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Early Effects of the Affordable Care Act on Health Care Access, Risky Health Behaviors, and Self-Assessed Health

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The goal of the Patient Protection and Affordable Care Act (ACA) was to achieve nearly universal health insurance coverage in the United States through a combination of policies largely implemented in 2014. Several recent studies have shown that the ACA led to gains in insurance coverage. We evaluate whether or not such coverage increases translated to changes in access to care, risky health behaviors, and, ultimately, short-run health outcomes.

A number of 2014 ACA provisions involved overhauling nongroup insurance markets in an effort to ensure that one's health history did not provide a barrier to obtaining coverage. Specific regulations included guaranteed issue laws, which forbid insurers from denying coverage on the basis of an applicant's health status, and modified community rating, which imposes uniform premiums regardless of observable applicant characteristics aside from age and smoking status. In addition, the federal government established a health insurance marketplace to facilitate insurance purchases for

individuals and small businesses. Each state was given the option of establishing its own insurance marketplace, and 15 did so in 2014.

These reforms alone would likely lead to an adverse-selection death spiral, with the influx of high-cost beneficiaries causing relatively low-cost beneficiaries to drop their coverage, thus driving up premiums for those remaining in the insurance pool. This concern motivated another component of the ACA: the individual mandate. Beginning in 2014, individuals deemed to be able to afford coverage but electing to remain uncovered were penalized. The largest penalty that could be imposed was the maximum of either the total annual premium for the national average price of a bronze exchange plan, or \$285 and \$975 in 2014 and 2015, respectively. In addition, an employer mandate, which required employers with 100 or more full-time equivalent employees to offer "affordable" coverage to at least 95 percent of their full-time employees and their dependents (children up to age 26) or face a penalty, took effect in 2015.

The remaining challenge associated with promoting universal coverage—affordability—was addressed by the ACA in 2014 in two ways. First, sliding scale subsidies in the form of premium tax credits became available to consumers in every state with incomes of 100 percent to 400 percent of the federal poverty level (FPL) who did not qualify for other affordable coverage. Second, in states that opted to expand Medicaid via the ACA, low-income adults (with incomes at or below 138 percent of the FPL) who were not elderly, disabled, or parents of a dependent child became eligible for Medicaid coverage. Previously, Medicaid eligibility was typically restricted to those with low incomes among specific groups (categories of eligibility), such as children, single parents, pregnant women, the disabled, and the elderly. According to the Kaiser Family Foundation, 27 states participated in the Medicaid expansion in 2014, with three more implementing it in 2015 and another two in 2016.

Theoretically, the expansion of insurance coverage brought about by the ACA should increase access to care because of the reduction in out-of-pocket costs, but this is not automatically the case. On the demand side, newly insured individuals may not have sufficient knowledge of the health care system to easily secure a regular primary care doctor. Stephen Somers and Roopa Mahadevan of the Center for Health Care Strategies report that only 12 percent of adults have proficient health literacy. On the supply side, concerns have been raised about whether there are sufficient numbers of primary care physicians to treat all of these newly insured patients. While the federal government increased Medicaid primary care reimbursement rates to Medicare levels in 2013 and 2014, only a few states fully maintained this “fee bump” in 2015.

Insurance coverage expansions could influence risky health behaviors—such as smoking, drinking, and overeating—in either direction. On the one hand, improved access to care among the affected population could translate to improvements in health behaviors via information, accountability, or treatments such as smoking-cessation drugs or weight-loss programs. Conversely, insurance expansions can theoretically worsen health outcomes through *ex ante* moral hazard, as the reduction in financial risks associated with unhealthy behaviors incentivizes such behaviors. Moreover, income effects from gaining free or subsidized coverage could influence behaviors by enabling consumers to spend money they had budgeted for the direct purchase of health care on alcohol, cigarettes, and junk food or, conversely, on healthy food and gym memberships.

The net effect of insurance expansions on population health depends on the changes in both access to care and health behaviors and, therefore, is also theoretically

ambiguous. The extent to which increased health care utilization translates to better population health depends on the distribution of affected individuals’ initial locations along the health production function. Evidence suggests that “flat of the curve” care—perhaps due to uncertainty over treatment effectiveness, the principal-agent nature of the patient-doctor relationship, fee-for-service reimbursement, lack of coordination across health care providers, or malpractice liability—is common in the United States. Moreover, the same issues with health literacy that could hamper efforts by the newly insured to find a primary care doctor could also limit their ability to understand and comply with treatment recommendations.

The purpose of our research is to estimate the impact of the ACA’s 2014 provisions on a variety of outcomes related to health care access, risky health behaviors, and self-assessed health. We separately identify the effects of the private and Medicaid-expansion portions of the ACA by estimating the impact of the ACA on insurance coverage using differences across local areas in pretreatment uninsured rates. To be more specific, we use the differences coming from time, state Medicaid-expansion status, and local area pretreatment uninsured rates. If our objective were merely to isolate the effect of the Medicaid expansion, that could potentially be achieved with a simpler model comparing changes in states that expanded Medicaid to changes in nonexpansion states. However, identifying the impact of the other components of the ACA (e.g., mandates, subsidies, and marketplaces) is more difficult due to their national nature. We therefore exploit an additional layer of plausibly exogenous variation arising from the fact that universal coverage initiatives provide the most intense treatments in areas with high uninsured rates.

Our data come from the 2011–2015 waves of the Behavioral Risk Factor Surveillance System (BRFSS), with the sample restricted to nonelderly adults. The BRFSS is well suited to our study for three reasons. First, it includes a wide range of questions on health care access and self-assessed health. Second, with over 300,000 observations per year, it is large enough to precisely estimate the effects of state-level interventions. Third, it was among the first large-scale health data sets to release data from 2015, allowing us to examine two calendar years of data after the full implementation of the ACA.

Our results suggest that the ACA substantially improved access to health care among nonelderly adults. Gains in insurance coverage were 8.3 percentage points in Medicaid-expansion states compared to 5.3 percentage points in nonexpansion states, while reductions in cost being a barrier to care were 5.1 percentage points in expansion states and 2.6 percentage points in nonexpansion states. The ACA also

increased the probabilities of having a primary care doctor and a checkup by 3.0 and 2.4 percentage points, respectively, in non-Medicaid-expansion states, with the effects not being statistically different in expansion states. Gains in access were generally largest among individuals with lower incomes.

However, the effects of the ACA on risky health behaviors and self-assessed health were less pronounced—at least after two years. For risky behaviors, we examine smoking, alcohol consumption, and body mass index. For health outcomes, we examine self-assessed health, days in poor mental health, days in poor physical health, and days with health-related functional limitations. For the full sample, we find no statistically significant impacts on any of the risky behavior or health outcomes in either Medicaid-expansion or nonexpansion states. This general pattern of null results persists even among the lower-income subsample, though we do observe a marginally

significant improvement in mental health in Medicaid-expansion states for that group.

In summary, the insurance expansions in 2014 in the ACA had a large impact on insurance coverage, along with a large price tag. One of the key stated benefits for expanding insurance coverage is to improve the overall health of the population; our work shows that at least in the short run, such benefits were minimal.

NOTE:

This research brief is based on Charles Courtemanche, James Marton, Benjamin Ukert, Aaron Yelowitz, and Daniela Zapata, “Early Effects of the Affordable Care Act on Health Care Access, Risky Health Behaviors, and Self-Assessed Health,” *Southern Economic Journal* 84, no. 3 (January 2018): 660–91.