

The Effects of the Affordable Care Act's Individual Mandate on Ethnic and Racial Minorities

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Abstract: This paper examines the quantitative impact of the Affordable Care Act's (ACA) individual mandate on health insurance coverage rates. This study will include race, ethnicity, and immigration status into a conventional model for predicting insurance coverage rates. This will illustrate the groups in the US population that may have been most influenced by the individual mandate, and potentially experienced the largest changes in coverage rates under the ACA. The data utilized in this research is in two pools, 2010-2011 and 2013-2014, as these are the years preceding the ACA's implementation and directly after. The results reveal that while there was an increase in overall coverage, there was little impact on the disparate coverage between the base group and racial minorities.

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1.0 Introduction

Americans continually top the charts in terms of expenditures on health care costs. Additionally, the US is one of the only remaining developed economies in the world that does not provide some form of guaranteed or universal public health care coverage. This study will aim to quantify the impact of the latest piece of health care legislation, the Affordable Care Act, on different ethnic and racial groups, to provide a deeper understanding of its benefits to the population on a granular level. Studies like these are critical to the ongoing debate over health care, and analysis like these should be the backbone of political decision making going forward.

For nearly eight years now, health care reform has been one of the most contentious issues in the political sphere. Americans face exorbitant costs for even the most basic of care at hospitals, and there are consistently large numbers of uninsured Americans across the country. The Patient Protection and Affordable Care Act (ACA) was a 2010 attempt to begin mitigating these issues by expanding coverage to more Americans and attempting to make it more affordable. A key component of this bill was the individual mandate; which requires all citizens to purchase and own health insurance or pay a penalty, unless covered by some form of public or employer plan. In 2012 this portion of the bill was upheld after a highly publicized Supreme Court case as a part of Congress' ability to levy taxes. The goal of this bill was to help lower costs for the insured and get coverage for the uninsured who were most susceptible to medical bankruptcies.

Under the newest presidential administration extensive promises have been made to repeal and replace the ACA with a new piece of legislation. The question remains though, with costs steadily rising in the health care market, and the aging population of the United States continuing to grow, how much longer can the country wait for a final solution to the health care issue? As the baby boomers head into retirement, a smaller than ever workforce is called on to support them through public programs such as Social Security and Medicare, which means they will be facing rising costs and potentially less public options to turn towards in their retirement. With an issue as potentially disastrous as this, it is important to establish a suitable answer sooner rather than later.

The purpose of this study is to examine the impact of the ACA and individual mandate on a more refined level than overall insurance coverage rates in the United States. This study will aim to examine the impact of the ACA and its individual mandate on different ethnic and racial

groups utilizing survey data from the American Community Survey and U.S. census micro data. It will have two primary objectives; first to see if the individual mandate was effective in decreasing the number of uninsured Americans, and second to see if it impacts any specific racial and ethnic group to a more significant degree. This analysis will include two logit models, one for the two years before the 2012 Supreme Court ruling (2010 and 2011) and for two years afterwards (2013 and 2014). By including racial and ethnic variables alongside traditional variables for determining likelihood of having health insurance, this paper aims to pinpoint communities in the general population that may see a severe decline in coverage rates should the individual mandate and ACA be repealed.

The rest of this paper is organized as follows: Section 2 will discuss current literature on the topic. Section 3 outlines current trends in the health care field and their importance to this research. Section 4 will be an analysis of the data and empirical model. Section 5 will present and discuss the empirical results, followed by concluding remarks in section 6.

2.0 Literature Review

Since this paper is seeking to answer two separate questions, two areas of research were explored. The first concerns the efficacy of an individual mandate as a means to encourage individuals to act, and the second, whether there is evidence for any single group within the population being more susceptible to this mandate or not. In terms of the individual mandate portion of the overall research objective, research by Hackmann et al. (2013) finds significant evidence for this claim. Given their research in Massachusetts during the state's health care reform they found that premiums not only decreased after the introduction of an individual mandate but also that, as a result of the reduction in adverse selection, a not insignificant welfare gain. Their model predicts that for a national individual mandate, a penalty of \$2,190 could achieve near universal coverage in the United States

Backing up the research done by Hackmann et al. is Auerbach et al. (2010) whose research indicates that a well-executed individual mandate would provide an economically sound incentive structure to encourage individual to purchase health insurance. Their research indicates that given a penalty larger than the price of insurance, the utility maximizing consumer would rather purchase insurance (even at the barest coverage) instead of suffering the penalty. This is

due to both seeking to minimize costs, as well as actually seeing a tangible benefit from insurance instead of simply surrendering the money to the government.

Connecting the two research questions is the work of Chun and Park (2012) who studied insurance coverage for routine care costs in the case of clinical trials. Their work found that a state imposed mandate requiring insurers to help cover the associated costs of these trials helped lower racial bias. Given a state imposed mandate, clinical trials saw a higher proportion of black residents participating, which subsequently helped mitigate race-based biases in the research. That said, they did not find any evidence that these policies helped to reduce the gap between the rich and poor in these trials. Since a large portion of the ACA was helping to expand coverage to those traditionally denied insurance, this research proves promising that a statistically significant change will be found in coverage rates between years.

Examining the second portion of the research objective for this paper, research by Prus et al. (2010) on Canadian and American native and foreign racial minorities found that these groups in the US were significantly disadvantaged in the health market. Not only did these groups report worse health outcomes in the two countries, but also lower levels of coverage, which means they subsequently incurred larger debt than their white counterparts. These groups also had lower access to care than the rest of the population.

Kirby and Kaneda (2010) further expanded the literature in this area by focusing specifically on racial and ethnic disparities in insurance coverage in the United States. In addition to their findings that the average American will spend 12 years without health insurance coverage, with almost half of that time in an unhealthy state, they found significant racial bias. Their research indicates that regardless of a shorter overall lifespan, black Americans will spend a longer time uninsured and in a less healthy state than the rest of the population. This indicates that there could be a strong correlation between race and lack of health insurance.

Additional research into this area has proven even larger racial discrepancies in health insurance. Findings include the fact that blacks, Asians, and Latinos tend to lose their insurance at a faster rate than whites, some of which could be explained by a combination of rates of job loss and education (Fairlie and London, 2008). Goonatilake and Herath (2016) also found that immigrants and other nonnative Americans tended to have lower rates of insurance coverage than did natives, but again, they found a correlation between education and insurance rates,

indicating that race cannot solely be relied on as a metric of whether or not an individual possesses health insurance.

3.0 Trends in Health Insurance

While the Affordable Care Act was signed into law in 2010 it faced an almost immediate challenge to its constitutionality in the courts. This would eventually reach the Supreme Court who ruled on two portions of the law; the individual mandate and the Medicaid expansion. Most relevant to this study was that the Court upheld the constitutionality of the individual mandate under the premise that it functions as a tax, and thus was within Congress’s powers under the Constitution. This marks the before and after point for this study. Based on the court’s ruling, it guaranteed that by the beginning of 2014 the individual mandate would be in place, with a penalty that would increase every year until 2016, where it would cap at \$695 or 2.5% of a person’s income, whichever is greater. Figure 1 illustrates a brief timeline of the implementation process of the Affordable Care Act. This timeline is the basis for selecting data from the years 2010-2011 and 2013-2014, as explained in Section 4.1.

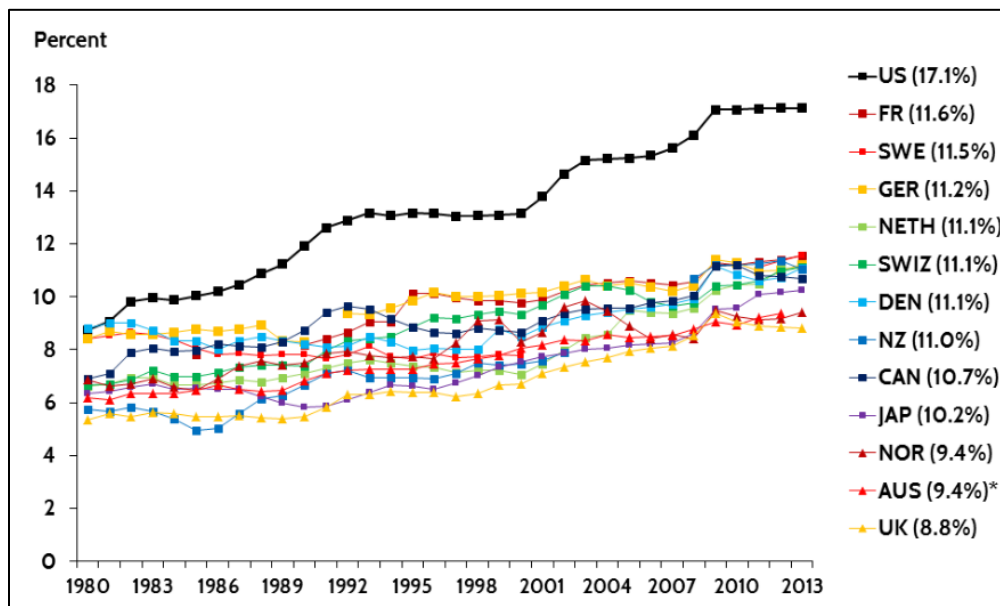
Figure 1: Timeline of the Affordable Care Act

Dataset - Before			Dataset 2 - After	
2010	2011	2012	2013	2014
Affordable Care Act signed into law. Health plans grandfathered in immediately, over the next 180 days benefits for those with preexisting conditions and retirees begin.	Coverage extensions begin for dependents, annual and life time limits removed or restricted. Appeals processes opened.	Supreme Court upholds the Constitutionality of both the Medicaid expansion and the individual mandate.	No major portions of the law came into effect this year.	New health insurance exchanges open, federal subsidy programs begin. No restrictions for preexisting conditions for adults. Individual mandate is implemented. Penalty is \$95 or 1% if income, whichever is greater.

Source: Author Compilation. Information from eHealth Insurance, 2016.

The ACA was a response to the rising costs in the US health care markets. Figure 2 shows the percentage of GDP spent on health care over a more than thirty year period. During that period, the US has become far and away the global leader in health care expenditures, dedicating almost a fifth of GDP to this one area. Compared to 12 OECD countries the US maintains around a 6% gap over the next highest spender. Considering the size of the total US GDP this is a vast sum being dedicated to health care. Add to this the continually aging baby boomer population, and it seems likely that these cost's upward trajectory will continue into the foreseeable future. Based on these rising costs policy action is almost certainly required, as a significant portion of GDP growth is being wasted on costs well above what the average developed nation is facing, indicating severe inefficiency.

Figure 2: Health Care Spending as Percentage of GDP, 1980-2013














Source: OECD Health Data 2015, from the Commonwealth Fund.

Despite this, it is widely noted that the US does not lead the world in health care outcomes. Figure 3 illustrates a comprehensive study done by the Commonwealth Fund which found that of 11 OECD countries, the US ranked last in health care quality and outcomes. The vast divide between what the US spends and what they receive is a primary reason that comprehensive health insurance reform is a necessary step for the United States.

Examining the individual failings illustrated here reveals many of the areas this paper focuses on. Categories that the US came last in included cost-related problems, efficiency, equity, and healthy lives. Cost-related problems are certainly an issue that could be solved by insurance reform and a decrease in the number of uninsured Americans. Further, as covered in Prus et al. (2010) and Kirby and Kaneda (2010), a large portion of the equity issues in health care relate to race in the United States, with racial minorities recording significantly lower health insurance coverage rates than whites. These issues form the basis for the topic of this study.

Figure 3: Health Care Rankings

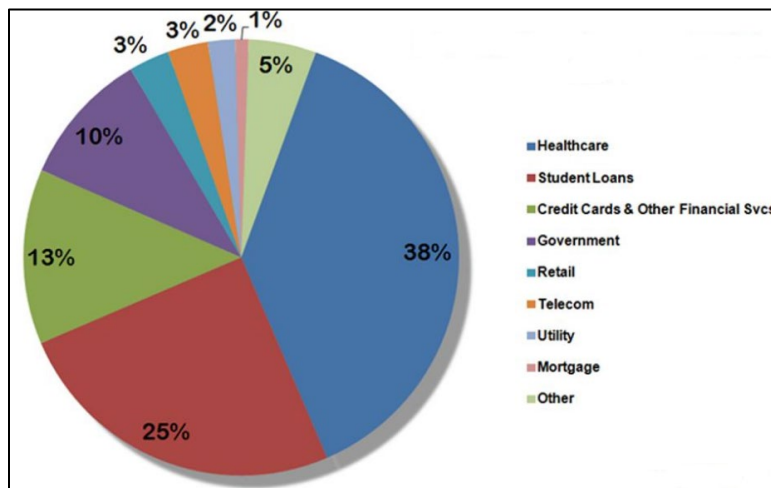
COUNTRY RANKINGS											
	Top 2*		Middle		Bottom 2*						
											
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

Source: Calculated by the Commonwealth Fund, 2010.

Note in Figure 3 that the US ranks last of the surveyed countries in ‘Cost-Related Problems’. Due to the obscenely high costs of health care (almost \$3,000.00 more than the next highest country per capita) Americans are finding themselves buried with medical debt. Figure 4 below illustrates how large this issue has become. Health care debts make up almost 40% of all debts collected from consumers in 2013, larger than all other sources of debt combined except for student loans. This type of debt is one of the leading causes of bankruptcy in the United States, and one of the central issues the individual mandate was hoping to remedy. The plan behind the ACA and individual mandate was to both reduce costs across the board and increase the number

of insured Americans. Even having the barest minimum insurance required by the individual mandate would help to insulate individuals from medical debt related bankruptcies. Additionally, as the literature review covered, since racial minorities are far more likely to not possess health insurance, they are much more susceptible to this type of health care related debt and bankruptcy.

Figure 4: Debt Collected from Consumers in 2013



Source: D. Munro, Forbes, 2014.

Given these trends in the health care industry this research will focus on if the ACA has helped to protect racial and ethnic minorities. These groups are more susceptible to high cost medical spending (with poorer outcomes than is seen on an international level) therefore leaving them open to medical bankruptcy at a higher rate than their white counterparts.

4.0 Data and Empirical Model

4.1 Data

Based on the how different portions of the ACA were implemented as illustrated in Figure 1 (Section 3) this study will use data from the years 2010 and 2011 to make up the before ACA pool and 2013 and 2014 for the after pool. While the ACA was signed into law in 2010 the individual mandate was not upheld until 2012 and did not come into effect until the beginning of 2014. These pools then allow this study to capture two years before and after the confirmation of the individual mandate.

Selecting 2010 and 2011 as the before pool, provides the benefit of helping to answer whether or not the individual mandate was the motivation for many to get insurance, as only after 2012 was it confirmed that everyone would need coverage under this law. It can be assumed that those who would be most motivated by a penalty tax might hold out on purchasing insurance until after the Supreme Court ruled on that provision. This goes back to the first research objective, whether or not the ACA decreased the number of uninsured Americans. By creating several dummy variables for race and ethnicities this study will also be able to breakdown which groups if any demonstrated the most significant change in the post ACA years of 2013 and 2014. Since the beginning of 2014 was when the individual mandate first began, these two years will capture individuals who purchased insurance leading up to the start, and then after.

This study uses the following variables collected from the University of Minnesota: Minneapolis' Integrated Public Use Microdata Series (IPUMS) (Genadek et al. 2015). This data consists of US Census microdata. This microdata is individual level data that is collected on persons and households by the census and organized for use by the university's team.

Table 1: Variables and Definitions

Coverage	The dependent variable. Dummy variable indicating the presence of any form of health insurance coverage.	Hispanic	Dummy variable indicating whether or not the individual is of Hispanic descent
Age	Variable indicating the age of the individual in years.	Immigrant	Dummy variable indicating whether or not the individual is an Immigrant.
Female	Dummy variable indicating whether or not the individual is female.	Education	Variable indicating the years of schooling the individual has received. Ranges from 0 to 24.
Black	Dummy variable indicating whether or not the individual is African American.	Income	Variable measuring the amount of wage and salary income received by the individual.
Asian	Dummy variable indicating whether or not the individual is of Asian descent		

The following are summary statistics for the two datasets; Before (2010 – 2011) and After (2013 – 2014). All data management and regression analysis was done using STATA 13.

Table 2: Before (2010 – 2011) Summary Statistics

Variable	N	Mean	Max	Min	Std. Dev.
Coverage	4,973,976	0.848	1	0	0.358
Age	-	47.755	95	16	19.105
Female	-	0.519	1	0	0.499
Black	-	0.105	1	0	0.306
Asian	-	0.047	1	0	0.211
Hispanic	-	0.120	1	0	0.324
Immigrant	-	0.146	1	0	0.353
Education	-	13.006	24	0	3.204
Income	-	24,165.07	607,000.00	0	42,694.58

Table 3: After (2013 – 2014) Summary Statistics

Variable	N	Mean	Max	Min	Std. Dev.
Coverage	5,092,406	0.872	1	0	0.334
Age	-	48.201	96	16	19.237
Female	-	0.517	1	0	0.499
Black	-	0.104	1	0	0.305
Asian	-	0.050	1	0	0.219
Hispanic	-	0.124	1	0	0.329
Immigrant	-	0.148	1	0	0.355
Education	-	13.141	24	0	3.239
Income	-	26,279.25	660,000.00	0	47,964.45

Looking at these summary statistics it is clear that there is a significant amount of consistency between the two datasets for almost all variables. Additionally, the mean for the variable Coverage actually answers the research objective posed earlier, was the ACA successful in decreasing the number of uninsured Americans. Since Coverage is a dummy variable ranging from 0 to 1, a mean of 0.848 translates to 84.8% of surveyed Americans having coverage. The second dataset's mean of 0.872 (87.2%) means there was an increase of 2.4% after the ACA. This will be further discussed in Section 6 of this paper.

The following are correlation statistics for the two datasets. All correlations are fairly low between both datasets, except for a few key circumstances, namely the Immigrant variable. Immigrant and Asian and Hispanic have a correlation around .4 for both variables in both datasets. This makes sense from a logical perspective, since a large portion of immigrants would fall into a racial category outside of the base group of white males. Additionally, the signs for each independent variable makes intuitive sense, i.e. racial variables tend to be negatively related to each other and income and age are positively related. This shows that the data gathered can be used for empirical study.

Table 4: Before (2010 – 2011) Correlation Coefficients

	Coverage	Age	Female	Black	Asian	Hispanic	Immigrant	Education	Income
Coverage	1.000								
Age	0.218	1.000							
Female	0.062	0.056	1.000						
Black	-0.062	-0.053	0.011	1.000					
Asian	-0.004	-0.043	0.008	-0.076	1.000				
Hispanic	-0.200	-0.143	-0.012	-0.102	-0.073	1.000			
Immigrant	-0.151	-0.030	0.002	-0.040	0.400	0.394	1.000		
Education	0.166	-0.006	0.007	-0.070	0.051	-0.219	-0.117	1.000	
Income	0.125	-0.057	-0.148	-0.060	0.034	-0.056	0.003	0.327	1.000

Table 5: After (2013 – 2014) Correlation Coefficients

	Coverage	Age	Female	Black	Asian	Hispanic	Immigrant	Education	Income
Coverage	1.000								
Age	0.191	1.000							
Female	0.054	0.054	1.000						
Black	-0.058	-0.048	0.009	1.000					
Asian	0.002	-0.046	0.009	-0.079	1.000				
Hispanic	-0.185	-0.140	-0.008	-0.103	-0.078	1.000			
Immigrant	-0.138	-0.020	0.005	-0.037	0.404	0.372	1.000		
Education	0.159	0.002	0.012	-0.066	0.054	-0.214	-0.108	1.000	
Income	0.106	-0.052	-0.147	-0.061	0.038	-0.055	0.009	0.309	1.000

4.2 Empirical Model

The specification for this study's model will include all of the variables assessed above. These include traditional determinants of possessing health care coverage such as age, income, and education, as well as the grouping variables being included for the sake of this study, namely female, black, Asian, Hispanic, and immigrant. This creates the following specification:

$$COVERAGE = \beta_0 + \beta_1 AGE + \beta_2(FEMALE) + \beta_3 BLACK + \beta_4 ASIAN + \beta_5 HISPANIC + \beta_6 IMMIGRANT + \beta_7 EDUCATION + \beta_8 INCOME + \epsilon$$

Given that the dependent variable for this study, Coverage, is a limited dependent variable (i.e. it is a Boolean variable that can only hold the value of 0 or 1) the standard OLS regression technique cannot be used. This is due in part to a limited dependent variable only taking on two values, which creates a binomial error term which is a violation of the Classical Assumptions. Additionally, the OLS regression using a dummy dependent variable cannot be assumed to still possess a homoscedastic error term, even if there were no serial correlation, violating another Classical Assumption. Given this, the traditional OLS model cannot be used for this study.

Instead this study will utilize a binomial logit model. This estimation technique is used for limited dependent variables because it avoids unboundedness problems by utilizing a variation of the cumulative logistic function. These logit models produce a logit coefficient that measures increasing or decreasing probabilities based on one unit increases in the independent variables. More meaningful though, is using these coefficients for generating odds ratios through exponentiation. These ratios represent probabilities of a certain outcome being true, in this case, having coverage. Thus for a variable such as income, the odds ratio will represent the increase in odds of coverage that is associated with an increase in income.

When comparing these odds ratios for dummy variables it is important to keep in mind that in this specification these odds ratios are being compared to the base group, which in this model is white males. An odds ratio of 1 would mean equal odds of having coverage as the base group. Therefore, an odds ratio of .5 for female would mean that females are about half as likely to possess coverage as males, whereas a 1.5 would mean they are one and a half times as likely to

have coverage. This study will look to see if there is a significant change in odds ratios for each racial group before and after the ACA was implemented using two logit models.

5.0 Empirical Results

The following are the regression results tables and a brief description of the outcomes.

Table 6: Logit Regression Results for Before (2010 – 2011) Dataset

Variable	Coefficient	Odds Ratio	Std. Err.	Z	P > Z
Age	0.032	1.032	0.0000741	441.60	0.000
Female	0.425	1.529	0.0027	156.11	0.000
Black	-0.469	0.625	0.0039	-118.61	0.000
Asian	0.225	1.252	0.0068	32.92	0.000
Hispanic	-0.656	0.518	0.0039	-164.63	0.000
Immigrant	-0.779	0.458	0.0040	-193.55	0.000
Education	0.067	1.069	0.0004	148.49	0.000
Income	0.000018	1.000018	$7.07 * 10^{-8}$	264.79	0.000
Constant	-0.759	-	0.0067	-112.81	0.000

Iteration 0	-2,112,556.0
Iteration 1	-1,853,837.7
Iteration 2	-1,808,296.7
Iteration 3	-1,806,566.6
Iteration 4	-1,806,562.3

Iteration 5	-1,806,562.3
Log Likelihood	-180,656.3

Observations	4,973,976
Pseudo R²	0.1448
LR Chi² (8)	611,987.37
Prob > Chi²	0.0000

Table 7 Logit Regression Results for After (2013 – 2014) Dataset

Variable	Coefficient	Odds Ratio	Std. Err.	Z	P > Z
Age	0.030	1.030*	0.000076	393.55	0.000
Female	0.390	1.477*	0.0028	136.76	0.000
Black	-0.475	0.621*	0.0041	-115.04	0.000
Asian	0.302	1.353**	0.0070	42.69	0.000
Hispanic	-0.626	0.534**	0.0040	-155.33	0.000
Immigrant	-0.779	0.458	0.0040	-190.13	0.000
Education	0.073	1.076**	0.0004	161.85	0.000
Income	0.000014	1.000014*	$6.68 * 10^{-8}$	220.30	0.000
Constant	-0.496	-	0.0068	-71.91	0.000

Iteration 0	-1,947,837.4
Iteration 1	-1,739,254.0
Iteration 2	-1,697,373.6
Iteration 3	-1,696,047.0
Iteration 4	-1,696,043.9

Iteration 5	-1,696,043.9
Log Likelihood	-1,696,043.9

Observations	5,092,406
Pseudo R²	0.1293
LR Chi² (8)	503,587.04
Prob > Chi²	0.0000

** indicates a decrease in odds ratios between datasets, ** indicates an increase.*

The results of the logit regressions showed that all variables were statistically significant for both datasets. For the Before (2010 – 2011) dataset the Asian variable had an unexpected positive coefficient despite preceding literature indicating that it should be expected to be negative. Despite this unexpected result, the rest of the coefficient signs were as expected, which resulted in fairly expected odds ratios. In the before model, Age (1.032), Female (1.529), Asian (1.252), Education (1.069), and Income (1.000018) all made it more likely that an individual

would possess health care coverage. As expected, most racial and ethnic minority groups had lower odds of having coverage than the base white male group, including Black (.625), Hispanic (.518), and Immigrant (.458).

Moving to the After (2013 – 2014) dataset, again all variables were statistically significant. Looking at the variables that saw a change in their odds ratios, Age (1.032 > 1.030), Female (1.529 > 1.477), Income (1.000018 > 1.000014), Black (.625 > .621) all saw a decrease in their odds of possessing coverage, while Asian (1.252 > 1.353), Education (1.069 > 1.076), and Hispanic (.518 > .534) all saw an increase. Despite the differences between regressions, the overall changes to each variable were very low, indicating no strong change to the odds of any given variable. The largest overall change occurred in the Asian variable, where the odds ratio increased by ~0.1.

6.0 Concluding Remarks

The purpose of this study was to answer a two part research objective, first, did the ACA decrease the number of uninsured Americans, and second, did the ACA impact a specific racial or ethnic group to a larger degree than any other. The first research objective was actually answered by the summary statistics for each dataset. Based on the means for the Coverage variable in each dataset (.848 to .872) there was an increase in coverage of 2.4% from before the ACA to after. This indicates that there was a small, but noticeable, increase in insurance coverage.

As for the second research objective, the answer appears to be no. Given the low absolute values of the change between models it seems that there was no one minority group that was impacted over any other. The findings in this study seem to line up well with preceding literature, indicating that minority racial groups (with the exception of those of Asian descent) had significantly lower odds of possessing health insurance coverage than the base group of white males. Despite this, the odds ratios remained significantly lower despite the ACA being implemented, which indicates that the ACA and individual mandate did not address the inconsistencies in health coverage among racial and ethnic groups.

6.1 Limitations

Unfortunately, this research faced two primary limitations, both of which concerned availability of data. The first was the limitation on the health insurance coverage variable from the IPUMS website. The latest year available is 2015, and the latest increase in the individual mandate occurred at the beginning of 2016. Future research should look increasingly at this newest data, as it shows the mandate at its full cost, which is still significantly lower than the theorized \$2,000 that would be required to attain nearly universal coverage. Additionally, census microdata does not record a critical target of the ACA, Americans with preexisting conditions. A significant portion of the ACA went to aiding those who were previously denied health insurance due to their preexisting conditions. So while this study showed a general increase in coverage rates, it did not show a particular group that these increases could be attributed to in particular. Had there been microdata available that captured individuals with preexisting or long-lasting conditions this study may have been able to conclusively attribute this overall coverage increase to this group.

6.2 Policy Recommendations

This study was able to show that a very marginal increase in coverage rates took place after the ACA was signed into law. A 2.4% increase at the cost of increased premium costs across the board is certainly a difficult tradeoff, especially taking into account the disparate coverage rates among minority groups. Likely this increase is coming from individuals who are only now able to gain coverage due to the changes to rules regarding preexisting conditions. That said, a tradeoff must be considered. Given the ACA's inability to help those minorities who tend to suffer through longer periods of being uninsured, and the rising costs associated with the ACA's implementation a new start may be in order.

Starting from the ground up may be a better way to tackle the health insurance question in the United States, especially if it is grounded in sound economic research. The bill would primarily need to focus on a larger individual mandate, programs to help minorities acquire insurance, as well as keeping current rules to aid those with preexisting conditions. Unfortunately, the highly politicized nature of health insurance makes this a tall order, but any future policy plans should proceed with these priorities in mind.

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