Casey Mulligan Q&A – What Happens Next
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Larry Bernstein:
Should we have raised taxes on alcohol when the government gave these cash payments during this COVID crisis to minimize the damage?

Casey Mulligan:
Other countries, and I use their experience with alcohol taxes. Gorbachev had increased the alcohol tax and Yeltsin had cut it, and the deaths moved right along with that. Finland had also cut their alcohol tax and they had a bunch of deaths come on. So, it's something to consider. My job is just to say what the consequences are of ... are of these things and it's our elected leaders who need to weigh the choices, but they need to know what the consequences of different choices are and that's my job.

Larry Bernstein:
Alcohol use increased during the pandemic and likely changed behavior for the short and long-term. It will have consequences in the years ahead as well. How do you think about a broad increase in alcohol use as one of the problems of a lockdown and social isolation?

Casey Mulligan:
This is a human capital type of issue and being addicted to a harmful substance; it's a loss of human capital and it's one of those legacies of the pandemic that we'll have. Now, one could make the argument, "Well, it was worth sacrificing human capital to make ourselves feel better," or, or whatever that may be. But still, as an economist, I can say there will be that learned long-term consequence, whether it was a good choice or a bad one. That's the way life works. Choices have consequences, even if they were justified choices.

Larry Bernstein:
When the government bonus checks were first proposed, you stated that these payments would result in a surge in alcohol and drug deaths and as a result you were attacked for making these predictions. What was the essence of these attacks?

Casey Mulligan:
Well, (laughs) I, I, I'm not a, a psychologist. I, I, I can guess. You know, knowing some of the people, uh, they, they felt, and I agree, that these policies were well-intentioned, and so any time you have good intentions and harmful unintended consequences, it can be upsetting. And you'd rather imagine a world that those aren't happening. The sort of people I talk to are not accountable, so if they're wrong, as long as they don't notice, it all, all feels okay.

Larry Bernstein:
Some economists and politicians advocate a negative income tax. Individuals would receive periodic payments from the Federal Government independent of work effort. One of the consequences of your research is that these proposals will lead to greater access to alcohol and drugs leading to more deaths. Why don't people worry about the negative consequences of government payments replacing work?

Casey Mulligan:
Yes. And it doesn't get talked about a lot.

Before this pandemic we had studies. And it was found, the key issue was none of these programs happen in isolation. When the government's cutting the checks for the people, what are kind of the strings attached? Are they encouraged to get, engage with work or, or the opposite? A lot of the programs that have happened historically were encouraging people to engage with work so you didn't see these kinds of effects.

Another issue would be that the United States is different in terms of especially drug problems, and the prevalence of them. And something then that might work in, in Norway might have a very different effect here because the dangerous drugs are a very real option over here.

Larry Bernstein:
America has some of the lowest employment participation rates in modern times and that was true even before COVID. And it was a function potentially of government programs that allowed or encouraged people not to work, but to choose leisure that included availability to both alcohol, opioids and other drugs. Should we consider the consequences of the benefits associated with work and the negative consequences associated with certain elements of not working?

Casey Mulligan:
We want to recognize that there are, there are complements, as we say. They go together, being not work and, and the substance use. Not every person but on an average basis, and the causality therefore goes in both directions because they are kind of joined like that. And drugs have gotten a lot cheaper and a lot more available and that can discourage people from working without any other, any change in fiscal policy. Is that a benefit or a cost? I mean, there's a certain libertarian point of view that would celebrate somebody's opportunity to take these drugs, even if it's they're risking their lives.

But certainly, there are family members and a lot of people upset. I mean, that's part of where 2016 came from, a lot of people upset at attending these funerals and they would say, "Please consider these unintended consequences, we really want them to go away."

Larry Bernstein:
Your recently published paper linking Covid checks with alcohol and opioid deaths using novel econometric methods. Can you explain how you proved your thesis?

Casey Mulligan:
Well, I have a model. (laughs) And now, in, in the alcohol case it's a fairly straightforward demand model, and there we have historical estimates that I mentioned earlier. Finland, Yeltsin, Gorbachev, places in the United States. We have an idea how price translates into alcohol deaths. Alcohol consumption measured in gallons, but today we're talking about the deaths.

There's also an income piece which I looked at the amount of income and said, "Well, let me just suppose that people get all this money and they spend some of it and they spend it on a lot of things, not just alcohol and not just drugs." Kind of according to how they bought things before, but they've got more money to buy the things that they bought before.

Meth is similar except all the drugs I have this employment connection. And there, we knew a lot about how money prices affect drugs that's been studied a lot. And then I said, "Well, the opportunity costs of not working, that's in addition to the money pro- costs. Not only you have to spend money but you hurt your ability to make money." So, I just translate it, and that's a standard tool, at least since Gary Becker, in economics to think about prices as having these two parts, a money part and a time-part.

Once I take that step it's fairly easy because I know how much the bonuses are. I mean, they were $300 and $600 pretty easy to measure in the world of illegal drugs where the money prices actually can be quite hard to measure.

Now what's most novel it's work that I had done before the pandemic is the opioids have these two organic and synthetic products that are coexisting. A shock to the market we had seen before and I expected we would see it again, can cause people to switch from the expensive prescriptions or even heroin by comparison being expensive, to something cheaper like fentanyl. Especially fentanyl, and so their stocks kind of get amplified compared to the alcohol and meth cases.

We had seen that before. We had seen various policy changes around prescriptions and then we were surprised. Like, "Oh, gee, these people switched to fentanyl and they ended up dying more than they were dying on the prescriptions." I had a numerical estimate of that from before the pandemic so I used that number as well to apply.

This is not an exact science. I'm not using a scalpel here. There's a lot of sensitivity analysis in the paper and if somebody tells me, "Casey, you were off by 20% or on this effect or that effect," it's hard to argue in a number of these elements. While we have five or six different pieces and some are maybe over-estimated and some are under-estimated and maybe the totals not so bad.

Larry Bernstein:
Deaths in the US are up year over year. Our natural tendency is to assume that the increase in deaths relate to Covid. But you are saying that the increase in mortality relates to changes in behavior caused by lockdowns or bad government policies.

Casey Mulligan:
There's two parts to that. A lot of the movement to being at home would've happened anyway. Certainly, we had state governors and counties putting down rules, but a lot of people would've done that anyway. And there would've been deaths, especially alcohol deaths from that anyway. And maybe also the drug deaths, too. So, I blame it on the pandemic. The government can make it better, maybe could warn people, maybe not over-hype the danger so that they're running home in cases when they don't really need to run home. Like 20, 25-year-olds maybe didn't need to run home.

I would blame that on the pandemic, and one of the things I want to look for in the data going forward is the other countries that didn't have our policies but obviously had the pandemic, what on, what, what happened with them? And I think you're going to see alcohol deaths in an awful lot of countries.

The drug deaths are in my view, much more tied to the fiscal policy. Now you could say, well we had to have that fiscal policy because of the pandemic. But other countries didn't have that fiscal policy, so we didn't have to. Maybe you decide it's a good choice, and this was just a unfortunate byproduct of a, ultimately a good choice. But it's a choice that other countries did not make. So I'm not expecting to see elevated drug deaths nearly to the degree, even in percentage terms. I mean, we were already starting from a high base, but in percentage terms I don't expect 30, 40% increases in drug deaths in, in other countries.

Other countries do have drug deaths, but at a lower level. And I don't expect they increased so much in the pandemic.

Larry Bernstein:
Your paper uses loss of years of life as a metric. If a 90-year-old dies of COVID the expected loss of life might be one year. If a 20-year-old dies from a drug overdose, then the loss of life might be 70 years or 70x more. How should we think about loss of life years in public policy terms?

Casey Mulligan:
I mean, it's a tricky issue. It happens on both sides, so... and it's not really 20-year-olds that are dying. I, think the third, I estimated 33 life years left from the drug deaths, compared to the COVID deaths which were maybe, like, eight years, it's in the paper.

Now Somebody who's 45 who dies from drugs, maybe they weren't going to live to 75. Maybe they were just going to live to 65, I can see that. But also the 75 year old who died from COVID, maybe they weren't going to live to 82, they were going to live to 76. So, it goes on both sides.

I think people have the perception that these dangerous drugs are like instant death, and they are not. There's over a hundred people who have a substance disorder. And that's the flip side, I mean the chances of dying in a year are less than one in 100.

So, the life expectancy of somebody using these dangerous drugs is, is pretty long. The drug's probably not going to kill them in the next 20 years, it's just that there's so many people using these drugs, and one out of 200 chance of dying is still, is not a chance I want my children taking, or I want to take for myself. That as occupations go, that's probably a bit more dangerous than being a commercial fisherman. But still, it's not an instant death. You hear stories like, oh, so and so took drugs for their first time in their life and they dropped dead. I mean that, there's enough people taking drugs that that happens every once in a while, enough to make it in the newspaper, but that's not, I don't think, what the data show us.

Larry Bernstein:
How have other economists reacted to your COVID and Drugs paper?

Casey Mulligan:
Well, I was kind of pessimistic, although the president of the NBR had me make a video yesterday about it, he's very excited about the paper, which very much surprised me. Because a lot of them were cheering for their bonuses and were upset with me when I said that this might be a side effect of it. My profession is very much moved, become what I call causality police. They don't want to talk about something, and, unless it's a postmortem, and in this case, literally. They, they want to see a smoking gun that, that proves that whatever hypothesis is actually guilty. Or, or, or the real cause.

And that's going to take decades. I think the circumstantial evidence is strong. I think we're all are Bayesian when we really want to make a decision in life, but the Bayesian approach is not the, the vogue in my profession.

Larry Bernstein:
And why is that?

Casey Mulligan:
I mean, we've made some technological advances that people are excited about and they're kind of, that's... their vision is a little bit narrow, because that's what, where the progress is. And then progress is a good thing. But sometimes you lose sight of the rest of the landscape.

Larry Bernstein:
Let me explain what Casey meant by we are all Bayesians. Thomas Bayes in the 1700s was a mathematician who created a formula that incorporated your predictions in the model. You had your own predicative value, and then after seeing some results, you would then adjust your probability estimate. So, if you live in Miami Beach and you wanted to estimate the high temperature tomorrow, and your guess was 80 degrees and then the high temperature was in fact 68, you would adjust your guess for tomorrow's high to be 77 degrees.

And the relevance of Bayes to this discussion is that Casey made a prediction that if you give money to someone who just left their job and is an occasional drug user, he expected them to buy more drugs and that some would die. In contrast, other economists in his field would be agnostic about the relationship and they would want to set up experiments to figure out if there were any relationship between having more money and mortality due to increased drug use. It makes a big difference in experimental design and analysis if you start with a working assumption about how the world works. The reality is that is exactly how all of us interact with the world.

My next question is causality, how can we be sure that there wasn't something else going on that caused the increase in Fentanyl deaths. Like let's say the police were too scared to bust drug dealers because of COVID and that was the true factor.

Casey Mulligan:
I mean, it's a great question, certainly if there was just one spike in April, it'd be like, well, a lot of things happened in April. When you get the second spike in January, now we're starting to wonder. And, we had the red and blue states change their unemployment benefits at different times, it'd be interesting to see how that plays out. Now, the data I only have is through June 2021, so we can't do that. But in six months or a year, we can make that sort of comparison and principle.

Larry Bernstein:
The psychologist Jeremy Clorfene was on What Happens Next and he highlighted that during COVID that in person therapy for drugs and AA were closed, and that this loss of in-person therapy caused lapses and drug deaths.

Casey Mulligan:
I mean that's a thing I would take seriously. I had a paper over a year ago where I said a lot's changed with supply and demand, and we're going to need to be worried, and one of the things is people being alone. It could be just simply they're not there to call 911, because again, these things aren't instant death. You have some kind of acute situation, you're not dead immediately. And if you're with somebody you might be saved. People are trying to kick the habit, and, it helps to have companionship to be successful there. So, it could've been a very big factor. I don't know quite how to measure it yet, um, you know maybe different states would've been different in terms of allowing people in that profession to, to engage with each other again.

Larry Bernstein:
Casey, you have presented on What Happens Next four times. One of the reasons that I keep having you back on the program is that you are a very creative economist; you choose very important and controversial topics and then apply innovative methods to under-utilized datasets. Tell us the interesting things that you did in this paper.

Casey Mulligan:

For each one that dies, there's over 100 who are using, and so there's a potential for a lot more, and sharper, data on the consumption. Now, when it's illegal can be tough. Although, law enforcement data can be helpful there. I like to have data on law enforcement activities.

I mean, I live in a county where they don't put people in jail anymore, or prison, and it has that been a factor? That's pretty different story than I told in the paper, but we know, for example, in these data, that the increase, and this was coming before the pandemic. The increase for blacks is very different than for whites. Is that because they're in cities that don't really put people in prison anymore, and drugs are much cheaper and more available? I don't know, but these are the sort of things to investigate.

I do know some MDs who are looking at data on prescriptions. That's a legal market, and they told me they're finding quite a bit more prescriptions for opioids. Was it opioids or benzodiazepines? Which are often used with opioids. I don't remember which they were finding, but that's an example of the type of study that can be done, and then you can get some pretty reliable numbers in this sort of area. I mean, as you can sense that pay a lot of attention to the measurement here, because when you're dealing with it- potentially illegal products, it's a big concern. Often, what we do is driven by our ability to measure.

Larry Bernstein:
Were there differences across races related to drug deaths for Covid checks?

Casey Mulligan:
I haven't looked at that super thoroughly. It was pretty similar. It's just that the blacks had this higher trend, especially on opioids? Blacks were not having opioid deaths for many years.

People say, "Well, that's because they didn't have prescriptions," and they talk about why don't blacks have prescriptions. Interesting topic, but once fentanyl came into the markets in its permanent way, which is more or less 2015, 2014, the narcotics death among blacks started growing like crazy, and it passed the whites in 2019, and it's continued at a faster pace, dynamics and differences by gender and stuff, I don't see that much difference, but it's not something I studied exhaustively, and it's a little tricky, because blacks are,, 13 or 14% of the population. So, there's that much less data for them. Tends to be a little noisy for some of these questions.

Larry Bernstein:
Angus Deaton won the Noble Prize n Economics for his work related to the declining life expectancy of white men in particular related to drug deaths caused by Opioids, and now you are saying that these drugs are hurting African Americans in a bigger way. What is going on?

Casey Mulligan:
I mean, it already happened when they were put that book in process- Like I said, they were- from between 20- let's say 15 and 2019. Lot more deaths among blacks. They had reached par with the

whites by that point, and then, it's gone passed, so that was maybe not good timing on their part. It was a nice story for many years, but not anymore.

Larry Bernstein:
What government policies can reduce drug deaths?

Casey Mulligan:
One thing I was urging for in the White House. I had a lot of trouble, I'm afraid, was just for the government to think about, "Well, what is it doing to add to the problem?" Because you think, in principle, the government could control itself, but neither Democrats or Republicans are all that interested, (laughs) and that they would rather blame pharma companies. Maybe a political entrepreneur could figure out how to do it because we still subsidize prescriptions.

The doctors and hospitals realized if they sent home a nice, big bottle of Oxycontin (laughs), and that they would get a bigger bonus from the federal government, and they obliged and did it, and we only got rid of that in 2019, and CMS, the agency in charge of that went kicking and screaming. Trump has to force them to do that, and they said, "No, we don't need to do this. there's no reason to think that prescribing blah, blah, blah."

So, we subsidized benzodiazepines, which people like them with opioids. In fact, anesthesiologists, they- if you have a surgery, a totally legitimate (laughs) surgery in a legitimate hospital, probably they're going to give you fentanyl, and a benzodiazepine, because it- it makes the fentanyl work better, and, the recreational users know this, and Obamacare, for the first time in our history, began subsidizing benzodiazepines.

Medicaid, they knew that they were abusive, and abuse potential there, and they refused to cover them, but not Obamacare, we have to cover everything. So, they covered that can be reversed. Obamacare could be repealed all together. If it did, that would go with it, but certainly, that part of Obamacare should be considered, because there, you're subsidizing fentanyl, (laughs) but- because it's something people use with fentanyl.

Emptying the prisons has consequences. Again, it's not for me to weigh, but I think we'll want to recognize that maybe the reason we have so much fentanyl is because- is it just a coincidence that, within months of ending the federal war on drugs, as Obama and Holder put it, that fentanyl came into our country to stay? It had been in our country dozens of times before, going back to the 70s, and the DEA always found it, and beat it back, put the people in prison.

Then, they changed the sentencing policy, and within month, we have fentanyl in our country in a very big way, and actually, at the same time in 2014, Sweden got fentanyl in their country, and they escalated their way on drugs, and they beat it out.

So, this is- Again, (laughs) there's more questions than answers, but the questions need to be raised, and I haven't heard anybody raise the question of, you know, it's a drug problem, one of the unintended side effects of incarceration justice, or whatever- (laughs) whatever they call it criminal justice.

Larry Bernstein:
How can we improve the war on drugs?

Casey Mulligan:
I'm a big fan of innovation, (laughs) and trying things, and some of the states out West are trying safe injections sites, and I'm very skeptical, but I believe you've got to try, (laughs) even if you have an idea that seems bad. I mean, innovation is needed here.

Larry Bernstein:
Casey, I end each episode on a note of optimism. What are you optimistic about?

Casey Mulligan:
Innovation- we've had a lot of health problems, historically. Water borne diseases, polio, COVID itself, AIDS, and they seemed pretty intimidating at the time, and innovation maybe didn't totally solve the problem, but they made the problem a lot more manageable, and so, I'm optimistic that medical innovation will help in this area, too.

Larry Bernstein:
Casey, thank you so much for your remarks.