

The Effects of Universal Health Coverage: Evidence from Georgia*

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Abstract

In 2010, less than a third of the population of Georgia had some form of health insurance coverage. The expansion of the Medical Assistance for the Poor (MAP) program in 2012 and the implementation of the Universal Health Coverage Program (UHCP) in 2013 extended health insurance coverage to those who were previously uninsured. This paper examines how these expansions of public health insurance coverage affected newly insured households, focusing on the health care, education, and food shares of total household consumption spending, the incidence of catastrophic health spending, and household-level measures of health care utilization. Using biennial panel data from UNICEF Georgia's Welfare Monitoring Survey, we find mixed evidence of a positive association between the household-level health insurance coverage rate and inpatient care utilization. We find no evidence of an impact of health insurance coverage on the health care share of total household consumption spending or on the incidence of catastrophic health spending. However, we find weak evidence that health insurance coverage is associated with a slightly higher food share of household expenditures and slightly higher education spending among households with children.

Keywords: Universal health coverage, catastrophic health spending, financial risk protection, public health insurance expansions, inpatient care, outpatient care, essential benefits coverage, Georgia

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1. Introduction

One of the Sustainable Development Goals of the United Nations is the achievement of universal health coverage, which includes “...financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (UN General Assembly, 2015).¹ The two indicators for tracking universal health coverage at the country level are “coverage of essential health services” and the “proportion of [a country’s] population with large household expenditures on health as a share of total household expenditure or income” (UN General Assembly, 2017). When the latter indicator exceeds 10%, health spending is commonly viewed as being “catastrophic.”

One country where the annual incidence of catastrophic health spending has been particularly high in recent years is Georgia. According to the World Bank’s Health Equity and Financial Protection indicators, between 2009 and 2013, more than a quarter of the population of Georgia spent more than 10% of total household consumption on health care. This figure far exceeds the global incidence of catastrophic health spending, which was estimated to be 11.7% in 2010 (Wagstaff et al., 2018b). In fact, the World Bank’s Health Equity and Financial Protection indicators suggest that Georgia had the highest incidence of catastrophic health spending in the world between 2009 and 2013, at least among those countries for which survey figures were available (Wagstaff et al., 2018a). As we report below, the most recent data from UNICEF Georgia’s Welfare Monitoring Survey suggest that the incidence of catastrophic health spending has increased over time, even though coverage of essential health care services has improved in recent years with a series of public health insurance expansions. Thus, we believe that Georgia offers an excellent case study regarding the effects of public health insurance expansions, one which ultimately points to the necessity of greater depth of coverage.

¹ All members of the United Nations have committed to achieving this goal by 2030.

In this paper, we examine how the expansion of Georgia’s Medical Insurance for the Poor (MAP) program in 2012 and the implementation of the Universal Health Coverage Program (UHCP) in 2013 have affected access to (and utilization of) inpatient and outpatient care services, the health care, education, and food shares of total household consumption spending, and the incidence of catastrophic health spending among newly insured households.² Using biennial household-level panel data from UNICEF Georgia’s Welfare Monitoring Survey, we find that the household-level health insurance coverage rate is associated with an increased likelihood of applying for inpatient care, and, in some specifications, increased utilization of inpatient care. We find no evidence that health insurance coverage is associated with a lower health care share of total household consumption spending or a lower incidence of catastrophic health spending. However, we find weak evidence that health insurance coverage is associated with a slightly higher food share of household expenditures and slightly higher education spending among households with children. Surprisingly, we only find evidence of an impact of health insurance on utilization of outpatient care when the time period is restricted to 2011-2015 (rather than 2011-2017). Lastly, we find no evidence of an effect of health insurance on purchases of medicines, which is consistent with the design of the UHCP, given that most medicines purchased at retail pharmacies were not covered as part of the benefits package, at least until 2017, when some were (for those eligible).

This study contributes to the literature on the economics of public health insurance expansions (see, e.g., Sloan, Mitchell, and Cromwell, 1978 and Garthwaite, 2012).³ Much of this literature has examined the effects of Medicaid expansion in the United States.⁴ However, researchers have also examined the effects of public health insurance expansions in Georgia. For instance, Bauhoff,

² We also estimate the effects of health insurance for the full population.

³ Our research also contributes to the literature on catastrophic health spending (see, e.g., Wagstaff et al., 2018b).

⁴ See Antonisse et al. (2018) for a review of this literature; Gruber and Sommers (2019) also assess the effects of the Affordable Care Act in general.

Hotchkiss, and Smith (2011) use a regression discontinuity design to examine the effects of the MAP. They find that the program reduced out-of-pocket spending on health care (on inpatient services, in particular) for certain groups. However, they find no evidence that the program affected health care utilization, health behavior, patient satisfaction, or the management of chronic illnesses.

This paper proceeds as follows. Section 2 discusses the evolution of private and public health insurance coverage in Georgia in recent years. Section 3 introduces the data from UNICEF Georgia's Welfare Monitoring Survey and Section 4 presents our household fixed effects panel regression model. The regression results are discussed in Section 5. In Section 6, we consider the implications of the main findings and discuss areas for future research. Section 7 concludes the paper.

2. Background

Over the past two and a half decades, out-of-pocket health expenditure (as a percentage of total health expenditure) in Georgia has fallen considerably. According to data from the World Health Organization, in 2000, 77.4% of health expenses were paid out-of-pocket. Yet even with (modest) growth in employer-sponsored health insurance in the 2000s and the introduction of the Medical Assistance for the Poor (MAP) program for eligible groups in 2006 (and its subsequent extension of coverage to select groups in 2012), the out-of-pocket share of total health expenditure remained above 60% between 2000 and 2014. It only fell below 60% for the first time in 2015 (to 57.3%), following the introduction of the UHCP in 2013.⁵

Despite the progress that has been made in reducing out-of-pocket expenditure over the past two decades, the incidence of catastrophic health spending remains alarmingly high, and Georgia

⁵ In particular, out-of-pocket expenditure as a percentage of total health expenditure declined from 69.1% in 2013 to 57.3% in 2015, while government health expenditure as a percentage of total expenditure rose from 22.9% to 38.8% over the same time period, according to the most recent figures from the World Health Organization. Notably, the health care share of GDP fell from 8.4% in 2013 to 7.9% to 2015.

appears to be an outlier relative to other countries in Central and Eastern Europe with regard to the share of total health care expenditure that is paid out-of-pocket (Thomson, Cylus, and Evetovits, 2019). Out-of-pocket expenditure on drugs purchased at retail pharmacies is particularly high (UNICEF Georgia, 2017).

Prior to the introduction of the Universal Health Coverage Program (UHCP) in 2013, most of the population did not have health insurance coverage.⁶ According to the 2011 wave of the UNICEF Welfare Monitoring Survey, around 27% of the population had been covered by the Medical Assistance for the Poor (MAP) program, and a much smaller percentage had employer-sponsored health insurance coverage. Consequently, most health expenditures were paid out-of-pocket. The MAP was extended to around 45% of the population in September 2012, prior to parliamentary elections which saw a new government come into power (Richardson and Berdzuli, 2018).

The introduction of the UHCP by the newly elected government constituted a major expansion in public health insurance coverage. During the first stage of the program, starting from February 28, 2013, the government financed primary care services and inpatient/outpatient emergency care services for those who were enrolled in the program. This had an immediate impact on outpatient utilization in the aggregate, as “1,347,658 people were registered for scheduled outpatient and polyclinic services from February 28 until July 1” (MoLHSA Annual Report, 2013). During the second stage of the program, starting from July 1, 2013, the government started covering expanded coverage to planned surgeries, cancer treatments, and child deliveries. By 2014, the health services coverage rate reached 99.9% of the population (for those health services included in the package of benefits), according to the Health Utilization and Expenditure Survey (National Center for Disease Control and Public Health, 2018).

⁶ Gilauri (2017: p. 149) notes that less than one percent of the population had some form of health insurance coverage in 2006.

One noteworthy feature of the UHCP was how it led to a sharp decline in the number of policies issued via private health insurance companies. Rather than finance health care through a voucher system (as had been done with the MAP for the payment of private health insurance premiums), the new government decided to finance health care directly via the Social Services Agency (SSA) of the Ministry of Labor, Health, and Social Affairs.⁷ While nearly two million policies were issued by private health insurance companies at the end of 2013, only 540,000 policies were issued privately (in total) one year later, according to figures compiled by the Insurance State Supervision Service of Georgia.

3. Data

In order to examine the effects of health insurance coverage on newly insured households, we use restricted-use panel data based on the 2011, 2013, 2015, and 2017 waves of UNICEF Georgia's Welfare Monitoring Survey (WMS).⁸ The majority (57.8%) of households in the 2011 wave of the survey remain in the panel over time. Of those households remaining in the panel across the four waves of the WMS, 56.5% did not have any form of health insurance in 2011; 43.5% of households had at least one member with some form of health insurance coverage. The former households are referred to as "newly insured households" throughout this paper.

The summary statistics for our variables are presented in Table 1 (and Table 2 for the newly insured households) in the Appendix. For the newly insured households in the panel, the average health care share of total household expenditure fell from 8.8% in 2011 to 7.0% in 2013 with the

⁷ As noted by Richardson and Berdzuli (2017), the SSA now reimburses providers according to a fixed price list, though pharmaceutical prices are not set (or regulated) by the government. Previously, private health insurers had negotiated reimbursement rates with providers individually. Under the UHCP, official patient cost sharing varies by service and by coverage group (see Table 3.2: "Summary Table of UHCP Benefits and User Charges, December 2017" in Richardson and Berdzuli, 2017).

⁸ The survey covers all regions controlled by the government of Georgia. See UNICEF Georgia and ACT (2018) for a complete description of the survey methodology.

expansion of the MAP and implementation of the UHCP, but *rose* to 8.8% in 2015 and to 10.2% in 2017.⁹ Similar trends are observed for the median health care share of total household expenditure (for both the newly insured households and the full panel of households). The incidence of catastrophic health spending (using the 10% threshold) also fell significantly from 2011 to 2013, but then rose significantly from 2013 to 2015 and from 2015 to 2017, as shown in Figures 1 and 2.¹⁰ This provides *prima facie* evidence that the UHCP did not provide sufficient coverage to reduce the incidence of catastrophic health spending—one of the main indicators for the achievement of universal health coverage—mostly because of the program’s limited drug coverage; in 2017, spending on medicines purchased at retail pharmacies comprised more than two thirds of all out-of-pocket health-related expenditures (UNICEF Georgia and ACT, 2018).

4. Methods

We estimate how the household-level health insurance coverage rate is associated with a variety of aggregated, household-level outcomes related to access to, utilization of, and out-of-pocket spending on health care (along with self-assessed health status). By examining the association between health insurance coverage and several outcomes related to health and health care utilization, we are able to shed light on the effects of the expansion of the MAP and the rollout of the UHCP. We focus primarily on newly insured households, given non-random selection into health insurance coverage.¹¹

The outcome variables of interest include average outpatient application (where 0 = “did not apply for care” and 1 = “did apply”) and average outpatient care utilization (the number of visits),

⁹ Across the full panel, the average health care share of total household expenditure also fell from 8.8% in 2011 to 7.2% in 2013 and rose to 9.4% in 2015 and to 10.4% in 2017.

¹⁰ This may be partly due to the fact that the prices of medicines increased markedly over that time period (UNICEF Georgia, 2017), and select medicines were only included in the benefits package as of 2017.

¹¹ The newly insured households are different from households that previously had health insurance coverage under the MAP program, had employer-sponsored health insurance coverage, or purchased health insurance on their own.

average inpatient application (where 0 = “did not apply for care” and 1 = “did apply”) and the average number of inpatient admissions, average purchases of medicines (where 0 = “did not purchase” and 1 = “did purchase”), and average self-assessed health status (where 1 = “very bad” ... 5 = “very good”).¹² Note that “application” refers to whether an individual visited the doctor’s office or the hospital, for example. We also estimate the impact of health insurance coverage on the health care share of total household consumption expenditure and on catastrophic health expenditure.¹³

To examine whether (or how) the above outcomes are associated with the household-level health insurance coverage rate, we estimate the following household fixed effects panel regression model:

$$Y_{ht} = \beta_{HI}HI_{ht} + C'_{ht}\gamma + \delta_h + \theta_t + \varepsilon_{ht}$$

where

- Y_{ht} is the outcome of interest for household h in year t
- HI_{ht} is the household health insurance coverage rate in year t
- C_{ht} is a vector of additional household-level covariates
- δ_h is a household fixed effect
- θ_t is a time fixed effect
- ε_{ht} is the error term, with standard errors clustered at the survey cluster level

We also explore whether there are any heterogeneous effects of health insurance coverage. For instance, we would like to examine whether increased eligibility for the MAP and the rollout of the UHCP affected those living in Tbilisi (the capital city), in an urban area in general, or in a mountainous region (rather than in a lowland region) differently. It is also important to know whether health insurance coverage affects spending on non-health care goods and services (e.g., education, for those households with children, or food for all households).

¹² We also constructed a measure, “in good health,” which takes on a value of 1 if the individual is reported to be in “good” or “very good” health, and 0 otherwise. In the interest of space, the results are not reported here, but they are qualitatively the same as the average self-assessed health status variable.

¹³ Health spending is “catastrophic” if the health care share of total annual household consumption expenditure exceeds 10%.

To address these questions, we also estimate the following household fixed effects panel regression model:

$$Y_{ht} = \beta_1 HI_{ht} + \beta_2 HI_{ht} \times I_{ht} + C'_{ht} \gamma + \delta_h + \theta_t + \varepsilon_{ht}$$

where

- I_{ht} is the (time-invariant) indicator variable of interest for the interaction term
- $HI_{ht} \times I_{ht}$ is the interaction term of interest
- $\beta_1 + \beta_2$ is the effect of health insurance coverage (for different groups)

Lastly, we consider the association between the household health insurance coverage rate and health care utilization (or health care expenditure) for the full panel—that is, newly insured households and households that had at least one member with some form of health insurance coverage in 2011. However, these estimates should not be interpreted causally, given the non-random assignment of health insurance coverage.

5. Results

In this section, we will first present the panel estimations of the effects of health insurance on health services utilization between 2011 and 2015. We will then extend the time period to include 2017 as well. We distinguish between the two periods for several reasons. First, we would like to examine the immediate effects of the expansion of public health insurance (up until 2015) and to further estimate the panel regressions up until 2017 to evaluate whether the effects of the UHCP have lasted over time. It is also important to examine the time periods separately because there was a significant depreciation of the Georgian currency (the lari) from 2015 onwards, which led to higher prices for imported goods (including medicines).¹⁴ The depreciation of the lari also contributed to lower household consumption expenditures and higher poverty rates between 2015 and 2017 (UNICEF Georgia and ACT, 2018).

¹⁴ Between July 2015 and July 2017, the health component of the consumer price index increased by 11.3%, compared to an overall consumer price inflation rate of 7.6% (UNICEF Georgia and ACT, 2018).

Lastly, in 2017, the government announced that those with incomes above a certain threshold would be excluded from UHCP coverage starting in July 2017 (Richardson and Berdzuli, 2018). Around 43,000 people were subsequently dropped from the program.¹⁵

The average likelihood of outpatient application (shown in Columns 1 and 2 of Tables 3 and 4) increased significantly with health insurance coverage across the households between 2011 and 2015, after controlling for household size, average age in the household, year fixed effects and household fixed effects. However, we find no evidence of an association between the health insurance coverage rate and the number of outpatient visits. Our estimates also suggest that the health insurance coverage rate is positively associated with the average likelihood of inpatient care application, though we find mixed evidence of an effect on the average number of inpatient admissions. Consistent with the fact that UHCP didn't cover purchases of medicines (until 2017, when select medications were financed by the government for certain groups), we find no evidence of an impact of health insurance coverage on this variable across the board.

In Tables 6 and 7, we report the panel regression estimates regarding the association between the health insurance coverage rate and the health care share of total consumption expenditure, the incidence of catastrophic health spending, and (household average) self-assessed health status. We find no evidence that the health insurance coverage rate is associated with the health care share of total household consumption spending, or with the incidence of catastrophic health spending. The lack of evidence of an effect of health insurance coverage on self-assessed health status may be due to the lagged effects of the program, or due to the fact that self-assessed health status is not significantly influenced by the provision of health insurance coverage (as other factors may be more important, including age, gender, socioeconomic factors, behavioral risk factors, etc.). Still, the lack of

¹⁵ The fifth wave of the Welfare Monitoring Survey was conducted from July-August 2017.

evidence of an effect of the UHCP on self-assessed health status is worrying considering that Georgia has the worst self-assessed health outcomes in the transition region (EBRD, 2016).

Somewhat surprisingly, we find no evidence of differential effects of health insurance for those households in Tbilisi, in an urban area, or in a mountainous region.¹⁶ This is consistent with the results presented by UNICEF Georgia and ACT (2018, p. 116), which suggest that “the difference in total spending on healthcare between urban and rural parts of the country is not significant, though there are differences in spending on particular services.”

In Tables 15 and 16, we report the estimated impact of health insurance coverage on non-health related household expenditures for the newly insured population (Table 15) and the total population (Table 16). We find that there is a positive impact of health insurance on the education share of household expenditure as the number of children in the household increases (see Column 1 of Tables 15 and 16), though the estimated effect is only weakly statistically significant when restricting the sample to newly insured households. Interestingly, the impact of the number of children on this outcome is negative, possibly due to the fact that households with a large number of children have much higher total expenditures. However, these households benefit from having health insurance coverage and are able to spend more on education. Next, we look into other types of household expenditures, including the food share, outside food share, and nonfood share of total expenditure (Columns 2-4 of Tables 15 and 16). We find that having health insurance is associated with increases in the food share of total household expenditure, though once again the estimated effect is only weakly statistically significant in the first regression.

¹⁶ The estimated effects of health insurance coverage on inpatient utilization for newly insured households remain statistically significant. In the interest of space, these results are not presented below, but are available from the authors upon request.

5.1. Limitations

While it would be ideal to examine how health insurance coverage is associated with individual-level health outcomes by using within-individual variation in health insurance coverage, the individuals within each household are not matched in the household panel data. Thus, we use aggregated, household-level information on health insurance coverage, health care utilization, and health care expenditure.

Another limitation of this study is that the health insurance coverage rate is self-reported. While all individuals/households were eligible for the UHCP (at least until 2017), some respondents reported that they did *not* have any form of health insurance coverage (UNICEF Georgia and ACT, 2018).

Regarding the results for the full panel, it should be noted that health insurance coverage was not randomly assigned. That is, those households that previously had health insurance coverage had it because it was assigned to them by the government (on a means-tested basis, via the previous health insurance program, the MAP), or because they received health insurance coverage through their employer (or purchased it on their own).

6. Discussion

Immediately after the expansion of the MAP and the rollout of the UHCP, up until 2015, we do find evidence of a significant impact of health insurance coverage on the likelihood of applying for outpatient care (e.g., going to the doctor's office), both for newly insured households and for the general population. However, once we expand the estimations to include 2017, we do not find any evidence of an effect of health insurance on outpatient care utilization, which is rather surprising considering that outpatient utilization rose in the aggregate.

As noted by the Ministry of Labor, Health, and Social Affairs of Georgia in its 2013 Annual Report,

At the beginning of 2013, only half of the population of Georgia was insured under the state insurance [program]. Another half had to pay the full cost of the medical care from their own pockets, which led to extremely high expenses, poverty and accumulation of debts. In most cases, these people could not afford medical care and applied to the doctor only in extreme necessity.

However, over time, it appears that patients were encouraged to use emergency inpatient care services more frequently than outpatient care services. Further, there may have been concerns about the quality of outpatient care (see Lomsadze, 2018).

While these findings are important considering the recent rollout of the UHCP across the country, many questions remain. For example, with fixed provider reimbursement rates set by the government, and limited polyclinic and hospital capacity, what happens when most of the population becomes insured in a relatively short period of time? One area for future research is examining whether the rollout of the UHCP had any displacement effects (regarding those who were previously insured), given the likely limited supply response. It would also be important to investigate whether the UHCP led to longer wait times for inpatient or outpatient care. Researchers could also consider the fiscal sustainability of the UHCP, given concerns about the cost of the program for the government (see Ellena, 2015 and Ergeshidze, 2015 for more).

7. Conclusion

How do different public health insurance programs affect access to, utilization of, and out-of-pocket spending on health care? What must be done to ensure that health care reforms lead to the achievement of universal health coverage, which is one of the Sustainable Development Goals of the United Nations? It is crucial that policymakers in low- and middle-income countries know the answers to these questions.

This paper considers the case of Georgia, focusing on the effects of a series of expansions of public health insurance coverage on newly insured households. Using biennial panel data from UNICEF Georgia’s Welfare Monitoring Survey, we find mixed evidence that the expansion of public health insurance coverage led to an increase in inpatient care utilization. However, we find no evidence that it affected the incidence of catastrophic health spending; indeed, the annual incidence of catastrophic health spending actually *increased* between 2011 and 2017. Interestingly, we also find limited evidence of an impact of health insurance on outpatient care utilization, which may be indicative of incentives that encourage inpatient care utilization over (less-costly) outpatient care.

It is notable that even with the UHCP in place, Georgia still has an extraordinarily high incidence of catastrophic spending on health (World Health Organization, 2018), mostly due to the fact that medicines were not included in the benefits package of the UHCP until 2017, when the government started covering certain medications for select groups (UNICEF Georgia, 2017).

Given that Georgia has one of the highest rates of incidence of catastrophic health spending in the world, much more needs to be done in order to reach the Sustainable Development Goal of universal health coverage by 2030, particularly with regard to reducing out-of-pocket costs for essential medicines. While the Ministry of Health, Labor, and Social Affairs has recently taken steps to improve the affordability of certain generic medicines, international donors should also focus their efforts on improving the affordability of drugs purchased at retail pharmacies.¹⁷

¹⁷The Ministry of Labor, Health, and Social Affairs recently announced that the copayments for drugs used to treat chronic diseases (including cardiovascular diseases, lung diseases, thyroid gland diseases, and type 2 diabetes) would be capped at one lari for socially vulnerable persons (Ministry of Labor, Health, and Social Affairs, 2019).

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Figure 1: Annual Incidence of Catastrophic Health Spending Among Newly Insured Households

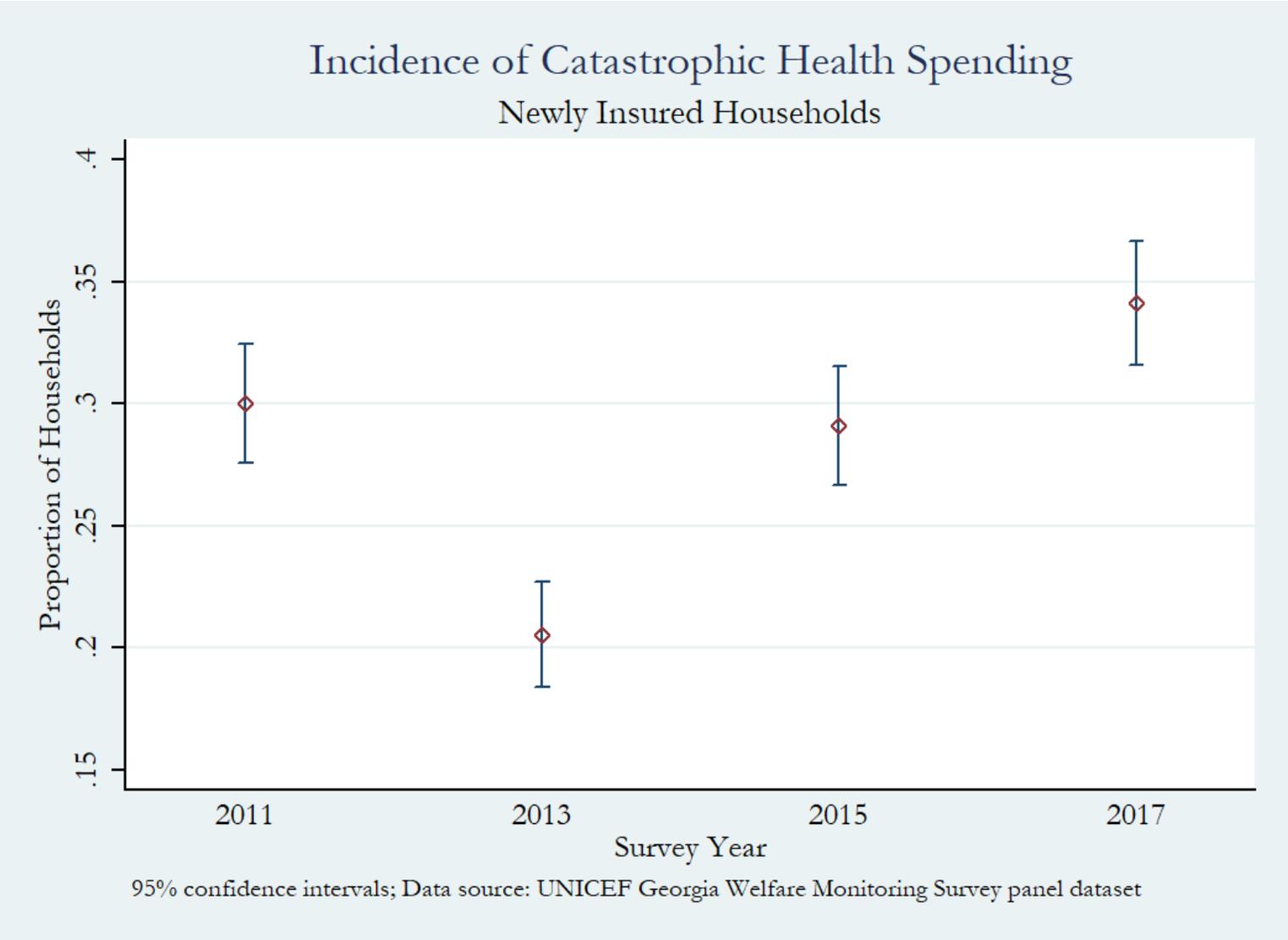


Figure 2: Annual Incidence of Catastrophic Health Spending Among All Households

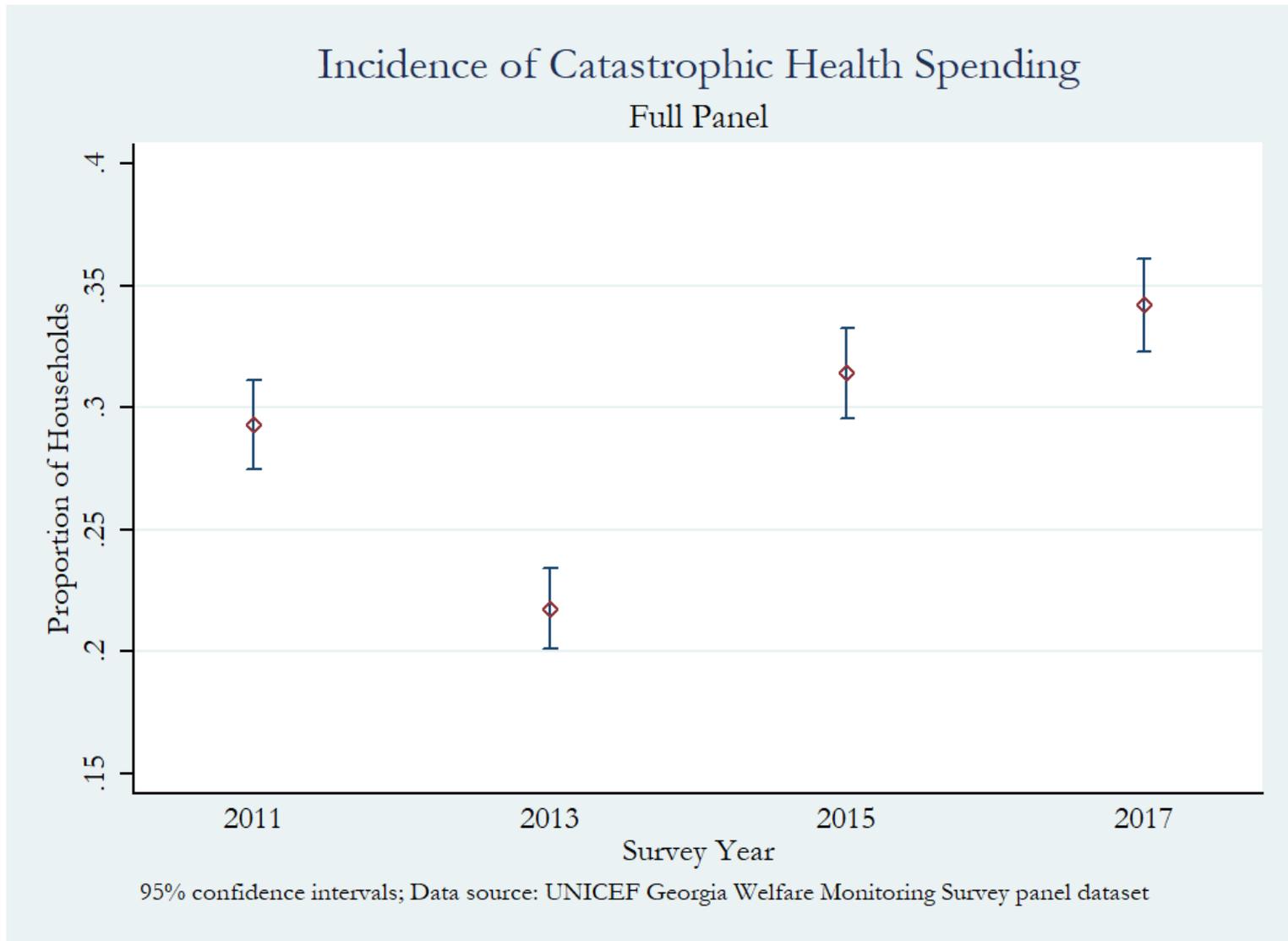


Table 1: Summary Statistics (Full Panel)

Variable	N	Mean	Std. Dev.	Min	Max	Median
Health Insurance Coverage Rate	9,582	0.789	0.393	0	1	1
Newly Insured Household	9,584	0.565	0.496	0	1	1
Household in Mountainous Region	9,584	0.118	0.323	0	1	0
Household Size	9,584	3.687	1.981	1	18	3
Average Health Status (HH)	9,582	3.162	0.818	1	5	3.250
In Good Health (Average, HH)	9,582	0.433	0.362	0	1	0.500
Average Age (HH)	9,582	47.40	16.96	9.667	96	43.83
Outpatient Application	9,582	0.164	0.268	0	1	0
Outpatient Visits	9,582	0.289	0.709	0	15	0
Purchased Medicine	9,582	0.393	0.345	0	1	0.333
Inpatient Application	9,582	0.0516	0.148	0	1	0
Inpatient Admissions	9,582	0.140	0.792	0	32.50	0
Household in Tbilisi	9,584	0.0601	0.238	0	1	0
Household in an Urban Area	9,584	0.252	0.434	0	1	0
Health Spending/Total Consumption Expenditure (%)	9,580	8.957	10.76	0	93.23	5.182
Non-Medicine Health Spending/Total Consumption Expenditure (%)	9,580	2.655	6.400	0	84.84	0
Catastrophic Health Care Expenditure (10%)	9,580	0.292	0.455	0	1	0
Catastrophic Health Care Expenditure (25%)	9,580	0.0815	0.274	0	1	0

Table 2: Summary Statistics (Newly Insured Households)

Variable	N	Mean	Std. Dev.	Min	Max	Median
Health Insurance Coverage Rate	5,416	0.691	0.456	0	1	1
Household in Mountainous Region	5,416	0.113	0.317	0	1	0
Household Size	5,416	3.681	1.978	1	18	3
Average Health Status (HH)	5,416	3.208	0.795	1	5	3.333
In Good Health (Average, HH)	5,416	0.445	0.362	0	1	0.500
Average Age (HH)	5,416	47.48	16.37	9.667	92	44.50
Outpatient Application	5,416	0.155	0.261	0	1	0
Outpatient Visits	5,416	0.273	0.708	0	15	0
Purchased Medicine	5,416	0.388	0.342	0	1	0.333
Inpatient Application	5,416	0.0458	0.139	0	1	0
Inpatient Admissions	5,416	0.133	0.810	0	32.50	0
Household in Tbilisi	5,416	0.0510	0.220	0	1	0
Household in an Urban Area	5,416	0.246	0.431	0	1	0
Health Spending/Total Consumption Expenditure (%)	5,415	8.724	10.55	0	82.87	5.062
Non-Medicine Health Spending/Total Consumption Expenditure (%)	5,415	2.903	6.747	0	80.11	0.190
Catastrophic Health Care Expenditure (10%)	5,415	0.284	0.451	0	1	0
Catastrophic Health Care Expenditure (25%)	5,415	0.0774	0.267	0	1	0

**Table 3: Household Fixed Effects Panel Regression Estimates:
Health Care Utilization by Newly Insured Households, 2011-2015**

	(1)	(2)	(3)	(4)	(5)
	Outpatient Application	Outpatient Visits	Inpatient Application	Inpatient Admissions	Purchases of Medicines
Health Insurance Coverage Rate	0.0557** (0.0269)	0.0276 (0.0615)	0.0439*** (0.0134)	0.0946* (0.0513)	0.00951 (0.0364)
2013	-0.0439 (0.0287)	-0.0235 (0.0675)	-0.0413*** (0.0140)	0.0110 (0.0621)	0.0243 (0.0389)
2015	-0.0122 (0.0260)	-0.0322 (0.0586)	-0.0143 (0.0119)	0.00827 (0.0382)	0.0356 (0.0351)
Constant	0.148*** (0.00579)	0.301*** (0.0178)	0.0348*** (0.00283)	0.0575*** (0.0120)	0.357*** (0.00701)
Observations	4,062	4,062	4,062	4,062	4,062
R-squared	0.008	0.000	0.015	0.008	0.007
Number of hhid	1,354	1,354	1,354	1,354	1,354

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 4: Household Fixed Effects Panel Regression Estimates:
Health Care Utilization by Newly Insured Households, 2011-2015 (With Controls)**

	(1)	(2)	(3)	(4)	(5)
	Outpatient Application	Outpatient Visits	Inpatient Application	Inpatient Admissions	Purchases of Medicines
Health Insurance Coverage Rate	0.0553** (0.0266)	0.0248 (0.0609)	0.0405*** (0.0132)	0.0728 (0.0488)	0.0178 (0.0352)
Household Size	-0.00202 (0.00536)	0.00250 (0.0155)	0.00182 (0.00302)	-0.00409 (0.0139)	-0.0188*** (0.00628)
Average Age (HH-Level)	-0.00286 (0.00364)	-0.00658 (0.00965)	-0.00485*** (0.00178)	-0.0352*** (0.0118)	0.00241 (0.00353)
Age Squared	6.31e-05* (3.73e-05)	0.000142 (9.80e-05)	5.28e-05*** (1.88e-05)	0.000345*** (0.000119)	6.75e-05* (3.50e-05)
2013	-0.0491* (0.0283)	-0.0327 (0.0668)	-0.0386*** (0.0140)	0.0325 (0.0613)	0.000492 (0.0376)
2015	-0.0198 (0.0256)	-0.0465 (0.0583)	-0.0119 (0.0120)	0.0292 (0.0380)	0.00540 (0.0341)
Constant	0.139 (0.0881)	0.261 (0.249)	0.126*** (0.0452)	0.877*** (0.306)	0.162* (0.0936)
Observations	4,062	4,062	4,062	4,062	4,062
R-squared	0.021	0.006	0.019	0.013	0.092
Number of hhid	1,354	1,354	1,354	1,354	1,354

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 5: Household Fixed Effects Panel Regression Estimates:
Health Care Utilization by Newly Insured Households, 2011-2017 (With Controls)**

	(1)	(2)	(3)	(4)	(5)
	Outpatient Application	Outpatient Visits	Inpatient Application	Inpatient Admissions	Purchases of Medicines
Health Insurance Coverage Rate	0.0214 (0.0169)	-0.0300 (0.0413)	0.0233*** (0.00865)	0.0973*** (0.0369)	-0.00657 (0.0236)
Household Size	-0.00820** (0.00392)	-0.00893 (0.0111)	-0.00136 (0.00215)	-0.00955 (0.0111)	-0.0273*** (0.00506)
Average Age (HH-Level)	-0.00517** (0.00247)	-0.00681 (0.00701)	-0.00485*** (0.00157)	-0.0217*** (0.00836)	-0.00456 (0.00292)
Age Squared	7.04e-05*** (2.56e-05)	0.000126* (7.46e-05)	5.23e-05*** (1.52e-05)	0.000229*** (7.91e-05)	0.000131*** (2.94e-05)
2013	-0.0134 (0.0196)	0.0241 (0.0475)	-0.0216** (0.00995)	0.00516 (0.0445)	0.0250 (0.0247)
2015	0.0136 (0.0181)	0.00593 (0.0453)	0.00334 (0.00866)	0.00213 (0.0326)	0.0279 (0.0237)
2017	-0.0502*** (0.0174)	-0.110** (0.0433)	-0.00619 (0.00897)	0.00893 (0.0329)	0.00823 (0.0232)
Constant	0.251*** (0.0618)	0.353** (0.170)	0.139*** (0.0407)	0.552** (0.235)	0.365*** (0.0753)
Observations	5,416	5,416	5,416	5,416	5,416
R-squared	0.022	0.013	0.015	0.008	0.111
Number of hhid	1,354	1,354	1,354	1,354	1,354

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 6: Household Fixed Effects Panel Regression Estimates:
Health Care Spending and Health Status for Newly Insured Households, 2011-2015**

	(1) Health Care Share of Total Consumption Expenditure (%)	(2) Catastrophic Health Spending	(3) Health Status
Health Insurance Coverage Rate	1.257 (0.986)	0.0584 (0.0449)	-0.0576 (0.0819)
2013	-3.119*** (1.095)	-0.153*** (0.0491)	0.0894 (0.0847)
2015	-1.122 (0.951)	-0.0617 (0.0431)	0.120 (0.0769)
Constant	8.834*** (0.226)	0.300*** (0.0102)	3.154*** (0.0172)
Observations	4,061	4,061	4,062
R-squared	0.015	0.017	0.003
Number of hhid	1,354	1,354	1,354

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 7: Household Fixed Effects Panel Regression Estimates:
Health Care Spending and Health Status for Newly Insured Households, 2011-2015 (With Controls)**

	(1) Health Care Share of Total Consumption Expenditure (%)	(2) Catastrophic Health Spending	(3) Health Status
Health Insurance Coverage Rate	0.957 (0.952)	0.0420 (0.0436)	-0.0851 (0.0808)
Household Size	0.692*** (0.219)	0.0298*** (0.0114)	0.0348** (0.0163)
Average Age (HH-Level)	-0.286** (0.124)	-0.0178*** (0.00594)	-0.0183** (0.00832)
Age Squared	0.00440*** (0.00120)	0.000247*** (5.73e-05)	-0.000112 (8.14e-05)
2013	-3.026*** (1.067)	-0.146*** (0.0479)	0.165* (0.0853)
2015	-1.115 (0.930)	-0.0589 (0.0421)	0.214*** (0.0787)
Constant	8.975*** (3.435)	0.422** (0.169)	4.114*** (0.239)
Observations	4,061	4,061	4,062
R-squared	0.029	0.034	0.147
Number of hhid	1,354	1,354	1,354

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 8: Household Fixed Effects Panel Regression Estimates:
Health Care Spending and Health Status for Newly Insured Households, 2011-2017 (With Controls)**

	(1) Health Care Share of Total Consumption Expenditure (%)	(2) Catastrophic Health Spending	(3) Health Status
Health Insurance Coverage Rate	0.398 (0.826)	-0.0172 (0.0313)	0.0246 (0.0465)
Household Size	0.558*** (0.164)	0.0249*** (0.00817)	0.0420*** (0.0114)
Average Age (HH-Level)	-0.306*** (0.0922)	-0.0167*** (0.00415)	-0.0180*** (0.00633)
Age Squared	0.00469*** (0.000908)	0.000231*** (3.99e-05)	-8.76e-05 (6.10e-05)
2013	-2.490*** (0.911)	-0.0864** (0.0356)	0.0514 (0.0517)
2015	-0.643 (0.821)	-0.00474 (0.0321)	0.110** (0.0486)
2017	0.557 (0.885)	0.0362 (0.0333)	0.213*** (0.0464)
Constant	9.751*** (2.523)	0.429*** (0.121)	4.018*** (0.177)
Observations	5,415	5,415	5,416
R-squared	0.038	0.036	0.167
Number of hhid	1,354	1,354	1,354

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 9: Household Fixed Effects Panel Regression Estimates:
Health Care Utilization, 2011-2015**

	(1)	(2)	(3)	(4)	(5)
	Outpatient Application	Outpatient Visits	Inpatient Application	Inpatient Admissions	Purchases of Medicines
Health Insurance Coverage Rate	0.0442*** (0.0120)	0.0532 (0.0414)	0.0188*** (0.00679)	0.0507* (0.0261)	0.0206 (0.0142)
2013	-0.0283** (0.0111)	-0.0489 (0.0369)	-0.0130** (0.00604)	0.0513** (0.0243)	0.0160 (0.0131)
2015	0.00124 (0.0107)	-0.0472 (0.0346)	0.00807 (0.00582)	0.0541*** (0.0208)	0.0260** (0.0129)
Constant	0.151*** (0.00610)	0.307*** (0.0197)	0.0375*** (0.00320)	0.0534*** (0.0132)	0.360*** (0.00730)
Observations	7,186	7,186	7,186	7,186	7,186
R-squared	0.007	0.001	0.008	0.006	0.006
Number of hhid	2,396	2,396	2,396	2,396	2,396

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 10: Household Fixed Effects Panel Regression Estimates:
Health Care Utilization, 2011-2015 (With Controls)**

	(1)	(2)	(3)	(4)	(5)
	Outpatient Application	Outpatient Visits	Inpatient Application	Inpatient Admissions	Purchases of Medicines
Health Insurance Coverage Rate	0.0421*** (0.0120)	0.0499 (0.0413)	0.0173** (0.00687)	0.0441* (0.0262)	0.0181 (0.0140)
Household Size	0.00237 (0.00437)	0.00861 (0.0113)	0.00285 (0.00254)	0.00463 (0.00876)	-0.0150*** (0.00486)
Average Age (HH-Level)	-0.00245 (0.00250)	-0.00315 (0.00677)	-0.00650*** (0.00141)	-0.0302*** (0.00728)	0.000834 (0.00280)
Age Squared	6.46e-05** (2.56e-05)	9.11e-05 (6.98e-05)	6.64e-05*** (1.45e-05)	0.000307*** (7.35e-05)	8.23e-05*** (2.83e-05)
2013	-0.0321*** (0.0112)	-0.0541 (0.0371)	-0.0117* (0.00612)	0.0565** (0.0240)	0.00373 (0.0130)
2015	-0.00632 (0.0109)	-0.0575 (0.0350)	0.00922 (0.00594)	0.0582*** (0.0204)	0.00424 (0.0127)
Constant	0.102 (0.0638)	0.204 (0.175)	0.167*** (0.0374)	0.692*** (0.188)	0.187** (0.0727)
Observations	7,186	7,186	7,186	7,186	7,186
R-squared	0.021	0.004	0.014	0.012	0.090
Number of hhid	2,396	2,396	2,396	2,396	2,396

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 11: Household Fixed Effects Panel Regression Estimates:
Health Care Utilization, 2011-2017 (With Controls)**

	(1)	(2)	(3)	(4)	(5)
	Outpatient Application	Outpatient Visits	Inpatient Application	Inpatient Admissions	Purchases of Medicines
Health Insurance Coverage Rate	0.0314*** (0.00936)	0.0165 (0.0303)	0.0176*** (0.00516)	0.0597** (0.0233)	0.0125 (0.0125)
Household Size	-0.00315 (0.00303)	-0.00287 (0.00812)	1.18e-05 (0.00188)	-0.00186 (0.00771)	-0.0224*** (0.00386)
Average Age (HH-Level)	-0.00290 (0.00179)	-0.00264 (0.00494)	-0.00558*** (0.00124)	-0.0125* (0.00739)	-0.00249 (0.00240)
Age Squared	5.50e-05*** (1.84e-05)	7.67e-05 (5.25e-05)	5.98e-05*** (1.24e-05)	0.000141* (7.58e-05)	0.000112*** (2.48e-05)
2013	-0.0238** (0.0103)	-0.0322 (0.0317)	-0.0126** (0.00517)	0.0436* (0.0230)	0.00726 (0.0120)
2015	0.00219 (0.0102)	-0.0379 (0.0310)	0.00794 (0.00522)	0.0452** (0.0204)	0.00720 (0.0119)
2017	-0.0609*** (0.00972)	-0.144*** (0.0294)	0.000990 (0.00511)	0.0695*** (0.0250)	-0.00835 (0.0121)
Constant	0.170*** (0.0456)	0.270** (0.122)	0.151*** (0.0321)	0.296* (0.174)	0.299*** (0.0597)
Observations	9,582	9,582	9,582	9,582	9,582
R-squared	0.023	0.011	0.012	0.006	0.110
Number of hhid	2,396	2,396	2,396	2,396	2,396

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 12: Household Fixed Effects Panel Regression Estimates:
Health Care Spending and Health Status, 2011-2015**

	(1) Health Care Share of Total Consumption Expenditure (%)	(2) Catastrophic Health Spending	(3) Health Status
Health Insurance Coverage Rate	-0.262 (0.477)	-0.0226 (0.0212)	-0.0387 (0.0337)
2013	-1.434*** (0.450)	-0.0609*** (0.0191)	0.0684** (0.0315)
2015	0.710* (0.419)	0.0339** (0.0169)	0.0719** (0.0294)
Constant	8.902*** (0.241)	0.301*** (0.0112)	3.116*** (0.0187)
Observations	7,184	7,184	7,186
R-squared	0.015	0.016	0.002
Number of hhid	2,396	2,396	2,396

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 13: Household Fixed Effects Panel Regression Estimates:
Health Care Spending and Health Status, 2011-2015 (With Controls)**

	(1)	(2)	(3)
	Health Care Share of Total Consumption Expenditure (%)	Catastrophic Health Spending	Health Status
Health Insurance Coverage Rate	-0.409 (0.478)	-0.0289 (0.0210)	-0.0320 (0.0322)
Household Size	0.855*** (0.171)	0.0373*** (0.00862)	0.0244* (0.0125)
Average Age (HH-Level)	-0.204** (0.0908)	-0.00846* (0.00436)	-0.0138** (0.00585)
Age Squared	0.00382*** (0.000884)	0.000163*** (4.11e-05)	-0.000150*** (5.70e-05)
2013	-1.499*** (0.454)	-0.0639*** (0.0190)	0.107*** (0.0305)
2015	0.526 (0.424)	0.0258 (0.0170)	0.138*** (0.0294)
Constant	5.963** (2.518)	0.162 (0.125)	4.003*** (0.171)
Observations	7,184	7,184	7,186
R-squared	0.033	0.032	0.142
Number of hhid	2,396	2,396	2,396

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

**Table 14: Household Fixed Effects Panel Regression Estimates:
Health Care Spending and Health Status, 2011-2017 (With Controls)**

	(1) Health Care Share of Total Consumption Expenditure (%)	(2) Catastrophic Health Spending	(3) Health Status
Health Insurance Coverage Rate	-0.402 (0.426)	-0.0353** (0.0175)	-0.00637 (0.0259)
Household Size	0.661*** (0.125)	0.0293*** (0.00587)	0.0255*** (0.00914)
Average Age (HH-Level)	-0.248*** (0.0733)	-0.00934*** (0.00314)	-0.0136*** (0.00435)
Age Squared	0.00417*** (0.000724)	0.000162*** (2.96e-05)	-0.000141*** (4.23e-05)
2013	-1.506*** (0.415)	-0.0591*** (0.0171)	0.0886*** (0.0268)
2015	0.514 (0.396)	0.0305* (0.0156)	0.121*** (0.0269)
2017	1.489*** (0.423)	0.0540*** (0.0166)	0.250*** (0.0242)
Constant	7.907*** (1.978)	0.237*** (0.0899)	3.961*** (0.125)
Observations	9,580	9,580	9,582
R-squared	0.039	0.033	0.172
Number of hhid	2,396	2,396	2,396

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Table 15: Household Expenditure Categories, 2011-2017 (Newly Insured Households, With Controls)

	(1) Education Share of TCE (%)	(2) Food Share of TCE (%)	(3) Outside Food Share of TCE (%)	(4) Nonfood Share of TCE (%)
Health Insurance Coverage Rate	0.0874 (0.299)	2.295* (1.230)	-0.621 (0.661)	-2.138** (1.058)
Number of Children * Health Insurance	0.231* (0.132)			
2013	-0.00638 (0.326)	-5.869*** (1.464)	0.518 (0.656)	6.829*** (1.134)
2015	-0.505* (0.296)	-11.55*** (1.378)	0.841 (0.595)	6.397*** (1.059)
2017	-0.385 (0.286)	-18.29*** (1.370)	1.841*** (0.693)	13.61*** (1.129)
Number of Children	-1.252*** (0.287)			
Household Size	0.434*** (0.102)	0.194 (0.333)	-0.0679 (0.0738)	0.211 (0.215)
Average Age (HH-Level)	-0.197*** (0.0576)	-0.123 (0.177)	0.175*** (0.0501)	0.281** (0.113)
Age Squared	0.00109** (0.000492)	0.00250 (0.00176)	-0.00179*** (0.000465)	-0.00293*** (0.00106)
Female	0.504 (0.544)	0.919 (2.253)	-1.644** (0.753)	1.384 (1.245)
Constant	7.394*** (1.639)	57.14*** (5.072)	-1.895 (1.343)	-6.325* (3.421)
Observations	5,415	5,415	5,415	5,415
R-squared	0.034	0.162	0.034	0.200
Number of hhid	1,354	1,354	1,354	1,354

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Table 16: Household Expenditure Categories, 2011-2017 (Full Panel, With Controls)

	(1) Education Share of TCE (%)	(2) Food Share of TCE (%)	(3) Outside Food Share of TCE (%)	(4) Nonfood Share of TCE (%)
Health Insurance Coverage Rate	-0.159 (0.180)	2.012*** (0.750)	-0.203 (0.272)	-0.239 (0.431)
Number of Children * Health Insurance	0.325*** (0.124)			
2013	0.101 (0.152)	-5.643*** (0.811)	0.0361 (0.199)	5.023*** (0.488)
2015	-0.349** (0.144)	-11.26*** (0.810)	0.316* (0.191)	4.063*** (0.458)
2017	-0.251 (0.154)	-18.10*** (0.810)	1.399*** (0.273)	11.65*** (0.478)
Number of Children	-1.260*** (0.230)			
Household Size	0.494*** (0.0847)	0.191 (0.239)	-0.0419 (0.0611)	0.205 (0.166)
Average Age (HH-Level)	-0.178*** (0.0423)	-0.0522 (0.124)	0.106*** (0.0325)	0.249*** (0.0800)
Age Squared	0.000941** (0.000367)	0.00197 (0.00122)	-0.00119*** (0.000300)	-0.00259*** (0.000734)
Female	0.288 (0.368)	-0.853 (1.642)	-0.784 (0.479)	-0.423 (0.845)
Constant	6.805*** (1.264)	56.90*** (3.608)	-0.551 (0.934)	-4.455* (2.466)
Observations	9,580	9,580	9,580	9,580
R-squared	0.037	0.177	0.027	0.199
Number of hhid	2,396	2,396	2,396	2,396

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1