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## Research Notes

### *U.S. Healthcare Reform: How Can Social Science Contribute to Understanding Its Effects?\**

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#### **ABSTRACT**

In these updated remarks to the 2015 IASS conference, I review the recent developments in health reform and the role of social science research. The Affordable Care Act has many aims, the primary three of which are to insure the uninsured, to reduce the cost growth of healthcare, and to improve the quality of services received. These changes are seen as necessary to improve population health and efficiency in the healthcare sector. I summarize the major changes in health-insurance delivery that have taken place through the law, discuss key findings from social science research to date, and anticipate what other paths the budding research may take in the future.

**KEY WORDS** Affordable Care Act; Health Reform

It was a great honor and pleasure to speak with the 2015 IASS conference attendees regarding recent developments in health reform and the role of social science research.

In March 2010, President Obama signed into law the most sweeping set of changes for the delivery of healthcare in the United States since the introduction of Medicare and Medicaid in 1965.

The Affordable Care Act (ACA) has many aims, the primary three of which are to insure the uninsured, to reduce the cost growth of healthcare, and to improve the quality of services received. These changes are seen as necessary to improve both population health and efficiency in the healthcare sector. The aim of my talk is to summarize the major changes in health insurance delivery that have taken place through the law, discuss key findings from social science research to date, and anticipate what other paths the budding research may take in the future.

The ACA is a complex piece of legislation, and a short summary cannot begin to do justice to many of its provisions. My comments do not touch upon the policies that

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aim to contain cost growth and improve quality of healthcare services. I note that healthcare spending growth has slowed in recent years (Keehan et al. 2016); causes for this slowdown are highly debated, however, with some arguing that these impacts are the legacy of the recent recession and others attributing some of the decline to the ACA's provisions. Interested readers can find many excellent sources for greater detail about the structure and components of the law, such as the Kaiser Family Foundation's "Summary of the Affordable Care Act" (2012, 2013) and Politico's "Understanding Obamacare" (Nather 2013).

As of the first quarter of 2013, 17.1 percent of non-elderly adults were uninsured (Long et al. 2015:Figure 1), and the average cost of a family health insurance policy stood at \$16,029. The population 65 years and older receives universal coverage through Medicare, and since the Children's Health Insurance Program (CHIP) expansions of the late 1990s, almost all children who would otherwise be uninsured have access to public health insurance through CHIP and Medicaid.

By the first quarter of 2015, uninsurance among non-elderly adults had dropped to 10.1 percent (Long et al. 2015). Much of the gains are attributed to the ACA because the pattern shows a trend break moving from the third quarter of 2013 to the first quarter of 2014, right as the major insurance provisions of the law went into effect. Although there will be much research investigating the impact of access to health insurance on social, economic, and health outcomes, there is little question that the ACA has made a major dent in the rate of uninsurance. It is estimated that ACA financial assistance provides non-employment-based insurance for approximately 21 million people (Congressional Budget Office 2016), of whom 10 million are subsidized through the Marketplaces, while 11 million are insured through Medicaid, as of the end of 2016.

At the same time, the ACA may have not achieved as much of a reduction in uninsurance as initially anticipated, due largely to the 2012 Supreme Court decision that allowed states to opt out of the Medicaid expansion. The ACA originally required that all states expand Medicaid to non-elderly adults whose family incomes were below 138 percent of the federal poverty line (FPL) while sliding-scale subsidies for private coverage delivered through the Marketplace would encourage coverage for those above the Medicaid eligibility threshold, until 400 percent FPL.<sup>1</sup> The result of the 2012 Supreme Court decision allowing states to opt out of this requirement was that only 27 states had expanded Medicaid by the end of 2014: 2 in 2011, 4 in 2012, and 21 in 2014 (Sommers, Kenney, and Epstein 2014). Indiana itself expanded Medicaid in February 2015. Prior to the expansions, public health insurance was rarely available to low-income, non-elderly, nondisabled childless adults. Parents' Medicaid eligibility was affected to a lesser degree because of an earlier program during the welfare-reform era that established an avenue for parental Medicaid to a median of 100 percent FPL in the states that later adopted Medicaid expansion (Artiga and Cornachione 2016). In non-expansion states, those below 100 percent FPL do not have access to new insurance subsidies even through Marketplaces; these individuals are often referred to as those in the "coverage gap."

Looking beyond levels of coverage, Buchmueller et al. (2016) find that the ACA reduced disparities in coverage between racial/ethnic groups. Several papers have

examined the impact of the ACA on aspects beyond coverage. One important outcome that the law sought to improve was access to preventive care (US Department of Health and Human Services 2015, 2016). These ideals were furthered by requirements that all health insurance plans, both public and private, for the under-65 population cover a list of preventive services at no cost to the patient at the point of use; these are referred to as the 10 Essential Benefits and include services such as preventive vaccines. The only published research to date on the preventive care effects of 2014 Medicaid expansions shows that a state's Medicaid-adoption decision increased visits to physicians, hospital stays, and diagnosis of diabetes and high cholesterol (Wherry and Miller 2016).

Other work on the ACA (e.g., Akosa Antwi, Moriya, and Simon 2015) has examined impacts of the Young Adult provision in 2010 on several outcomes, but work on the 2014 Medicaid expansions is still at an early stage. Work in progress examines hospital and emergency-department healthcare use, out-of-pocket medical spending, and financial health. Many areas remain untouched and ripe for social science research. Topics include understanding take-up of coverage, the role of social and peer networks, information spreading (in the field of sociology), the motivations and actions of state lawmakers (political science and public administration), the comparison of court decisions on several challenges to the law (legal studies), differences in state perceptions of government involvement in redistribution and attitudes (ethics), and whether mental models and risk taking change once uninsured people have coverage (psychology).

Although the research on the law is still in its infancy, political uncertainty about its future persists. Aside from presidential-election uncertainty, more immediate concerns regard rising consolidation in the insurer and provider markets, whether private insurers will continue to offer plans in the Marketplaces, and whether states will change their decisions regarding Medicaid expansions. Regardless of how these events turn, there is a demonstrated interest in society to design a healthcare policy that is comprehensive and insures the uninsured, and social science research will contribute greatly to guiding decisions and understanding their consequences.

## **ENDNOTE**

1. The subsidies are such that an individual at 100 percent FPL in 2014 buying a certain type of plan available in his or her location would pay no more than 2 percent of family income toward a premium; this caps out at 9.5 percent of income at 400 percent FPL. Those in the 100–250 percent FPL range also receive government assistance that makes the plan more generous than otherwise (Kaiser Family Foundation 2012). The subsidies for coverage through Marketplaces are expected to average \$4,240 per subsidized individual in 2016.

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