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DISCUSSION PAPER SERIES

IZA DP No. 15346

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ABSTRACT

Does Public Policy Affect Attitudes? Evidence from Age-Based Health Insurance Coverage Policies in the United States*

The existing literature provides evidence that public opinion and attitudes often affect public policy. However, little is known on how public policy might affect public attitudes and norms. I present new evidence on this topic by using age-based health insurance policies in the United States as natural experiments. I first exploit the discrete change in insurance coverage rates at age 26 due to the Affordable Care Act's dependent coverage mandate and show that this policy is associated with statistically significant deterioration in attitudes towards the necessity of health insurance among young adults who are affected by this policy the most. Next, I show that gaining health insurance at 65 due to the onset of Medicare does not have a significant impact on attitudes towards health insurance among the elderly. These findings are widespread across different demographic groups, robust under alternative model specifications, observed only after the policies are adopted, and highlight the importance of age in attitude formation.

JEL Classification: I12, I13, I18
Keywords: attitudes, beliefs, health insurance coverage, public policy

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1 Introduction

The question of whether public policy affects attitudes has been studied across many disciplines, but empirical knowledge is sparse. I present new evidence on this topic by using age-based health insurance policies in the United States as natural experiments. My main analysis is based on the Affordable Care Act's (ACA) dependent coverage provision, which requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. I exploit the discrete change in insurance coverage rates at this cutoff age and use a regression discontinuity (RD) design to compare the outcomes of those who are slightly younger than 26 (control group) with those who are slightly older than this age (treatment group). Since observable and unobservable characteristics of young adults are likely to be distributed smoothly across the cutoff age, the change in health insurance rates and outcomes related to attitudes towards health insurance at this age can solely be attributed to the policy itself. I also investigate how age contributes to the relationship between public policy and attitudes by using another age-based health insurance coverage policy in the United States, i.e., Medicare. To the best of my knowledge, this is the first paper that uses an RD design and data from a large, nationally representative survey to investigate the impact of public health policy on attitude formation.

The majority of the existing literature on the effects of the Affordable Care Act and Medicare focuses on outcomes related to healthcare utilization, spending, and self-reported physical and mental health and provides no empirical evidence on how these policies may affect public attitudes (Soni, Wherry, and Simon, 2020). Understanding the effects of policies on attitudes is important for policy-makers since some of the potential changes in attitudes may be negative and persistent. In the case of age-based health insurance coverage policies, losing or gaining health insurance at certain age cutoffs may result in permanent or long-lasting changes in attitudes towards health insurance. These changes may have a negative impact on health insurance coverage rates among those who were affected by these policies the most.

In this paper, I explore the impact of losing health insurance coverage at age 26 due to the ACA's dependent coverage provision on attitudes towards health insurance among young adults. Kotsadam and Jakobsson (2011) argue that attitudinal change is more likely among the individuals who notice and are directly affected by the policy. Since the dependent coverage provision's main impact is on those who are not eligible for an employer-sponsored plan, my empirical analysis focuses on those who are not employed. I use data from the $2011 - 2017$ waves of the self-administered questionnaire

(SAQ) component of the Medical Expenditure Survey (MEPS), which contains detailed information on certain attitudes related to the necessity of health insurance coverage. In particular, the respondents were asked whether they believe that health insurance is not necessary; health insurance is not worth the money it costs, and they can overcome illness without help from a medically trained person. The survey also contains a question that enables me to assess the overall risk-taking behavior of each respondent.

Consistent with earlier literature (Dahlen, 2015; Dillender, 2015; Yörük, 2018), I find a statistically significant and considerable drop in health insurance coverage rates at age 26. This effect is stronger for those who are not employed. For this group, ACA's dependent coverage mandate has also a significant impact on attitudes towards health insurance. The most conservative estimates suggest that losing health insurance coverage at age 26 is associated with a statistically significant 5.1 percentage point increase in the likelihood that a respondent agreed that she does not need health insurance. At the same age cutoff, the likelihood of agreeing with the statement that insurance is not worth the money it costs or that one can overcome illness without help from a medically trained person also goes up significantly. I show that sudden changes in attitudes towards health insurance at age 26 cannot be attributed to the potential decrease in risk-taking behavior at the same cutoff age. The analysis of trends in data provides some evidence that the changes in attitudes towards health insurance are long-lasting and may have an impact on long-run insurance coverage rates among young adults.

I show that those who are not covered by a public insurance plan and healthier and married young adults are more likely to form negative attitudes towards health insurance when they lose coverage at age 26. I also investigate the role of age in shaping attitudes towards health insurance using another age-based health insurance coverage policy in the United States. i.e., Medicare. I find that gaining health insurance coverage at 65 due to Medicare does not lead to statistically significant changes in attitudes towards health insurance among the elderly. This result highlights how attitudes towards health insurance-related policies may change over the life cycle.

2 Background and review of the literature

The existing literature provides ample evidence that public opinion, attitudes, and beliefs affect public policy (Burstein, 2003). However, the literature on how public policy might affect public attitudes and norms is quite limited. A common argument for why policies might affect attitudes in the

political science literature is that policies and laws create feedback effects once they are introduced. Normative feedback effects are likely to arise when policies provide citizens with a sense of what is desirable (Svallfors, 2009). People may also internalize values signaled by laws or policies to increase their cooperation opportunities (Cooter, 1998). McAdams (2000) argues that laws may change public behavior by signaling underlying attitudes in society to individuals concerned with approval. Laws and policies may also help people to update their prior beliefs by creating a focal point (Cooter, 1998). However, changes in attitudes do not necessarily follow the signals sent out by the legislature. Public reaction to the law can either reinforce or undermine its impact (Carbonara et al., 2008).

Several recent studies investigate the impact of public policies on attitudes.[1] However, the majority of the existing studies are descriptive. Among few those that are based on relatively large samples and clearly identify treatment and control groups, Soss and Schram (2007) investigate whether public opinion shifted because of the welfare reform in the United States in the 1990s. They argue that the reforms did not affect mass opinion since they were distant to most people. Kotsadam and Jakobsson (2011) show that the implementation of a Norwegian law criminalizing the purchase of sexual services made people more negative toward buying sex. This effect was primarily observed in the areas where prostitution is more viable before the policy change. Aksoy, et al. (2020) find that legal same-sex relationship recognition policies across Europe are associated with statistically significant improvements in attitudes towards sexual minorities. Barabas (2009) shows that participants of Individual Retirement Accounts (IRA) are more likely to favor Social Security privatization, while Health Savings Account (HSA) participants are less likely to prefer consumer consumer-driven health coverage in which individuals are empowered to make choices. Arni (2015) investigates the impact of a coaching program on various labor market outcomes and attitudes. He documents the positive short-run effects of the program on motivation, self-confidence, and beliefs.

Two recent papers in political science literature focus on the feedback effects of health policies. Using data from 1200 adults before and after the implementation of the ACA, Jacobs and Mettler (2018) find that those who have experienced personal or familial impacts of the ACA's specific features are more likely to report that it has also enhanced their overall access to health coverage by 2014 compared to 2010. Chattopadhyay (2017) tests whether $19-25$-year-olds differ from $26-34$-year-olds in support for the ACA, civic predisposition, political efficacy, and political participation and finds no statistically significant differences between these two groups. The current paper differs from these two papers in several ways since it uses a different empirical methodology, focuses on different outcomes,

[1] Larsen (2019) and Campbell (2012) provide a review of the existing literature.

and uses a much larger sample size from a nationally representative panel data.

Starting from September 23, 2010, The ACA required private health insurance plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for this coverage. Several papers used an RD design to exploit the discrete change in health insurance coverage rates at age 26 to investigate the impact of the dependent coverage mandate on several outcomes such as health care utilization and expenses, labor market outcomes, and workers' compensation filing (Dillender, 2015; Nguyen and Yörük, 2020; Kim, 2021; Yörük and Xu, 2019; Yörük, 2018; Dahlen, 2015). In contrast to these papers, I focus on the effects of the dependent coverage mandate on attitudes towards health insurance.

Soss and Schram (2001) and Kotsadam and Jakobsson (2011) argue that policies may affect people differently depending on the context in which they are introduced. Attitudinal change is more likely among the individuals who notice and are directly affected by the policy. ACA's dependent coverage mandate did not have an impact on the entire 26-year-old population in the United States. It mainly affected the health insurance coverage rates among those who are not employed full-time and therefore, not eligible for coverage under employer-sponsored plans. Therefore, although I present the results from the full sample, the majority of the empirical analysis in this paper focuses on those who are not employed, i.e., who were affected by the policy change the most.

The effects of public policies on attitudes may also differ by age and across cohorts. Svallfors (2009) argues that people whose life course transition into adult life has already been fully accomplished should be more resistant to attitudinal change. Similarly, young people are expected to adapt quickly to new rules since they have fewer previous formative experiences that need to be reconsidered (Svallfors 2009). Therefore, one might expect the change in attitudes to be larger among younger individuals. To test this hypothesis, I consider another age-based health insurance coverage policy in the United States: Medicare. Medicare provides health insurance coverage to those who are 65 and older. Using data from the MEPS and RD design, I investigate whether gaining health insurance coverage at age 65 has a significant impact on attitudes towards health insurance among older individuals and compare the effects of this policy with that of the ACA's dependent coverage mandate.

3 Data

The MEPS is a nationally representative survey of families and individuals, their medical providers (doctors, hospitals, pharmacies, etc.), and employers across the United States. In the MEPS, each individual is interviewed for up to five rounds over two full calendar years. Individuals who leave their original family unit are followed and remain in the survey. Every year, a new panel of approximately $15,000$ individuals is added to the survey. Therefore, two panels overlap at any given point in time, resulting in roughly $30,000$ individuals being interviewed each year. Since the ACA's dependent coverage mandate was enforced after September 2010, I use data from the $2011-2017$ waves of the MEPS.[2] I restrict my sample to those who are at most 8 years younger or older than the age 26 cutoff (18-34-year-olds) but also consider alternative age bandwidths such as 4 or 6 years as a robustness check.[3]

In the household component (HC) of the MEPS, each respondent is asked about their health insurance coverage status and the type (public, private, etc.) of insurance that they held for each month during the two years that they remained in the survey. To investigate the potential change in the insurance coverage status of individuals upon turning 26, I create a binary variable representing whether the respondent was covered under any type of medical insurance plan at a given month. The data for attitudes towards health insurance coverage comes from the self-administered questionnaire (SAQ) component of the MEPS, which was completed by a subsample of respondents of the HC.[4] The SAQ includes four questions that ascertain certain health-related attitudes. Two items deal with attitudes toward health insurance. The other two questions deal with attitudes that might influence decisions to purchase health insurance or to use health services. These questions are whether the respondent believes that he/she does not need health insurance; health insurance is not worth the money it costs; he/she is more likely to take risks than the average person; and he/she can overcome illness without help from a medically trained person. The SAQ reports answers to these questions in

[2] I was not able to use data from the recent waves of the MEPS because the most recent (2018-2020) waves of the SAQ component of the MEPS do not contain information on the exact interview date of the respondents, which is used to calculate the precise age in months at the time of the interview.

[3] Since information on the exact birth date is not available, it is not possible to determine the exact date of turning 26 for each respondent. Therefore, it is impossible to determine the treatment status of a respondent for the month that she turns 26. In order to address this problem, I exclude the month that each respondent turns 26 from the sample (when the running variable, i.e., the number of months before or after the 26th birthday, is equal to 0).

[4] A person was considered eligible to receive an SAQ if that person did not have a status of deceased or institutionalized, did not move out of the U.S. or to a military facility, was not a non-response at the time of the Round 2 or Round 4 interview date, and was 18 years of age or older. New respondents added in Round 3 or Round 5 were not asked to complete an SAQ.

five discrete categories: agree strongly, agree somewhat, uncertain, disagree somewhat, and disagree strongly. For the main empirical analysis, I generated a binary variable for each outcome which equals to one if the respondent reported agreeing with the statement either somewhat or strongly.

Unlike the HC, respondents completed the SAQ only once a year. I matched the health insurance coverage status from the HC with the month that the respondent completed the SAQ for each survey year.[5] I dropped the observations for which insurance coverage status is not available since for these observations, it is not possible to determine whether the change in attitudes is a result of the change in health insurance coverage. The final SAQ sample has more than $40,000$ observations for each outcome. Appendix Table A1 reports the summary statistics for the full sample and by employment status. Approximately 79% of the respondents in the sample have health insurance, with those who are older than 26 being slightly less likely (78.3%) compared with those who are younger than 26 (79.4%). The difference between the health insurance coverage rates of these two groups is more pronounced if the sample is restricted to those who are not employed (68.9% vs. 78.4%).

Compared to those who are younger than 26, those who are older than 26 are less likely to take risks (0.24 vs. 0.29). However, they are more likely to report that insurance is not worth the money it costs (0.32 vs. 0.25) and more likely to report that they can overcome illness without help from a medically trained person (0.33 vs. 0.31). Similar to the differences in health insurance coverage, the differences in attitudes towards health insurance between these two age groups widens among those who are not employed.

4 Methodology

The identification strategy for the empirical analysis relies on the assumption that those who are slightly younger or older than 26 have very similar observable and unobservable characteristics. However, due to the ACA's dependent coverage mandate, compared to those who are slightly older than 26 (who are at risk of losing their insurance coverage), those who are slightly younger than 26 are more likely to be covered under a health insurance plan. Since individuals have no control over their age, the ACA's dependent coverage mandate creates an exogenous variation in health insurance coverage status at the cutoff age of 26. I exploit this variation and use an RD design to estimate the

[5] Some respondents of the 2017 wave of the MEPS completed the SAQ in 2018. For these respondents information on control variables and health insrurance coverage status come from the 2018 wave of the MEPS.

discrete change in attitudes towards health insurance at this cutoff age.[6] In particular, I estimate the following RD model:

$$Y_{it} = \beta_1' \mathbf{X}_{it} + \alpha_1 Age26_{it} + f(age_{it}) + \varepsilon_{it}. \tag{1}$$

In this equation, Y_{it} one of the outcomes representing different beliefs and attitudes towards health insurance coverage for individual i at time t. The individual-specific control variables are denoted by $\mathbf{X}_{it}$ and include family size, log of household income, and a set of binary variables controlling for employment status, gender, race, and marital status of the respondent. The binary treatment variable is denoted by $Age26_{it}$ and is equal to 1 if the respondent is at least 26 years old in a given month and 0 otherwise. The coefficient of interest, α_1, is the estimated effect of turning 26 and losing eligibility for the dependent coverage on outcome variables. A smooth function of the age profile is the forcing variable in the context of the RD design. Since information on the birth month and year of each respondent is available in the MEPS, it is possible to calculate the difference between the date of the actual outcome and the respondent's 26^{th} birthday in months. Therefore, for each respondent, the variable age_{it} represents the number of months before or after the 26^{th} birthday. Modeling the smooth function of the forcing variable correctly is one of the main problems in implementing the RD design. Although I use a parametric model that contains a quadratic polynomial of the forcing variable as the preferred specification, to test the robustness of the results under alternative model specifications, I also estimate models that contain the first or third-order polynomial of age_{it} which is fully interacted with the treatment variable. Therefore, the complete age profile for alternative parametric models with different degrees of polynomials can be expressed as:

$$f(age_{it}) = \sum_{j=1}^{k} \delta_j age_{it}^j + \sum_{j=1}^{k} \lambda_j (Age26_{it} \times age_{it}^j) \text{ for } k = \{1, 2, 3\}. \tag{2}$$

I restrict the data from the MEPS to all observations in which the respondent is up to 96 months (8 years) younger or older than the cutoff age. Since the RD estimates may be sensitive to the selection of this bandwidth, I also report results for alternative choices of bandwidths, i.e., $|age_i| \leq 72$ (6 years) and $|age_i| \leq 48$ (4 years). To control for birthday celebration effects and different treatment of age across insurance providers, in all models, I exclude the month that each respondent turns 26 from the sample ($age_i = 0$). I use the sample weights as reported in the MEPS and report standard errors, that are two-way clustered at the individual level and by the forcing variable.[7] I also estimate

[6] Imbens and Lemieux (2008), Porter (2003), and Lee and Lemieux (2010) present a detailed discussion of the RD design and related issues.

[7] I use two different sample weights as reported in the MEPS. For insurance coverage outcome, I use the sample weights as reported in the HC of the MEPS. For outcomes representing different attitudes towards health insurance, I

separate models for different demographic groups and by marital status.

As a robustness check, I also estimate non-parametric RD models following Hahn, Todd, and van der Klaauw (2001) and Porter (2003). In these models, I use local linear regressions to estimate the left and right limits of discontinuity at age 26. In all non-parametric models, I use mean squared error (MSE) optimal bandwidth selection procedure to determine the optimal bandwidth as discussed in Calonico, et al. (2017). Following Cattaneo, Titiunik, and Vazquez-Bare (2019), I conduct a formal power analysis to test whether the SAQ sample is large enough to detect meaningful changes in outcome variables as a response to a change in health insurance coverage status at age 26. I find that for all outcomes, I have a sufficient number of observations in the sample to detect approximately 0.1 standard deviation change from the mean with a 90% power.

The identifying assumption in the RD models is that at age 26, the change in the insurance coverage status should be solely due to the age-based cutoff and other observable and unobservable characteristics of respondents that may affect insurance coverage and health care utilization patterns should not exhibit a discrete change around the 26^{th} birthday. In appendix Figure A1, I plot the 30-day averages of selected control variables around the 26^{th} birthday. The figures show that control variables vary smoothly around the cutoff age. Therefore, they should have very little effect on the estimates of the discontinuity and serve mainly to increase the precision of the estimates. The main results that are presented in the next section also show that the inclusion of control variables to the models has virtually no effect on main estimates. Another possible threat to the identification strategy comes from the possibility of non-random sorting of respondents to either side of the age cutoff. Appendix Figure A2 shows the distribution of observations around the age-26 cutoff. Overall, the distribution of the frequency of observations is smooth across the cutoff age and thus, there is no evidence of nonrandom sorting around the cutoff age in the sample.

5 Results

In Table 1, I report the RD estimates of the change in outcome variables at age 26 under alternative parametric and non-parametric models for the full sample. Similar to the estimates from the previous literature (Dahlen, 2015; Yörük, 2018; Yörük and Xu, 2019), age 26 cutoff is associated with a 3.1 to 5.9 percentage points decrease in health insurance coverage rates among young adults. Table 1 also shows that young adults are more likely to believe that they do not health insurance when they

use the sample weights as reported in the SAQ of the MEPS.

turn 26. However, estimates for this outcome are not statistically significant. The effect of turning 26 on the probability of agreeing with the statement that health insurance is not worth the cost is statistically significant under non-parametric and high-order parametric model specifications. In particular, young respondents are 6.3 to 9.1 percentage points more likely (25 to 36 percent change compared to pre-age-26 mean) to agree with this statement when they turn 26. On the other hand, coefficient estimates on the remaining outcomes are small in magnitude and statistically insignificant. Figure 1 also illustrates these findings.

Soss and Schram (2001) and Kotsadam and Jakobsson (2011) argue that policies may affect people differently depending on the context in which they are introduced. The impact is more likely to be observed among the individuals who notice and are directly affected by the policy the most. The ACA's dependent coverage mandate did not have an impact on the entire 26-year-old population in the United States. It mainly affected the health insurance coverage rates among those who are not employed full-time and therefore, not eligible for coverage under employer-sponsored plans. Those who are employed may have already been covered under an employer sponsored plan before they turn 26, especially if they do not live close to their parents or can easily switch to an employer-sponsored plan after turning 26.[8] To test this hypothesis formally, I estimate separate models for those who are employed and who are not and report the results in Table 2. The difference between these two samples is striking. For those who are employed (approximately two thirds of the sample), the estimated effect of the age 26 cutoff on insurance coverage rates becomes statistically insignificant for the majority of the specifications. Similarly, for this group of young adults, the effects of ACA's dependent coverage mandate on attitudes towards health insurance are small in magnitude and estimated coefficients are not statistically significant for the majority of alternative model specifications. Figure 2 also shows that for those who are employed, there is no discrete change in attitudes towards health insurance at age 26.

Panel B of Table 2 shows that for those who are not employed, age 26 cutoff is associated with a 10.5 to 13.2 percentage points decrease in health insurance coverage rates among young adults. These estimates are highly significant and much larger compared to full sample estimates. For this group of young adults, those who are slightly older than 26 are much more likely to agree that they do not need health insurance. In particular, the probability of agreeing with the statement that one does not need health insurance goes up by 9.7 to 13.3 percentage points (52 to 72 percent increase from the

[8] Chatterji, Liu, and Yörük (2022) show that the ACA's dependent care mandate is associated with an increased likelihood that young adults live with or close to their parents since most health insurance plans' in network providers are concentrated within a certain geographical area.

mean of the control group) at age 26. This effect is highly significant and robust to the inclusion of control variables and selection of alternative model specifications. The likelihood of agreeing with the statement that insurance is not worth the money it costs also goes up by 9.3 to 14.3 percentage points (43 to 66 percent increase from the mean of the control group) at age 26. This effect is not significant under a non-parametric model, however. Results in panel B of Table 2 also show that among those who are not employed, those who just turned 26 are much more likely to agree that they can overcome illness without the help of a medically trained person. In particular, the likelihood of agreeing with the statement that one can overcome illness without the help of a medically trained person goes up by 9.5 to 15.6 percentage points (38 to 63 percent increase from the mean of the control group). It is possible that those who lose their health insurance coverage at age 26 are less likely to take risks to avoid urgent medical care. If this is the case, sudden changes in attitudes towards health insurance at age 26 may be attributed to the decrease in risk-taking behavior rather than the policy itself. The results reported in panel B of Table 2 show that there is little evidence to support this hypothesis. The change in the probability of agreeing with the statement that the respondent is more likely to take risks is positive and statistically significant, which implies that unemployed young adults are more likely to take risks when they turn 26 rather than avoid risky behaviors. Figure 3 illustrates these findings and show the discrete changes in health insurance coverage rates and attitudes towards health insurance at age 26 among those who are not employed.

So far, I have documented the change in attitudes towards health insurance at age 26 for aggregated responses. Although these findings are easy to interpret and document the direction and magnitude of the effects, they do not fully show the intensity of the behavioral changes. To address this potential problem, I estimate RD models for each of the five discrete choices in the SAQ for those who are not employed and report the results in appendix Table A2. The results are in line with those reported in panel B of Table 2 and reveal that for the majority of outcomes, there are no statistically significant changes in the "disagree strongly", "disagree somewhat", or "uncertain" categories.

5.1 Alternative samples

I have documented the impact of losing health insurance coverage at age 26 on attitudes towards health insurance for those who are employed and those who are not. In this section, I test the robustness of the statistically significant results for those who are not employed for alternative subsamples. Some young adults are eligible for public insurance such as Medicaid before turning 26, and therefore are not likely to be affected from the policy change. Not surprisingly, excluding these respondents from the

sample of unemployed young adults yields stronger effects of turning 26 on attitudes towards health insurance. Table 3 shows that among those who are not covered by a public health insurance plan, turning 26 is associated with a 18.3 percentage points increase in the likelihood of reporting health insurance is not necessary, a 16.8 percentage points increase in the likelihood of reporting health insurance is not worth the cost, and 17.1 percentage point increase in the likelihood of reporting one can overcome illness without help from a professional.

Employers are not required by federal law to offer health insurance to spouses or domestic partners, but most employers do. It is plausible that unmarried young adults are more likely to lose coverage at age 26 and hence, change their behavior towards health insurance at this age. Table 3 shows that this is the case. For this group, the likelihood of agreeing with the statement that there is no need for health insurance or insurance is not worth the money it costs goes up by 13.2 and 14.9 percentage points at age 26, respectively. Similarly, unmarried young adults are significantly more likely to report that they can overcome illness without help when they turn 26.

There is an extensive literature, which documents that individuals belonging to different demographic groups may have different attitudes towards risk.[9] These differences may also affect attitudes towards health insurance. Compared to males, the effect of losing health insurance coverage on attitudes towards health insurance is more pronounced for females. When they turn 26, females are more likely to report that they do not need health insurance or they can overcome illness without help. They are also more likely to report that they are more likely to take risks.

Results in Table 3 show that the effect of the ACA's dependent coverage mandate on unemployed blacks are relatively limited. This group of young adults are 10 percentage points more likely to report that they do not need health insurance at age 26. However, for this group, the effect of the policy on the remaining outcomes is not statistically significant.

Health status may play an important role in shaping attitudes towards health insurance. The majority of young adults in the MEPS report very good or excellent health. Relatively healthy young adults may be more likely to believe that health insurance does not worth the cost. Table 3 supports this hypothesis and shows that at age 26, the likelihood of agreeing with the statement that insurance is not worth the money it costs goes up by up 18.7 percentage points for those who reported good or excellent health status. Similarly, relatively healthy young adults are more likely to agree that they do not health insurance and they can overcome illness without help when they turn 26.

The MEPS has detailed information on income and categorizes individuals into different income

[9] See, for example, Booth and Nolen (2012) and Powell and Ansic (1997).

groups based on the federal poverty level (FPL). Table 3 shows that the effect of ACA's dependent coverage mandate on attitudes towards health insurance among the poor (100% or less of the FPL) and the near-poor ($100 - 124\%$ of the FPL) are considerable and statistically significant for certain outcomes. When they turn 26, these individuals are more likely to report that they do not need health insurance (11.9 percentage points increase from the pre-age-26 mean) and can overcome illness without the help of a health care professional (17.5 percentage points increase from the pre-age-26 mean). To sum up, for those who are not employed, the statistically significant impact of the ACA's dependent mandate on attitudes towards health remains robust for the selection of alternative subsamples and the estimated impact of the policy becomes more pronounced when sample is restricted to those who are expected to be affected from the policy the most, i.e., those who are unemployed and not covered by a public insurance plan or those who are unemployed and not married.

5.2 Robustness checks

So far, I have documented that the statistically significant and sizable impact of a sudden change in health insurance coverage at age 26 on attitudes towards health insurance among unemployed young adults is robust under parametric model specifications that include a quadratic or cubic polynomial of the forcing variable. Table 4 shows that these results are not sensitive to alternative selections of parametric specifications. In particular, under a parametric model that is estimated with a first order polynomial of the forcing variable, the estimated impact of turning 26 on attitudes towards health insurance remains statistically significant with the exception of the probability of reporting that health insurance is not worth the cost.

For the main analysis, I restrict my sample to those who are at most 8 years (96 months) younger or older than the age 26 cutoff (18-34-year olds). Table 4 shows that the majority of results remain robust under relatively shorter bandwidths of 72 and 48 months. Estimates from these alternative models are also relatively larger compared to the main results reported in Table 2.

Another possible concern for the validity of the results is that young adults who are about to turn 26 and lose dependent coverage, may anticipate this beforehand and increase their health care consumption just before their 26^{th} birthday. This could generate a discrete drop in health care utilization at age 26 even if there is no true change in actual behavior. If this is the case, young adults may be more likely to report that they do not need health insurance (at least in the short run) when they turn 26. To investigate this possibility, I compare the attitudes of those who are about to turn 26 with those who are about to turn 25 or 27. If those are slightly younger than 26 are more

likely to use medical care, one would expect that compared with those who are slightly younger than 25 or 27, those who are slightly younger than 26 would be more likely to report that health insurance is important and worth the money it costs since the ACA's dependent coverage mandate should not affect the insurance coverage rates around these alternative age cutoffs. However, Figure A3 in the Appendix shows that the attitudes towards health insurance among young adults up to six months before the 25^{th}, 26^{th}, and 27^{th} birthdays exhibit similar trends. Therefore, there is no evidence that young adults anticipate the effects of the ACA's dependent coverage provision and significantly alter their health care consumption just before their 26^{th} birthday. I further investigate this potential problem using a donut RD design, in which I exclude observations for three months before and after the cutoff age of 26 from our sample. The results reported in Table 4 show that the estimates from the donut RD analysis for all outcomes are highly significant and comparable to the main results.

Change in attitudes towards health insurance at age 26 may be due to potential mood changes during the birthday and short period following it. If this is the case, the estimates may reflect the birthday effect rather than the true effect of the policy change. The last two specifications in Table 4 show that this is not the case. Estimating similar RD models for alternative age cutoffs (25^{th} and 27^{th} birthdays) yields statistically insignificant coefficients for the treatment effect for all outcome variables with the exception of the probability of reporting that health insurance is not worth the cost. Therefore, at least three main outcomes out of four (probabilities of reporting there is no need for health insurance, one can overcome illness without help, and the respondent is more likely to take risks) passes all the robustness checks, which implies that the change attitudes towards health insurance at age 26 among unemployed young adults is not sensitive to selection of alternative parametric or non-parametric models or alternative age bandwidths, exclusion of observations around the cutoff age, and estimating models with placebo treatment variables.

5.3 Does age matter? Evidence from Medicare

Another age-based health insurance coverage policy in the United States is Medicare, which is a public health insurance program that provides insurance coverage for people aged 65 and older regardless of income or health status. Using an RD design, several recent papers document a discrete jump in health insurance coverage rates in the United States at age 65 (Card, Dobkin, and Maestas, 2008 and 2009; Barcellos and Jacobson, 2015; Chatterji, Nguyen, and Yörük, 2022). How does this policy affect attitudes towards health insurance among the elderly? On the one hand, in line with the findings for young adults who lose insurance at age 26, one may expect that older people may value health

insurance more when they get access to Medicare. On the other hand, age may be a significant factor in shaping attitudes towards health insurance. Alternatively, gaining health insurance may not necessarily generate the opposite impact of losing health insurance. Thus, the effect of Medicare on attitudes towards health insurance is ambiguous. To investigate the impact of access to health insurance through Medicare at age 65 on attitudes towards health insurance, I use data from the 2011-2017 waves of the MEPS and estimate RD models similar to equation (1) in which I replace the treatment variable with a binary variable for age 65 cutoff and model the age profile similar to equation (2), where age_{it} represents the number of months before or after the 65^{th} birthday. To make results comparable with the results for young adults, I use an age bandwidth of 96 months (8 years) and estimate separate models for those who are employed and who are not.

Table 5 shows that the onset of Medicare eligibility at age 65 leads to sharp increases in the health insurance coverage rates among older people. In particular, I find that at age 65, the probability of having insurance goes up by 10.7 percentage points for the full sample, 8.6 percentage points for those who are employed, and 13.5 percent for those who are not employed. The signs of coefficient estimates imply that older people are less likely to agree that they do not need health insurance, insurance is not worth the cost, and they can overcome illness without medical help when they gain health insurance coverage at age 65. These results appear to be consistent with the results for young adults. However, the magnitudes of the estimates for older people are small and almost always statistically insignificant. Figure 4 further illustrates these results. These findings imply that age may be a significant factor in shaping attitudes towards health insurance. As people get older and their health-related risks increase, they might value health insurance more. Health insurance coverage rates among the elderly are also significantly higher compared to those among young adults.[10]

5.4 Policy implications

The Census Bureau provides population estimates by age (United States Census Bureau, 2022). Based on these estimates, in 2019, slightly more than 1.4 percent of the U.S. population was 26-years-old.[11] My estimates of the sizable and statistically significant effects of the ACA's dependent coverage mandate on attitudes towards health insurance are mainly observed for those who are not

[10] For comparison, in my sample, health insurance coverage rate among 25 year olds is 78 percent. These group of young adults are covered under ACA's dependent care mandate and therefore, more likely to have health insurance compared to those who are slightly older. On the other hand, among 64 year olds, who are not elligible for Medicare, insurance coverage rate is 88 percent.

[11] In 2019, estimated U.S, population was 328,239,523 and there were 4,611,220 26-year-olds.

employed, which corresponds to 25.8 percent of the full sample from the MEPS. My most conservative estimates suggest that at age 26, the likelihood of agreeing with the statement that one does not need health insurance goes up by 5.1 percentage points (parametric model estimated using a first order polynomial of the forcing variable as reported in Table 4). The estimated effects of the change in other attitudes at age 26 such as the likelihood of reporting health insurance does not worth the money it costs or one can overcome illness without a help from medical professional are also similar. Using this estimate, a back-of-the-envelope calculation implies that at their 26^{th} birthday, approximately $5,056$ young adults start to express negative attitudes over the necessity of health insurance.[12]

According to the 2019 American Community Survey (ACS), 26-year-olds had the highest uninsured rate among all ages, followed by 27-year-olds (Conway, 2020). The raw data from the MEPS show that insurance coverage rates among 31-year-olds or older are comparable or higher than those who are slightly younger than 26. This implies that on average, young adults may struggle up to 5 years after turning 26 to regain access to health care. Those who are not employed remain uninsured for even longer periods. How much of this persistent effect can be attributed to changes in attitudes towards health insurance is not clear. Although it is possible to estimate models of health insurance coverage rates for the post-age-26 period in which attitudes are controlled for, this approach will certainly generate biased estimates of the effect of attitudes on health insurance coverage rates due to reverse causality. Nevertheless, to further document the correlation between attitudes and health insurance coverage rates during the post age-26 period for the unemployed, I plot the trends in health insurance coverage rates and attitudes for 3-month blocks around the age-26 cutoff in Figure 5. Following the sudden drop in insurance coverage rates, the deterioration in attitudes towards the necessity of health insurance occurs at the 26^{th} birthday and continues approximately two years into the post age-26 period. Attitudes towards the necessity of health insurance start to improve afterwards accompanied by the increase in insurance coverage rates. Since Figure 5 excludes those who are employed full-time, the slow recovery in health insurance coverage rates cannot be attributed to the availability of employer-sponsored health insurance plans over time.

[12] I estimate that in 2019, among 4,611,220 26-year-olds, 1,189,695 were not employed (25.8 percent of the sample). Using the estimated RD estimate of 0.051, approximately 60,674 young adults are affected every year. This suggests that 5,056 young adults are affected at a given month. This estimate reflects the findings from the most conservative model. Coefficient estimates from many models suggest that the estimated impact may be up to three times larger.

6 Conclusion

Understanding more about the responses to changes in health insurance status is essential to evaluate public policies that are aimed at increasing access to health care. I exploit the discrete change in health insurance coverage rates at age 26 and 65 in the United States to investigate whether health policy affects attitudes towards health insurance. Using detailed data from the MEPS and an RD design, I first document that insurance coverage rates exhibit a sudden drop at age 26 due to the ACA's dependent coverage mandate. Young adults who are expected to be affected the most by the ACA's dependent care mandate, i.e. those who are not eligible for employer-sponsored health insurance plans, significantly change their attitudes towards health insurance at age 26. At this age, the probability of agreeing with the statement that one does not need health insurance goes up by 9.7 to 13.3 percentage points among this group. Similarly, the likelihood of agreeing with the statement that one can overcome illness without the help of a medically trained person goes up by up to 15.6 percentage points at age 26. These effects are stronger for those who are not married and thus, not eligible for spousal coverage and for those who are not covered under a public health insurance plan. I also document that age plays an important role in shaping attitudes towards health insurance. The onset of Medicare eligibility at age 65 leads to sharp increases in the health insurance coverage rates. However, this change does not lead to statistically significant changes in attitudes towards health insurance among the elderly.

Since all RD designs estimate local treatment effects, the findings of this paper represent the short-run effects of the ACA's dependent coverage provision and Medicare on attitudes towards health insurance. However, a simple analysis of trends in health insurance coverage rates and attitudes provide some evidence that changes in attitudes among young adults due to policy changes may be persistent in the long run. These persistent changes may also have a negative impact on long-run insurance coverage rates among this population.

The literature on how public policy might affect public attitudes and norms is sparse. The existing literature often explores the effects of policies via large-scale and politically infeasible changes such as natural disasters or wars. Bhavnani (2009) argues that such natural experiments provide few possibilities for policy advice compared to investigations of effects of small-scale policy change. Furthermore, the existing literature on the effects of health policy on attitudes is based on mainly descriptive analysis of relatively small samples and does not rely on credible estimation techniques. This paper fills this gap and provides new information for policymakers to understand more about

the unintended consequences of the impact of health policies on public attitudes.

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Table 1. Change in health insurance coverage and attitudes towards health insurance at age 26: Full sample

	Has health insurance		No need for insurance		Insurance is not worth the cost		Can overcome illness without help		More likely to take risk	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(7)	(8)
Parametric (Quadratic)	-0.056***	-0.059***	0.022	0.020	0.017	0.016	-0.009	-0.011	-0.000	-0.004
	(0.016)	(0.015)	(0.017)	(0.017)	(0.021)	(0.021)	(0.016)	(0.016)	(0.017)	(0.017)
Parametric (Cubic)	-0.031*	-0.032*	0.028	0.023	0.065***	0.063***	0.008	0.003	0.005	0.000
	(0.018)	(0.019)	(0.021)	(0.022)	(0.024)	(0.024)	(0.020)	(0.020)	(0.024)	(0.022)
Pre-age-26 mean	0.794	0.795	0.228	0.228	0.250	0.250	0.312	0.312	0.285	0.285
No. of obs.	41231	41101	40867	40739	40719	40589	40797	40667	40687	40557
Non-parametric	-0.032*		0.017		0.091***		0.007		-0.014	
	(0.020)		(0.022)		(0.026)		(0.020)		(0.026)	
No. of obs.	10061		11233		6591		11329		7868	
Controls	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes

Notes: Results from RD models with alternative parametric and non-parametric specifications. Sample weights are used in all models. Standard errors are two-way clustered by the forcing variable and at the individual level and reported in parentheses. The signs * and *** denotes statistical significance at 10 and 1 percent levels.

Table 2. Change in health insurance coverage and attitudes towards health insurance at age 26: Employed vs. unemployed

	Has health insurance		No need for insurance		Insurance is not worth the cost		Can overcome illness without help		More likely to take risk	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(7)	(8)
A. Employed										
Parametric (Quadratic)	-0.049***	-0.048***	0.004	0.003	0.000	0.000	-0.033*	-0.033*	-0.021	-0.023
	(0.017)	(0.016)	(0.019)	(0.019)	(0.025)	(0.025)	(0.020)	(0.019)	(0.020)	(0.019)
Parametric (Cubic)	-0.017	-0.017	0.008	0.005	0.054*	0.053*	-0.023	-0.027	-0.013	-0.017
	(0.019)	(0.020)	(0.024)	(0.024)	(0.028)	(0.028)	(0.026)	(0.025)	(0.026)	(0.024)
Pre-age-26 mean	0.799	0.798	0.244	0.244	0.262	0.262	0.338	0.338	0.305	0.305
No. of obs.	30486	30475	30251	30240	30145	30134	30195	30184	30118	30107
Non-parametric	-0.025		0.003		0.105***		-0.013		-0.023	
	(0.020)		(0.025)		(0.029)		(0.027)		(0.027)	
No. of obs.	9333		8957		4586		8936		8923	
B. Not employed										
Parametric (Quadratic)	-0.105***	-0.107***	0.107***	0.114***	0.093**	0.102**	0.095***	0.102***	0.106***	0.105***
	(0.039)	(0.040)	(0.031)	(0.031)	(0.041)	(0.040)	(0.036)	(0.035)	(0.035)	(0.033)
Parametric (Cubic)	-0.116**	-0.115**	0.132***	0.133***	0.142**	0.143***	0.153***	0.156***	0.089**	0.086**
	(0.050)	(0.052)	(0.040)	(0.041)	(0.055)	(0.054)	(0.048)	(0.047)	(0.044)	(0.041)
Pre-age-26 mean	0.784	0.785	0.185	0.185	0.217	0.217	0.247	0.247	0.235	0.235
No. of obs.	10635	10626	10508	10499	10464	10455	10492	10483	10459	10450
Non-parametric	-0.132**		0.097**		0.073		0.115***		0.067*	
	(0.058)		(0.038)		(0.058)		(0.045)		(0.039)	
No. of obs.	1925		2243		1983		3033		3027	
Controls	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes

Notes: Results from RD models with alternative parametric and non-parametric specifications. Sample weights are used in all models. Standard errors are two-way clustered by the forcing variable and at the individual level and reported in parentheses. The signs *, **, and *** denote statistical significance at 10,5, and 1 percent levels.

Table 3. Change in attitudes towards health insurance at age 26: Alternative samples

	No need for health insurance	Insurance is not worth the cost	Can overcome illness without help	More likely to take risk
Not covered by public insurance	0.183***	0.168***	0.171***	0.116***
	(0.042)	(0.047)	(0.046)	(0.039)
Pre-age-26 mean	0.211	0.232	0.265	0.241
No. of Obs.	6051	6038	6045	6031
Not married	0.132***	0.149***	0.144***	0.148***
	(0.041)	(0.048)	(0.048)	(0.043)
Pre-age-26 mean	0.185	0.208	0.246	0.245
No. of Obs.	8086	8053	8077	8051
Female	0.127***	0.090*	0.095**	0.101**
	(0.039)	(0.049)	(0.045)	(0.041)
Pre-age-26 mean	0.145	0.205	0.213	0.185
No. of Obs.	6457	6428	6443	6428
Male	0.097*	0.128**	0.101	0.113
	(0.056)	(0.062)	(0.067)	(0.075)
Pre-age-26 mean	0.229	0.230	0.284	0.289
No. of Obs.	4042	4027	4040	4022
Black	0.099*	0.048	0.089	0.032
	(0.057)	(0.056)	(0.073)	(0.054)
Pre-age-26 mean	0.181	0.183	0.251	0.295
No. of Obs.	2704	2685	2697	2690
Excellent or very good health	0.187***	0.131**	0.157***	0.089**
	(0.042)	(0.056)	(0.049)	(0.039)
Pre-age-26 mean	0.225	0.235	0.274	0.248
No. of Obs.	6262	6248	6255	6241
Poor or near poor	0.119**	0.059	0.175***	0.152***
	(0.050)	(0.064)	(0.057)	(0.052)
Pre-age-26 mean	0.183	0.215	0.259	0.269
No. of Obs.	4553	4518	4544	4524

Notes: Results from RD models estimated using a quadratic polynomial of the forcing variable that is fully interacted with the treatment variable. The sample includes those who are not employed. All models include a set of control variables as discussed in the text. Sample weights are used in all models. Standard errors are two-way clustered by the forcing variable and at the individual level and reported in parentheses. The signs *, **, and *** denote statistical significance at 10,5, and 1 percent levels.

Table 4. Change in attitudes towards health insurance at age 26: Robustness checks

	No need for health insurance	Insurance is not worth the cost	Can overcome illness without help	More likely to take risk
Parametric (Linear)	0.051**	0.042	0.042*	0.062***
	(0.023)	(0.028)	(0.023)	(0.022)
Pre-age-26 mean	0.185	0.217	0.247	0.235
No. of Obs.	10499	10455	10483	10450
Bandwidth = 72 months	0.132***	0.152***	0.150***	0.106***
	(0.036)	(0.047)	(0.040)	(0.037)
Pre-age-26 mean	0.185	0.233	0.251	0.227
No. of Obs.	6981	6953	6969	6950
Bandwidth = 48 months	0.148***	0.082	0.102**	0.068
	(0.044)	(0.055)	(0.049)	(0.041)
Pre-age-26 mean	0.194	0.249	0.258	0.213
No. of Obs.	4276	4258	4271	4261
Donut RD	0.131***	0.122**	0.086**	0.118***
	(0.036)	(0.049)	(0.043)	(0.040)
Pre-age-26 mean	0.185	0.215	0.248	0.236
No. of Obs.	10246	10202	10230	10197
Placebo treatment (Age = 25)	-0.037	-0.081**	0.020	-0.003
	(0.030)	(0.041)	(0.036)	(0.030)
Pre-age-26 mean	0.187	0.225	0.247	0.230
No. of Obs.	9663	9623	9648	9620
Placebo treatment (Age = 27)	0.027	0.052**	-0.013	0.003
	(0.020)	(0.026)	(0.025)	(0.020)
Pre-age-26 mean	0.185	0.217	0.246	0.235
No. of Obs.	9962	9920	9947	9914

Notes: Except for the first specification, results are from RD models estimated using a quadratic polynomial of the forcing variable that is fully interacted with the treatment variable. The sample includes those who are not employed. All models include a set of control variables as discussed in the text. Sample weights are used in all models. Standard errors are two-way clustered by the forcing variable and at the individual level and reported in parentheses. The signs *, **, and *** denote statistical significance at 10,5, and 1 percent levels.

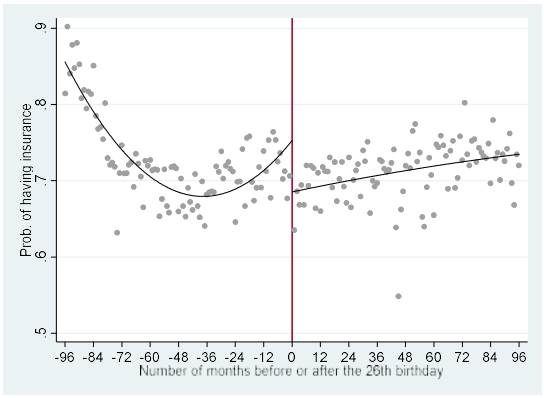
Table 5. Change in health insurance coverage and attitudes towards health insurance at age 65

	Has health insurance	No need for health insurance	Insurance is not worth the cost	Can overcome illness without help	More likely to take risk
A. Full sample	0.107***	-0.009	-0.023	-0.007	0.008
	(0.008)	(0.011)	(0.018)	(0.018)	(0.017)
Pre-age-65 mean	0.886	0.082	0.236	0.172	0.169
No. of Obs.	29644	29250	29119	29223	29087
B. Employed	0.086***	-0.027	-0.020	-0.036	-0.000
	(0.015)	(0.023)	(0.033)	(0.029)	(0.026)
Pre-age-65 mean	0.899	0.096	0.254	0.195	0.175
No. of Obs.	13630	13479	13432	13468	13420
C. Not employed	0.135***	-0.000	-0.036**	0.007	0.006
	(0.013)	(0.011)	(0.018)	(0.018)	(0.020)
Pre-age-65 mean	0.864	0.057	0.203	0.131	0.157
No. of Obs.	16014	15771	15687	15755	15667

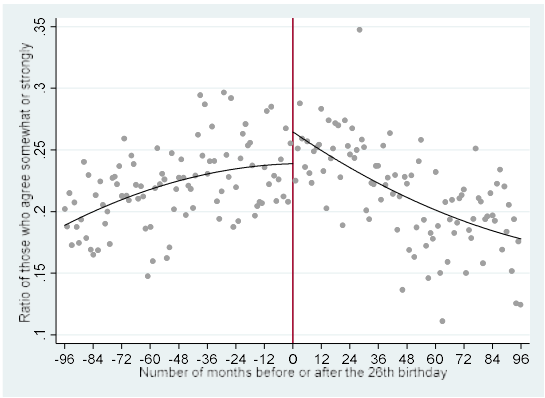
Notes: Results from RD models estimated using a quadratic polynomial of the forcing variable that is fully interacted with the treatment variable. The sample includes those who are not employed. All models include a set of control variables as discussed in the text. Sample weights are used in all models. Standard errors are two-way clustered by the forcing variable and at the individual level and reported in parentheses. The signs ** and *** denotes statistical significance at 5 and 1 percent levels.

Figure 1. Change in health insurance coverage and attitudes at age 26 (Full sample)

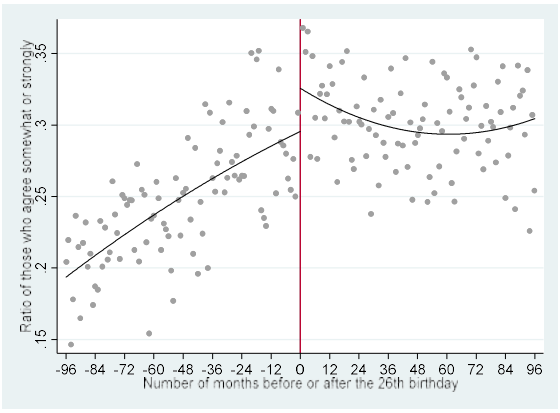
Has health insurance



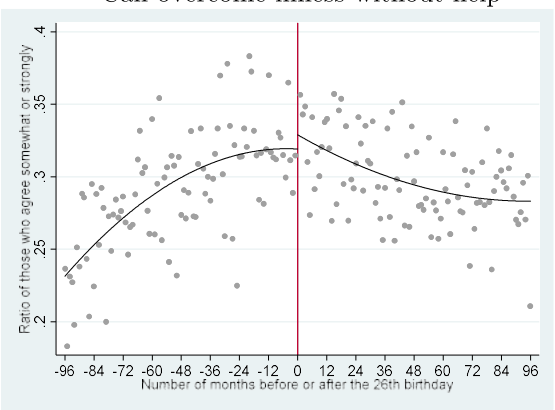
No need for health insurance



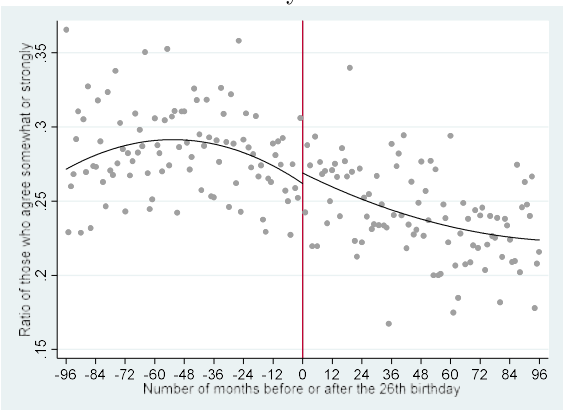
Insurance is not worth the cost



Can overcome illness without help



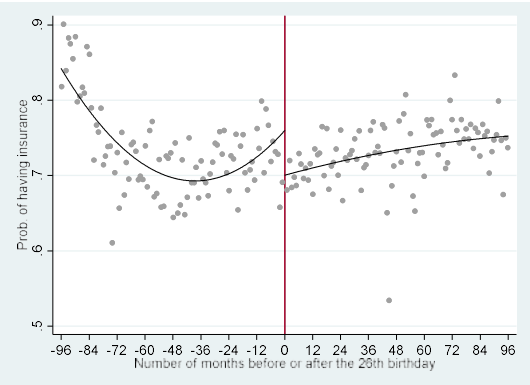
More likely to take risk



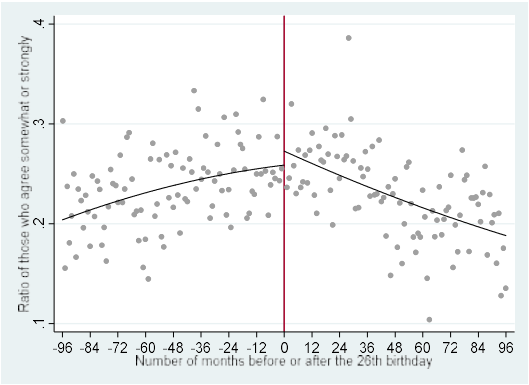
Notes: Means of the outcome variables for 1-month intervals, eight years before and after the 26th birthday, are plotted. The solid lines are the second-order polynomials fitted on individual observations on both sides of the age-26 cutoff.

Figure 2. Change in health insurance coverage and attitudes at age 26 (Employed)

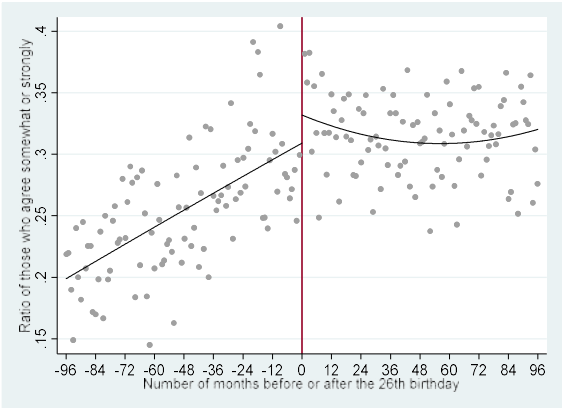
Has health insurance



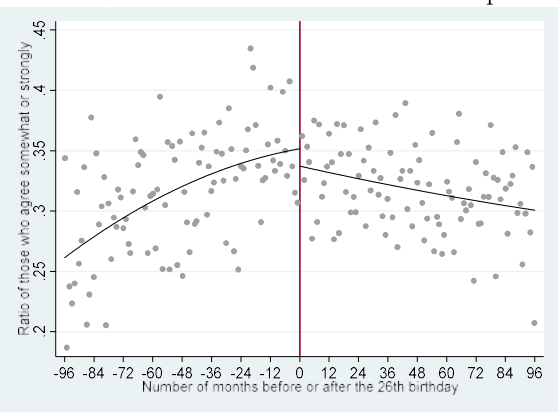
No need for health insurance



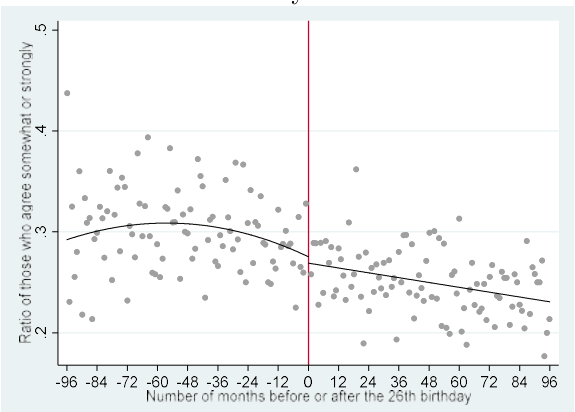
Insurance is not worth the cost



Can overcome illness without help



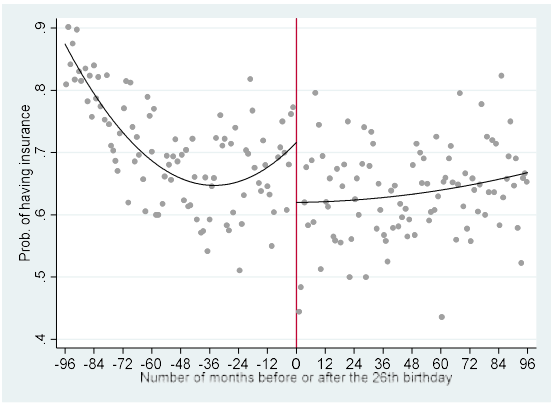
More likely to take risk



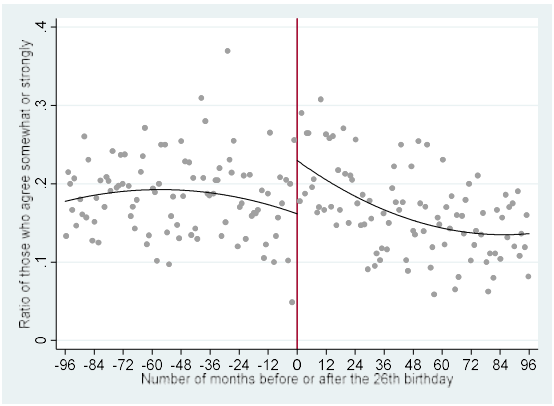
Notes: Means of the outcome variables for 1-month intervals, eight years before and after the 26th birthday, are plotted. The solid lines are the second-order polynomials fitted on individual observations on both sides of the age-26 cutoff.

Figure 3. Change in health insurance coverage and attitudes at age 26 (Not employed)

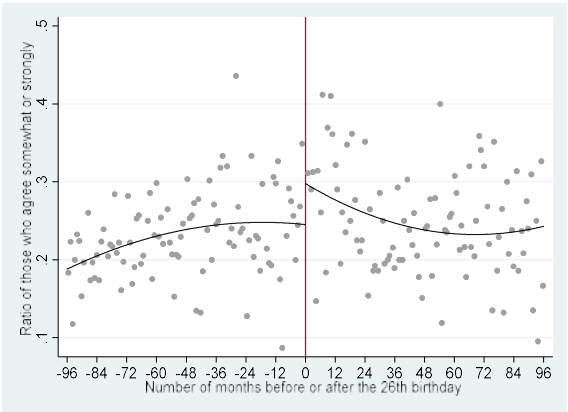
Has health insurance



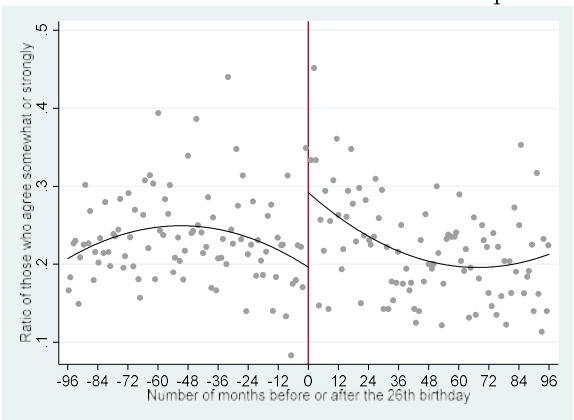
No need for health insurance



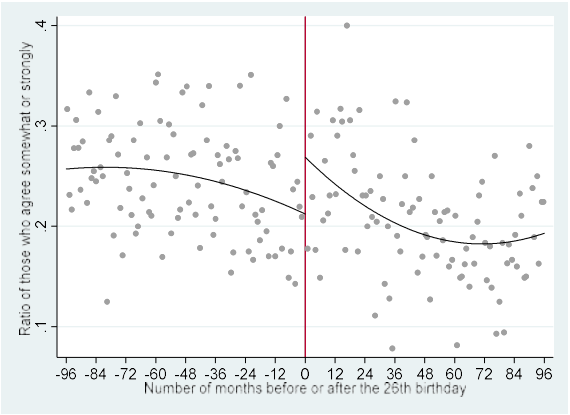
Insurance is not worth the cost



Can overcome illness without help

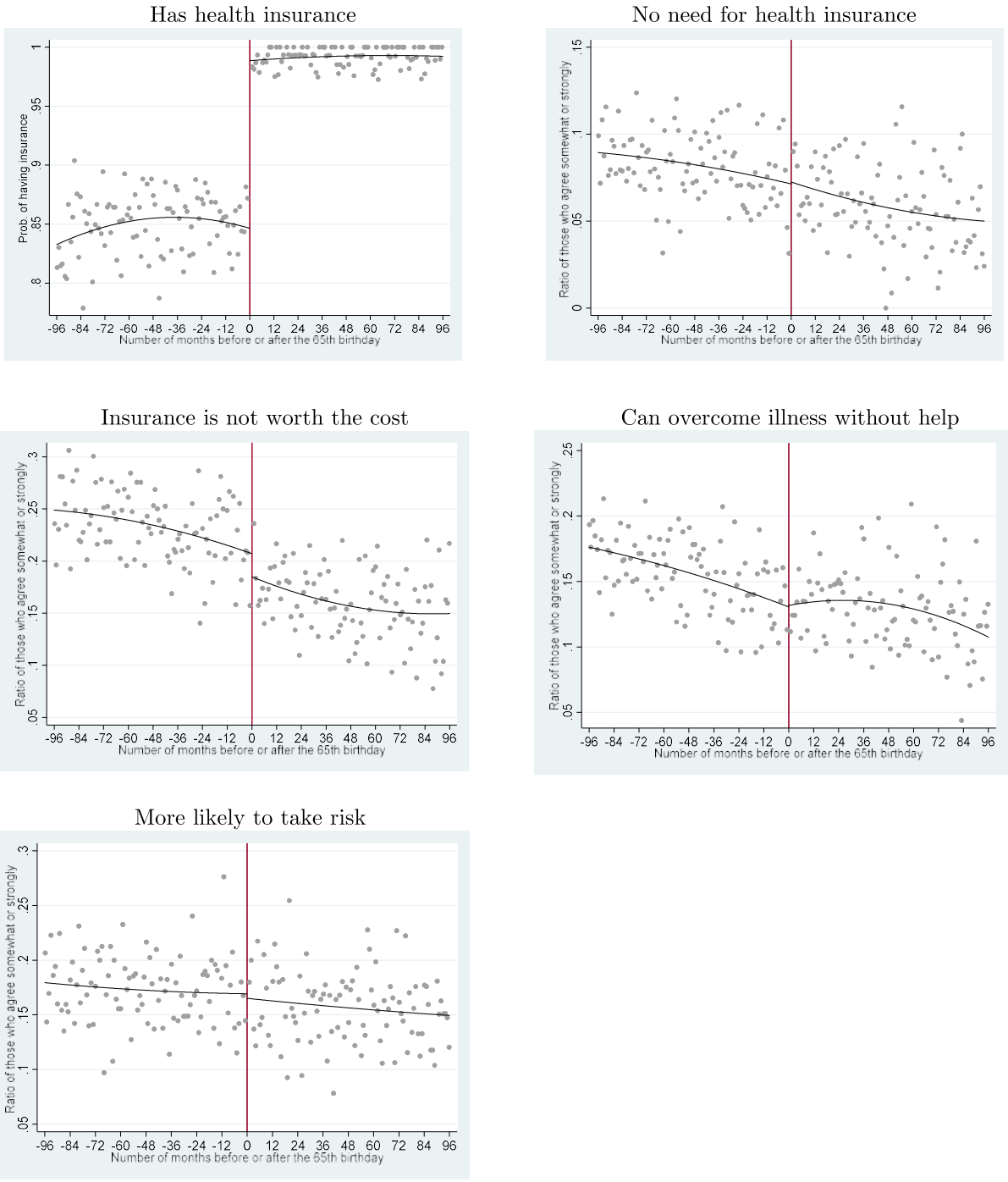


More likely to take risk



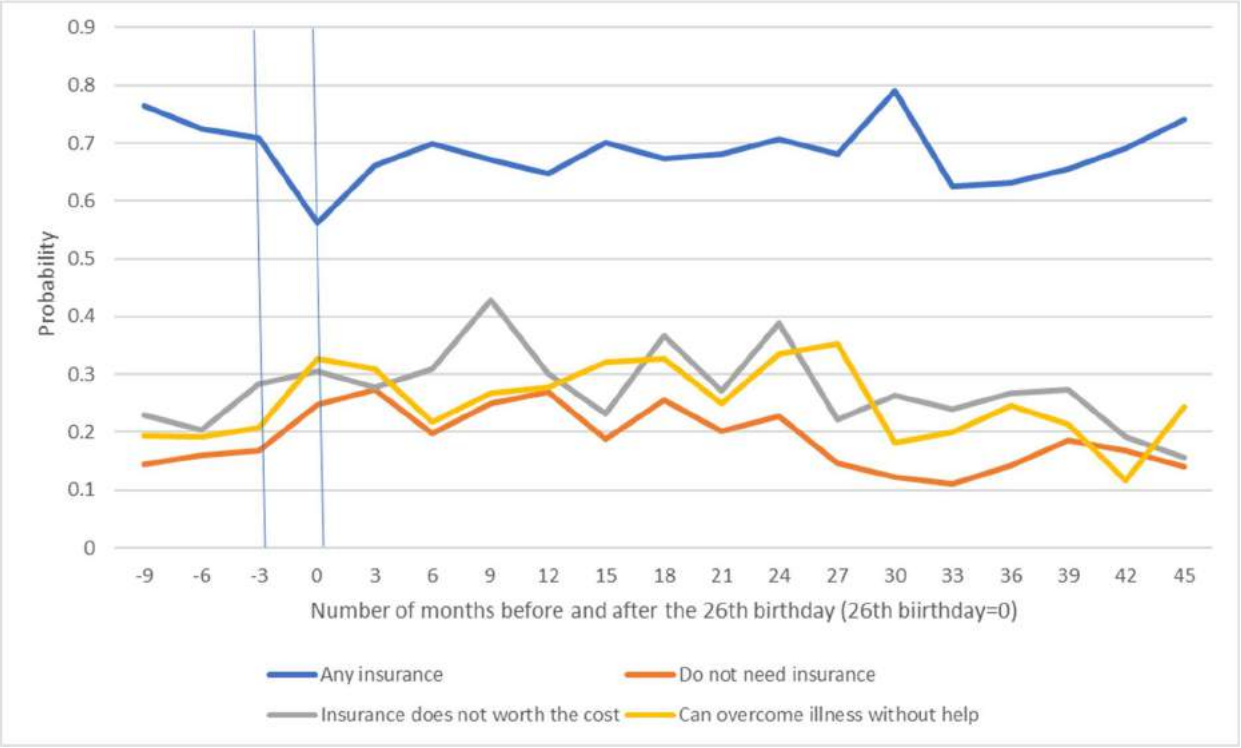
Notes: Means of the outcome variables for 1-month intervals, eight years before and after the 26th birthday, are plotted. The solid lines are the second-order polynomials fitted on individual observations on both sides of the age-26 cutoff.

Figure 4. Change in health insurance coverage and attitudes at age 65 (Full sample)



Notes: Means of the outcome variables for 1-month intervals, eight years before and after the 26th birthday, are plotted. The solid lines are the second-order polynomials fitted on individual observations on both sides of the age-26 cutoff.

Figure 5. Change in attitudes towards health insurance over time



Notes: Those who are employed are excluded from the sample. Sample averages for 3-month periods before and after the 26th birthday are plotted for different outcomes.

Appendix

Table A1. Summary statistics

	Full sample			Younger than 26			Older than 26		
	No. of obs.	Mean	S.D.	No. of obs.	Mean	S.D.	No. of obs.	Mean	S.D.
A. Full sample									
Has health insurance	41231	0.788	0.408	20101	0.794	0.404	21130	0.783	0.412
No need for health insurance	40867	0.227	0.419	19912	0.228	0.419	20955	0.227	0.419
Insurance is not worth the cost	40719	0.285	0.452	19850	0.250	0.433	20869	0.321	0.467
Can overcome illness without help	40797	0.320	0.466	19891	0.312	0.463	20906	0.328	0.469
More likely to take risk	40687	0.262	0.440	19836	0.285	0.452	20851	0.239	0.426
B. Employed									
Has health insurance	30486	0.799	0.401	13538	0.799	0.401	16948	0.799	0.401
No need for health insurance	30251	0.241	0.428	13431	0.244	0.430	16820	0.238	0.426
Insurance is not worth the cost	30145	0.299	0.458	13386	0.262	0.440	16759	0.329	0.470
Can overcome illness without help	30195	0.340	0.474	13415	0.338	0.473	16780	0.342	0.474
More likely to take risk	30118	0.274	0.446	13379	0.305	0.460	16739	0.247	0.431
C. Not employed									
Has health insurance	10635	0.751	0.433	6496	0.784	0.411	4139	0.689	0.463
No need for health insurance	10508	0.177	0.382	6415	0.185	0.388	4093	0.163	0.370
Insurance is not worth the cost	10464	0.237	0.425	6397	0.217	0.412	4067	0.275	0.447
Can overcome illness without help	10492	0.247	0.431	6409	0.247	0.431	4083	0.248	0.432
More likely to take risk	10459	0.220	0.414	6390	0.235	0.424	4069	0.193	0.395

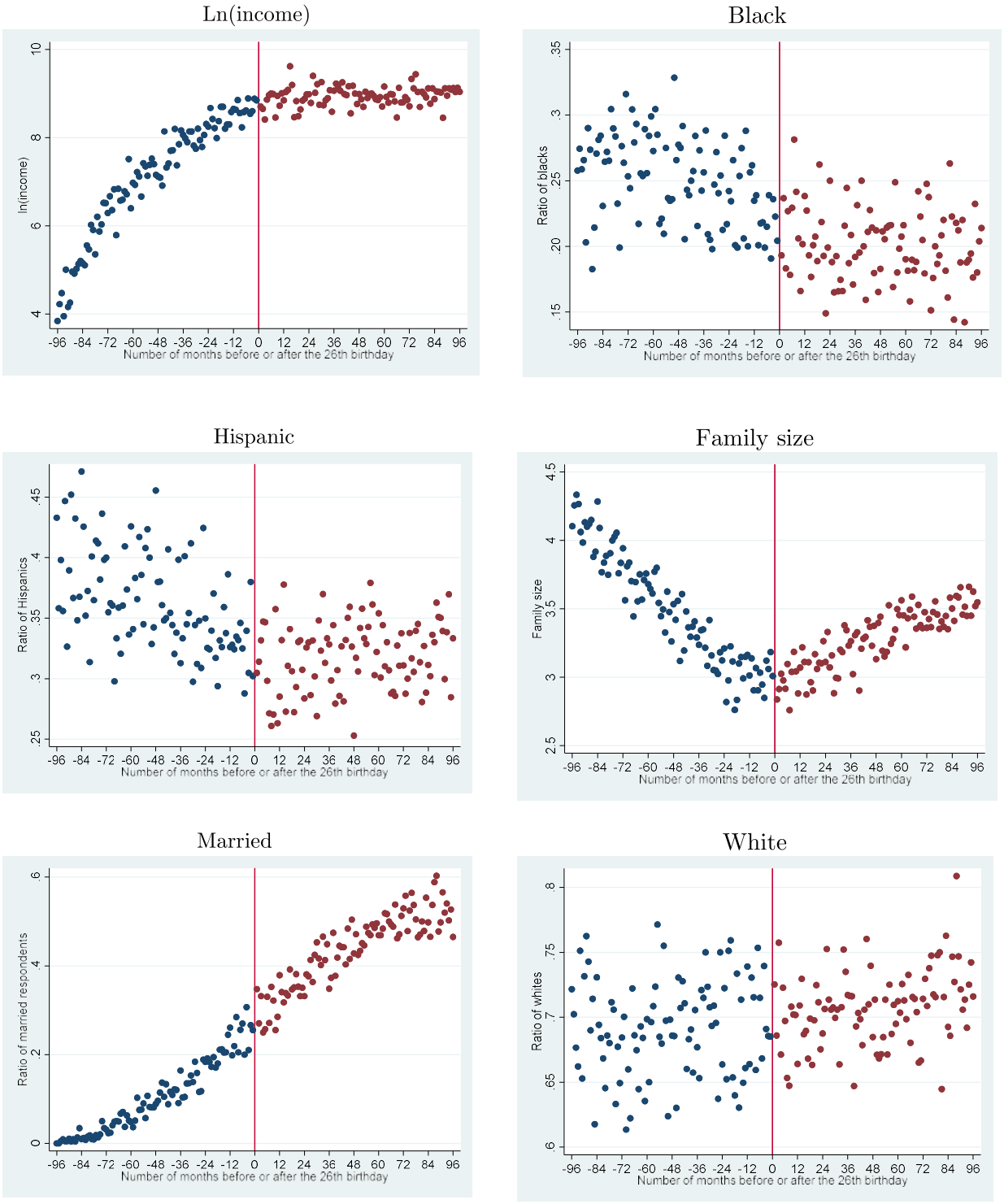
Notes: Sample weighted means are reported. The sample includes those who are up to 96 months older and younger than 26. The month that the respondent turned 26 is excluded from the sample.

Table A2. Change in attitudes towards health insurance at age 26: Discrete choices

	Disagree strongly	Disagree somewhat	Uncertain	Agree somewhat	Agree strongly
No need for health insurance	-0.066	-0.008	-0.038	0.087***	0.026
	(0.044)	(0.039)	(0.025)	(0.026)	(0.018)
Pre-age-26 mean	0.458	0.188	0.168	0.137	0.049
No. of obs.	10508	10508	10508	10508	10508
Insurance is not worth the cost	-0.054	-0.032	-0.014	0.050	0.049**
	(0.042)	(0.034)	(0.035)	(0.034)	(0.023)
Pre-age-26 mean	0.347	0.189	0.247	0.136	0.08
No. of obs.	10464	10464	10464	10464	10464
Can overcome illness without help	-0.041	-0.025	-0.036	0.050	0.051***
	(0.037)	(0.040)	(0.030)	(0.033)	(0.017)
Pre-age-26 mean	0.353	0.221	0.179	0.193	0.053
No. of obs.	10492	10492	10492	10492	10492
More likely to take risk	-0.096**	0.050	-0.059*	0.083***	0.022
	(0.040)	(0.039)	(0.034)	(0.024)	(0.019)
Pre-age-26 mean	0.330	0.224	0.211	0.179	0.056
No. of obs.	10459	10459	10459	10459	10459

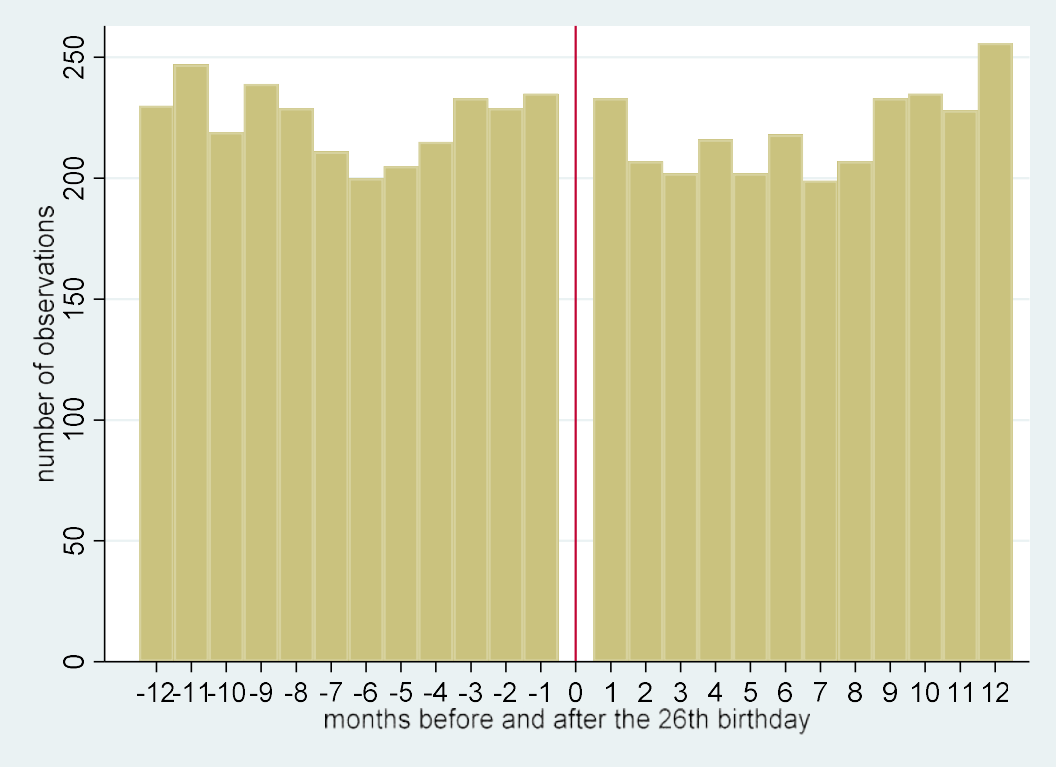
Notes: Results from RD models estimated using a quadratic polynomial of the forcing variable that is fully interacted with the treatment. Those who are employed are excluded from the sample. Sample weights are used in all models. All models include control variables as discussed in the text. Standard errors are two-way clustered by the forcing variable and at the individual level and reported in parentheses. The signs ** and *** denote statistical significance at 5 and 1 percent levels, respectively.

Figure A1. Change in selected control variables at age 26



Notes: Data from the HC of the MEPS. Those who are employed or covered by a public health insurance plan are excluded from the sample. Means of the selected control variables for 1-month intervals eight years before and after the 26th birthday are plotted.

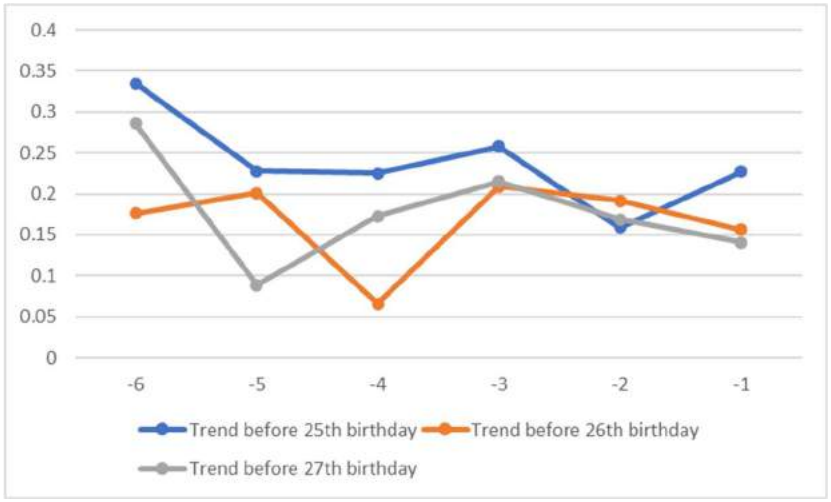
Figure A2. Distribution of the number of observations by month



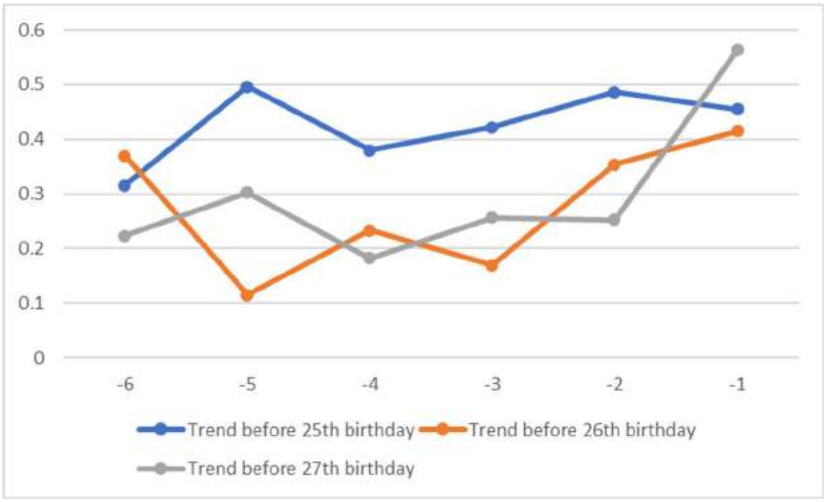
Notes: The number of observations for each month one year before and after the 26th birthday is plotted.

Figure A3. Change in attitudes towards health insurance up to six months before the 25th, 26th, and 27th birthdays

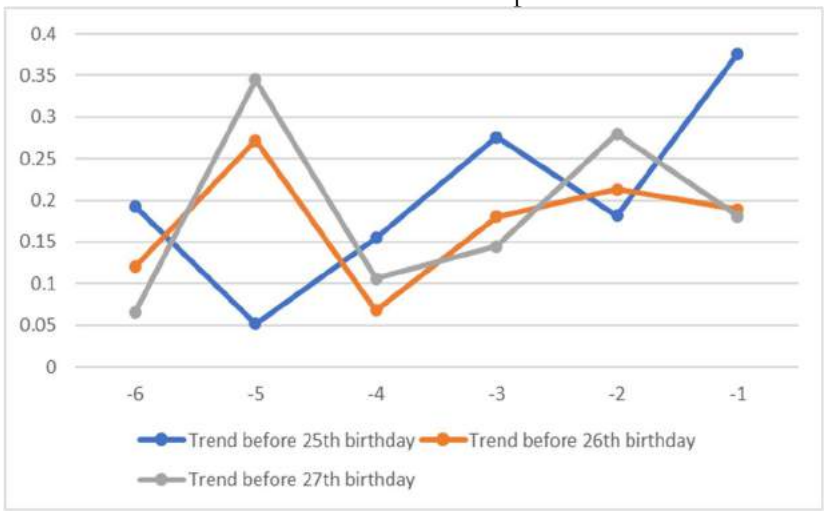
A. No need for health insurance



B. Insurance is not worth the cost



C. Can overcome illness without help



D. More likely to take risk