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Is health insurance an antidepressant?

New findings show that wider coverage has one clear effect on the population, and it's not one that anyone is talking about. hi2

By: Leon Neyfakh - June 22, 2013

For those who support President Obama's health care law, which has already begun to expand the number of Americans with health insurance, the rationale is a no-brainer: Having medical coverage makes people healthier and enables them to get the care they need when they get sick or injured. And broader coverage could help control our national health care bill by encouraging regular doctor visits and preventive care that cuts down on expensive emergency treatment.

But over the past several years, a stream of new information has dealt blows to both those ideas. Data from a pioneering Medicaid program in Oregon suggest that expanding health coverage hasn't saved the state any money—in fact, it increased annual health care spending by about 35 percent. Even more surprising is that, after two years, having Medicaid has done little to improve people's physical health.

But the Oregon data have revealed a separate, intriguing upside to the experiment that has thus far gotten little attention. According to a paper published in the New England Journal of Medicine this past May, people with access to Medicaid were a whopping 30 percent less likely than their counterparts to screen positive for depression.

This startling result raises the novel and perplexing notion that when we talk about health care, we're focusing on the wrong thing. It may be that, overall, the most important advantage of getting more Americans insured isn't that it lowers their risk for heart attacks, or helps them avoid last-minute surgery. It's that it just makes them happier.

"I was surprised initially," said Jonathan Gruber, a health care economist at MIT who is considered one of the architects of the Affordable Care Act and is a coauthor of the NEJM paper. "I didn't realize what a mental health toll being uninsured was taking on people."

The idea that medical insurance acts as an antidepressant hasn't been a big part of arguments from either side of the health care debate. That fight usually comes down to questions about whether or not society has a moral obligation to provide a safety net for sick people who can't afford to pay for their own health care—and whether affording them that protection is worth the price. But the new finding suggests that what's really at stake is how much we're willing to pay to give all Americans the less stressful, more fulfilling lives that come with having health insurance.

“Health insurance is about reducing financial uncertainty,” said Amitabh Chandra, a professor of health policy at the Harvard Kennedy School of Government, who was not involved in the Oregon study. “And it’s very good for well-being—not in a placebo sense, but in an actual sense.”

“Well-being” is an admittedly squishy concept: It’s difficult to measure objectively, and it’s hard to convincingly put forward as the focus of a huge piece of public policy. But in principle, at least, there are few more deeply held national ideals than the pursuit of happiness: To think of that pursuit as a public health issue is to realize that the Affordable Care Act’s real legacy may be quite different than what we expect.

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Among the handful of states that already offer Medicaid to a wide swath of low-income people, Oregon is uniquely useful to researchers. In 2008, a small budget surplus allowed for an additional 10,000 people to enroll in Medicaid, and state officials held a randomized “lottery” to determine who would be able to apply. This created a rare opportunity for researchers, setting into motion a sort of accidental science experiment. When the only difference between two groups of random people is that one has access to Medicaid and the other doesn’t, it’s possible to draw conclusions about the program’s impact by tracking patients’ progress over time.

Since the lottery, a team of the country’s top health care experts has been doing just that, zeroing in on about 12,000 people and carefully monitoring various aspects of their medical status through interviews and questionnaires. The data that have come out of their closely watched effort so far, covering the first two years of the program, show that people who won the lottery cost the system, on average, $1,172 more per year than those in the “control” group. They bought more prescription drugs, had more mammograms and cholesterol screenings, and made more doctor visits, but didn’t reduce their costly use of emergency rooms. “When apples are on sale, people tend to eat more apples,” explained MIT economist Amy Finkelstein, one of the principal investigators on the study. And when the apples are being paid for in large part by the state, that means higher costs for taxpayers.

It would be one thing if all those apples were making people healthier. But according to the sweeping set of findings published in May, Finkelstein and her team found that after two years, the people in the Medicaid group were no better off than their counterparts in terms of their blood pressure, cholesterol, or blood sugar, and their risk of having a heart attack was not significantly lower. Instead, the big difference was in the realm of mental health: Of the lottery-losers who didn’t get to apply for a Medicaid slot, almost 1 in 3 showed signs of depression when researchers interviewed them. In the Medicaid group, just over 1 in 5 did—a relative decline of about 30 percent.

Finkelstein says she doesn’t yet know why having insurance might make people less prone to depression, and along with the other principal investigator on the study, health economist Katherine Baicker from the Harvard School of Public Health, she cautioned against jumping to conclusions. One possibility might be that depressed people with insurance are more likely to get treatment. The Oregon researchers have not yet analyzed the possible role of talk therapy, but they’ve found that the group with access to Medicaid was not prescribed antidepressants at a significantly higher rate than the group without.

For Gruber and Chandra, the Oregon findings point to a striking conclusion: The coverage itself was what made the difference. In other words, the individuals in the Medicaid group—whose risk of catastrophic medical expenses was almost entirely eliminated—were less depressed simply because they had insurance.

"People who are uninsured live under constant daily stress," said Gruber. "They're worried about getting sick, and they're worried about paying the bills if they get sick. And I think that manifests [itself] in many aspects of life, including…depression."

Gruber's belief is supported by a large body of research showing that stress in general, and financial hardship in particular, frequently lead to the onset of mental health problems. In 2010, Sidra Goldman-Mellor, a postdoctoral fellow at the Center for Developmental Science at the University of North Carolina at Chapel Hill, systematically surveyed the medical literature and reported that "dozens of studies have found statistically significant associations between negative economic transitions and depression." One of the studies cited was a survey of Mexican-Americans, which found that the odds of experiencing an episode of clinical depression for the first time ever were five times higher for people who had lost their jobs during the 7 to 12 months before the survey.

Financial crises like bankruptcy and mortgage difficulties are linked to stress and depression as well. A study by Kenneth Kendler, a psychiatry professor at Virginia Commonwealth University, found that individuals who had experienced a major financial setback were almost seven times more likely to experience the onset of depression during the subsequent month. Kendler also found that unlike other traumatic events—the death of a loved one, for instance—financial catastrophes tend to be continuous, not discrete events, and thus can cause depression several months down the line.

Paying for health care, especially when it's life-or-death emergency treatment or chronic care for conditions like diabetes and cancer, is an enormous cause of financial hardship. A 2009 study by a team that included Senator Elizabeth Warren found that more than half of all personal bankruptcies happen because of medical bills. In that light, health insurance can be seen as a financial instrument designed specifically to protect against such a crisis. According to the Oregon study, being insured made people almost 60 percent less likely to have to borrow money or miss a payment on a bill.

For health care economists, it is intuitive to see health insurance first and foremost as an economic tool, and it's frustrating to them that more people don't talk about it that way. Health insurance, after all, doesn't prevent terrible things from happening to us. It just makes it easier for us to cope with them when they do, and provides us with the peace of mind associated with knowing that a health emergency won't destroy us financially.

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The idea that insurance is most effective at protecting us against our own fears—without making us significantly healthier physically—leads to a difficult question: Just how important is that?

That was the reaction from some quarters following the publication of the recent Oregon paper. A writer for the National Review suggested satirically that instead of going through with Obamacare, the government could get the same results for far less money by just putting Prozac in the water. Others made the argument more directly: “The absence of physical-health improvements indicts the entire enterprise,” wrote Michael Cannon, the director of health policy studies at libertarian think tank the Cato Institute. More independent voices echoed the sentiment: “Given this result,” wrote the Bloomberg View columnist Megan McArdle, “what is the likelihood that Obamacare will have a positive impact on the average health of Americans? Every one of us, for or against, should be revising that probability downwards.”

For Gruber, such responses reflected the widespread belief that mental health issues are not as serious, or worthy of attention, as diseases like cancer and diabetes. “We as a society just don’t care about mental health in the way we care about physical health,” Gruber said. “It is just not viewed as real health.”

There are good reasons to think it should be. For one thing, studies have shown that depression increases the risk of stroke, heart disease, and diabetes. For another, depression costs society a lot of money, just like other medical issues: According to one widely cited paper, the annual economic burden in the United States alone is on the order of tens of billions of dollars.

Even more to the point, though, is the argument that making people happier—relieving their stress, making them less depressed, and better able to pursue their goals—is exactly what public policy is for. “The role of social policy is not to improve GDP, necessarily, but to improve well-being,” said Gruber. Or, as Finkelstein put it, “There are lots of things we pay for as a society, from bridges to public housing to national security, which we don’t do to save money—we do them because we think they have some other benefits, and then we measure those benefits to try to decide if they’re worth the costs.”

As data collection continues, the Oregon study may yet show that over the long term, having insurance does in fact make people physically healthier. But in the meantime, we face a central question: How much are we willing to invest in helping people live less anxious, more stable lives? That’s a relatively mysterious cost-benefit calculation to bring to a political debate. When it comes to national health policy, said Katherine Baicker, “This study can’t tell you what the goal should be.” What seems more certain is that, as the Affordable Care Act plays out the Oregon experiment on a much larger scale, we will need to broaden the conversation about what constitutes “well-being,” and consider what we, as members of society, owe one another.