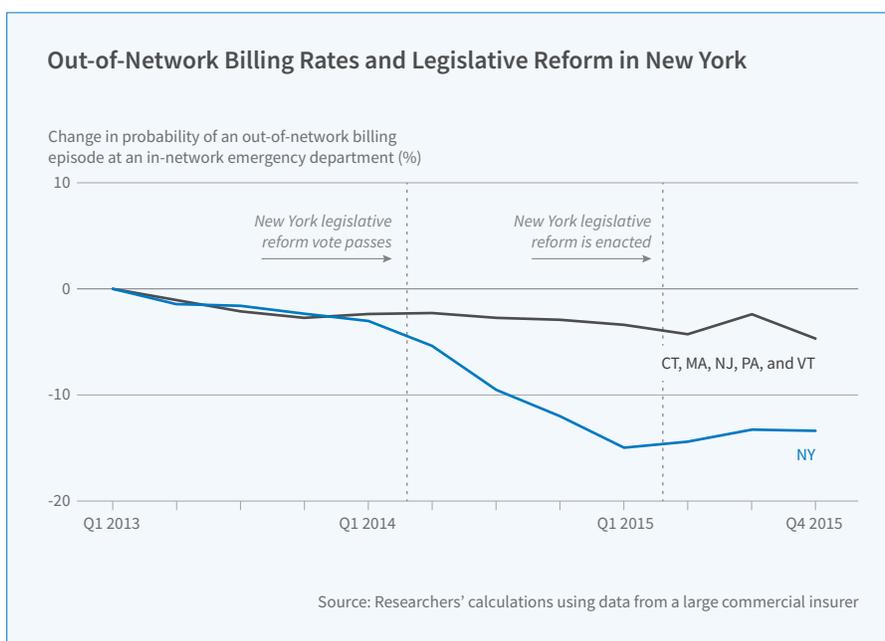
network physician charge is \$786, more than six times the Medicare payment for these services. The average physician payment from the insurer and patient cost-sharing is \$327, leaving patients facing an average potential balance bill of \$448.

The practice of out-of-network billing is more common at for-profit hospitals and hospitals that outsource their ED services to EmCare. This leads the researchers to evaluate how practices change when a physician-outsourcing firm takes over the management of the ED. Following the entry of EmCare,

out-of-network billing rates increase by 81 to 90 percentage points and physician services are 43 percent more likely to be coded using the most high-intensity, high-paying code. EmCare’s entry also results in increases in the use of imaging services and inpatient admits from the ED to the hospital. This pattern is consistent with hospitals incurring a reputational cost from out-of-network billing and receiving a transfer from physicians — in the form of higher fees from imaging, for example — to compensate them.

Finally, the researchers examine the impact of an innovative 2014 New York state law, which banned the practice of balance billing and required insurers and physicians to use binding arbitration to settle disputed bills. Following the law’s passage, the out-of-network billing rate fell by substantially more in New York than in other nearby states. However, the law’s protection is incomplete because it does not apply to insurance plans that are exempt from state regulation (about half of all privately insured patients are enrolled in such plans) and also does not ensure that physician ED charges are competitively set.

Indeed, as the researchers explain, the fundamental problem is that there is a missing contract between physicians and insur-



their deductible; The data do not capture other patient payments made in response to balance billing. The researchers mine publicly available data to identify the hospitals in their sample that have contracts with EmCare and TeamHealth.

The researchers find that 22 percent of patients visiting an in-network hospital are treated and billed by an out-of-network provider, but the mean doesn’t tell the whole story. The share of patients receiving an out-of-network bill varies significantly across hospitals — in the 15 percent of hospitals where such billing is most common, over 80 percent of patients receive an out-of-network bill. Nearly half of ED patients in Texas receive an out-of-network bill, as do a third of patients in many Southern states. The average out-of-

ers. Some states have tried to address this by setting a regulated payment rate, although this does not restore a competitively set price to the market. The researchers note that “an alternative policy approach would be for states to require hospitals to sell an ED service package that includes both physician and facility services. In a state with this type

of packaged payment, hospitals would negotiate ED payment rates with insurers and reach competitively set prices that reflect the cost of both the physician and the facility. Under this alternative policy, a patient using an in-network ED would be treated by in-network physicians. Further, this alternative policy would promote competition at all lev-

els of the health system. Crucially, under this type of alternative policy, privately insured patients accessing EDs in emergencies would also be fully protected from surprise bills.”

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*The researchers acknowledge funding from the National Institute for Health Care Management Foundation.*

## NBER Affiliates’ Work Appearing in Medical Journals

### [A Comparison of Programmable and Non-Programmable Compression Devices for Treatment of Lymphedema Using an Administrative Health Outcomes Dataset](#)

*P. Karaca-Mandic, A. T. Hirsch, S. G. Rockson, and S. H. Ridner, British Journal of Dermatology, June 2017, (Published online).*

### [Challenges to Reducing Discrimination and Health Inequity through Existing Civil Rights Laws](#)

*A. Chandra, M. Frakes, and A. Malani, Health Affairs, 36(6), June 2017, pp. 1041–7.*

### [A Commitment Contract to Achieve Virologic Suppression in Poorly Adherent Patients with HIV/AIDS](#)

*M. Alsan, J. Beshears, W. S. Armstrong, J. J. Choi, B. C. Madrian, M. T. Nguyen, C. Del Rio, D. Laibson, and V. C. Marconi, AIDS, 31(12), July 2017, pp. 1765–9.*

### [Distribution of Lifetime Nursing Home Use and of Out-of-Pocket Spending](#)

*M. D. Hurd, P. Michaud, and S. Rohwedder, PNAS, 114(37), July 2017, pp. 9838–42.*

### [Small Cash Incentives Can Encourage Primary Care Visits by Low-Income People with New Health Care Coverage](#)

*C. Bradley and D. Neumark, Health Affairs, 36, August 2017, pp. 1376–84.*

### [Association between FDA Black Box Warnings and Medicare Formulary Coverage Changes](#)

*S. S. Dhruva, P. Karaca-Mandic, N. D. Shah, D. L. Shaw, and J. S. Ross, American Journal of Managed Care, 23(9), September 2017, pp. e310-5.*

### [Trends in Omalizumab Utilization for Asthma: Evidence of Suboptimal Patient Selection](#)

*M. M. Jeffery, N. D. Shah, P. Karaca-Mandic, J. S. Ross, M. A. Rank, The Journal of Allergy and Clinical Immunology: In Practice, September 2017, (Published online).*

### [Estimating the Effects of Health Insurance and Other Social Programs on Poverty under the Affordable Care Act](#)

*D. K. Remler, S. D. Korenman, and R. T. Hyson, Health Affairs, 36(10), October 2017, pp. 1828–37.*

### [Income, Physical Activity, Sedentary Behavior, and the ‘Weekend Warrior’ among U.S. Adults](#)

*K. Shuval, Q. Li, K. P. Gabriel, and R. Tchernis, Preventive Medicine, 103, October 2017, pp. 91–7.*

### [Describing Wait Time Bottlenecks for ED Patients Undergoing Head CT](#)

*J. G. Rogg, R. Huckman, M. Lev, A. Raja, Y. Chang, and B. A. White, The American Journal of Emergency Medicine, 35, October 2017, pp. 1510–3.*

Many NBER-affiliated researchers publish some of their findings in medical journals that do not allow pre-publication distribution. This makes it impossible to include these papers in the NBER working paper series. This is a partial listing of recent papers in this category.

## Abstracts of Selected Recent NBER Working Papers

w23530

[The Role of Hospital and Market Characteristics in Invasive Cardiac Service Diffusion](#)

**Jill R. Horwitz, Charleen Hsuan, Austin Nichols**

Little is known about how the adoption and diffusion of medical innovation is related to and influenced by market characteristics such as competition. The particular complications involved in investigating these relationships in the health care sector may explain the dearth of research. We examine diagnostic angiography, percutaneous coronary interventions (PCI), and coronary artery bypass grafting (CABG), three invasive cardiac services. We document the relationship between the adoption by hospitals of these three invasive cardiac services and the characteristics of hospitals, their markets, and the interactions among them, from 1996–2014. The results show that the probability of hospitals adopting a new cardiac service depends on competition in two distinct ways: 1) hospitals are substantially more likely to adopt an invasive cardiac service if competitor hospitals also adopt new services; 2) hospitals are less likely to adopt a new service if a larger fraction of the nearby population already has geographic access to the service at a nearby hospital. The first effect is stronger, leading to the net effect of hospitals duplicating access rather than expanding access to care. In addition, for-profit hospitals are considerably more likely to adopt these cardiac services than either nonprofit or government-owned hospitals. Nonprofit hospitals in high for-profit markets are also more likely to adopt them relative to other nonprofits. These results suggest that factors other than medical need, such as a medical arms race, partially explain technological adoption.

w23551

[Pathways to Retirement through Self-Employment](#)

**Shanthi Ramnath, John B. Shoven, Sita Nataraj Slavov**

We examine the role of self-employment in retirement transitions using a panel of administrative tax data. We find that the hazard of self-employment increases at popular retirement ages associated with Social Security eligibility, particularly for those with greater retirement wealth. Late-career transitions to self-employment are associated with a larger drop in income than similar mid-career transitions. Data from the Health and Retirement Study suggest that hours worked also fall upon switching to self-employment. These results suggest that self-employment at older ages may serve as a “bridge job,” allowing workers to gradually reduce hours and earnings along the pathway to retirement.

w23585

[Check Up Before You Check Out: Retail Clinics and Emergency Room Use](#)

**Diane Alexander, Janet Currie, Molly Schnell**

Retail clinics are an innovation that has the potential to improve competition in health care markets. We use the universe of emergency room (ER) visits in New Jersey from 2006–14 to examine the impact of retail clinics on ER usage. We find significant effects of retail clinics on ER visits for both minor and preventable conditions; Residents residing close to an open clinic are 4.1–12.3 percent less likely to use an ER for these conditions. Our estimates suggest annual cost savings from reduced ER usage of over \$70 million if retail clinics were made readily available across New Jersey.

w23607

[The Effects of the Affordable Care Act on Health Insurance Coverage and Labor Market Outcomes](#)

**Mark Duggan, Gopi Shah Goda, Emilie Jackson**

The Affordable Care Act (ACA) includes several provisions designed to expand insurance coverage that also alter the tie between employment and health insurance. In this paper, we exploit variation across geographic areas in the potential impact of the ACA to estimate its effect on health insurance coverage and labor market outcomes in the first two years after the implementation of its main features. Our measures of potential ACA impact come from pre-existing population shares of uninsured individuals within income groups that were targeted by Medicaid expansions and federal subsidies for private health insurance, interacted with each state’s Medicaid expansion status. Our findings indicate that the majority of the increase in health insurance coverage since 2013 is due to the ACA and that areas in which the potential Medicaid and exchange enrollments were higher saw substantially larger increases in coverage. While labor market outcomes in the aggregate were not significantly affected, our results indicate that labor force participation reductions in areas with higher potential exchange enrollment were offset by increases in labor force participation in areas with higher potential Medicaid enrollment.

w23622

[Is It Who You Are or Where You Live? Residential Segregation and Racial Gaps in Childhood Asthma](#)

**Diane Alexander, Janet Currie**

Higher asthma rates are one of the more obvious ways that health inequalities between African American and other children are mani-

fested beginning in early childhood. In 2010, black asthma rates were double non-black rates. Some but not all of this difference can be explained by factors such as a higher incidence of low birth weight (LBW) among blacks; however, even conditional on LBW, blacks have a higher incidence of asthma than others. Using a unique data set based on the health records of all children born in New Jersey between 2006 and 2010, we show that when we split the data by whether or not children live in a “black” zip code, this racial difference in the incidence of asthma among LBW children entirely disappears. All LBW children in these zip codes, regardless of race, have a higher incidence of asthma. Our results point to the importance of residential segregation and neighborhoods in explaining persistent racial health disparities.

**w23645**

#### [Addressing the Opioid Epidemic: Is There a Role for Physician Education?](#)

**Molly Schnell, Janet Currie**

Using data on all opioid prescriptions written by physicians from 2006 to 2014, we uncover a striking relationship between opioid prescribing and medical school rank. Even within the same specialty and county of practice, physicians who completed their initial training at top medical schools write significantly fewer opioid prescriptions annually than physicians from lower ranked schools. Additional evidence suggests that some of this gradient represents a causal effect of education rather than patient selection across physicians or physician selection across medical schools. Altering physician education may therefore be a useful policy tool in fighting the current epidemic.

**w23664**

#### [Debt and Financial Vulnerability on the Verge of Retirement](#)

**Annamaria Lusardi, Olivia S. Mitchell, Noemi Oggero**

We analyze older individuals’ debt and financial vulnerability using data from the Health and Retirement Study (HRS) and the National Financial Capability Study (NFCS). Specifically, in the HRS we examine three different cohorts (individuals age 56–61) in 1992, 2004, and 2010 to evaluate cross-cohort changes in debt over time. We also use two waves of the NFCS (2012 and 2015) to gain additional insights into debt management and older individuals’ capacity to shield themselves against shocks. We show that recent cohorts have taken on more debt and face more financial insecurity, mostly due to having purchased more expensive homes with smaller down payments.

**w23729**

#### [Social Security Claiming Decisions: Survey Evidence](#)

**John B. Shoven, Sita Nataraj Slavov, David A. Wise**

While research shows that there are large gains in lifetime wealth from delaying claiming Social Security, most people claim at or before full retirement age. We fielded an original, nationally representative survey to gain insight into people’s rationales for their Social Security claiming decisions, their satisfaction with their past claiming decisions, and how they financed any gap between retirement and claiming. Common rationales for claiming Social Security before full retirement age include stopping work, liquidity, poor health, and concerns about future benefit cuts due to policy changes. Claiming upon stopping work and claiming at full retirement age appear to be viewed as social norms. But while Social Security claiming is strongly associated with stopping work, the roughly quarter of the sample who have a gap of two or more years between retirement and claiming used employer-sponsored pensions and other saving to finance the delay. Individuals who claimed at full retirement age are more satisfied with their claiming decisions than individuals who claimed early or delayed. There is little evidence that claiming decisions and rationales for claiming are correlated with financial literacy or knowledge of Social Security rules.

**w23748**

#### [Politics, Hospital Behavior, and Health Care Spending](#)

**Zack Cooper, Amanda E Kowalski, Eleanor N Powell, Jennifer Wu**

This paper examines the link between legislative politics, hospital behavior, and health care spending. When trying to pass sweeping legislation, congressional leaders can attract votes by adding targeted provisions that steer money toward the districts of reluctant legislators. This targeted spending provides tangible local benefits that legislators can highlight when fundraising or running for reelection. We study a provision — Section 508 — that was added to the 2003 Medicare Modernization Act (MMA). Section 508 created a pathway for hospitals to apply to get their Medicare payment rates increased. We find that hospitals represented by members of the House of Representatives who voted ‘Yea’ on the MMA were significantly more likely to receive a 508 waiver than hospitals represented by members who voted ‘Nay.’ Following the payment increase generated by the 508 program, recipient hospitals treated more patients, increased payroll, hired nurses, added new technology, raised CEO pay, and ultimately increased their spending by over \$100 million annually. Section 508 recipient hospitals formed the Section 508 Hospital Coalition, which spent millions of dollars lobbying Congress to extend the program. After the vote on the MMA and before the vote to reauthorize the 508 program, members of Congress with a 508 hospital in their district received a 22% increase in total campaign contributions and a 65% increase in contributions from individuals working in the health care industry in the members’ home states. Our work demonstrates a pathway through which the link between politics and Medicare policy can dramatically affect U.S. health spending.

w23760

[Public Insurance and Psychotropic Prescription Medications for Mental Illness](#)

**Johanna Catherine Maclean, Benjamin L. Cook, Nicholas Carson, Michael F. Pesko**

Mental illnesses are prevalent in the United States and globally, and cost is a critical barrier to treatment receipt for many afflicted individuals. Affordable insurance coverage can permit access to effective healthcare services and treatment of mental illnesses. We study the effects of recent and major eligibility expansions within Medicaid, a public insurance system in the U.S. that finances healthcare services for the poor, on psychotropic medications prescribed in outpatient settings. To this end, we estimate differences-in-differences models using administrative data on medications prescribed in outpatient settings for which Medicaid was a third-party payer between 2011 and 2016. Our findings suggest that these expansions increased psychotropic prescriptions by 22% with substantial heterogeneity across psychotropic class and state characteristics that proxy for patient need, expansion scope, and system capacity. We provide further evidence that Medicaid, and not patients, primarily financed these prescriptions. These findings suggest that public insurance expansions have the potential to improve access to evidence-based treatments among low-income populations suffering from mental illnesses.

w23781

[Access to Long-Term Care after a Wealth Shock: Evidence from the Housing Bubble and Burst](#)

**Joan Costa Font, Richard Frank, Katherine Swartz**

Home equity is the primary self-funding mechanism for long term services and supports (LTSS). Using data from the relevant waves of the Health and Retirement Study (1996–2010), we exploit the exogenous variation in the form of wealth shocks resulting from the value of housing assets, to examine the effect of wealth on use of home health, unpaid help, and nursing home care by older adults. We find a significant increase in the use of paid home health care and unpaid informal care but no effect on nursing home care access. We conduct a placebo test on individuals who do not own property; their use of LTSS was not affected by the housing wealth changes. The findings suggest that a wealth shock exerts a positive and significant effect on the uptake of home health and some effect on unpaid care but no significant effect on nursing home care.