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Lifetime Consequences of Early and Midlife Access to Health Insurance: A Review

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In 2012, 48 million Americans had no health insurance coverage. By mid-2014, increases in enrollment reduced this number by 10.3 million, and some forecast that another 11.1 million Americans will gain coverage in the long run. While there has been much debate about the coverage effects of health policy, there has been surprisingly little discussion about what it means for population health and economic outcomes.

It is not hard to imagine why health insurance could be important for both individual health and economic outcomes. However, how to estimate the causal effect of health insurance is not obvious. For example, people who value health insurance may be inherently sicker. Thus, simple observational studies comparing individuals who are enrolled in health insurance to those who are uninsured might find that health insurance makes individuals less healthy. In addition to reverse causality, omitted variable bias could also be present. For example, consider ability, which is unobserved in many data sets. Individuals with higher latent ability may be more likely to have health insurance due to their participation in the labor force, as well as be able to maintain their health. This omitted variable would bias upward estimates of health insurance on health. Given the examples above, it is clear that in order to answer the question of how health insurance affects health or economic outcomes, researchers must control for the endogeneity of health insurance.

This article reviews the literature on how health insurance affects health and economic outcomes in the United States prior to automatic Medicare eligibility at age 65 with the aim of providing a snapshot of the existing evidence's breadth. A targeted approach was used to identify and review experimental or quasi-experimental articles deemed most likely to measure the health insurance's causal impact.

A randomized control trial is the gold standard in inference and could potentially shed light on the effects of health insurance. Three large-scale experiments conducted in relation to health insurance provide valuable information: the Rand Health Insurance Experiment, conducted from 1974 to 1982, which randomized more than 5,000 people into one of 14 different health insurance plans; the Oregon Health Insurance Experiment, that consisted of a lottery to be eligible to apply for Oregon Health Plan public health insurance; and the Accelerated

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Benefits Demonstration, which randomized new Social Security Disability Insurance beneficiaries into receiving immediate health care benefits.

In addition to randomized experiments, researchers have used several policy changes (so-called "quasi-experiments" or "natural experiments") to attempt to measure the causal impact of health insurance on economic outcomes and health. Key examples include Medicaid eligibility expansions, notably since the 1980s; the 2006 Massachusetts Health Care reform, which instituted state-wide, near-universal coverage; and, most recently, the national implementation of the Patient Protection and Affordable Care Act, which expanded the objectives of the Massachusetts Reform at the national level. There were also smaller changes to state programs or mandates that have been exploited. For example, changes to Hawaii's employer mandates, TennCare (Tennessee), and Badger Care (Wisconsin) have all been used as natural experiments.

The most relevant studies were identified using a targeted approach, and systematically reviewed by outcome category. Seven health outcomes were considered: mortality, self-reported health, risk factors such as obesity and high blood pressure, limitations and functional status, preventable hospitalizations, chronic conditions, and mental health. Seven economic outcomes also were considered: labor-force participation, wages and other related labor-market outcomes, welfare participation, education, savings and asset accumulations, household well-being, and delayed care due to costs.

The effects of health insurance on economic outcomes are well studied, but not conclusive. There is some evidence that individuals choose their labor supply based on health insurance, but it depends how one measures labor supply, as well as the population studied. Similarly with wages, there is no resounding evidence that health insurance increases or decreases earnings. We identified welfare participation as an understudied area. In particular, more research on the long-term effects of health insurance on welfare take-up is needed. Additionally there is variation across states in enrollment processes for Medicaid and other welfare programs that should be noted and studied. There is evidence that health insurance affects education, particularly during childhood. Household well-being may improve due to health insurance, but the measure is important. Additionally, it appears that households are less likely to delay care due to costs because of insurance.

Evidence on the relationship between health insurance and several aspects of health has strengthened over the last decade, but uncertainty remains about its overall impact. Results from several studies suggest that insurance improves child mortality in low-income populations and mortality in high-risk adults, but it was not shown to impact mortality in the overall population. Evidence suggests that insurance does not impact risk factors such as glucose and cholesterol levels, exercise, smoking, and drinking, but leads to improved blood pressure management, especially among hypertensives, and fewer health limitations in adulthood. Analyses of the impact of insurance on subjective health are quite inconclusive, but inconsistent definitions confound cross-study comparisons of this outcome. Finally, recent findings on mental health have shown positive effects, but these appear to contradict the Rand Health Insurance Experiment, which remains the most compelling source of causal evidence.

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