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Research Article

AN EMPIRICAL ANALYSIS OF THE IMPACT OF HEALTH POLICIES ON OUT-OF-POCKET HEALTHCARE EXPENDITURE IN USA: THE PRELIMINARY RESEARCH ON DEVELOPING IMPROVED HEALTH POLICIES IN THE UNITED STATES

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ABSTRACT

This study examines the impact of U.S. health policies on out-of-pocket healthcare expenditures, revealing that certain policies are notably more effective in reducing costs for individuals. The regression model explains 99.5% of the variation in out-of-pocket expenses (R^2 = 0.995). Key findings show the Inflation Reduction Act (IRA) as the most impactful, reducing costs by $0.43 per unit (β = -0.426, p = 0.007), followed by COVID-19 Response and Health Policy Changes (CRHPC), which reduces costs by $0.16 (β = -0.162, p = 0.019). Government Expenditure on Health, however, has a positive impact, increasing out-of-pocket spending by $0.69 per dollar spent (β = 0.695, p = 0.001), suggesting inefficiencies. Inflation also drives costs up, with each 1% increase resulting in an additional $0.02 out-of-pocket (β =

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0.017, p = 0.032). The findings recommend focusing on high-impact policies like the IRA and CRHPC, while reevaluating lower-impact programs to optimize resource allocation and control healthcare inflation.

KEYWORDS

Health Policies, Out-of-Pocket Expenditure, Inflation, Reforms, JEL Codes: I18, I13, H51, E31, H75.

INTRODUCTION

The issue of high cost of healthcare in the United State is a burning topic in political debates. It poses a major financial burden for millions, with inflation worsening the strain on household budgets. The healthcare industry's profit-driven practices, including inflated pricing, complex insurance policies, and a system that rewards quantity over quality, drive up expenses. Insurance practices—such as high deductibles, network restrictions, and delays in care—add further financial and logistical barriers for patients. Additionally, a corporate focus within healthcare organizations diverts resources from essential services to profit-generating areas, increasing costs.

This situation necessitates an analysis of U.S. healthcare policies to determine which, at any point in time, have reduced the financial burden of healthcare costs on individuals and this is the objective of this research as a first phase of a project geared towards formulating better health policies in the United States. In this research, the analysis was conducted by applying a new methodology designed by Omolara Adekanbi, an economist, and a social scientist. She introduced this methodology in a comparative analysis between Mexico and Nigeria, where she used econometric tools innovatively to quantitatively evaluate 11 national policies and their corresponding variables over a 48-year period. The variables were grouped into two groups –growth and development categories (Adekanbi, 2024). For the development category, Adekanbi combined econometric tools in an innovative way by using a structural detection software to identify the year intervals that needed further analysis. Then, regression analysis was run on each of the intervals when structural change was detected.

However, the methodology used in the development category was applied in the analysis of the variables that are relevant to this topic which are Out-of-Pocket Expenditure on Health Care the dependent variable), the independent variables are Government Expenditure on Health Care in current US dollars, and the policies implemented in the United States from 2000-2024 in the form of dummy variables.

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Overview of the Current Situation Due to High Healthcare Costs in the United States

The high cost of healthcare in the United States has emerged as a pressing concern, imposing significant financial strain on individuals and families across the nation. While medical advancements have introduced life-saving treatments and improved quality of care, the associated costs have escalated, placing essential healthcare services out of reach for many Americans. Rising inflation exacerbates the issue, as prices for everyday necessities—such as food and utilities—continue to climb, stretching household budgets to their limits and often forcing individuals to choose between basic needs and healthcare. Reports indicate that nearly half of U.S. adults struggle with healthcare affordability, with a significant portion delaying or foregoing necessary treatments due to prohibitive costs.

The high cost of healthcare in the United States has reached a critical level, deeply impacting the financial security and well-being of millions. Rising inflation has intensified these challenges, with November 2021 marking a 6.8% surge—reaching a 39-year high. Essential items like eggs, meat, and poultry saw prices jump by 12.5%, straining household budgets and making it even harder for Americans to afford necessary healthcare services. As a result, nearly one in three Americans (30%) reported skipping essential medical care in late 2021, a stark increase from earlier in the year. More than half of healthcare consumers experience daily stress related to healthcare costs, and 42% worry about being able to afford the medical care they need in the near future (Sarasohn-Kahn, 2022). Prescription drug costs are a significant pain point, with one-third of consumers concerned about affording their medications and 20% of Americans skipping prescriptions to save money. The burden is particularly heavy for older Americans on Medicare, many of whom struggle to afford multiple chronic care medications even under Medicare Part D coverage. Together, these figures illustrate a healthcare landscape in the U.S. that has become unaffordable for many, revealing urgent systemic issues that need to be addressed to improve access and affordability in the American healthcare system.

A 2024 KFF survey highlights that nearly half of U.S. adults find healthcare costs difficult to afford, with one in four having trouble paying healthcare bills in the past year. Additionally, 61% of uninsured adults skipped care due to cost. The public's primary concern remains lowering out-of-pocket healthcare expenses (Lopes, Montero, Presiado, & Hamel, 2024).

Factors That Drive Rising Cost of Health Care

A major driver of these rising costs lies in systemic factors within the healthcare industry. Hospitals,

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insurers, and pharmaceutical companies operate within a "medical-industrial complex," as described by Rosenthal (2017) in An American Sickness, where profit-driven practices often prioritize financial gain over patient well-being. This commercialization has led to inflated prices for treatments, medications, and diagnostic services, frequently resulting in unexpected, exorbitant bills that leave patients financially burdened and confused.

As Elisabeth Rosenthal illustrate the pervasive price gouging in the healthcare industry. Simple items like a single Tylenol tablet, which costs only a few cents at a drugstore, are often billed to hospital patients at $15 or more. Routine procedures, such as MRI scans, cost Americans upwards of $2,000, while similar scans are available in other developed countries for only a few hundred dollars. Laboratory tests, which cost around $10 to $20 to process, are routinely billed at several hundred dollars due to excessive administrative markups. Emergency room visits alone carry a facility fee between $500 and $3,000, applied simply for entry, before any treatment is provided.

For patients requiring specific medications, costs are even more staggering: a single dose of the cancer drug Avastin can cost as much as $6,000, while insulin, essential for diabetes management, has surged to hundreds of dollars per vial despite unchanged production formulas. These high prices highlight the healthcare system's shift toward profit over patient care, forcing millions to face insurmountable financial burdens and difficult choices between healthcare and other essentials. This unsustainable pricing model reflects a systemic issue within U.S. healthcare, making reform essential to restoring accessibility and equity for all Americans.

Insurance practices in the U.S. healthcare system contribute to exorbitant costs, shifting insurers' focus from patient support to maximizing profit. Opaque pricing structures negotiated between insurers and providers mean that patients often face shockingly high bills for services they assumed were covered. For example, patients are sometimes charged $500 or more for a simple blood test due to administrative markups and hidden fees, while the same test might cost a fraction elsewhere. High-deductible health plans, now increasingly common, require patients to pay thousands of dollars out-of-pocket before any insurance coverage begins, with annual deductibles often exceeding $5,000 for individual plans. Additionally, co-pays for medications and visits quickly accumulate, especially for patients managing chronic conditions—some insulin-dependent diabetics, for instance, are forced to pay hundreds of dollars monthly for insulin, despite insurance coverage (Rosenthal, 2017).

Even when a service is covered, insurers may delay or deny care through practices like "step therapy," where patients must try less effective treatments

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before accessing the one initially recommended by their doctor. These denials can lead to prolonged appeals processes and delayed care. Network restrictions further increase costs; if a patient inadvertently sees an out-of-network provider—even in emergencies—they can be liable for hundreds or thousands of dollars. Rosenthal highlights a case where a woman was charged nearly $20,000 for an out-of-network surgeon she did not choose but who assisted during her in-network procedure. These practices collectively create a confusing, financially burdensome landscape that restricts access to care and leaves patients to shoulder much of the financial risk while insurance companies focus on profitability over patient well-being (Rosenthal, 2017).

Another factor driving up cost of health care is that the U.S. healthcare system often incentivizes doctors and hospitals to increase the volume of treatments and procedures, even when they may not be necessary, due to a reimbursement model that rewards quantity over quality of care. This "fee-for-service" model means that hospitals and physicians earn more for each test, surgery, or procedure performed, creating financial motivation to recommend additional care. Rosenthal highlights cases where patients underwent costly imaging scans, procedures, or specialty consultations with limited medical justification. For example, Medicare reimbursements make it more profitable for doctors to perform high-tech scans, such as MRIs or CTs, which can cost over $2,000 each, rather than focusing on preventive care or patient counseling. Such incentives lead to overutilization of services, increasing healthcare costs while providing little added value to patients. This approach not only inflates costs but also exposes patients to potential harm from unnecessary treatments, from radiation exposure in excessive imaging to complications from unneeded surgeries (Rosenthal, 2017).

Additionally, healthcare pricing is notably opaque compared to other industries, leaving patients unaware of costs until they receive overwhelming bills. Unlike typical goods and services, where prices are clear upfront, medical bills arrive post-treatment, often with staggeringly high charges for seemingly simple procedures. Basic procedures like blood tests or minor treatments can cost hundreds or even thousands of dollars, leaving patients unable to anticipate or manage these expenses.

Furthermore, as hospitals and healthcare organizations increasingly adopt a business-first approach, patient welfare can take a backseat to financial objectives. Rosenthal describes how many hospitals now function more like corporations, with executives and administrators earning some of the highest salaries in healthcare. For example, in 2017, the CEO of a major nonprofit hospital earned over $5 million, while other top administrators routinely make

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six-figure incomes. In contrast, the average salary for a primary care physician, who directly cares for patients, is often half that amount. This shift has led hospitals to invest more in revenue-generating departments, such as cardiology and orthopedics, which yield higher profits, while underfunding critical but less lucrative areas like mental health and primary care. The focus on profit margins has transformed healthcare facilities from places of healing into profit-driven entities, where patients are seen as revenue sources and medical decisions may be swayed by financial rather than medical considerations.

Prediction of Higher Rise in Cost

Recent analyses, such as PwC's projection for 2025, underscore that medical costs are expected to continue rising, driven by inflationary pressures, higher drug prices, and increased demand for behavioral health services. Without systemic reform, these trends are likely to persist, further intensifying the financial challenges facing Americans in accessing quality healthcare. The critical need for a more sustainable and equitable healthcare model has never been more apparent, as millions of Americans contend with the unaffordability of care in one of the world's most advanced healthcare systems.

The projected medical cost trend in 2025 is anticipated to hit 8% for group plans and 7.5% for individual plans, marking the highest rate in over a decade. Key drivers of this increase include inflation, elevated prescription drug costs—especially from high-utilization drugs like GLP-1 agonists for diabetes and weight management—and increased demand for behavioral health services post-pandemic. Operational costs for healthcare providers are also rising, fueled by wage inflation and attempts to recover these expenses through health plan contracts. Furthermore, ongoing consolidation among hospitals, private equity, and physician groups is a significant factor, intensifying contract negotiations and driving costs higher. Although the adoption of biosimilar medications presents some cost-saving opportunities, these deflators are insufficient to counteract the overall upward trend, suggesting that new strategies are urgently needed to address rising healthcare expenses effectively (PwC, 2024).

However, the CMS reported that Medicare "retail" prescription drug spending is initially expected to face upward pressure due to the Inflation Reduction Act (IRA) restructuring Part D benefits, including a $2,000 cap on out-of-pocket costs and a shift of rebates from the program to the point of sale once drug negotiations commence. In contrast, downward pressure on Medicare spending is anticipated from manufacturer discounts for low-income beneficiaries (starting in 2025) and IRA provisions tying drug price increases to the Consumer Price Index (CPI) and enabling drug price negotiations. Beginning in 2028,

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growth rates for Medicare outpatient hospital, physician, and clinical services spending are projected to decrease, largely due to the IRA's drug negotiation provisions affecting Medicare Part B drugs. The National Health Expenditure (NHE) projections also indicate reduced out-of-pocket costs due to more generous Medicare Part D benefits, including the elimination of the 5% coinsurance for catastrophic coverage in 2024, a $2,000 cap on Part D out-of-pocket expenses in 2025, and the start of drug price negotiations in 2026

Efforts to address healthcare affordability, including legislation like the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA), have focused on expanding access to care and ensuring parity for mental health services. However, these initiatives have not been fully effective in controlling the root causes of high healthcare costs. For example, while the ACA increased insurance coverage, it fell short of directly controlling costs, leaving many insured individuals still struggling with high premiums, deductibles, and out-of-pocket expenses. Therefore, it is necessary to study the various policies that has been implemented in the United States.

Brief History of HealthCare Policies in USA

The history of health policies in the United States reflects a gradual evolution shaped by social needs, economic pressures, and political ideologies. The earliest initiatives began in the early 20th century, with the Progressive Era endorsing social insurance, including health coverage. As outlined in a journal publication, Smith (2023) outlined the policies from historical dates to recent years. The Sheppard-Towner Act of 1921 provided federal funding for maternal and child health, laying a foundation for federal involvement in healthcare

During the Great Depression, economic hardship prompted President Franklin D. Roosevelt to propose broad social reforms, culminating in the Social Security Act of 1935, which included public health and welfare components. After World War II, President Truman's call for national health insurance brought the issue to the forefront, though legislative action stalled amid opposition (Smith, 2023).

The 1960s marked significant advancements with the establishment of Medicare and Medicaid under President Lyndon B. Johnson, providing healthcare access to the elderly, low-income families, and vulnerable populations. Subsequent decades saw incremental reforms, including the Emergency Medical Treatment and Labor Act (EMTALA) in 1986, ensuring emergency care for all, regardless of ability to pay (Smith, 2023).

In 2010, the Affordable Care Act (ACA) represented the most sweeping reform in decades, expanding

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insurance coverage, protecting those with pre-existing conditions, and mandating essential health benefits. While it increased access, high costs and systemic inefficiencies persisted, leading to ongoing debates about healthcare reform. Each policy milestone reflects the nation's complex journey towards balancing access, quality, and affordability in healthcare (Smith, 2023).

Policies on Implemented on Health Care 2000-2024

2000 - Breast and Cervical Cancer Treatment and Prevention Act

In 2000, the U.S. government enacted the Breast and Cervical Cancer Treatment and Prevention Act, which allowed states to expand Medicaid coverage for uninsured women diagnosed with breast or cervical cancer through screenings conducted by the Centers for Disease Control and Prevention (CDC). This act aimed to reduce mortality rates from these cancers by providing critical access to treatment for women who might otherwise lack financial resources for care. By incorporating these services into Medicaid, the legislation targeted populations at greater risk of late-stage diagnoses due to limited healthcare access. The act was pivotal in advancing preventative healthcare services, especially for low-income women, by aligning cancer treatment with federal health support.

2002 - Health Center Growth Initiative

The Health Center Growth Initiative of 2002 focused on expanding federally funded health centers to reach medically underserved communities across the U.S. These centers, commonly located in rural and low-income urban areas, provide primary care services regardless of patients' ability to pay, offering a sliding fee scale based on income. The initiative sought to reduce healthcare disparities by improving access to basic medical care and preventive services for populations historically underserved by the healthcare system. This program was a crucial step toward reducing emergency room dependency for non-urgent care and enhancing healthcare equity.

2003 - Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 introduced substantial changes to Medicare, including the creation of Medicare Part D, which offered voluntary prescription drug coverage for seniors and disabled individuals. This program allowed beneficiaries to access discounted medications through private insurance plans approved by Medicare, addressing the high out-of-pocket costs previously faced by those relying on prescription drugs. Additionally, the MMA established Health Savings Accounts (HSAs), which allowed individuals with high-deductible health plans to set aside tax-free funds for medical expenses. Together, these provisions sought to modernize Medicare,

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alleviate drug costs, and incentivize savings for healthcare expenses.

2005 - Deficit Reduction Act

In 2005, the Deficit Reduction Act was enacted to curb federal spending, notably impacting Medicaid. The act authorized states to adjust Medicaid premiums, cost-sharing, and benefits, effectively giving states greater flexibility to manage their budgets. It introduced measures that allowed states to impose higher premiums and restrict benefits for Medicaid enrollees, especially those deemed capable of cost-sharing. As part of the act, changes to Medicare took effect in 2006, aligning Medicaid rules more closely with private insurance standards to reduce costs. The act represented a shift toward a more conservative approach to healthcare financing within public programs.

2006 - State-Level Healthcare Reforms (Massachusetts and San Francisco)

In 2006, Massachusetts introduced a landmark healthcare reform aimed at achieving near-universal coverage. This policy required all residents to obtain health insurance and provided subsidies to make coverage affordable for low- and middle-income individuals. A few months later, San Francisco implemented a similar reform through its "Healthy San Francisco" program, designed to provide universal healthcare access for city residents, though not necessarily through insurance. These reforms were pioneering at the state level, inspiring the structure of the Affordable Care Act (ACA) and underscoring state governments' role in addressing healthcare gaps and experimenting with universal coverage models.

2008 - Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 expanded on previous parity laws to mandate that group health plans offering mental health and substance use disorder benefits could not impose more restrictive limits on these services than on medical/surgical benefits. This act aimed to reduce the stigma and discrimination in healthcare coverage that often led to inadequate mental health treatment. By enforcing parity, the law sought to make mental health and substance use services more accessible and affordable, marking an important milestone in addressing mental health as an integral part of overall health.

2009 - Children's Health Insurance Program (CHIP) Reauthorization Act

The 2009 reauthorization of the Children's Health Insurance Program (CHIP) significantly increased funding, allowing states to expand coverage for uninsured children. Originally established in 1997, CHIP provides health insurance to children in low-income families who do not qualify for Medicaid but cannot

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afford private insurance. The reauthorization included measures to cover an additional four million children, focusing on preventive care, routine checkups, and access to essential health services. By boosting funding and expanding eligibility, the act aimed to reduce the number of uninsured children and support healthier developmental outcomes.

2010 - Patient Protection and Affordable Care Act (ACA)

Enacted in 2010, the Affordable Care Act (ACA) represented the most comprehensive healthcare reform since Medicare and Medicaid's establishment. The ACA required most Americans to have health insurance and provided subsidies to make coverage more affordable for low- and middle-income individuals. It expanded Medicaid eligibility in participating states and prohibited insurance providers from denying coverage due to pre-existing conditions. Additionally, the ACA allowed young adults to remain on their parents' insurance until age 26 and required essential health benefits across all insurance plans. By 2014, the individual mandate took effect, aiming to create a more inclusive insurance pool, while the act's provisions significantly reduced the uninsured rate and increased access to preventive services.

2016 - Affordable Care Act Adjustments by President Trump

In 2016, President Trump initiated adjustments to the ACA, including removing the penalties associated with the individual mandate, which had required most Americans to maintain health insurance. His administration promoted short-term, limited-duration health plans as an alternative to ACA-compliant plans, appealing to those seeking lower-cost, minimal-coverage options. Additionally, new Medicare Advantage options were introduced to offer beneficiaries increased flexibility. Transparency in healthcare pricing became a priority, along with efforts to lower Medicare Advantage premiums. These adjustments aimed to address criticisms of the ACA's affordability but raised concerns over the adequacy of coverage and long-term impacts on insurance markets.

Critics of President Trump's actions on the Affordable Care Act (ACA) highlight several key points of contention. First, the administration significantly reduced funding for ACA outreach and shortened the enrollment period, which limited public awareness and accessibility to insurance exchanges. Second, Trump's administration cut subsidies for insurance companies participating in ACA exchanges, undermining financial stability for insurers and increasing premiums. Third, it promoted alternative, lower-quality insurance plans that did not meet ACA standards, attracting healthier individuals and destabilizing the exchanges by leaving them with

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higher-risk enrollees. Fourth, the administration encouraged states to implement work requirements and other barriers for Medicaid beneficiaries, which critics argue led to decreased enrollment among eligible individuals. Fifth, a "public charge" rule discouraged legal immigrants from enrolling in Medicaid, creating additional barriers to healthcare access for vulnerable populations. Finally, the Trump administration supported a Supreme Court challenge to invalidate the ACA, aiming to dismantle the law entirely, an action that could jeopardize coverage for millions. These actions have been seen by critics as systematic attempts to weaken the ACA's foundation and accessibility (Thompson, 2020).

2020-2021 - COVID-19 Response and Health Policy Changes.

The COVID-19 pandemic led to unprecedented policy actions, including the launch of Operation Warp Speed to accelerate vaccine development and distribution. The government expanded telemedicine access, especially in rural and underserved areas, to reduce in-person visits and ensure continuity of care during lockdowns. Additionally, several emergency measures allowed for increased flexibility in Medicaid enrollment and extended insurance subsidies to mitigate the pandemic's economic impact. These policies underscored the critical role of government in addressing public health crises and highlighted telemedicine's potential in increasing healthcare accessibility.

2021-2024 - Biden Administration Initiatives

Under the Biden administration, several healthcare initiatives were introduced. The American Rescue Plan Act (ARPA) expanded ACA subsidies, making health insurance more affordable for millions of Americans, and extending temporary subsidies that had been introduced during the pandemic. The Inflation Reduction Act (IRA) continued these subsidies, encouraged states to maintain continuous Medicaid enrollment, and promoted Medicaid expansion, resulting in a reduced uninsured rate. Together, these policies aimed to solidify gains in healthcare access achieved by the ACA and address long-standing coverage gaps, particularly for low-income individuals and families.

On June 2021, the Biden administration has proposed a rule to reverse several Trump-era changes to the Affordable Care Act (ACA) marketplaces, aiming to restore protections and improve coverage access, particularly for underserved communities. Key aspects include reinstating Obama-era guidelines for Section 1332 waivers, which require states to demonstrate that their proposed changes will maintain comprehensive, affordable coverage that protects vulnerable populations—contrasting with the Trump-era relaxation of these standards. Additionally,

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the rule restricts states from using private entities for ACA enrollment, ensuring that consumers, especially those in need, can access coverage through public marketplaces. The proposed rule also repeals the Trump "two-bill" abortion policy, restoring flexibility in compliance and allowing insurers alternative ways to meet the ACA's separate premium requirement for abortion services. To expand access, the Biden administration plans to allow individuals with incomes up to 150% of the federal poverty level to enroll or switch plans monthly, a provision that complements the American Rescue Plan Act. The open enrollment period would be extended through January 15, giving people more time to adjust plans if necessary. Furthermore, increased funding for navigators would allow them to provide post-enrollment support to assist enrollees in resolving issues. Together, these changes represent a significant shift back to reinforcing ACA marketplaces, expanding outreach, and supporting vulnerable populations (Jost, 2021).

Another policy enacted by President Biden is the Inflation Reduction Act, a prescription drug law, into effect on August 16, 2022. This legislation offers substantial financial relief for millions of Medicare beneficiaries by enhancing benefits, reducing drug prices, and reinforcing Medicare's long-term sustainability.

On June 7, 2023, the U.S. House of Representatives and Senate introduced the Screening for Communities to Receive Early and Equitable Needed Services (SCREENS) for Cancer Act. This legislation aims to extend the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) through 2028. For over 30 years, the NBCCEDP has been instrumental in providing essential breast and cervical cancer screenings, follow-up care, and treatment for low-income, uninsured, and underinsured women. The SCREENS Act seeks to expand outreach efforts, helping underserved communities access these vital cancer detection services (American Cancer Society, 2023). These policies reflect an evolving U.S. healthcare landscape focused on expanding access, improving affordability, and adapting to changing health needs, such as mental health, preventative care, and public health emergencies (American Cancer Society, 2023).

On February 3, 2024, the Biden administration finalized the rolling back of Trump's rules on ACA.

METHODOLOGY

Data analysis was conducted on SPSS software by running a regression between Out-of-pocket expenditure on health which represents personal spending by individuals on health, government expenditure on health and the policies implemented from year to year but only from 2000 to 2023.

SOURCES OF DATA

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The values for the Out-of-Pocket Expenditure on Health Care were obtained from World Bank Data which indicated that this variable is the health expenditure through out-of-pocket payments per capita in USD. Out of pocket payments are spending on health directly out of pocket by households in each country. The available data from this source is from year 2000 to 2021, hence data for 2022 was obtained from CMS.gov which is the website of the Centers for Medicare & Medicaid Services and converted to per capita values. CMS reported that out of pocket spending grew 6.6% to $471.4 billion in 2022.

Note that the 2023 value is a projection obtained from Fiore et al (2024) as information for recent years are not immediately reported.

Likewise, the values of Government Expenditure on health care were obtained from World Bank Data and is described as the domestic general government health expenditure per capita, PPP (current international $), which is the public expenditure on health from domestic sources per capita expressed in international dollars at purchasing power parity, available values are from 2000-2021. In 2022, the total government expenditure is 4.465 trillion as reported by Peterson KFF Health System Tracker . Fiore et al (2024) presented an exhibit of projections in a journal publication based on data from sources such as Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, and Department of Commerce, Bureau of Economic Analysis and Census Bureau. The projection shows that in 2023, national health expenditures are projected to have totaled $4.8 trillion as growth is estimated to have accelerated to 7.5 percent (from 4.1 percent in 2022). The PPP conversion factor is constantly 1, therefore these figures were retained as they are and then divided by the population for each year.

The policies implemented on health care in the United States from 2000-2024 to be used in form of dummy variables in the analysis, were obtained from the compiled literature as referenced.

Model Specification

$$Y = \beta_o + \beta_1 X_{1t} + \beta_2 D_{it} + \beta_3 X_{3t} + \beta_4 X_{4t} + \beta_5 X_{5t} + \varepsilon_t \qquad (1)$$

Where Yt = Out-of-Pocket/capita, Xt = Government Expenditure on Health, Dit = Policies (when not implemented = 0, when implemented = 0, X3 = Inflation Rate, εt = error term

Result of Regression Analysis

Table 1.0

Model Summary[b]

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Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.998[a]	.995	.987	.0206294
a. Predictors: (Constant), TIPCG , HCGI, RMHHI, INFL , MHPAE, MMA, ACA_A, IRA, DRA, ACA, SLHR, CRHPC, CHIP_A, Government Expenditure on Health				
b. Dependent Variable: Out-of-pocket expenditure				

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.739	14	.053	123.983	<.001[b]
	Residual	.003	8	.000		
	Total	.742	22			

a. Dependent Variable: Out-of-pocket expenditure

b. Predictors: (Constant), TIPCG , HCGI, RMHHI, INFL , MHPAE, MMA, ACA_A, IRA, DRA, ACA, SLHR, CRHPC, CHIP_A, Government Expenditure on Health

Coefficientsa

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.548	2.755		.562	.590
	Government Expenditure on Health	.695	.142	1.604	4.907	.001
	HCGI	-.009	.035	-.011	-.271	.793
	MMA	.019	.030	.036	.641	.540
	DRA	-.005	.029	-.011	-.170	.869
	SLHR	-.002	.028	-.005	-.080	.938
	MHPAE	-.035	.032	-.094	-1.111	.299
	CHIP_A	.013	.040	.035	.327	.752
	ACA	-.060	.035	-.165	-1.687	.130
	ACA_A	-.028	.033	-.059	-.845	.422
	CRHPC	-.162	.055	-.304	-2.945	.019
	INFL	.017	.006	.152	2.601	.032
	IRA	-.426	.119	-.484	-3.587	.007
	RMHHI	-.041	.305	-.014	-.133	.897
	TIPCG	.001	.003	.011	.379	.715

a. Dependent Variable: Out-of-pocket expenditure

Source: SPSS Analysis run by authors

Interpretation of Results

The regression results provide insights into the impact of various factors on out-of-pocket healthcare expenditure.

The R squared value is .995 which means that the model explains 99.5% of the variation in the dependent variable (out-of-pocket expenditure on health) caused by the independent variables.

Constant: The intercept (1.548) is not statistically significant (p = 0.590), indicating that when all predictors are zero, the baseline level of out-of-pocket expenditure is not meaningfully different from zero.

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Government Expenditure on Health: This variable has a positive and statistically significant effect on out-of-pocket expenditure (B=0.695, p=0.001), when there is a unit increase ($1) in government expenditure, out-of-pocket expenditure on health will increase by 0.695 (approx. $0.69) indicating that higher government spending on health is associated with increased out-of-pocket costs. This suggests that government spending may not be sufficiently reducing individual costs.

CRHPC (COVID-19 Response and Health Policy Changes): This variable has a negative effect but reducing effect on out-of-pocket costs (B=–0.162, p=0.019), meaning it significantly reduces out-of-pocket spending. This indicates that Health Center Growth Initiative are effective in reducing the financial burden on individuals.

INFL (Inflation): Inflation has a positive effect but increasing effect on out-of-pocket expenditure (B=0.017, p=0.032), showing that as inflation rises by 1%, out-of-pocket costs also increases by $0.02. This result aligns with the understanding that inflation drives up healthcare costs.

IRA (Inflation Reduction Act): The Inflation Reduction Act has a significant and negative association with out-of-pocket costs (B=–0.426, p = 0.007), suggesting that it effectively reduces individual healthcare expenditures. Since programs cannot be measured in units, it is assumed that the existence of the program has a potential of reducing out of pocket cost at the rate of $0.43 each year.

ACA (Affordable Care Act) and ACA_A (Amended ACA): Neither ACA nor its amendments have a statistically significant impact on out-of-pocket spending in this model (p=0.130 and p=0.422, respectively), indicating their effect might be limited or inconsistent in reducing out-of-pocket costs. Nevertheless, ACA has an estimate coefficient of -.060 signifying that it has the potential of reducing out of pocket cost by $0.06 as the program continues, while ACA amended by Trump's administration had a less effective impact on out-of-pocket expenditure at –0.028 which means that it had a potential of reducing out of pocket expenditure at the rate of $0.03 per year.

Other Variables (HCGI, MMA, DRA, SLHR, MHPAE, CHIP_A, RMHHI, TIPCG): These variables do not show significant effects on out-of-pocket expenditure, as their p-values are all above 0.05, suggesting they have no meaningful impact within this model. The Health Center Growth Initiative has a potential of reducing out of pocket expenditure at the rate of $0.09 each year, the Medicare Prescription Drug, Improvement, and Modernization Act has a potential of causing an increase of approx. $0.02 each year in out-of-pocket expenditure, the Deficit Reduction Act shows a potential of reducing out of pocket expenditure which

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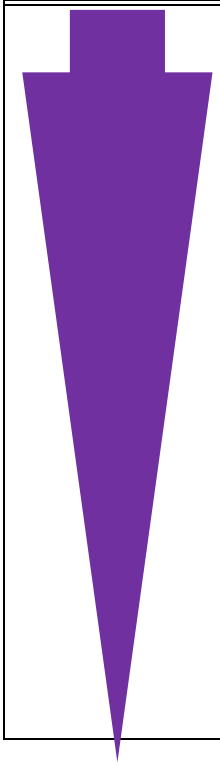
conforms to the expectation that increased government spending can lead to crowding out, in which demand will increase and then prices will eventually shoot up, but the deficit reduction act puts a limit to government spending on health.

The State-Level Healthcare Reforms are only implemented in Massachusetts and San Francisco; however, it shows a good potential at a coefficient of -0.002, showing it can reduce out of pocket expenditure if implemented nation-wide. The Mental Health Parity and Addiction Equity Act shows a potential of reducing out of pocket expenditure by $0.35, the Children's Health Insurance Program (CHIP) Reauthorization Act will cause out of pocket expenditure to increase by $0.01, The Real Medium Household Income will have a reducing impact of -.041for every unit increase in the independent variable. The Taxes on Income, Profits, & Capital Gains has an increasing but low effect on out-of-pocket expenditure at $0.001 per unit increase.

Fig. 2.0 Effectiveness Ranking of Policies and Economic Variables

Effectiveness Rank	Policies and Economic Variables
	• Inflation Reduction Act (IRA) • COVID-19 Response and Health Policy Changes (CRHPC) • Affordable Care Act (ACA) • Mental Health Parity and Addiction Equity Act (MHPAE) • State-Level Healthcare Reforms (SLHR) • Deficit Reduction Act (DRA) • Health Center Growth Initiative (HCGI) • Medicare Prescription Drug, Improvement, and Modernization Act (MMA) • Children's Health Insurance Program Reauthorization Act (CHIP_A) • Real Medium Household Income (RMHHI)

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Effectiveness Rank	Policies and Economic Variables
	• **Taxes on Income, Profits, & Capital Gains (TIPCG)**

Source: Composed based on the Details of the Regression Result

RECOMMENDATIONS

Based on the results, it is recommendable to continue and strengthen government actions and policies implemented during the period of COVID break out, as well as the Inflation Reduction Act: Both the COVID-19 Response and Health Policy Changes (CRHPC) and the Inflation Reduction Act (IRA) as variables have shown significant reductions in out-of-pocket costs. Efforts should focus on maintaining and possibly expanding these programs to maximize their cost-reducing effects.

It is necessary to reassess Government Health Expenditure Allocation because despite high spending, government expenditure on health appears to increase out-of-pocket costs, possibly due to inefficiencies. A detailed review of fund allocation and spending efficiency could help redirect resources to areas with direct impacts on reducing individual expenses. This could also be ascribed to the common effect of government spending which is inflation.

It will be beneficial to expand ACA's Cost-Reduction Potential. Although not statistically significant, the Affordable Care Act (ACA) shows potential in lowering out-of-pocket expenses. Future modifications could strengthen its effectiveness, particularly by enhancing provisions that directly reduce individual costs.

To address inflation impact since it correlates with higher out-of-pocket costs, policies focusing on price regulation in healthcare, especially in high-cost areas like pharmaceuticals and hospital services, could help mitigate inflation's effect on consumer expenses.

Policies with minimal or no statistically significant impact on reducing out-of-pocket costs, such as CHIP_A may need reevaluation or restructuring.

Overall, efforts should prioritize cost-reducing policies like the Inflation Reduction Act (IRA) and COVID-19 Response and Health Policy Changes (CRHPC), which have demonstrated effective reductions in out-of-pocket expenses. Additionally, exploring strategies to manage inflationary pressures in healthcare could further help contain rising costs for individuals.

CONCLUSION

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The purpose of the research is to identify which policies have a reducing effect on out-of-pocket healthcare expenditures borne by individuals in the United States. The findings show that not all health policies are equally effective in reducing out-of-pocket costs, and a targeted approach is essential. Policies like the Inflation Reduction Act (IRA), COVID-19 Response and Health Policy Changes (CRHPC), Affordable Care Act (ACA), and Mental Health Parity and Addiction Equity Act (MHPAE) demonstrate measurable success in alleviating out-of-pocket costs for individuals. In contrast, other programs, such as the Children's Health Insurance Program Reauthorization Act (CHIP_A) and the Health Center Growth Initiative (HCGI), may benefit from resource reallocation to more impactful initiatives. Inflation control measures in healthcare, alongside expanded state-level and mental health reforms, would further ensure that U.S. health policy effectively addresses affordability challenges for individuals. Continued focus on proven cost-reduction policies will lead to a more sustainable and equitable healthcare system for all. The significance of this research is grounded in the premise that health should be considered a fundamental right, and under this premise, public policies should be designed to ensure universal access to healthcare.

This paper represents the initial phase of research aimed at developing improved health policies in the United States. The subsequent phase will involve an in-depth investigation into the deliberate inflation of prescription drug and treatment costs, with the objective of examining the potential collusion among business entities, pharmaceutical manufacturers, and medical practitioners. The ultimate goal of the second phase is to propose policy frameworks designed to prevent and mitigate intentional price manipulation in the healthcare sector.

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