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**Involved, Informed, Enrolled: The Role of Social Integration and Social Capital in
ACA Enrollment**

by

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ABSTRACT

This study hypothesizes that Durkheim's theory of social integration can be applied to the Affordable Care Act (ACA) enrollment rates. Group membership leads to the social integration of individuals allowing them to access social capital, which enables them to access information about ACA and health insurance and subsequently influences the decision to enroll in the ACA. Based on this theory, I tested the correlation between social integration (measured with suicide rates) and enrollment rates. The hypothesis was disproved, but I found correlations between enrollment rates and need, percent male, percent minority, and citizen political ideology. Mapping suicide rates and enrollment rates by states offered some proof that enrollment and social integration were linked. A case study was conducted of the highest and lowest enrollment states. The case study shows that socioeconomic factors likely affect enrollment rates and that some of these factors are also linked to social integration and social capital. The paper concludes with a discussion of future research options for exploring social integration, social capital, and ACA enrollment rates.

Chapter 1- Literature Review and Theory

On March 23rd, 2010 the Patient Protection and Affordable Care Act (ACA) was passed in the U.S. as an attempt to reduce the escalating costs of health care in the U.S., as well as to protect individuals from harmful practices many health insurance companies were engaging in. Before the passing of the ACA, 81 million adults or 44 percent of the adult population, between the ages of 19 and 64 were either uninsured or underinsured (Schoen et al 2011:1762). “The underinsured have health insurance but face significant cost sharing or limits on benefits that may affect its usefulness in accessing or paying for needed health services.” (KFF.org 2002). Many health insurance companies placed limits on the amount of money an individual could receive for medical care and would then require the individual to pay in full, or drop them from coverage entirely. Individuals with certain preexisting conditions were once unable to find health coverage, but since the passing of the ACA, insurers can no longer refuse service to individuals with preexisting conditions. Many if not all of the provisions put in place by the ACA were and continue to be hotly debated by politicians, academics, and the public. This literature review synthesizes the history, debate, and economics of health insurance.

The Patient Protection and Affordable Care Act

The ACA was passed on March 23rd, 2010 and put into place many reforms of the previous healthcare system. The majority of the legislation was implemented between 2010 and 2014, with only one piece of legislation to be implemented in each year after that until 2018. The ACA is a very large piece of legislation which made many changes to the health care system in the U.S. This overview will highlight some of the more

important changes. There are four categories of changes in the ACA: 1. Consumer protections; 2. Improving quality and lowering costs; 3. Increasing access to affordable care; 4. Holding insurance companies accountable (HHS.gov 2010).

Many of the changes implemented by the ACA were designed to protect consumers from harmful practices, such as denying coverage for preexisting conditions and enforcing lifetime payment limits. The ACA made it illegal for companies to deny children coverage because of preexisting conditions, prohibited companies from finding minor errors in paperwork to deny payment; eliminated lifetime and annual payment limits, as well as other changes (HHS.gov 2010). These changes were designed to curb discrimination, and guarantee coverage with no threat of being dropped. Prior to the passing of the ACA, the U.S. was experiencing a dramatic increase in the cost of healthcare. 68.8 percent of individuals filing bankruptcy cited some type of medical cost as a contributing factor to their bankruptcy (National Patient Advocate Foundation 2012:1). According to the National Patient Advocate Foundation (NPAF), around “20,000 insured Americans reached the lifetime limits of their coverage each year,” this in turn increased the amount of debt or caused insurance companies to drop these individuals from their policies (2012:6).

Improving the quality of care and lowering costs was another major objective of the legislation. The ACA tried to achieve this by providing health insurance tax credits for small businesses, providing free preventive care, increasing efforts in fighting fraud, offering prescription discounts, linking payment to health outcomes, improving preventive health coverage, and establishing the insurance marketplace, among other changes (HHS.gov).

The third category of changes, improving access to affordable care, also contains many pieces of legislation that were implemented. Some of these changes allowed young adults to stay on their parents' plans until age 26, rebuild the primary care workforce, allowed states to cover more people on Medicaid, and increased Medicaid payments to primary care doctors (HHS.gov).

The fourth and final category of changes brought on by the ACA pertains to holding insurance companies accountable. The ACA requires 85 percent of premiums to be spent on health care services, addressing overpayments to Medicare Advantage insurance companies, requiring insurance companies to justify premium increases, allowing consumers to appeal insurance company decisions, and more (HHS.gov). The changes in all four categories will have substantial effects for consumers.

Schoen et al were able to show that the ACA could potentially reduce the number of underinsured adults by 70 percent (2011:1762-3), and increase the number of insured in the U.S. by 30 million (Sommers et al 2013:165). This is due in large part to the reduction of premiums and setting premiums based on income, as well as expanding Medicaid (Schoen et al 2011). The ACA also allows young adults to remain on their parents insurance until the age of 26, which in turn led to an increase in care received by young adults, particularly for those with worse health (Sommers et al 2013).

“The ultimate goal of this policy was not only to increase coverage for young adults but also to improve access to care.” (Sommers et al 2013:166). Sommers et al were able to show the ACA reduced delays in care of young adults due to costs by 4 percent, and reduced the number of young adults that would have not received care by 2.3 percent (2013:170). Sommers et al showed that ultimately the ACA increased the

amount of coverage held by young adults across all racial and ethnic groups, and in turn increased the amount of care young adults received (2013). Sommers et al observed an increase in the amount of young adults gaining coverage and obtaining medical care in the first few quarters after the implementation of this policy (2013). This is likely due to young adults with increased medical problems seeking coverage and care quickly, and healthier individuals signing up for coverage and seeking care at a more gradual rate (Sommers et al 2013).

History of Health Insurance

The idea of health insurance was first conceived of by Otto van Bismarck in Germany in 1883 (Ross 2002). Bismarck was attempting to counter the growth of socialism in Germany, and did so by implementing health insurance as a means for raising the quality of life for workers in Germany while diminishing dissent among the public. The success of the German program encouraged many other European nations to adopt similar health insurance models (Ross 2002).

The U.S. soon followed their European counterparts. They attempted to apply the German model of health insurance in the U.S. during the early parts of the twentieth century, with the stated goals of improving workers health to increase industrial efficiency and social equality (Ross 2002). This attempt at providing health insurance was quickly defeated for a number of reasons, such as Roosevelt's defeat in the 1912 election and lobbying efforts by the life insurance industry against health insurance (Ross 2002). Health insurance was not discussed again in American politics until the 1930's (Ross 2002). Health insurance once again became part of the political agenda, this time

due to the rising costs of healthcare in the U.S. The Committee on the Costs of Medical Care (CCMC) was formed in an attempt to offer solutions to the fact that many middle class people at the time were unable to pay for medical services (Ross 2002). The CCMC issued a report which recommended adopting a form of health insurance that would reduce costs to patients, allowing them to pay for medical services rendered, as well as slow down the increase of medical costs (Ross 2002). This recommendation was quickly defeated as many politicians and medical doctors viewed health insurance as a form of dreaded socialism (Ross 2002). While the CCMC's suggested policy was ultimately defeated, it did lead to the passing of the Social Security Act of 1935 which provided federal grants to states to fund public health services, and helped pave the way for Blue Cross (Ross 2002) and modern health insurance as we know it (Moran 2005).

The passing of the Hill-Burton Act in 1946 allowed for the renovation of many hospitals, which signaled a period of investing in and increasing medical services (Moran 2005). This is further illustrated by the Health Professionals Education Act of 1963 which was also enacted to increase the availability of medical services (Moran 2005). However, the cost of medical care continued to climb. Which increased the need for health insurance.

Health insurance soon evolved to be a benefit of employment, and by the 1960's employer sponsored health insurance programs became the dominant means of providing health insurance in the U.S. (Moran 2005). This model of health insurance was based on the assumption that healthy employees would be more efficient, and that a minor investment into the health of employees would increase the profits of employers (Moran 2005). While this system proved to be successful at the time, many people fell through

the cracks. The elderly, the young, and the poor, did not have access to health insurance sponsored by an employer. In 1965 Medicare and Medicaid were created to cover the elderly and the poor, which “made the federal government the dominant force in the U.S. health care finance.” (Moran 2005:1417). Due to inflation and high unemployment rates throughout the 1960’s, the U.S. government had to enact policies designed to constrain supply, such as the Comprehensive Health Planning and Services act in 1966 to allocate resources more effectively (Moran 2005). Various amendments to the Social Security Act were passed in 1972 further limiting the amount of medical services that could be provided based on medical necessity (Moran 2005). Costs continued to rise, and many companies resorted to managed care in the 1980’s and 1990’s (Moran 2005).

Managed care plans are “contractual arrangements that integrate the financing and delivery of medical care.” (Henderson 2012:210). In other words, purchasers of health insurance attempt to contract with providers in order to deliver packages of health insurance at a predetermined price (Henderson 2012). These plans became the dominant structure of health insurance plans in the 1990’s, but enrollment in Medicare and Medicaid also continued to grow (Moran 2005).

While government-provided insurance in the form of Medicare and Medicaid greatly affects policies and standards of health insurance in the U.S., the majority of citizens in the U.S. are covered by private insurances. According to the Census Bureau, in 2013 64.2 percent of Americans attained health insurance through private companies; while 34.3 percent of the population was covered by government sponsored insurance, i.e. Medicare, Medicaid, CHIP, or Military health care (Smith and Medalia 2014). The majority of people who were insured through private companies received their insurance

from their employers, with 53.9 percent of the total population having employer sponsored health insurance (Smith and Medalia 2014). Another 11 percent of the U.S. population purchased health insurance individually, and 13.4 percent of Americans were uninsured in 2013 (Smith and Medalia 2014).

As discussed in depth in the following section, health insurance in its most basic form is a diffusion of risk from the individual to community. Many in the U.S. believe that health insurance is necessary in order to reduce the risks and effects of becoming ill. The Kaiser Family Foundation (KFF) found that 87 percent of citizens in the U.S. state that insurance is personally important for them to have, while only 11 percent feel they are healthy enough to not need insurance (2013). With the passing of the ACA, not having health insurance can now be legally punished.

One of the stated goals of the ACA is to decrease the number of American citizens that are not covered by health insurance. Understanding the economics behind health insurance will provide more insight as to why people seek to be insured, and the effects of insurance on the medical field and health of the population.

Economics of Health Insurance

The economics of health insurance and medical care in general, is extremely complex and is affected by many outside forces such as government involvement, uncertainty and randomness of illness, the difference in knowledge between patients and providers, and how the behaviors of some affect the costs or benefits of others (Phelps 2010). The demand for health insurance and medical care must be considered together (Phelps 2010). While the economics of health insurance may be complex, the rising costs

of healthcare and the call for healthcare reform has shown the importance for understanding how insurance works, and how and why it was developed.

The simplest way to think about insurance is to take a club with 100 members. Each member lives a similar lifestyle, and members notice that usually once a year, one of the members at random gets sick and has a medical bill of around \$2,000. This is upsetting to the club as they don't want their members to experience any losses, so they collect \$20 from each member and save it for any future medical expenses. In this scenario, only one of the club members was sick, but everyone in the club paid into the fund to cover the cost of the medical care for the sick individual. While not paying into the fund would have saved each member \$20, paying into the fund protected them from the risk of having to pay \$2,000 for a medical treatment (Folland et al. 2007). These club members "enter into insurance contracts to share the uncertainty of financial risk with others." (Henderson 2012:180). While extremely simplified, this is the basic principle and structure of health insurance.

There is uncertainty and randomness to health and illness (Phelps 2010). Individuals may have some knowledge about some medical costs they may incur, but one cannot predict when they or anyone else will need medical care, or what the exact dollar amount of those medical costs may be (Cutler and Zeckhauser 1999). The purchase of health insurance then, is to protect against the financial risk of becoming ill (Phelps 2010). This is known as being *risk averse*, or the "degree to which a certain income is preferred to a risky alternative with the same expected income." (Folland et al. 2007). The idea of risk aversion is generally accepted as a legitimate explanation for purchasing insurance (Nyman 1999). People are choosing to pay a relatively small amount for health

insurance because it is less risky than the risk of financial catastrophe caused by large medical costs (Phelps 2010). By pooling economic resources, individuals are able to spread the risk of incurring medical costs across a much larger number of people, and potentially reduce the amount of money spent on medical care as an individual (Cutler and Zeckhauser 1999). Going back to our club example, each member had the potential risk of paying \$2,000 for medical care when they became ill. Because they were risk averse, they chose to spread individual risk across the club by pooling their money into a general fund, which was then used to pay for medical care, instead of expecting the individual to pay the \$2,000 on their own. Nyman asserts that risk aversion is not the sole reason why individuals purchase health insurance (1999). The cost of medical treatment is generally much higher than the cost of health insurance, and many people would not be able to access medical care without insurance simply because they could not afford to pay the high cost of many medical treatments (Nyman 1999). While health insurance may reduce the cost of medical care for the individual, it does have some downfalls, like *moral hazard*.

A moral hazard of health insurance is when an individual seeks medical care for some illness or health concern when he or she would not seek care if they were paying for the service themselves (Cutler and Zeckhauser 1999). Because individuals are paying for smaller portions of their health care through insurance, it is thought that they will seek out excess care that they wouldn't normally seek because their insurance is paying for a large share of their medical costs (Cutler and Zeckhauser 1999). While a moral hazard is an unfortunate side effect of health insurance, the cost of a moral hazard is "embedded in

the insurance company's share of the expenditure" and is accounted for with insurance fees (Phelps 2010:317).

Another potential problem is *adverse selection*, which occurs because individuals are more aware of their medical needs than the insurance company (Henderson 2012). This gives an individual a chance to hide their medical risks, and purchase insurance that was intended for individuals that are healthier, which "leads to higher-than-average premiums for the group and creates an incentive for low-risk individuals to drop out of the group in search of lower-cost coverage elsewhere." (Henderson 2012:188). In theory, a high risk individual would want to purchase a generous health insurance plan that paid more for medical services, while a low risk individual would not need such a generous plan (Cutler and Zeckhauser 1999). Obviously, the high risk individual would have to pay more for the generous plan, but if they were able to conceal their condition, they could potentially purchase the cheaper plan, and in effect cause the insurance company to raise the premiums for that plan, costing the low risk person more money (Cutler and Zeckhauser 1999). This problem is combated in several ways.

Insurance companies attempt to mitigate adverse selection by manipulating plans in a way that causes those with high risk to choose the most expensive plan, and those with low risk to choose the appropriate plan from them (Cutler and Zeckhauser 1999). One way of achieving this is by creating a plan that limits the amount paid for services, or reduces the type of services provided. It is expected that high risk consumers would see that this plan is not right for them (Cutler and Zeckhauser 1999). Another response by health insurance companies is to charge a deductible or coinsurance in order to combat

overspending (Henderson2012). Overspending was also combated by denying coverage to anyone with preexisting condition (Henderson2012).

While much of the literature claims that the risk averse consumer purchases health insurance to avoid financial loss, Nyman asserts that having access to medical care is another reason why individuals purchase insurance (1999). The consumer not only purchases health insurance to avoid risk, but to guarantee access to medical care, especially to treatments that are costly (Nyman 1999). Having access to medical care is important. Individuals that are ill are often times unable to work, and run the risk of a financial loss due to the cost of medical care and lost wages as well (Currie and Madrian 1999). Being ill is often stigmatized because individuals are less productive. Parsons argues that being ill places people into a new role that requires certain behaviors (Cockerham 2001). This is known as the sick role, and Parson's described four different categories that make up the sick role. These categories are: 1. A sick individual is exempt from their normal roles; 2. A sick individual must not be responsible for his or her condition; 3. A sick individual should attempt to get well; 4. A sick individual should seek help from a qualified physician, and cooperate with the physician (Parsons 1951). This implies that the healthcare system is a form of social control, as Parsons asserts that being sick is a deviant behavior, and one that is potentially harmful to the function of society (Cockerham 2001).

Several studies explored the positive relationship between health and wages. Currie and Madrian state "historical literature again suggests that improvements in health as measured by declines in mortality and increases in body size are linked to changes in living standards over time." (1999:3318). There is evidence showing the positive

relationship between many health indicators (height, BMI, caloric intake) and wages (Currie and Madrian 1999). The loss in wages due to illness is not entirely due to a decrease in the amount earned for completing a job, but the hours that individuals are unable to work due to their illness (Currie and Madrian 1999). There is also evidence that the loss in productivity that an individual experiences due to illness may affect their wage (Currie and Madrian 1999). Being ill, or unable to maintain health has a detrimental effect on an individual's ability to participate in the labor force, and can make it difficult for individuals to earn wages. As mentioned earlier, the majority of citizens in the U.S. receive health insurance as a benefit to employment. This potentially sets up individuals that are dealing with illness for disaster, as they may not receive medical care due to a lack of health insurance, and may have trouble participating in the labor force due to their illness.

As mentioned in the discussion on moral hazards, having health insurance increases the likelihood of seeking medical care for various ailments (Bernstein et al 2010). Estimating the number of individuals that do not obtain medical care because of a lack of insurance is extremely difficult, but some have estimated that over 44,000 people die in the U.S. every year because they are unable to seek medical care due to a lack of insurance (Bernstein et al 2010:1). Children without insurance are also 70 percent less likely than their insured counterparts to see a medical professional for common illnesses like strep throat, and uninsured adults are 20 percent less likely to receive medical care after an automobile accident (Bernstein et al 2010:1). In short, having insurance provides individuals with the opportunity to seek medical care that they would not otherwise be able to afford. The inability of the uninsured to receive medical care not only affects

their general well-being, but their economic viability, and causes uninsured children to miss more school days than their insured classmates (Bernstein et al 2010). Schoen et al show that “46 percent of the underinsured and 63 percent of the uninsured went without needed or recommended care because of costs during the year” in 2010 (2011:1766).

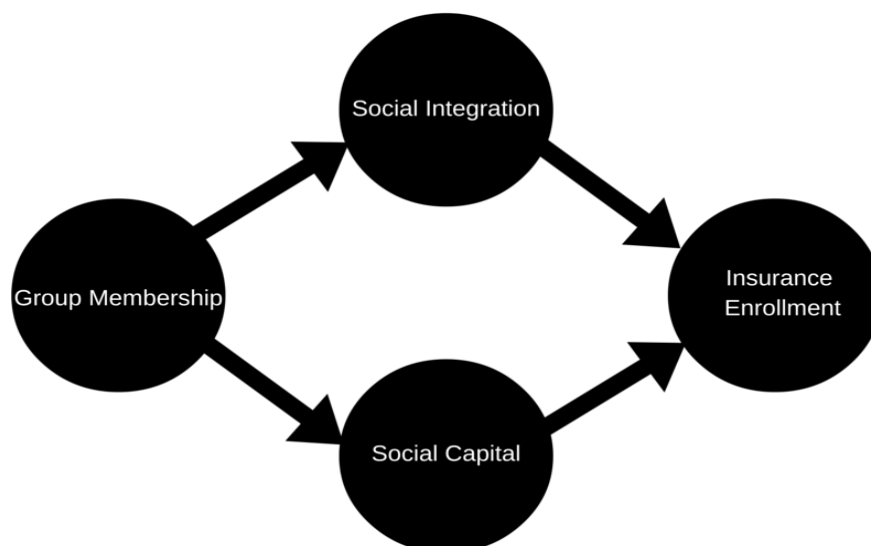
Many factors determine why an individual may seek to purchase insurance. The general consensus in the literature is that individuals are risk averse, and prefer the relatively minor cost of purchasing health insurance versus the uncertainty of future medical expenses. Nyman asserts that risk aversion is not the sole reason an individual seeks to be insured. Having access to medical care is also a reason for the decision to seek health insurance.

The risk associated with illness is often seen to lie with the individual: the risk of becoming ill, as well as the financial risk associated with medical treatments. Individuals in our club choose to enter the insurance contract in order to transfer individual risk to the collective risk. Going back to the club example, an individual still has the same amount of risk of becoming ill as before entering the contract. The financial risk though is now shared by the collective, and has become a collective risk. Risk, in economic terms, is trying to determine the gains or losses experienced, and determine whether a decision will have a net gain or net loss (Kahn 1962). Individual risk in terms of health and illness is then the net gains or losses from becoming ill, while the collective risk is the net gains or losses experienced by the group due to the actions of group members (Kahn 1962). This means that the insurance system is designed to diffuse the risk of an individual to the collective.

Theory

Why are individuals willing to join the collective arrangement? Are individuals aware of risk and join in order to mitigate this risk? How do individuals become aware of both individual and collective risk? Do individuals join insurance contracts because it is a type of collective organization that rewards group membership, and how do individuals know this organization exists? One explanation that has the potential to answer these questions is that individuals that are integrated are more likely to enter insurance contracts because the connections that come from being integrated give individuals the knowledge needed to determine their risks. It also provides individuals with the knowledge of the existence, purpose, and benefits of health insurance. As shown by Durkheim in his discussion on suicide, social bonds protect individuals from engaging in harmful behaviors (2006). Not only does group membership provide knowledge of risk and health insurance, it also builds connections with others. These connections give individuals a reason to maintain their health. This notion is briefly summarized in Figure 1 below.

Figure 1



The following is a synopsis of Durkheim's work *Suicide*, and will explore the concept of social integration (2006). This will allow us to link integration to insurance, and shape the method for this study.

Social integration, in its most simple terms, can be thought of as "the extent to which an individual participates in a broad range of social relationships." (Brissette et al 2000:54). While this definition does provide a clear starting point for understanding social integration, it is a simple definition, and one that does not capture the complexities of social integration like Durkheim's work *Suicide* (2006). Durkheim begins his work by explaining away many of the common misconceptions about causes of suicide, such as weather and psychological illnesses (2006). Durkheim has "shown that for every social group there is a specific tendency towards suicide which cannot be explained either by the physical and mental make-up of individuals, or by the nature of the physical environment." (2006:147). Concluding that these common explanations of suicide were not satisfactory, Durkheim argued that there was something within society, some "collective phenomenon," that was causing individuals to commit what is often times thought of as the most personal decision one can make (2006:147). Durkheim continues by identifying several types of suicide, the first of which being egotistic suicide (2006).

Durkheim claimed that modern industrial societies can experience what he called egoism, or "the lack of integration of the individual in the social group." (2006). Durkheim noticed that areas of Europe that were more heavily populated by Protestants were experiencing higher suicide rate, which led him to compare Protestant and Catholic religions to show the effects of egoism (2006). Durkheim claims that Protestants are more able to determine their own beliefs than Catholics, as Protestantism does not put a

strict interpretation on the Bible like Catholicism (2006). This “free inquiry” that is afforded to members of the Protestant religion loosens the bonds between individuals and the group, which creates a stronger sense of individualism (2006:164). “We therefore arrive at the conclusion that Protestantism’s numerical superiority in suicide derives from the fact that it is a less firmly integrated church than the Catholic one.” (Durkheim 2006:165).

The notion that free inquiry can lead to a decrease in the level of integration can also be shown by the increase in suicide by individuals that are highly educated (Durkheim 2006). Durkheim theorizes that this is due to “the weakening of traditional beliefs and to the state of moral individualism that derives from” gaining an education (2006:176). This loss of “cohesion” between the group and the individual increases the individual’s proclivity to commit suicide (Durkheim 2006:176). In other words, group membership and integration of members into the group protect members from committing suicide. Durkheim demonstrates this by showing the increased number of suicides in Protestant dominant areas, but also lower rates of suicide among other groups, most importantly married people (2006). When controlling for age, Durkheim was able to show that the unmarried commit suicide far more often than the married (2006:184). This protection against suicide that marriage offers is strengthened even more by the presence of children in the marriage (Durkheim 2006). Families integrate individuals and protect them from suicide (Durkheim 2006).

Group membership attaches people to a “common purpose” which in turn attaches these individuals to life (Durkheim 2006:225). Integration in a group results in the “continual exchange of ideas and feelings” which provides members of the group “moral

support, so that the individual” is able to “participate in the collective energy” of the group (Durkheim 2006:225-6). The “loosening of social bonds” allows for members of the group to stray away and engage in individual acts that may not be conducive to group life (Durkheim 2006:231). This lack of integration causes the individual to lose value over his or her own life, as they have no moral support or social bonds that typically come with group membership (Durkheim 2006).

Durkheim does dedicate a chapter to the discussion of altruistic suicide and fatalistic suicide. Durkheim claims that altruistic suicide is essentially non-existent in modern society and can only be seen in extremely integrated segments, such as the military (Durkheim 2006). Fatalistic suicide is also rare, only occurring in societies that are extremely oppressive and regulatory of individual behavior (Durkheim 2006). Because both are rare, there is no need to further explain these two types of suicide.

Another prevalent cause of suicide in modern societies is the lack of moral regulation, or anomie (Durkheim 2006). Durkheim begins his discussion on anomic suicide by noting that suicides increase in both times of economic boom and bust (Durkheim 2006). This is due in large part to the desires of individuals during these economic cycles. If society is unable to restrain the desires of its members, and they want more than they can have, the result is moral disillusion (Durkheim 2006). “So to pursue a goal that is hypothetically unattainable is to condemn oneself to a perpetual sense of dissatisfaction.” (Durkheim 2006:271). Society as a whole is the only power capable of regulating the morals of individuals, and as long as the individual submits to this “collective authority” then he or she will place a limit on their goals and desires (Durkheim 2006:273). Modern criminologists have applied this approach to studies

focusing on social disorganization (Barnett and Mencken 2002). Social disorganization is defined as the “inability of community members to achieve shared values or to solve jointly experienced problems” (Bursik 1988). Social disorganization theory is based on Durkheim’s argument of social integration, and utilizes variables such as poverty rates and percentage of high school graduates, to measure social integration (Barnett and Mencken 2002). Durkheim illustrates the differences in types of suicides in the following quote:

“Egotistical suicide derives from the fact that men no longer see any sense of living; altruistic suicide from the fact that this sense appears to them to be situated beyond life itself; and the third kind of suicide (anomic suicide), the existence of which we have just established, from their activity being disrupted and from their suffering as a result.” (2006:283).

Egotistical and anomic suicide derives from a lack of societies’ presence to its members (Durkheim 2006:284). Egotistical suicide derives from a lack of social integration, and anomic suicide derives from a lack of moral regulation. Egoism and anomie are even further linked, as they essentially cause the same condition in society “unrestrained egotism.” (Aho and Mordecai 1996:6).

Durkheim proposes economic causes and divorce rates as good predictors of anomie. He claims that the function of marriage is to regulate and restrict life’s passions (Durkheim 2006). Divorce removes this regulation, especially for the male. A divorce removes moral regulation experienced by the couple, and without this regulation desires are no longer limited (Durkheim 2006:299).

The club example presented earlier illustrates the association of integration and the choice to engage in collectivist endeavor of health insurance. Individuals joined the club in order to build social relationships or because of social relationships that they had already constructed. This club is almost certainly centered on common beliefs held by the members. It could be a religious club, a political club, or a professional club. The purpose of the club is not as important as the fact that a club exists and has built social bonds between individuals, effectively tying them to each other. Going back to Figure 1, club members have been integrated into this group relationship. This overrides their own individualistic desires, reducing both egoistic and anomic behaviors.

Group membership also provides individuals with social capital. Bourdieu defines social capital as

“the aggregate of the actual or potential resources which are linked to possession of a durable network or more or less institutionalized relationships of mutual acquaintance and recognition... which provides each of its members with the backing of the collectively-owned capital, a ‘credential’ which entitles them to credit.” (1986:21)

Social capital gives individuals what Bourdieu refers to as a “multiplier effect” on their cultural or economic capital (1986:22). In other words, social capital increases what an individual can accomplish with cultural and economic capital, and groups that are large increase social capital, which then increases this multiplication of capital. Social capital is then in essence the benefits derived from group membership, such as knowledge, kinship, and learned skills (1996:23). Individuals that maintain group membership are afforded social capital. Isolated nonmembers have less or no access to social capital.

Group membership then provides people with the knowledge of what health insurance is and the benefits of insurance in preventing and paying for illness. The larger the group and the stronger the connection to this group, the higher the likelihood that information pertaining to health risks and risk aversion will be available to individuals. Therefore, social capital gained through being integrated into a group can have a direct effect on the decision to purchase health insurance (See Figure 1).

Group membership gives the members a sense of belonging and a forum for ideas and emotions to be shared. The individual is no longer concerned with only him or herself, but instead with the preservation of the group as a whole. No individual wants to see a member of their group suffer, just as the group doesn't want any individual within the group to suffer. Engaging in individualistic acts is not conducive to group life, and members that do not behave and act for the betterment of the group will almost certainly find themselves on the outside of the group. The group then, also acts as a form of social control, or as Durkheim termed it, moral regulation (2006). Behaving how the group expects them to is rewarded, which is often times simply the benefit of social capital.

The formation of the club gives the group members social capital and the knowledge needed to measure the amount of risk of becoming ill. It also provides them with a reason to want to maintain good health, in order to be functioning members of the group. Being a part of the group provided the members with the opportunity to see that on average, one random individual becomes ill once a year. Not being connected to others would make it difficult for the individual to evaluate their own personal risk. Vintilla and Rouquette were able to show that individuals who had lived through, or knew someone that lived through an earthquake were more likely to engage in behaviors

that attempted to mitigate the risk of being in an earthquake (2007). The same would hold true for becoming ill, even though an earthquake is a rare occurrence, and becoming ill is a common experience.

Social capital gained from group membership allows individuals to be risk averse. Risk averse individuals would not want to suffer the same fate as their ill friend, or see anyone else suffer for that matter. Social capital acquired from the group also makes the financial risk of becoming ill visible. Charging each of the 100 members \$20 allowed each individual member to pass the financial risk of becoming ill onto the group. Paying \$20 for this service is 100 times cheaper than risking paying for medical care in full. This annual \$20 dollar payment not only benefited each individual, but the collective as a whole. The knowledge that group membership is beneficial will be passed around and shared between each member. It will also soon become apparent that choosing to pay the \$20 is a better option than risking paying \$2,000. This will become common knowledge within the group, and considered to be a necessary action to mitigate the financial risk of becoming ill.

The same can be said when applying this theoretical model to the U.S. and the ACA. Previous sections discussed the harm that individuals risk by not having health insurance, and have shown that 87 percent of survey respondents in the U.S. claim that insurance is personally important for them to have, while only 11 percent feel they are healthy enough to not need insurance (KFF.org 2013). Seeing one of the 68 percent of bankruptcies filed due to medical costs, or knowing one of the 44,000 people who died each year because of lack of insurance would certainly give an individual a reason to enroll in the ACA marketplaces (NPAf 2012:1; Bernstein et al 2010:1). Being integrated

into a group gives individuals social capital and the knowledge that being uninsured carries large financial risks, as well as the risk of not being able to access medical care. Entering the ACA marketplace not only reduces the risk of the individual, but benefits the collective as whole, by lowering prices for everyone.

As of February 2015, 11.6 million out of the 28 million eligible Americans, or 42 percent, had selected a health insurance plan from either the federal or state health insurance marketplaces put in place by the ACA (KFF.org 2015). The Kaiser Family Foundation define eligibility as

“all individuals eligible for tax credits as well as other legally-residing individuals who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage. The estimate excludes uninsured individuals with incomes below the poverty level who live in states that elected not to expand the Medicaid program. These individuals are not eligible for financial assistance and are unlikely to have the resources to purchase coverage in the Marketplace.” (2015)

When one looks at the numbers of enrollees per state, differences in enrollment rates are immediately observed (See Table 1-1). This begs the question why? Why are some states enrolling at much larger rates than others?

Table 1-1- Top and Bottom 5 State Enrollment Rates 2015

State	Marketplace Type	Percent of Potential Marketplace Population Enrolled
Vermont	State	77%

Florida	Federal	%57
Maine	Federal	%55
Pennsylvania	Federal	%57
Delaware	State Partnership	%53
Ohio	Federal	%23
Minnesota	State	%23
South Dakota	Federal	%22
Iowa	State Partnership	%21
Hawaii	State	%20

Source: (KFF.org 2015)

Notes: See Appendix B for Percent of Potential Marketplace Population Enrolled definition.

This research hypothesizes that states that experience higher levels of social integration have higher enrollment rates in the ACA. States with higher levels of integration are going to have stronger social ties between citizens. These social ties allow individuals to witness the risks associated with not having insurance; provide social capital highlighting the benefits and risk diffusion of having insurance; and provide a form of social control which mitigates the negative effects of social disorganization. The following chapter will discuss the methodological approach that was taken to test this hypothesis.

Chapter 2-Methods

This research is attempting to answer why enrollment rates in the ACA differ by state. I hypothesize that states that experience higher levels of social integration will be more likely to have higher enrollment rates through the ACA marketplaces. This research utilizes a mixed methods approach, conducting a statistical analysis and a case study in order to determine the validity of the hypothesis. The following is a description of the methods used to test this hypothesis.

Data for this project was gathered from a variety of sources. All data is aggregated to the state level including DC, which means this dataset has an N of 51. Table 1 is a list of all variables and the sources from which they were gathered. Variables were chosen from variables commonly used in the literature on social integration, specifically variables that were utilized by Durkheim and in the study of suicide in Idaho by Aho and Mordecai (1996). This research will follow the model used by Aho and Mordecai (1996). Aho and Mordecai were able to show that Durkheim's theory of suicide and social integration was still valid in contemporary U.S., specifically Idaho (1996). This was done by showing the correlation of suicide rates with variables measuring levels of social integration. Aho and Mordecai identified county clusters of high and low suicide rates, and presented a case study of these clusters (1996). This allowed Aho and Mordecai to show the connection of suicide rates to social integration in Idaho (1996). I will follow the Aho and Mordecai model, first by testing if a correlation between suicide and enrollment exists. Finally, a case study will be conducted of states with the highest and lowest ACA enrollment rate. The following is a discussion of the model used, beginning with an explanation of the variables that were chosen.

Variables

Unfortunately, much of the data was not available for the same year. The most recent available data was used for each variable in order to mitigate potential problems arising for the fact that data were gathered at different times. All data was taken from reputable sources.

Table 2-1 Variables and Data Sources

Variables		
Independent Variables	Source	Date Gathered
Social Integration		
Variables		
Suicide Rate	Center for Disease Control	2013
Population Density	Census	2014
Unemployment Rate	Bureau of Labor Statistics	2014
Marriage Rate	Center for Disease Control	2012
Divorce Rate	Center for Disease Control	2012
Percent Population Rural	Census	2010
Percentage Family	American Community	2013
Household	Survey	
Census Response Rates	American Community	2013
	Survey	
Median Age	American Community	2013
	Survey	

Median Income	Current Population Survey	2011-13
Percentage below poverty line	American Community Survey	2013
Percent Population Minority	Current Population Survey	2013
Percent High School Grads	National Center for Education Statistics	2011-12

Control Variables

Percentage Male	Current Population Survey	2014
Need	Kaiser Family Foundation	2015
State Political Ideology	Berry et al	2010
Citizen Political Ideology	Berry et al	2010

Dependent Variables

Enrollment percentage 2014	Kaiser Family Foundation	2014
Enrollment percentage 2015	Kaiser Family Foundation	2015

Notes: See Appendix B for codebook.

Most of the data was gathered from Census surveys, with varying dates. Census data from the American Community Survey (ACS), the decennial Census report, and the Current Population Survey (CPS) were used for this research. The data on suicide came from state records on leading causes of death. Marriage and divorce rates were taken from state records as well. Data on unemployment was taken from the Bureau of Labor Statistics (BLS). The percentage of high school graduates came from the National Center for Education Statistics (NCES). Marriage rates, divorce rates, and suicides were all

compiled by the Center for Disease Control (CDC). Data used to measure both state and citizen political ideology was taken from a study conducted by Berry et al (2010).

Finally, data gathered by the Kaiser Family Foundation (KFF) was used for the control variable “need”, and the independent variables, enrollment for 2014 and 2015.

Suicide rates, marriage rates and divorce rates were all used originally by Durkheim in his research (2006), and shown to still be valid by Aho and Mordecai (1996), as well as others (Brissette et al 2000). Durkheim claims that a high suicide rate indicates low levels of social integration, and also that low suicide rates indicate high levels of social integration (2006). According to Durkheim, suicide is the single strongest predictor of integration (2006). Marriage creates a group, or family, that ties an individual to others, while divorce dissolves this link. Marriage mitigates the effects of anomie and egoism, increasing an individuals’ integration into a group (Durkheim 2006). In addition to marriage rates, population density, family households and median age are all measures indicating social integration (Aho and Mordecai 1996). All indicate an opportunity for, or lack of group attachment, which is essential to social integration (2006). Literature on social disorganization was used to inform the choice of other variables that indicate a lack of social integration. Percentage below the poverty line, percent of owner occupied homes, percentage of high school graduates, and percent of minority population are all indicators of social disorganization, another measure of anomie derived from criminological literature (Sampson and Groves 1989). Barnett and Mencken claim that social integration is a central component of the theory of social disorganization, as shown by Kornhauser 1978, Sampson and Groves 1989, and Shaw and McKay 1942 (2002). The most important variable used by Durkheim to indicate

social integration is church affiliation (2006). Durkheim was able to show that Catholics have a stricter interpretation of the bible than Protestants, allowing Protestants to have more free inquiry (2006). This is why Protestants commit suicide at a higher rate than Catholics (Durkheim 2006).

Church affiliation was not used in this study for several reasons. First, church affiliation on the state level is not an accurate representation of the population living in the state. Specific affiliations populate different parts of each state. Secondly, Durkheim focused on the differences between Protestants and Catholics. In order to test the levels of social integration between religions in the U.S., one would have to explore and explain a large variety of different affiliations. Church attendance could also be used as an indicator of social integration, but has similar problems, and as pointed out, different religions are better at integrating than other religions. Just attending any church service does not necessarily increase social integration. Secondly, the only data available for this research on church attendance comes from the Pew Research Center Religious Landscape Study, and was collected in 2007. Church attendance is declining across the entire U.S. (Lipka 2013). This means that an accurate representation of church attendance was unavailable.

At the time of this writing, a nationwide dataset measuring community participation was not available. Census response rates were used to measure social capital. Martin and Newman were able to show that Census response rates are a valid, and much simpler, measure of social capital (2014). Martin and Newman's analysis of Census response rates shows a strong correlation to Putnam's aggregate measure of social capital (2014).

Several control variables were used to check for spurious correlation that may exist. These are potential factors that could influence the difference in enrollment rates between states. Need, or the percentage of population underinsured plus the percentage of population uninsured is likely the most important control variable. A state with higher need, or a higher amount of underinsured and uninsured individuals, could enroll more individuals simply because the ACA provided the ability for the uninsured to gain access to health insurance. In 2013, 20 percent of males were uninsured, while 17 percent of females were uninsured (KFF 2013). States that have a higher male population could potentially enroll more individuals, as the need for insurance may be greater. Preliminary reports also show differing enrollment rates between minorities and whites (New York Times 2014). In 2013, 12 percent of Whites were uninsured; 17 percent of Blacks were uninsured, and 25 percent of Hispanics did not have insurance (KFF 2013). The political ideology of both states and citizens could also affect the enrollment rate, as an individual with conservative beliefs may choose not to enroll for political reasons. Berry et al constructed a dynamic measure of citizen and state political ideology that was used for these variables (1998). Emerging literature on the Narrative Policy Framework (NPF) shows that the narrative structure used to discuss a policy has a large effect on the acceptance of that policy (Jones 2014, McBeth et al. 2014, Shanahan et al 2013). Shanahan et al sum up the theoretical underpinnings of the NPF nicely when they say the

“Narrative Policy Framework (NPF) is a new and maturing theory of the policy process that takes a systematic, scientific approach to understanding the social construction of policy realities. As such, NPF serves as a bridge between postpositivists, who assert that public policymaking is contextualized through

narratives and social construction, and positivists, who contend that legitimacy is grounded in falsifiable claims.” (2013:453).

Narratives construct a meaning of the ACA that is then adopted by individuals to determine their support or disdain for the ACA. The ACA received incredible amounts of attention from the media, which often times lobbied for one side or the other of the ACA debate. “It is widely accepted that how a story is rendered is as important to policy success and political longevity as what actions are undertaken.” (McBeth et al. 2014:225).

Table 2-2 below shows the descriptives of each of the variables. At the time of this study, there was no systematic study showing any correlation between these control variables and enrollment rates. The Models used for this study were constructed not only to test if a correlation exists between social integration and enrollments, but to also determine if the control variables are necessary.

Table 2-2- Mean, Median, and Standard Deviation for all Variables

Variables				
Independent Variables	N	Mean	Std. Dev.	Median
Social Integration				
Variables				
Suicide Rate	51	14.4	3.97	13.99
Population Density	51	384.40	1377.35	101.20
Unemployment Rate	51	5.80	1.27	6.10
Marriage Rate	51	7.53	4.35	6.80

Divorce Rate	45	3.60	0.75	3.50
Census Response Rates	51	89.87	1.03	90.10
Percent Population Rural	51	25.90	14.89	25.80
Percentage Family Household	51	65.49	4.24	65.70
Median Age	51	37.64	2.36	37.60
Median Income	51	52,690.35	7,975.89	51,939.00
Percentage below poverty line	51	15.16	3.36	15.60
Percent Population Minority	51	29.67	17.53	28.00
Percent High School Grads	51	80.98	6.70	82.00
Control Variables				
Percentage Male	51	49.10	0.83	49.20
Need	51	28.22	5.59	28.37
State Political Ideology	50	52.50	24.90	55.10
Citizen Political Ideology	50	47.43	15.47	47.51
Dependent Variables				
Enrollment percentage 2014	51	25.38	11.66	23.37
Enrollment percentage 2015	51	34.02	11.48	32.00

Model

In order to test the hypothesis that social integration is correlated with enrollment rates, a measure for social integration was needed. Building a social integration index using factor analysis would be ideal, but an N of 51 limited the applicability of a factor analysis.

Building a social integration index was still considered an interesting approach for this research. This would allow for a comparison of levels of social integration between states that would not only be beneficial for answering this research question of this research, but useful in the field in general. Without using factor scores, a Cronbach's Alpha was computed in order to determine the reliability of the variables used to measure social integration. This required that all the variables were measuring social integration in the same direction. For example, a decrease in suicide rate would signal a rise in social integration, but an increase in community participation would raise the social integration. A simple reverse order function was used to reverse variables with a negative effect on social integration. This yielded disappointing results, as the Cronbach's Alpha score was only 0.004. A score this low signals that this data set is not capable of building an index. Once again, having a larger N may produce different results that would allow for the construction of a social integration index. It was determined to compute a correlation between enrollments rates and social integration by using suicide rates as a proxy for social integration. Controlling for variables such as need and political ideology is necessary to reduce the risk of any spurious correlation.

This simple model utilized Pearson's R in order to determine a correlation between suicide rates and enrollment rates. The regression analysis was run with

enrollment rates from both 2014 and 2015. Model 1 was run with enrollment rates for 2014 and 2015 as dependent variables and suicide rate as the independent variable. Model 2 added the control variables, need, percent minority, percent male and state and citizen political ideology. Model 2 was then ran just as Model 1, with the only difference being the addition of the control variables.

Model 2 was run to determine if controlling for percent male, need, percent minority, state and citizen political ideology would increase the likelihood that suicide was correlated to enrollment rates. Need, or the percent uninsured plus the percent underinsured must also be controlled for, as we would expect a state with high need to enroll more individuals and vice versa. State and citizen political ideology may also effect individuals' decision to enroll or not. An individual or state with a liberal ideology would be more likely to support the ACA and therefore be more likely to choose a plan through the marketplace. The opposite is true for states and individuals that are conservative. Studies have shown that the narratives used to discuss a particular topic will sway an individuals' opinion (Jones 2014, McBeth et al. 2014, Shanahan et al 2013). The narrative strategy used by states and individuals to discuss a particular policy, like the ACA, has an effect on the success or failure of that policy (Jones 2014, McBeth et al. 2014, Shanahan et al 2013). Discussing the policy in a positive light would increase support for that policy, while being critical of the policy or those involved in the policy process, would decrease support (Jones 2014, McBeth et al. 2014, Shanahan et al 2013). In a sense, Model 2 is also testing the efficacy of political ideologies, and their effect on policy outcomes.

After Model 2 was ran, maps were created to provide a visible point of comparison. The first map shows suicide rates by state; the second map illustrates enrollment rates by state. Overlaying these maps provided support for the hypothesis of this study that suicide rates as a proxy for social integration are linked to enrollment rates. While Model 2 indicates that suicide is not correlated with enrollment, the maps offered some different evidence. Due to the visual pattern relating suicide rates and enrollment rates, it was determined that further analysis was necessary in order to understand the differences between states with high and low ACA enrollment. Model 2 indicates that states with high need, smaller male and minority populations, and liberal citizen political ideologies are likely to enroll at higher rates. Even though Model 2 explains 47percent of the variation in enrollment rates between states, the maps indicate that other factors are likely affecting enrollment rates as well. Because of this, case studies of the three states with the highest enrollment and the three states with the lowest enrollments were then conducted. When looking at enrollment rates for all fifty states and DC, there are no apparent breaking points. From top to bottom, there are small incremental changes from one state to the next, but large changes over all states. Conducting case studies of the three highest and three lowest enrollment states will provide enough information to allow patterns to emerge, and to determine any similarities and differences between these six states. Basic demographic and socioeconomic status (SES) variables were used to gather more information about these states. While the main purpose of the case studies was to determine other possible factors for differences in enrollments rates, many of the demographic and SES variables are also indicators of social integration (Aho and Mordecai 1996, Brissette et al 2000, Durkheim 2006). The case studies could thus also

provide some answers about the correlation between social integration and enrollment rates. The following chapter discusses the results of the Model 1, Model 2, and the case studies

Chapter 3-Results

This research hypothesizes that states that are experiencing higher levels of social integration are more likely to have higher ACA enrollment rates. The U.S. enrollment as a whole for 2015 was 36 percent, meaning that 36 percent of the potential ACA marketplace enrollees in the U.S. purchased health insurance (KFF.org 2015). As discussed in the previous chapter, Model 1 was run with enrollment rates for 2014 and 2015 as the dependent variable, and suicide rates as the independent variable. Data was used for 2014 and 2015 in order to determine if any trends in enrollment rates existed between these years. Table 3-1 shows the results of this model.

Table 3-1- Model 1 2014 and 2015 Enrollment Coefficients, with Suicide.

Enrollment 2014						Enrollment 2015				
<i>Beta</i>						<i>Beta</i>				
Variable	<i>B</i>	SE	<i>t</i>	<i>p</i>	<i>Coefficient</i>	<i>B</i>	SE	<i>t</i>	<i>p</i>	<i>Coefficient</i>
Suicide	-0.24	0.42	-0.59	0.56	-0.08	-0.37	0.41	-0.90	0.37	-0.13
R^2			0.01						0.02	

Notes: Model 1 utilizes bivariate linear regression. See Appendix B for codebook.

Model 1 did not show any significance, with both years having p-values far above 0.05. Each model also has a low R^2 , indicating that suicide is explaining little, if any of the variation in enrollment rates for both 2014 and 2015. Using suicide as a proxy for social integration did not show any correlation with enrollment rates. The lack of correlation between suicide rates and enrollment rates could possibly be accounted for by controlling for variables such as percent uninsured, percent minority, percent male, state political ideology, and citizen political ideology. Including these control variables in our

model should allow us to test the correlation between suicide rates and ACA enrollment more accurately. Table 3-2 below shows the coefficients for Model 2.

Table 3-2-Model 2 2014 and 2015 Enrollment Coefficients, with suicide and control variables.

Enrollment 2014						Enrollment 2015				
Independent					<i>Beta</i>					<i>Beta</i>
Variable	<i>B</i>	SE	<i>t</i>	<i>p</i>	<i>Coefficient</i>	<i>B</i>	SE	<i>t</i>	<i>p</i>	<i>Coefficient</i>
Suicide	-0.14	0.67	-0.21	0.83	-0.05	0.002	0.59	0.003	0.99	0.001
Control										
Variables										
Need	0.84	0.48	1.14	0.09	0.39	0.86	0.42	2.04	0.003**	0.41
Percent	-0.28	0.12	-2.25	0.03*	-0.41	-0.34	0.11	-3.14	0.003**	-0.51
Minority										
Percent	-2.72	2.28	-1.20	0.24	-0.19	-6.16	1.99	-3.08	0.003**	-0.43
Male										
State	-0.10	0.07	-1.28	0.21	-0.20	-0.13	0.07	-1.99	0.051	-0.28
Political										
Ideology										
Citizen	0.61	0.14	4.26	0.001***	0.81	0.60	0.13	4.76	0.001***	0.81
Political										
Ideology										
p-value	0.005**					0.001***				
R ²	0.34					0.47				

* p < .05. ** p < .01. *** p < .001.

Notes: Model 2 utilizes multivariate linear regression. See Appendix B for codebook.

Model 2 for 2014 and 2015 is significant with an overall p-value of 0.005 and 0.00008, respectively. The control variables can and do explain the variation in enrollment rates between states. Model 2 for 2014 has two significant variables, percent minority with a p-value of 0.03 and citizen political ideology with a p-value below 0.001. Percent uninsured was very close to being significant with a p-value of 0.09. Percent minority is negatively correlated with enrollment rates, meaning that as the percentage of minorities goes up, enrollment goes down. Citizen political ideology was positively correlated with enrollment rates: as citizen ideology goes up, or becomes more liberal, enrollment rates go up as well.

Model 2 for 2015 has four significant variables. Percent uninsured, percent minority, and percent male all have p-values of 0.003, while citizen political ideology once again has a p-value below 0.001. While state political ideology is technically not significant, it has a p-value of 0.051 and is extremely close to being significant. Percent minority and percent male are both negatively correlated with enrollment rates, while need and citizen political ideology are positively correlated with enrollment rates. The implications of these correlations will be discussed further in the next chapter.

Model 2 for 2014 has an R^2 of 0.34, which indicates that this model explains 34 percent of the variation in 2014 enrollment rates. Model 2 for 2015 has an R^2 of 0.47, which indicates that Model 2 explains 47 percent of the variation that occurs in 2015 enrollment rates. Both of these R^2 are high, and indicate that this model is measuring much of the variation in enrollment rates between states. This indicates that this model is a strong predictor of enrollment rates. Another interesting point is the increase in R^2 from 2014 to 2015, indicating that the trends that we are seeing in 2014 are becoming

more solidified in 2015. Every control variable also becomes a stronger predictor of enrollment rates in 2015 compared to 2014, with all variables but state political ideology being a significant indicator of enrollment rates in 2015

Suicide, as a proxy for social integration, is far from significant with p-values of 0.83 and 0.99 for 2014 and 2015 enrollment. This shows that suicide as an indicator of social integration does not have an effect on the variation in enrollment rates. But when looking at GIS data on a map, a pattern emerges. Many states with high enrollment have low suicide, and states with low enrollment have high suicide rates. The first map in Appendix A shows the suicide rates for each state, while the second map shows the enrollment rate for 2015 for each state. Enrollment rates in 2015 were used for these maps because 2015 data include enrollment data for 2014. These differing results between the Models and the maps may be due to problems with the Models' ability to measure social integration. A larger N, such as using county level data instead of state level data, could potentially show a link to social integration. States may have different social, cultural, economic, and demographic characteristics that exist within their own borders. Aho and Mordecai were able to show that Idaho has very different levels of social integration and different suicide rates in different regions. Northern Idaho experienced lower levels of social integration and high suicide rates; Eastern Idaho experienced high integration and low suicide rates (1996). This is likely true for many other states as well, and aggregating data to the county level would allow us to test social integration more accurately. While suicide has been theorized to be a strong indicator of social integration, there are other variables that also can be used as predictors of social integration (Aho and Mordecai 1996; Durkheim 2006; Brissette et al 2000). The other

possibility is that social integration is not a predictor of enrollment rates, and something else is occurring in states that are leading to different enrollment rates.

As shown above, Model 2 for 2014 and for 2015 explains 34 percent and 47 percent of the variation in enrollment rates, respectively. In order to further explore the differences in enrollment rates between states, a case study was conducted of the states with the lowest and highest enrollment rates, following Aho and Mordecai's approach (1996). The three states with the highest enrollment and the three states with the lowest enrollment rates were determined. The states with the highest ACA enrollment in 2015 were Florida, Maine, and Pennsylvania. The three states with the lowest enrollment in 2015 were South Dakota, Iowa, and Hawaii. This case study will provide an "in-depth examination" of the "social phenomenon" of enrollment rates, and explore the differences between high enrollment states and low enrollment states, along with similarities among high enrollment states compared to similarities among low enrollment states (Babbie 2011:519). Table 3-3 and 3-4 below lists these states, along with the enrollment percentages for each state.

Vermont is listed in Table 3-3, but proved to be an outlier, and was therefore not used in the case study. Vermont had a much higher enrollment rate than other states because in 2011, the state of Vermont created a law that essentially established it as the first single-payer health care system in the U.S. (Hsiao 2011). This caused Vermont to enroll many more individuals than other states. It should be noted that Vermont has since canceled its single-payer system, but data used for this research was gathered before this would have affected enrollment rates. Vermont chose to cancel the single payer system because new studies showed that the money saved by the state was not as much as

predicted, and that taxes would have to be raised in order for the single payer system to work (McDonough 2015). While Vermont's single payer system would have still offered some minor savings, it was determined that state funding alone could not keep a single payer system afloat (McDonough 2015). With Vermont eliminated Florida, Maine and Pennsylvania are the states with the highest ACA enrollment in 2015.

Table 3-3-States with the Highest Enrollment Rates

State	2015 Enrollment
Vermont	%77
Florida	%57
Maine	%55
Pennsylvania	%48

Source: Kaiser Family Foundation, 2015.

Notes: Vermont not included in case study due to its single payer health care system. See Appendix B for codebook.

Table 3-4-States with the Lowest Enrollment Rates.

State	2015 Enrollment
South Dakota	%19
Hawaii	%17
Iowa	%15

Source: Kaiser Family Foundation, 2015.

Notes: See Appendix B for codebook.

The top three and bottom three states were chosen in order to have a group of high and low enrollment states that would allow us to explore phenomena occurring in

the high enrollment states versus the low enrollment states. The three high enrollment states are all located in the eastern U.S., while two of the three low enrollment states are located in the Midwest. Hawaii, the third low enrollment state selected is obviously geographically isolated, which could very well have an effect on its enrollment rate. The following is a detailed discussion of the findings gathered from each case study, beginning with the high enrollment states.

The case study shows that other variables are likely having an effect on enrollment rates, and that a closer look into social integration is warranted. As will become apparent in the discussion of all six states in the case study, the states often fall on either end of the social integration spectrum: they will be highly integrated with one variable, but lowly integrated with another. We will begin with a brief discussion of the states with high enrollment rates, followed by a discussion of the states with low enrollment rates. I will highlight the similarities and differences in the six states chosen for the case study. This will allow for a more detailed understanding of what is happening in these states in regard to ACA enrollment. It will also allow us to determine if social integration still has some effect on enrollment rates, even though our first model indicated this not to be the case. This in turn will inform whether or not further research should be conducted into the possible link between social integration and enrollment in insurance or other phenomena occurring in the states that could explain the variation in enrollment rates.

Case Study-Florida, Maine, and Pennsylvania.

Florida, Maine and Pennsylvania enrolled 57 percent, 55 percent, and 48 percent of their potential enrollees in 2015 (KFF.org 2015). With the total enrollment rate in the U.S. being 36 percent, these three states are well above average and offer an insight into what is taking place in states with higher levels of enrollment (KFF.org 2015). Table 3-5 lists the basic demographic data for each state. Each state will be discussed individually beginning with Florida, followed by a comparison of the states.

Table 3-5- Demographics of Florida, Maine, & Pennsylvania.

Variables	Florida	Maine	Pennsylvania	Std. Dev	U.S.
Suicide Rates	13.73	17.40	13.25	14.87	13.02
Population Density	350.6	43.1	283.9	1377.35	33
Unemployment Rate	6.3	5.7	5.8	1.27	5.30
Marriage Rate	7.2	7.3	5.5	4.35	6.8
Divorce Rate	4.2	3.9	2.8	0.75	3.4
Percentage Family Household	64.7	63.2	64.8	4.24	65.49
Percentage High school Graduates	75	87	88	6.70	80.00
Community Participation	90.8	88.2	90.3	1.03	89.8
Poverty Rate	17	14	13.7	3.36	14.5
Median Income	47,114	50,487	52,768	7975.89	51,939
Median Age	41	43.2	40.3	2.36	37.64

Percentage of population in rural areas	8.84	61.34	21.34	14.89	19.30
Percent Male	48.46	48.83	49.30	0.83	49.00
Need	36	24	24	5.59	28
State Ideology	16.82	82.63	58.31	24.90	NA
Citizen Ideology	46.05	65.62	54.93	15.47	NA
Percent minority	42	5	22	17.53	38

Florida

Florida is an east coast state with an older population. The median age in Florida is 41 years which is more than one standard deviation away from the U.S median age. Florida also has a smaller male population than the U.S. and a large minority population. The median income in Florida is also less than the U.S. and the smallest median income of any of the states in the case study. This is also apparent with Florida's poverty rate, which is not quite one standard deviation higher than the U.S. poverty rate, and is the highest poverty rate of the six states in the case study. Florida has an aging population, with a high number of females and minorities that have a high need for health insurance due to the high poverty rate and low median income.

The first variable in Model 2 that was positively correlated to enrollments rates was Need. 36 percent of Florida's population was considered to be uninsured or underinsured in 2015, compared to 28 percent of the U.S. population as a whole (KFF.org 2015). Florida has the fourth highest need of any state. This is exactly what we would expect to find as need increases enrollment increases.

The next variable that was correlated to enrollment rates was percent minority. This variable was negatively correlated with enrollment rates, which is interesting as Florida has a high percentage of minority population at 42 percent, compared to the U.S. population of 38 percent (CPS 2013). Florida has the tenth highest minority population, which is the opposite of what we would expect.

The percentage of the population that is male is the next variable shown to be correlated with enrollment rates. This variable was also negatively correlated with enrollment rates. Florida has a low male population with 48.46 percent of the population being male compared to 49 percent of the U.S. population being male (CPS 2014). While these numbers do not appear to be that different, we would not expect to see that much variation in percentages of males vs. females. The standard deviation of percentage male is 0.83, meaning that differences between states male populations are relatively small. That being the case, there are only eleven states with smaller male populations than Florida.

The final variable, and the strongest variable, that was shown to be correlated to enrollment rates is citizen political ideology. Model 2 shows that the more liberal a population is, the higher that state's enrollment will be. However, Florida is relatively moderate, scoring 46.05 on the scale, which indicates that they are slightly conservative, as 0 is considered perfectly conservative and 100 perfectly liberal (Berry et al 2010). 27 states are more liberal than Florida. This goes against what we would expect, as high enrollment states would be expected to be more liberal.

26 states have a higher suicide rates than Florida, and according to the theory presented in this paper, we would expect a state with high enrollment to have low suicide

rates. Florida's suicide rate is 13.73, compared to 13.02 in the U.S (CDC 2013). Suicide is not correlated with enrollment rates, and because of this demographic variables will now be explored.

Florida is a densely populated state. Only nine states (including DC) have higher population densities. As would be expected, Florida also has a small percentage of its population living in rural areas, with 8.84 percent compared to 19.30 percent of the U.S. population (Census 2010). With large numbers of the population living in close contact with one another, we would expect Floridians to have more opportunity to come into contact with one another, resulting in the potential for higher levels of social integration. Florida also has a marriage rate that is above average, which according to Durkheim is an indicator of social integration (2006). Florida also has an above average Census response rate, which is used in this study as a proxy for community participation. Florida had 90.8 percent of the population respond to the Census, while the U.S. average was 89.8 percent (ACS 2013). This also indicates a higher level of social integration in Florida. Florida falls in towards the median in unemployment rates. Florida has an unemployment rate of 6.3, which is higher than the U.S. unemployment of 5.3, but twenty states have higher unemployment rates (BLS 2014).

Several variables also indicate lower levels of social integration: divorce rate, percentage high school graduates, and poverty rate. Florida has a divorce rate of 4.2 compared to the U.S. divorce rate of 3.4, with only nine states having a higher divorce rate than Florida (CDC 2012). (This could change as six states did not have divorce rate data available for the year used.) Florida has a low percentage of high school graduates, with 75 percent of high schoolers graduating compared to 80 percent for the U.S (NCES

2011-12). There are only six states that have lower percentages of high school graduates than Florida. Florida also has a high percentage of its population living in poverty with 17 percent, compared to the U.S. rate of 14.5 percent (ACS 2013). Fifteen states have a higher poverty rates than Florida. We also see that Florida has a low percentage of the population that live in family households with 64.7 percent of all households being considered a family household, while the U.S. has 65.49 percent of all households considered family households (ACS 2013).

As is apparent, it is difficult to determine whether or not social integration is having an effect of Florida's enrollment rates. When looking at the variables that are thought to measure social integration, Florida has several indicators of higher levels of social integration, but also has variables that would indicate lower levels of social integration. The only variable tested in Model 2 indicating a reason for higher enrollment rates in Florida is high need.

Maine

Maine is the state with the oldest population in the case study with a median age of 43.2, which is more than two standard deviations away from the U.S. median age (ACS 2013). Maine's population is more female than male, and the majority of the population is white. Maine's median income of \$50,487 is slightly lower than the U.S. median income of \$51,939 (CPS 2013). There are twenty-two states that have a smaller median income than Maine. Maine's poverty rate is also lower than the U.S. poverty rate, but higher than both Hawaii and Iowa's. Just as Florida, Maine is an aging state with a large female population that is poorer than other states in the case study. Unlike Florida,

Maine has a small minority population and has low need for insurance with fifteen states having less need than Maine.

Maine's population has a relatively low need when compared to the rest of the country, with 24 percent of its population considered underinsured or uninsured. 28 percent of the U.S. population is considered underinsured or uninsured, which means ten states have a lower need than Maine (KFF.org 2015). This is interesting as we would expect a state with low need to not enroll at such a high rate, but as will become apparent, Maine still has plenty of reason to enroll at such a high rate.

Only 5 percent of Maine's population is considered minorities, and as Model 2 has shown, states with a smaller minority population enroll at higher rates (CPS 2013). Maine has the third smallest population of minorities in the U.S. (CPS 2013). Maine also has a smaller population of males than other states, with 48.83 percent of Maine's population being male, compared to 49 percent of the U.S. (CPS 2014). The strongest correlation with enrollment rates, citizen political ideology also explains why Maine has high enrollment rates. Six states scored higher on the citizen ideology scale than Maine, which scored a 65.62 on the citizen ideology scale (Berry et al 2010). This indicates that Maine's population is relatively liberal, and is exactly what Model 2 indicated.

As discussed above, the variables used in this study indicate that Maine has low levels of social integration. This is in direct contrast to the theory presented earlier in this paper. Maine has a high suicide rate compared to the rest of the U.S. Maine's suicide rate is 17.4 compared to the U.S. suicide rate of 13.02 (CDC 2013). Maine has the 10th highest suicide rate in the U.S., and according to the theory presented in this paper, we would expect a state with high suicide, or in other words low social integration, to have a

low enrollment rate. This is obviously not the case with Maine, as it has both a high suicide rate and a high enrollment rate. Yet, Maine has two variables that indicate higher levels of social integration: high marriage rates and high percentage of high school graduates. Maine's marriage rate is 7.3, compared to the U.S. marriage rate of 6.8 (CDC 2012). This ranks Maine as the nation's fifteenth highest marriage rate. Maine also has a high school graduation rate of 87 percent compared to the U.S. rate of 80 percent, which ranks Maine as the ninth highest state in terms of high school graduation (NCES 2011-12). There are other variables though that would indicate something else is going on in Maine.

Maine's unemployment rate and poverty rate are average. Maine's unemployment rate is 5.7 compared to the U.S. unemployment rate of 5.3 (BLS 2014). There are twenty states with lower unemployment rates than Maine. Maine's poverty rate is 14 percent, compared to the U.S. poverty rate of 14.5 percent. Twenty-one states have a lower poverty rate than Maine (ACS 2013).

Maine has several variables that indicate low integration: population density, percent population in a rural area, divorce rate, percentage of family households, community participation, and suicide rate. Maine's population density is 43.1, which makes it the thirteenth least dense state, with 61.34 percent of Maine's population living in a rural area (Census 2014). Maine's divorce rate is 3.9 compared to the U.S. divorce rate of 3.4, which places Maine as the state with the fifteenth highest divorce rate (CDC 2012). 63.2 percent of households in Maine are considered family households, compared to 65.49 percent of households in the U.S. This ranks Maine towards the bottom, with only five states with less family households than Maine (ACS 2013). Maine also has low

census response rates, with a response rate of 88.2 percent compared to 89.8 percent in the U.S (ACS 2013). This means that only four states have lower census response rates than Maine. As mentioned above, we also see that Maine has a high suicide rate.

Maine would be considered to have low levels of social integration, which in turn goes against the hypothesis presented in this paper. Theoretically, we would expect a state with low levels of social integration to have low enrollment rates. The high ACA enrollment in Maine can be explained by high scores in citizen ideology and low percentage of minority populations.

Pennsylvania

Pennsylvania is also located on the east coast and also has an aging population with a median age of 40.3. This is more than one standard deviation away from the U.S. median age (ACS 2013). Pennsylvania also has a larger female population. As with Maine, Pennsylvania has a small minority population that is slightly less than one standard deviation away from the U.S. minority population. Pennsylvania is the richest of the three high enrollment states, and also has a smaller poverty rate than both Florida and Maine. As with Florida and Maine, Pennsylvania is poorer than the low enrollment states, with an aging population and a larger number of females. Unlike Florida, and similar to Maine, Pennsylvania has a small population of minorities. Pennsylvania and Maine also the same need for health insurance.

Pennsylvania has less need than the rest of the country, with 24 percent of Pennsylvania's population considered underinsured or uninsured (KFF.org 2015). Only ten states have less need than Pennsylvania. We would expect a state with high

enrollment to have a high need, based on the findings from Model 2, and this is not the case in Pennsylvania. The percentage of population that is male in Pennsylvania is 49.3 percent compared to the U.S at 49 percent (CPS 2014). Twenty-one states have a higher percentage of males than Pennsylvania, meaning Pennsylvania has an average male population. Pennsylvania does have a low population of minorities, with 22 percent of the population being considered minorities, compared to 38 percent of the U.S. population (CPS 2013). Pennsylvania also scores more liberal than thirty-six other states with a score of 54.93. This fits with the results from Models 2 (Berry et al 2010).

Pennsylvania's suicide rate of 13.25 is slightly higher than the U.S. suicide rate 13.02, but there are twenty-eight states that have a higher suicide rate than Pennsylvania, which means that it has an average suicide rate (CDC 2013). However, Pennsylvania has the tenth highest population density in the U.S., with a population density of 283.9 (Census 2014). Pennsylvania also has the fifth lowest divorce rate of 2.8, compared to 3.4 for the U.S (CDC 2012). 88 percent of high school students graduate in Pennsylvania, compared to 80 percent in the U.S. (NCES 2011-12). This ranks Pennsylvania as the eighth highest in terms of high school graduates. Pennsylvania also has a lower poverty rate than the U.S., ranking as the ninetieth lowest poverty rate. All of these variables would indicate a higher level of social integration in Pennsylvania.

Pennsylvania is close to average in regard to three variables indicating social integration: unemployment rate, community participation, and rural population. Pennsylvania's unemployment rate is 5.8 compared to the U.S. rate of 5.3 (BLS 2014). This ranks Pennsylvania as the twenty-first lowest unemployment rate. Pennsylvania also has the twenty-first highest census response rate at 90.3 percent (ACS 2013). There

are nineteen states that have smaller percentages of their population living in rural areas than Pennsylvania.

There are two variables that would indicate that Pennsylvania may have lower levels of social integration. Pennsylvania has the fourth lowest marriage rate in the nation, with a rate of 5.5 compared to the U.S. rate of 6.8 (CDC 2012). It also has the fifteenth lowest percentage of households that are considered family households. 64.8 percent of Pennsylvania households are family households compared to 65.49 percent of U.S. households (ACS 2013).

Pennsylvania's high enrollment rate could be explained by its high scores on citizen ideology, lower percentage of males, and its smaller percentage of minority population.

Summary: Florida, Maine, Pennsylvania

When looking for similarities between Florida, Maine, and Pennsylvania, we see that Florida and Pennsylvania are more similar to each other. Maine, on the other hand differs from both Florida and Pennsylvania. Pennsylvania leans towards higher levels of social integration, which would prove the hypothesis presented in this research. Florida's level of integration is inconclusive, and Maine is lowly integrated. Conducting a case study of the states with the highest enrollment has given inconclusive results, but some trends and similarities emerged.

Maine is very different than its two high enrollment counterparts. It is a much more liberal state, both in citizen and state political ideology than Florida or Pennsylvania. This likely has a large effect on Maine's enrollment rate, as we see from

Model 2 that more liberal states enroll at higher rates. Maine is also a state that has low community participation, a low percentage of family households, and a high percentage of the population that lives in rural areas. Maine also has the highest median age of the three high enrollment rates, and a low percentage of males living in the state. This indicates that Maine is an aging state, populated with more females and that the population is likely not very connected with each other. Maine's enrollment is high because it is a liberally minded state, with a low percentage of males and minorities. This means that Maine's opinion of the ACA is likely a positive one, and that its population is more receptive of the ACA, leading to higher enrollment rates.

As evidenced by the case studies, Florida and Pennsylvania are relatively similar to each other. Florida and Pennsylvania both have large metropolitan areas, high community participation, and low suicide rates. They have a higher median age than the U.S. Both are relatively moderate in terms of citizen political ideology. Pennsylvania has a moderate state ideology; Florida has a conservative state ideology. Florida's and Pennsylvania's populations are relatively connected to one another, and their moderate political views allow for some acceptance of the ACA. Florida is likely experiencing high enrollment due to its high need for health insurance. Pennsylvania on the other hand is a more liberal state, with a low percentage of minorities.

Case Study- South Dakota, Hawaii, Iowa.

The three states with the lowest enrollment are South Dakota, Hawaii, and Iowa which enrolled 19 percent, 17 percent, and 15 percent respectively (KFF.org 2015). These states are all well below the U.S. enrollment rate of 36 percent (KFF.org 2015).

We have already discussed if social integration could explain high enrollment rates, and we now continue with a discussion of the states with low enrollment.

Table 3-6- Demographics of South Dakota, Hawaii, & Iowa.

Variables	South Dakota	Hawaii	Iowa	Std. Dev	U.S.
Suicide Rates	18.20	11.58	14.42	14.87	13.02
Population Density	10.7	211.8	54.5	1377.35	33
Unemployment Rate	3.4	4.4	4.4	1.27	5.30
Marriage Rate	7.5	17.5	6.8	4.35	6.8
Divorce Rate	3	NA	2.2	0.75	3.4
Percentage Family Household	64.8	69.4	64.8	4.24	65.49
Percentage High school Graduates	83	78	89	6.70	80.00
Community Participation	91.1	89.9	91.4	1.03	89.8
Poverty Rate	14.2	10.8	12.7	3.36	14.5
Median Income	51,165	59,882	53,696	7975.89	51,939
Median Age	36.9	38.3	38.1	2.36	37.64
Percentage of	43.35	8.07	35.98	14.89	19.30

population in
rural areas

Percent Male	50.06	49.81	49.76	0.83	49.00
Need	27	22	23	5.59	28
State Ideology	21.48	66.40	78.41	24.90	NA
Citizen Ideology	40.85	71.04	48.76	15.47	NA
Percent minority	4	83	15	17.53	38

South Dakota

South Dakota is a Midwestern state and the youngest state in the case study with a median age of 36.9 (ACS 2013). South Dakota also has the largest male population in the case study with 50.06 percent of its population being male, larger than one standard deviation away from the U.S. male population (CPS 2014). South Dakota is the poorest state of the three low enrollment states, with a median income of \$51,165 and a poverty rate of 14.2 percent (CPS 2013; ACS 2013). South Dakota's population is also mostly white, with only 4 percent of the population considered a minority (CPS 2013).

South Dakota has a fairly average percentage of the population that is underinsured or uninsured with 27 percent, compared to the U.S. with 28 percent (KFF.org 2015). This places twenty-nine states with higher need than South Dakota, and is what we would expect to find with a low enrollment state. South Dakota's population is 4 percent minority, compared to the U.S. population of 38 percent (CPS 2013). South Dakota has the second smallest minority population in the country. We would expect a state with a small minority population to enroll at a higher rate, which is not the case with

South Dakota. Model 2 found that as the percentage of males goes down, enrollment goes up and we see this with South Dakota. South Dakota's population is 50.06 percent male, which ranks it as the state with the sixth highest percentage of males and is exactly what we would expect (CPS 2014).

South Dakota is also a state whose citizens have a conservative ideology. South Dakota scored 40.85 on the citizen ideology measure (Berry et al 2010). Sixteen states have citizens with a more conservative ideology than South Dakota. Model 2 indicated that as a state's citizen ideology becomes more conservative, we would see a decrease in enrollment, and this is the case in South Dakota.

South Dakota has the ninth highest suicide rate, with a rate of 18.2 compared to the U.S. rate of 13.02 (CDC 2013). This is what we would expect to find for a low enrollment state, based on the hypothesis presented earlier. That being said, suicide was shown not to have any correlation to enrollment rates when tested across all states. As with the states discussed previously, we will now discuss other demographic variables that could account for possible effects on the enrollment rates in South Dakota.

We see several variables that indicate South Dakota has high levels of social integration. First, South Dakota has the third lowest unemployment rate in the country, with a rate of 3.4 compared to the U.S. rate of 5.3 (BLS 2014). South Dakota also has a high marriage rate, ranking the twelfth highest in the country, and has the eleventh smallest divorce rate in the country. South Dakota also has the sixth highest census response rate, which indicates that South Dakota has high levels of community participation.

There are two variables for which South Dakota places average: percentage of high school graduates and poverty rate. South Dakota's high schoolers graduate at a higher percentage than the U.S. as a whole, 83 percent compared to 80 percent, and nineteen states graduate more high schoolers than South Dakota (NCES 2011-12). South Dakota also has a poverty rate of 14.2 percent, which is slightly lower than the U.S. rate of 14.5 percent. Twenty-two states have a lower poverty rate than South Dakota (ACS 2013).

In addition to a high suicide rate, we found three other variables that would indicate that South Dakota has low levels of social integration. South Dakota has the fifth smallest population density in the U.S., as well as the seventh largest percentage of the population that live in rural areas. South Dakota also has the seventeenth smallest percentage of family households in the U.S.

The hypothesis of this study states that a state with low enrollment should have low levels of social integration. This may be the case for some of the variables used as indicators, but there are other variables that indicate South Dakota has higher levels of integration. It is inconclusive if South Dakota is highly or lowly integrated. Factors that might account for the low enrollment in South Dakota are low scores on citizen ideology, higher percentage of male population, and a high suicide rate.

Hawaii

Hawaii is the most geographically isolated state in the case study. It is also the oldest state of the three low enrollment states, but is younger than all of the high enrollment states. Hawaii is the richest state in the case study, with a median income on

\$59,882, which is more than one standard deviation away from the U.S. median income of \$51,939 (CPS 2013). Hawaii also has the lowest poverty rate in the case study at 10.8 percent (ACS 2013). Hawaii also has a larger male population than every state in the case study, but South Dakota, and has the highest minority population in the country. Like South Dakota, Hawaii is a young state with a larger male population than the U.S. as a whole, and a low need for health insurance.

22 percent of Hawaii's population is considered underinsured or uninsured (KFF.org 2015). There are only six states with a lower need than Hawaii, and is exactly what Model 2 indicated. Hawaii also has the highest minority population in the country, and fits with the results of Model 2. Hawaii also has the eighth largest male population, with 49.81 percent of the population being male, and this also falls into what we would expect from Model 2 (CPS 2014).

The strongest indicator of enrollment rates according to Model 2 was citizen political ideology. Hawaii actually does not fall where we would expect a state with low enrollment, being the fifth most liberal population in the country. Hawaii disproves the hypothesis that low integration is correlated to low enrollment. Hawaii has low enrollment due to its high minority and male population, as well as its low need.

Hawaii has the ninth lowest suicide rate, with a rate of 11.58 (CDC 2013). We would expect a state with low enrollment rates to have a high suicide rate based on the hypothesis that low enrollment is correlated to low integration. Suicide rates are indicating that Hawaii is highly integrated, and other factors also indicate high levels of social integration. First, Hawaii has the fourteenth largest population density, as well as the sixth smallest percentage of its population that lives in rural areas. Hawaii also has

the ninth lowest unemployment rate, and the fifth smallest poverty rate. Hawaii also has the second highest marriage rate, but this statistic is likely inflated due to Hawaii being chosen for many destination weddings. Lastly, Hawaii has the fourth highest percentage of family households. All of these would indicate that Hawaii has high levels of social integration, which disproves the hypothesis. Hawaii has an average Census response rate, used as a proxy for community participation. Hawaii has the twenty-first smallest Census response rate.

One variable indicates Hawaii has low levels of integration. Hawaii has the fifteenth smallest percentage of high schoolers that graduate, with 78 percent graduating compared to the U.S. 80 percent graduation rate.

Iowa

Iowa is also a Midwestern state, and like South Dakota and Hawaii, is younger than the three high enrollment states. Iowa also has a larger male population than the three high enrollment states with 49.76 percent of Iowa's population being male (CPS 2014). This is slightly less than one standard deviation away from the U.S. male population. Like South Dakota and Hawaii, Iowa has a higher median income than the high enrollment states. Iowa's median income of \$53,696 is also higher than the U.S. median income (CPS 2013). As with Hawaii, Iowa also has a smaller poverty rate than the high enrollment states. Iowa's minority population is small, with only 15 percent of its population considered a minority (CPS 2013). Like the other low enrollment states, Iowa is a richer and younger state that has a higher male population than the high enrollment states. Iowa also has a low need for health insurance.

We see that Iowa has the tenth smallest need. Only 23 percent of Iowa's population is considered to be underinsured or uninsured, compared to the U.S. at 28 percent (KFF.org 2015). Model 2 shows that as need goes down, so does enrollment. We also see that Iowa has the tenth largest male population in the country, which aligns with the results of Model 2.

In contrast to Model 2, Iowa has a low minority population with only 15 percent of the population being considered minorities (CPS 2013). Model 2 indicates that states with low minority populations generally have higher enrollment. Iowa's citizens have the twenty-fourth most liberal ideology when compared to the other states, and Iowa's score of 48.76 indicates that it is relatively moderate (Berry et al 2010). We would expect a state with low enrollment to have a more conservative ideology.

Iowa has the lowest enrollment of any state. Based on the hypothesis of this study, we would expect Iowa to have a high suicide rate. Iowa has a suicide rate of 14.42, compared to the U.S. rate of 13.02 (CDC 2013). While Iowa's rate is higher than the U.S. rate, there are twenty-one states with higher suicide rates, indicating that Iowa's suicide rate is relatively average. In order to determine why Iowa's enrollment rate is low, this case study will continue with an exploration of demographic variables.

Iowa's unemployment rate of 4.4 is the ninth smallest in the country, and lower than the U.S. rate of 5.3 slightly less than one standard deviation (BLS 2014). Iowa also has the lowest divorce rate in the country and the fourteenth smallest poverty rate in the country. We also see that Iowa graduates 89 percent of its high schoolers, which makes it the fifth ranked state in high school graduates (NCES 2011-12). These four variables would indicate that Iowa has high levels of social integration. Along with the suicide

rate, there are is one other variable that Iowa places relatively average, marriage rate. Iowa has the same marriage rate as the U.S. as a whole, or a rate of 6.8 (CDC 2012).

There are three variables that would indicate Iowa has a low level of social integration. Iowa has the fifteenth smallest population density, with a density of 54.5 (Census 2014). This also means that Iowa has a substantial portion of its population living in rural areas, or 35.98 percent compared to the U.S. at 19.30 percent (Census 2014). Iowa also has the fifteenth smallest percentage of family households. As with Florida and South Dakota, the result of Iowa's level of social integration is inconclusive.

Summary- South Dakota, Hawaii, Iowa

As with the three high enrollment states, we see two states that have many similarities, Iowa and South Dakota, and one state that seems out of place, Hawaii. Hawaii is a highly integrated state, disproving the hypothesis of this research. Hawaii differs from South Dakota and Iowa in several ways. It has a high population density, a high percentage of family households, and a low percentage high school graduates. Hawaii also has a very low percentage of the population living in rural areas, and is a geographically isolated state. This indicates that Hawaii's population is highly connected and dependent on one another. Hawaii's low enrollment rate can be explained by its high minority population, higher percentage of male population, and its low need.

South Dakota and Iowa are both Midwestern states with low population densities, low family households, and a high percentage of the population living in rural areas. It is likely that both South Dakota and Iowa are states whose populations are not that connected or dependent on one another. We see that, as with Hawaii, South Dakota and

Iowa have a high percentage of males, and low need. Unlike Hawaii, South Dakota and Iowa are more moderate states, with South Dakota being fairly conservative. South Dakota and Iowa have a small population of minorities. This explains why both South Dakota and Iowa are experiencing low enrollment rates.

As with the high enrollment states, it is interesting that one state is so different to its low enrollment counterparts. Once again, as the ACA ages, the trends that were observed between 2014 and 2015 will likely strengthen. This will likely exacerbate the differences between high and low enrollment states.

Final Results

This research is attempting to show the link between high social integration and high enrollment rates. In order to test the hypothesis that social integration and enrollment rates are correlated, suicide rates were used as a proxy for social integration. Model 1 and 2 showed that suicide rates are not correlated to enrollment, but suicide rates are only one indicator of social integration. A case study on the states with the highest and lowest enrollment rates was then conducted. This allowed for a determination if social integrations can explain differing enrollment rates between states. Model 2 does indicate that there is a strong correlation between citizen political and enrollment rates. Model 2 and the case study also demonstrate that need is also strongly correlated to enrollment rates.

Table 3-7- SES Differences Between High and Low Enrollment States

States	Median Income	Median Age	Poverty Rate	Percentage Male
High Enrollment				
Florida	47,114	41	17	48.46
Maine	50,487	43.2	14	48.83
Pennsylvania	52,768	40.3	13.7	49.30
Average	50,123	41.5	14.9	48.86
Low Enrollment				
South Dakota	51,165	36.9	14.2	50.06
Hawaii	59,882	38.3	10.8	49.81
Iowa	53,696	38.1	12.7	49.76
Average	54,914	37.8	12.6	49.88

Notes: Average is the average of the three high enrollment states, and the average of the three low enrollment states.

What we see from the case study is that the high and low enrollment states differ on variables measuring socio-economic status (See Table 3-7). It appears that the states with low enrollment not only have a lower need than the states with high enrollment, but are generally better off economically. When averaging median income for the top three and bottom three states in terms of enrollment, we see the high enrollment states with an average median income of \$50,123, which is lower than the U.S. median income of \$51,939 (CPS 2013). The low enrollment states' average is \$54,914, higher than the high enrollment states, and the U.S. median income as well (CPS 2013). The average income

for the high enrollment states is less than one standard deviation away from the average income for the low enrollment states. The low enrollment states are also much younger than the high enrollment states, with an average median age of 37.77, on par with the U.S. median age of 37.64 (ACS 2013). The average median age for the high enrollment states is 41.5, nearly four years older than the low enrollment states which are greater than one standard deviation away from the average age for low enrollment states (ACS 2013). The difference between high and low enrollment states is also apparent in poverty rates. The high enrollment states have an average poverty rate of 14.9 percent, similar to the U.S. poverty rate of 14.5 percent (ACS 2013). The low enrollment states have a much lower average poverty rate at 12.57 percent, not quite one standard deviation away (ACS 2013). The low enrollment states are also more heavily populated by males, with an average male population of 49.88 percent, compared to the high enrollment states with an average male population equal to that of the U.S. male population of 49 percent (CPS 2014). The average poverty rate of the high enrollment states is slightly more than one standard deviation away from the average poverty rate for low enrollment states.

The high enrollment states are relatively poor, with an aging population comprised of more females. The low enrollment states on the other hand are comparatively richer, with more males and a younger population. This finding aligns with what was found in Model 2. These low enrollment states are likely experiencing less need for insurance due to their increased income bolstered by a young population of working males whom have an increased chance of having insurance through an employer, or were able to purchase insurance on their own before the ACA was passed. It is likely that as the ACA ages, and more enrollment periods pass, the trends that have

been discussed will strengthen. States that have a higher socioeconomic status will continue to enroll at lower rates than states with lower socioeconomic status.

There is conflicting evidence in support of the hypothesis, which will be picked up in detail in the following chapter. Median income, poverty rates, and age provide evidence in support of social capital's link to enrollment rates, while percent male offers support for a link to social integration. Pennsylvania proves the hypothesis, while the other case study states either disprove the hypothesis or are inconclusive. The case study shows that age and income are important variables that need to be considered when explaining differences in enrollment rates.

Another interesting point is the strength of citizen political ideology as an indicator of enrollment rates. Other than Hawaii, the more liberal states enrolled at a higher rate and the more conservative states enrolled less individuals. While this research is unable to comment on the narratives used to discuss the ACA in liberal states versus conservative states, it does provide evidence that an individuals' perception of a policy is linked to the success or failure of that policy.

This will all be discussed further in the following chapter, along with a discussion of the validity of the theory presented earlier, and if it could still be considered as an explanation of differing enrollment rates.

Chapter 4-Discussion

This research hypothesizes that levels of social integration are potentially correlated with enrollment rates for the ACA. Social integration was defined as “the extent to which an individual participates in a broad range of social relationships.” (Brissette et al 2000:54). Group membership combats social disorganization, or the “inability of community members to achieve shared values or to solve jointly experienced problems” (Bursik 1988). When an individual becomes integrated into a group, they obtain social capital. Social capital is defined as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition.” (Portes 1998:3). Group membership gives individuals the ability to measure their own risk of becoming ill, and the knowledge of how to prepare for such risk. In order to be an effective group member, individuals must be healthy, as ill individuals are unable to perform their duties in an effective and efficient manner. Groups also sanction individuals if they are not productive group members, so it is in the members’ best interest to maintain their health. The knowledge gained from group membership shows individuals that the best way to prepare for a potential health risk is to purchase health insurance. In order to prove this hypothesis, a measure for social integration was used. Model 1 was built and a simple regression analysis was then conducted using suicide rates as a measure for social integration. Durkheim showed that the best indicator of a lack of social integration is a high suicide rate, and low suicide rates indicate high levels of social integration (2006). Model 1 and 2 disproved the initial hypothesis, showing no correlation between suicide rates and enrollment rates.

When looking at differences in enrollment rates, we see that gender and race affect enrollment rates (New York Times 2014). To my knowledge, at the time of this study there are no systematic studies showing that gender, race, need, and citizen and state political ideology are predictors of enrollment rates. Because we do see differences in enrollment between various groups, these variables must be controlled for. Even when controlling for a states' need, percent male, percent minority, and state and citizen political ideology, suicide rates are not correlated to enrollment rates, disproving the hypothesis. Model 2 does show that need, percent male, percent minority, and citizen political ideology are correlated to enrollment rates. This lack of correlation between social integration and enrollment rates could be attributed to the small N. Mapping suicide rates and enrollment rates does provide some conflicting evidence, as a visual pattern of the relationship between suicide and enrollment rates emerged. A case study was then conducted in order to explore in more depth the states with highest and lowest enrollment. The case study shows that socioeconomic variables and political ideology are likely correlated with enrollment rates.

The strongest predictor of enrollment rates was citizen political ideology. As states become more liberal, enrollment rates go up. A narrative analysis would be able to explore the relationship between political ideology and enrollment rates. This research, however, is unable to comment on the narratives used to discuss the ACA, and how these narratives differ in states with high and low enrollment. However, this research does show that the political ideology of an individual has an effect on their opinion of the ACA. People form their political ideology from information around them. States with a larger liberal population are likely to have media outlets that cater to this mentality.

These outlets would then view the ACA in a positive light, further increasing support of the ACA among the liberally minded population. The opposite would be true for state populations with a conservative ideology. These statements do require further testing though, and a narrative analysis of the ACA should be conducted in order to provide more insights.

The correlation of citizen political ideology and enrollment rates is an important finding. Individuals are deciding to enroll or not enroll in the ACA based on their political ideology, not just based on their need. This means that many people might not enroll in the ACA, even if they would benefit from enrolling, due to their political leanings. Need, percent minority, and percent male were all correlated with enrollment rates as well, but none as strongly as citizen political ideology. While Model 2 indicates that citizen political ideology is the strongest predictor of enrollment rates, the case studies offer another explanation.

Model 2 and the case studies highlight the strength of need as a predictor of enrollment rates. It is a logical step to assume that states that have a higher need for insurance are going to enroll at a higher rate. The case study shows that the three high enrollment states are older, poorer, and have larger female populations than the three low enrollment states. These states have a lower SES and have a larger need for health insurance. Model 2 was able to show that as need goes up, so does enrollment. The states with a higher SES likely have less need for health insurance due to the ability of individuals in these states to access employer sponsored health insurance, and more people may afford to purchase private coverage. The average unemployment rate for the three low enrollment states was 4.1, more than one standard deviation away from the

average rate of 5.9 for the high enrollment states. The three low enrollment states had an average need of 24 percent, nearly one standard deviation away from the U.S. as a whole, which is 28 percent (KFF.org). The states with the highest enrollment, Florida, Maine, and Pennsylvania had an average need of 28 percent, identical to the U.S. need. The case studies show that the socioeconomic status (SES) of a state explains ACA enrollment. A state with a higher SES will have lower enrollment rates, and a state with a lower SES will have higher enrollment rates. South Dakota, Hawaii, and Iowa were the richer states in the case study: they had a higher median income, lower poverty rates, and had less need for health insurance. The three highest enrollment states have a median income that was about \$5,000 less than the median income for the three lowest enrollment states. Florida, Maine, and Pennsylvania's poverty rate of 14.9 percent is also higher than the poverty rate for the three low enrollment states at 12.6 percent. The higher income and lower poverty in by higher SES states not only leads to higher economic capital, but higher social capital as well.

Portes identifies two different sources of capital, this first being *consummatory*, and the second being *instrumental* (Portes 1998). Consummatory social capital is built through the socialization an individual receives from the various group they are a part of such as "families, kin networks, (and) class and occupational groups." (Narayan 1999:7). Instrumental social capital can be thought of as "purposive exchanges based on expectations of reciprocity." (Narayan 1999:7). Social capital has both a positive and negative effect. The positive effects of social capital can be "social control or norm observance, family support and benefits mediated through extra-familial networks." (Narayan 1999:7). The negative effects of social capital are the exclusion of

nonmembers from the group (Narayan 1999). People tend to mingle within their own social class, and rarely venture out to build strong ties to those that are either better off or poorer. People with a higher income have more economic resources to purchase health insurance, but they are also connected to others with similar economic resources. Being a member of this high income group provides them with the opportunity to see the benefit of health insurance. The social capital gained from being a member of this group would lead individual members to purchase insurance. The opposite would be true for individuals who are members of a group with a low SES.

The case study was also able to show the relation of age and gender to enrollment rates. The population in the high enrollment states is older, with an average age of 41.5 compared to 37.8. The higher enrollment states have smaller male populations, 48.86 percent male compared to 49.88 percent in lower enrollment states. Gender can indicate social integration, especially when linking this variable to suicide rates. Men commit suicide at a rate nearly four times more than women and make up 77.9 percent of all suicides (CDC 2014). This means that men are less integrated than women, which may in turn cause them to enroll in the ACA at lower rates. Model 2 shows that as the population of males increases, enrollment decreases. Age supports the argument that social capital is linked to enrollment rates. Older individuals are more likely to have experienced illness, or know someone that has experienced an illness. The increased exposure to illness by older people increases their knowledge about illness. Older people are thus afforded more social capital, which may incline them to engage in more risk averse behaviors than younger people. In order to offer a better explanation of age's relation to enrollment rates, further research should be conducted breaking age down into

groups and comparing the varying levels of integration and social capital among different age groups. Young people and males are less risk averse than older people and females. “The findings for age and sex have been consistent (over time): Use of health services is greater for females than for males, and is greatest for the elderly. (Cockerham 2001:115). Another explanation of the gender, income, and age differences in enrollment rates is the availability of employer sponsored health care. According to the Census Bureau Survey of Income and Program Participation, 73.9 percent of males are covered by employer sponsored health coverage compared to 65.3 percent of females (See Table 1; Janicki 2013). Income is also related to the likelihood of having employer sponsored health insurance. Only 50.5 percent of individuals with a family income that is 138 percent or less of the poverty threshold have employer sponsored health coverage (Janicki 2013). 73.2 percent of individuals with a family income that is 401 percent or higher of the poverty threshold have employer sponsored health insurance (Janicki 2013). If we were to describe an individual with the highest likelihood of having employer sponsored insurance, they would be a college educated white male between the ages of 26 and 64 with an income that places them well above the poverty threshold (Janicki 2013). The higher median income, lower poverty rates, and higher male population experienced by the three low enrollment states explain the lower need and lower enrollment rates.

Table 4-1- Employment-Based Coverage Rates By Selected Worker Characteristics

Characteristic	Percentage Covered
<i>Education</i>	
Less than high school	53.3

High school or some college	64.8
College degree	74.5
<i>Sex</i>	
Male	73.9
Female	65.3
<i>Race</i>	
White	70.6
Black	67.9
Hispanic	65.7
<i>Age</i>	
15 to 18	11.0
19 to 25	46.6
26 to 44	72.9
45 to 64	76.1
65 and older	49.2
<i>Family Income as Percentage of Poverty</i>	
138% or less	50.5
139% to 250%	64.9
251% to 400%	72.6
400% or higher	73.2

Source: U.S. Census Bureau, Survey of Income and Program Participation 2010.

Model 2 indicates that as the minority population goes down enrollment rates go up. It is difficult to make comparisons based on minority population in the case study states, as Hawaii's population is 83 percent minority (CPS 2013). The average minority population of the three low enrollment states is 34 percent, but removing Hawaii drops the average to 9.5 percent. The average minority population of the three high enrollment states is 23 percent. Maine is likely lowering this average, as its population is 5 percent minority, compared to 42 percent and 22 percent for Florida and Pennsylvania respectively (CPS 2013). Removing Maine raises the average to 32 percent. Model 2 indicates that as minority populations go down, enrollment rates go up. The case study indicates that the lower enrollment states have low minority populations, with the exception of Hawaii. The high enrollment states have a minority population close to the U.S. minority population, when removing Maine. The conflict in findings related to minority populations between Model 2 and the case study could merely be coincidence. States like Hawaii and Maine could also be skewing the results of the Model. Further testing is needed to make any definitive statements regarding the correlation between minority population and enrollment rates.

Model 1 and 2 shows no correlation between suicide rates (measure for social integration) and enrollment rates. The case study provides evidence in support for and against the hypothesis (See Table 2).

Table 4-2- Case Study Hypothesis Approval and Disapproval

State	Prove or Disprove Hypothesis
Florida	Inconclusive

Maine	Disprove
Pennsylvania	Prove
South Dakota	Inconclusive
Hawaii	Disprove
Iowa	Inconclusive

Notes: Overall, results of case study prove to be inconclusive.

Florida, South Dakota, and Iowa all offer inconclusive results, as they are all likely states with average levels of social integration. This study could not accurately determine the level of social integration for Florida, South Dakota, and Iowa. Pennsylvania, Maine, and Hawaii allow for a more accurate portrayal of their level of social integration. Maine is a state that has low levels of integration. It has a high suicide rate, low population density, low number of family households, and low community participation. Maine disproves my hypothesis as it has the second highest enrollment, and has a low level of social integration. Hawaii also disproves the hypothesis, because it is a state with high levels of integration and low enrollment. Hawaii has a low suicide rate, high population density, a large family population, and an average rate of community participation. Pennsylvania is the only state that proves the hypothesis, being a highly integrated state and having high ACA enrollment. It has an average suicide rate and an average size family population, a high population density, and a high rate of community participation.

The dataset used for this study is not without problems. An N of 51, the 50 states plus DC, limited the strength of any statistical analysis that could be conducted. Aggregating data to the county level could have yielded an N upwards of 3,000. This

would have been more than enough to build a social integration index. The index would have been a better and more complete measure of social integration, as suicide rates are just one indicator of social integration. States can also have varying levels of social integration within their own borders. Aho and Mordecai demonstrated this with Idaho. The northern part of Idaho is an area with low levels of integration, but the eastern part of Idaho experiences high levels of integration (1996). The case study offers some support for the hypothesis. Mapping the data does display some patterns, as it appears that higher suicide rates do align with higher enrollment rates. Differences in poverty rates and income between the high and low enrollment states also provide evidence in support of the hypothesis. Individuals that are members of a group with a high economic capability, (and a greater likelihood of employer sponsored insurance), are able to witness the benefits of having health insurance, in turn giving them social capital allowing for the decision to purchase health insurance. Knowing that males are less integrated than females also provides evidence in support of the hypothesis, as we see that states with higher male populations enroll less. Age offers conflicting evidence, as we would expect older states to be less integrated and enroll less. The case studies show the opposite taking place as the high enrollment states are older. On the other hand, older individuals are more likely to have experienced illness, or known someone who has been ill.

Health insurance, in its most simple state, is the diffusing of risk from the individual to the collective. The formation of a club binds the club members to one another. This allows them to compare and contrast their own personal risk to that of their fellow members. It also puts the group members into contact with others whose health may not be as well, and provides a clear example of the need to protect oneself from

potential illness. Group membership also places requirements on members in order to maintain their membership, combating social disorganization. These group requirements force individuals to behave in certain ways, generally in ways that benefit the group. The group must control its members, stopping them from engaging in anomic and egotistical behaviors that would increase the level of social disorganization in the group. Failing to meet group requirements because of illness may cause the individual to be sanctioned, and potentially removed from the group. It is then in the individuals best interest to maintain good health, and is in the groups best interest to be concerned with the well-being of its members. In order to protect its members, the group pools individual resources together, allowing the group to take care of the financial burden of becoming ill. Instead of leaving the individual to fend for themselves, the group then covers the cost of the medical care required. The cost to each individual to enter the group's insurance plan is small compared to the cost of medical care. Group membership also builds social capital. This social capital can be passed from one group member to the other in the form of knowledge. The knowledge of the benefits of health insurance and how it not only reduces the financial risk of becoming ill, but also allows many to have access to health care at all, will be readily available to those who have become integrated into the group. Nonmembers would not be able to obtain this social capital, as it is only afforded to members of the club. The social capital gained from being a member of the group would likely cause the individuals to become more risk averse, causing them to desire the protection of insurance.

The cost of health care in the U.S. is immense. This has created the need for health insurance in order for individuals to have access to care. This research was not

able to definitively show that higher levels of social integration are correlated with higher enrollment rates. That being said, further research needs to be conducted exploring this link. Data should be tested at the county level in any future studies. This will strengthen any statistical analysis and provide a more accurate portrait of the varying levels of integration not only between states, but within states as well. While suicide has shown to be the best indicator of social integration, future research should also attempt to use other indicators along with suicide rates. Doing so will provide a better measurement of social integration. A social integration index would be a valuable tool, as it would provide for an easy comparison of varying levels of social integration. This study links social integration and social capital together, claiming that becoming socially integrated into a group then allows members to access social capital. It also claims that this group membership would then combat social disorganization. Future research may need to separate social integration and social capital in order to explore their effects on enrollment rates separately, but there is a theoretical link between the two concepts. This research also shows the need for a narrative analysis in order to demonstrate the effect that citizen political ideology plays on the choice to enroll in health insurance or not.

This research does provide policy makers with some insights into reasons for different ACA enrollment rates between states. Knowing that states with a low SES and a high need are likely to enroll more individuals will allow policy makers to better prepare for future enrollment windows, and ease the implementation of any future changes. This research also highlights the importance of social integration and social capital in encouraging individuals to enroll in health insurance. Lastly, this research also

demonstrates the importance of citizen political ideology, and how it affects decision-making.

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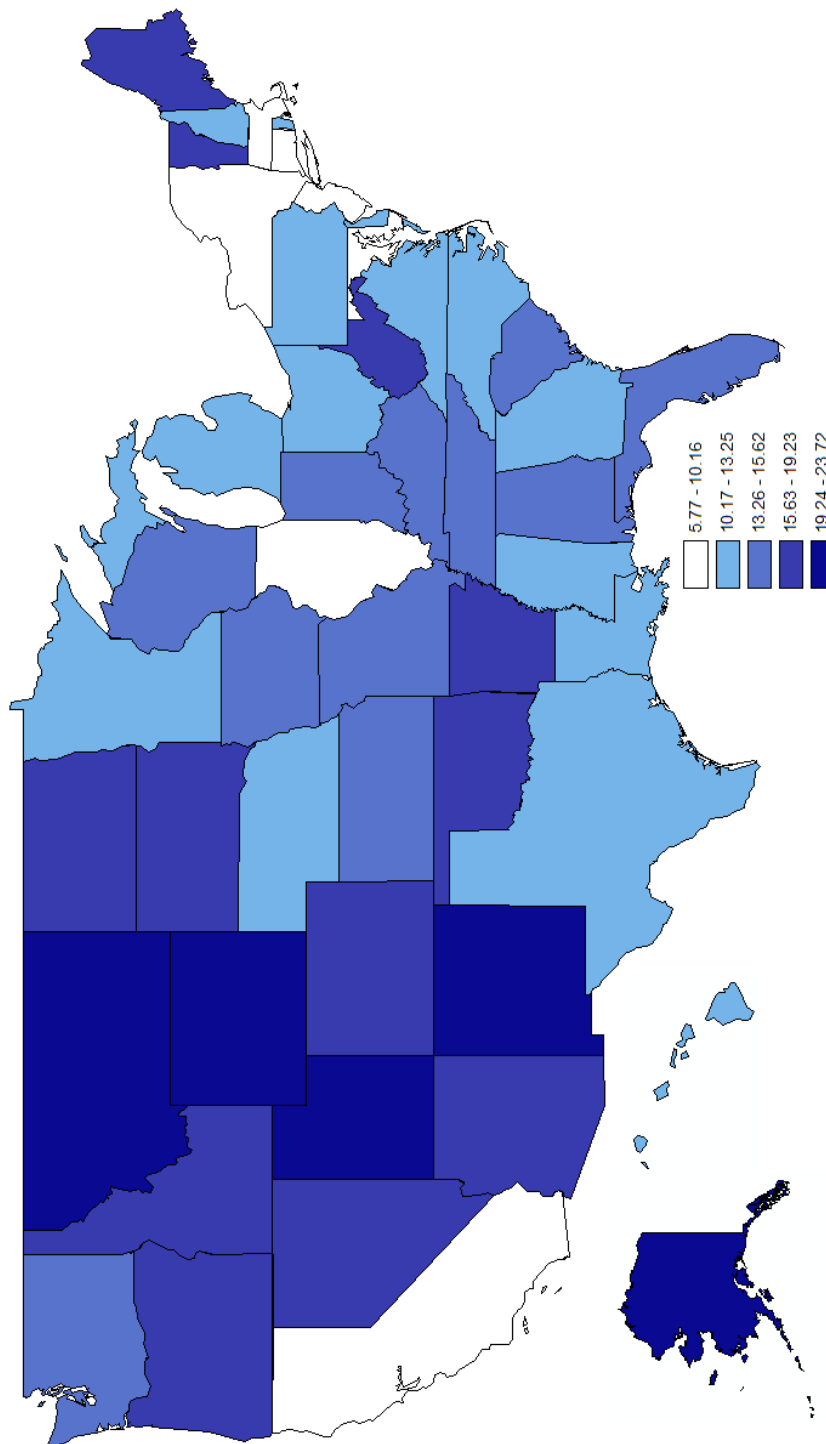
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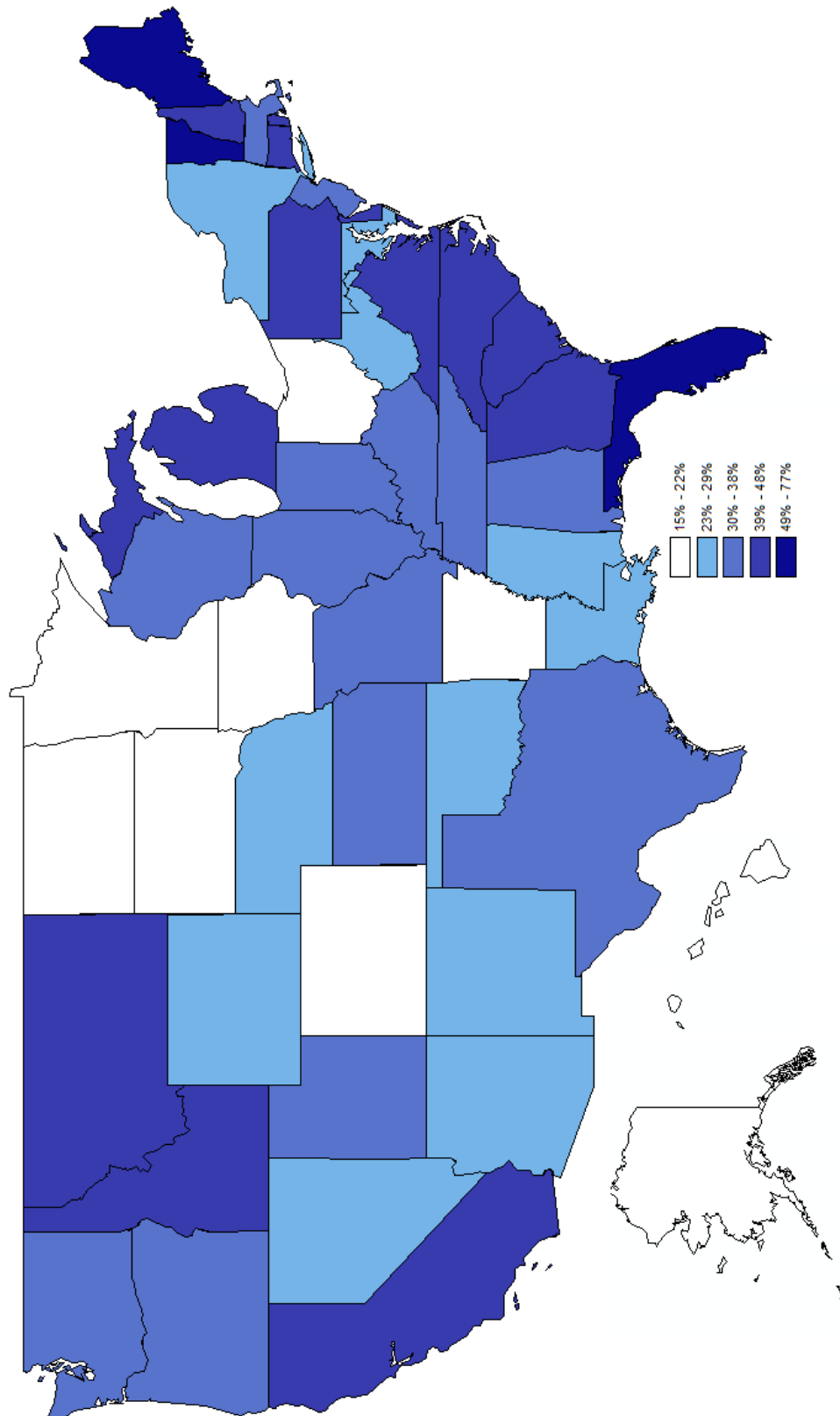
APPENDICES

Appendix A

Suicide Rates 2013



Enrollment Rates 2015



Appendix B

Codebook

Variables

Suicide- Age Adjusted Suicide Rate for 2013.

Population Density- Population per square mile of land area for 2014.

Unemployment Rate- Average unemployment rate for 2014.

Marriage Rate- 2012

Divorce- 2012 CDC.

Family Household- Percentage of family households for 2013.

Graduates- Percent of high school graduates for 2011-12.

Community participation- Census response rates for 2013 as Proxy. See Hawes, Rocha, and Meier; and Martin and Newman.

Gender- Percent of total population male for 2014.

Income- 3 year average median household income for 2011-13.

Poverty- Percent of total population below poverty line for 2013.

Age- Median age for 2013.

Rural- Percent of total population in rural areas for 2010.

Need- Percent of total population uninsured + percent underinsured for 2011-12.

State Politics- State Political Ideology from Berry et al. Ideology Measurement. 2010

Citizen Ideology- Citizen political ideology from Berry et al. Ideology Measurement.

2010

Homeowner- Percent owner occupied homes for 2010.

Percent Minority- percent of total population considered a minority for 2013.

Enrollment- Percent of potential marketplace enrollees who selected a plan in 2015.

Definitions

Total Enrollment: Represents the cumulative total number of unique individuals who had paid their premium and were enrolled in a Marketplace plan as of the date indicated.

Estimated Number of Potential Marketplace Enrollees: Includes all individuals eligible for tax credits as well as other legally-residing individuals who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage. The estimate excludes uninsured individuals with incomes below the poverty level who live in states that elected not to expand the Medicaid program. These individuals are not eligible for financial assistance and are unlikely to have the resources to purchase coverage in the Marketplace.