ACA Implementation—Monitoring and Tracking

A Decade of Coverage Losses: Implications for the Affordable Care Act

February 2012

Fredric Blavin, John Holahan,
Genevieve Kenney and Vicki Chen

Robert Wood Johnson Foundation

Urban Institute

INTRODUCTION

The Affordable Care Act (ACA) will fundamentally change access to health insurance coverage in the United States through a combination of a Medicaid expansion, subsidies offered for coverage provided through new health insurance exchanges, health insurance market reforms, and other policies such as the individual requirement to obtain coverage. Under the ACA, Medicaid eligibility will be expanded to a mandatory minimum of 138 percent of the federal poverty level (FPL) for all nonelderly citizens starting in 2014. The law also calls for the establishment of state-based health insurance exchanges. The exchanges will be organized markets where individuals and small businesses can purchase health insurance coverage that is subject to new regulations intended to promote greater transparency and competition in the market for health insurance.[1] Low- and moderate-income individuals and families with incomes up to 400 percent of the FPL will also be eligible for federal subsidies to purchase coverage in the exchanges if they do not have affordable access to employer-based insurance. With these new options in place, most individuals will be required to obtain a minimum level of coverage or pay a penalty.[2]

The ACA is expected to have varying impacts on adults without dependent children, parents, and children because of pre-ACA differences in health insurance coverage and eligibility for public coverage. Currently, children are more likely to have Medicaid/Children's Health Insurance Program (CHIP) coverage and less likely to be uninsured compared to both adult groups, and parents are more likely to have employer-sponsored insurance (ESI) coverage and less likely to be uninsured compared to adults without dependent children.[3] The differences in Medicaid/CHIP coverage rates are largely due to current income eligibility rules: Eleven states have eligibility thresholds for parents that would meet the requirements of the ACA, and of the seven states that provide Medicaid coverage for nondisabled adults without dependent children, just two (Vermont and Washington, D.C.) have eligibility thresholds that meet or exceed 138 percent of the FPL. In contrast, all states have Medicaid/CHIP eligibility thresholds for children that exceed 138 percent of the FPL, with the median eligibility threshold currently at 250 percent of the FPL.[4] Given this variation in eligibility rules, projections of ACA impacts indicate that Medicaid/CHIP enrollment could increase by over 3 million among children (due to higher take-up of already eligible children), 3 million among adult parents, and 10 million among adults without dependent children.[5]

Using the 2000 to 2010 Annual Social and Economic (ASEC) Supplement to the Current Population Surveys (CPS), this brief analyzes coverage trends among children, parents, and adults without dependent children as a guide to changes in coverage that could be expected in the coming years without the ACA. This study provides overall trends and trends by income, using "ACA-relevant" modified-adjusted gross income (MAGI) to categorize individuals: those below 138 percent of the FPL who could become newly eligible for Medicaid, those with income between 138 to 400 percent of the FPL who could become eligible for subsidies in the newly established health insurance exchanges, and those at or above 400 percent of the FPL. It also considers the extent to which changes in the income distribution contributed to the coverage patterns found over the last decade.

We find that over the past decade, rates of ESI steadily deteriorated across the populations that were examined, with more substantial declines occurring among lower-income groups. All three population groups saw increases in Medicaid/CHIP coverage, with children experiencing the largest increase. The percentage of parents and adults without dependent children who lacked health insurance steadily increased over the past decade, whereas the percentage of children without health insurance decreased (these trends were found overall and among the two lower-income categories). The decline in uninsurance among children is due to the fact that their drop in ESI was counteracted by an increase in the percentage of children covered by Medicaid/CHIP, which more than compensated for the decline in ESI.

Our results also provide insight into the factors that contributed to changes in coverage. The past decade included two recessions. At the same time, premiums for ESI outstripped income growth, and there were pronounced changes in employer offer and employee take-up behavior.[6,7] While the economic downturns had a profound negative effect on ESI over the decade, we find that ESI continued to deteriorate and rates of uninsurance increased even during periods of economic recovery. This is consistent with the trend during the economic boom of the 1990s, when health insurance coverage declined as fewer workers chose not to take up coverage in response

to rising premiums.[8] Overall, the U.S. population shift to those with low incomes due to the deep recession at the end of the decade accounted for only approximately one-third of the overall decline in ESI occurring between 2000 and 2010. These trends suggest that without the ACA, there would likely be continuing declines in ESI and increases in uninsurance among adults. They also suggest that the uninsurance rate would likely either hold constant or even decrease for children, so long as Medicaid and CHIP remain intact for them.

This is the first in a series of briefs that examine coverage trends among different groups targeted by the ACA coverage expansions. Subsequent briefs will focus on other areas, such as trends among workers (overall and low-wage workers in small firms) and different regions.

LITERATURE REVIEW

Several studies have explored trends in health insurance coverage. Holahan (2011) looked at recent changes in the health insurance distribution and examined economic trends over the past decade to assess how they correlate with changes in health insurance coverage.[9] Overall, Holahan (2011) found that the 2007–2010 period resulted in large reductions in employment and incomes which had a major impact on coverage: Nearly 10 million Americans lost ESI and the number of uninsured increased by 5.7 million, with noticeable growth in uninsurance among whites, native-born citizens, and residents of the Midwest and South. Over this period, ESI declined and the number of uninsured adults increased across all income groups, while the decrease in ESI among children was offset by coverage increases under Medicaid/CHIP.

In June 2011, the University of Minnesota's State Health Access Data Assistance Center released a state-by-state analysis of data from the CPS and Medical Expenditure Panel Survey that documents the decline in ESI coverage over the past decade.[10] Overall, the report finds that the percentage of the nonelderly population with ESI declined from 69 percent in 1999/2000 to 61 percent in 2008/2009. The authors attribute the decline in ESI to changes in employment levels and the distribution of employment by firm size, declines in the percentage of employers that offer health insurance, and declines in the percentage of eligible employees who take up health insurance offers. The report argues that rising premiums are likely contributing to declines in both offer and take-up and emphasizes that coverage and cost trends vary by state.

Similarly, a study by the Employee Benefit Research Institute analyzed CPS data from 1994 to 2009 on the number and percentage of nonelderly individuals with and without health insurance.[11] The author finds that the number and percentage of workers with coverage dropped significantly between 2008 and 2009 as a result of the weak economy and sustained high unemployment. He also concludes that demographic characteristics and many factors that vary by location, such as the strength and composition of the economy, affect the likelihood of an individual having health insurance and the source of that coverage. The analysis indicates that annual increases in health insurance coverage have been recorded in only four years since 1994 and that the 2009 uninsurance rate among the nonelderly (18.9 percent, up from 17.4 percent in 2008) was at its highest level over the entire 15-year period. Even during periods of strong economic growth, ESI rates have continued to erode.

Our analysis contributes to the literature in three ways. First, none of the prior studies focuses on "ACA-relevant" income groups that are targeted by the Medicaid expansion and exchange subsidies, respectively. Second, while some of the studies compare coverage trends among adults and children, none examines the trends separately for adults without dependent children and parents, which is important given current variation in Medicaid policies for these two groups. Third, this study provides the most up-to-date look at trends by incorporating results from the 2010 CPS.

DATA AND METHODS

This study uses 2000 to 2010 cross-sections of the CPS to analyze trends in coverage among the nonelderly population.[12] The CPS collects monthly employment statistics as well as information on the demographic status of the population, including health insurance coverage. The CPS is a large cross-sectional survey that

samples the entire civilian noninstitutionalized population. The 2010 CPS has a sample size of 95,958 households (204,983 individuals) and is the most frequently cited national survey on health insurance of Americans.[13] The strengths and weaknesses of this data source have been addressed elsewhere.[14]

There is debate over whether the CPS is measuring the number of uninsured for an entire year (as intended) or whether responses more closely reflect the number of uninsured at a point in time. In this paper, we assume that the CPS is essentially a measurement of point-in-time coverage, primarily because the number of uninsured in the CPS has historically been significantly closer to point-in-time estimates and well above the full-year estimates of other surveys.[15]

While there is also a concern that the CPS understates Medicaid/CHIP enrollment and thus possibly overstates the number of uninsured,[16,17] none of the estimates presented here were adjusted to take into account possible underreporting of Medicaid/CHIP coverage. However, it is unlikely that the size of the Medicaid undercount varies substantially over time; therefore the change in coverage estimates should be unaffected.

In this brief, we focus on three income groups: those under 138 percent of the FPL ("ACA Medicaid eligibles"), those between 138 percent and 400 percent of the FPL ("potential subsidy eligibles"), and those with incomes above 400 percent of the FPL. These poverty thresholds adjust for family size and inflation and are based on eligibility cutoffs for the Medicaid expansion and exchange subsidies under the ACA. We also use income relative to poverty based on the MAGI concept to be consistent with provisions of the ACA, which will be used to determine Medicaid and exchange subsidy eligibility across the nation.[18] To construct an adjusted version of MAGI on the CPS, appropriate to the ACA, we deduct public assistance income, Supplemental Security Income, child support, veterans' benefits, workers' compensation, and child care expenses from total income. In contrast to the standard definition of MAGI, we do not deduct Social Security benefits from total income in order to be consistent with the most recent legislation.[19] The health insurance unit (HIU) is the unit of analysis for determining income.[20] An HIU includes members of the nuclear family who can be covered under one health insurance policy: the policyholder, spouse, all children under age 19, and children under age 23 who are full-time students.[21]

Finally, a simple decomposition is used to provide insight into the extent to which the changes in coverage over the decade are attributable to macroeconomic factors and related shifts in the income distribution. To determine the extent to which changes in coverage over the decade were attributable to macroeconomic factors and accompanying shifts in income distribution, we estimate the overall 2010 coverage distribution while holding the coverage distribution within each of the three income categories constant at 2000 levels. This approximates how much of the ESI declines and Medicaid/CHIP and uninsurance increases are being driven by the income shifts as opposed to changes in coverage within an income group. To estimate the impact of other factors, we calculate the overall 2010 coverage distribution while holding the population and income distribution constant at 2000 levels. This approximates how much the coverage changes between 2000 and 2010 are being driven by factors, besides changes in income distribution, which is most indicative of how coverage would change in the coming years without the ACA, even during periods of economic expansion.

RESULTS

Figures 1 through 4 show trends between 2000 and 2010 in ESI, Medicaid, and uninsurance among parents, adults without dependent children, and children. Rates of nongroup and other public coverage were relatively constant over the period of analysis and are therefore not included in any of the figures. Tables for trends in these coverage categories for each subpopulation are available upon request.

Overall Trends in Health Insurance Coverage

Figure 1 shows overall trends from 2000 to 2010 in ESI (1.A), Medicaid (1.B), and uninsurance (1.C) among parents, adults without dependent children, and children. Figure 1.A illustrates the steady deterioration of ESI coverage during this period, as rates of ESI coverage decreased by 10 percentage points over the decade

among parents and adults without dependent children and 12 percentage points among children. ESI rates decreased in nearly each year, with smaller declines occurring between 2003 and 2007, when the economy was stronger. This suggests that factors beyond the recessions, such as rising premiums, had a negative effect on ESI over the course of the decade. This figure also shows that adults without dependent children and children had comparable ESI rates, but that parents had higher levels of ESI coverage in each year (8 to 10 percentage points higher).[22] The ESI differential between parents and adults without dependent children and between parents and children remained relatively constant over time.

Figure 1.B shows how Medicaid/CHIP coverage increased over the decade. In each year, consistent with Medicaid/CHIP policy, children had higher rates of Medicaid/CHIP coverage than adults. Overall, the percentage of children and parents covered by Medicaid/CHIP increased by 13 and 4 percentage points, respectively, nearly doubling for both groups. In contrast, Medicaid rates for adults without dependent children grew by 3 percentage points, from 4 percent in 2000 to 7 percent in 2010. The differences in the Medicaid rates across population groups are likely primarily attributable to differences in eligibility rules. However, Medicaid/CHIP rates increased among all three groups from 2008 to 2010 in response to the recession.

Given the steady declines in ESI shown in figure 1.A and the varying gains in Medicaid/CHIP coverage shown in figure 1.B, we see that the proportion of parents (at 14 percent in 2000 and 19 percent in 2010) and adults without dependent children (at 18 percent in 2000 and 24 percent in 2010) without health insurance of any kind increased over the decade, while the proportion of children without health insurance decreased by approximately 1 percentage point. For both adult populations, the increase in the uninsurance rate coincides with the decline in ESI, whereas for children, the uninsurance rate decreased because the decline in ESI was offset by increases in Medicaid/CHIP enrollment.

Trends in Health Insurance Coverage among Income Groups

Figures 2, 3, and 4 show how the coverage distribution changed between 2000 and 2010 for parents, adults without dependent children, and children across the three "ACA-relevant" income groups. In any given year, higher-income individuals are more likely to have ESI, less likely to have Medicaid/CHIP, and less likely to be uninsured than those in lower-income groups. However, these figures indicate that the trends within each income group are consistent with the overall trend occurring over the decade: In each income group, ESI rates decreased and Medicaid/CHIP rates increased for both children and adults, while uninsurance rates increased for adults but decreased for children. In addition, within each income group, adults without dependent children have lower ESI rates and higher uninsurance rates than parents (the exception being that these groups look similar among the lowest-income category), and children have the highest rates of Medicaid/CHIP and the lowest rates of uninsurance.

Focusing on the population with incomes below 138 percent of the FPL (referred to here as lower income), figure 2.A shows that from 2000 to 2010, ESI rates decreased by over 30 percent for parents and children and by 20 percent for adults without dependent children. This change represented the largest percentage decline in ESI over the decade among the three income groups. By 2010, approximately one in five lower-income individuals within each group was covered by ESI. Figure 2.B indicates that in 2010, 58 percent of lower-income children, 30 percent of lower-income parents, and 20 percent of lower-income adults without dependent children had Medicaid/CHIP, representing increases of 40, 30, and 25 percent from 2000, respectively.

Even though Medicaid/CHIP coverage rates substantially increased from 2000 to 2010, the lower-income population groups had the highest rates of uninsurance in each year during the decade. In 2000, 36 percent of lower-income parents, 38 percent of adults without dependent children, and 20 percent of children were uninsured. Over the decade, the uninsurance rate among lower-income parents and adults without dependent children increased by approximately 5 percentage points (or by 12 percent), and the uninsurance rate among lower-income children decreased 4 percentage points (or by 22 percent). Of all the population and income groups examined in this brief, only children with incomes below 138 percent of the FPL experienced substantial declines in uninsurance rates during the decade.

The population with incomes between 138 and 400 percent of the FPL ("potential subsidy eligibles") experienced trends similar to those of the lowest-income group, even though the two groups have substantially different coverage distributions. The potential subsidy eligible group had higher rates of ESI and lower rates of Medicaid/CHIP and uninsurance than their lower-income

counterparts. However, over the past decade, ESI rates decreased by 8 percentage points among parents (from 80 to 72 percent), 9 percentage points among adults without dependent children (from 68 to 59 percent), and 10 percentage points among children (from 78 to 68 percent) in this middle-income group. Medicaid/CHIP coverage rates for children more than doubled, increasing from 8 percent in 2000 to 18 percent in 2010. Adults in this income group experienced modest increases in Medicaid/CHIP rates from 2000 to 2010, rising by 3 percentage points for parents and 2 percentage points for adults without dependent children. On net, the uninsurance rate for the population that is potentially eligible for exchange subsidies increased by 34 percent among parents, from 13 percent to 17 percent; and by 23 percent among adults without dependent children, from 21 percent to 26 percent; but slightly decreased among children, from 9.5 percent to 9.0 percent. This trend mirrors what we found among the lower-income group, but adults in the subsidy-eligible income range experienced substantially higher percentage increases in uninsurance over the decade.

Compared to the other income groups, the coverage distribution among those with incomes above 400 percent of FPL remained relatively stable, though the overall pattern of coverage changes for the higher-income population echoed what was found among the lower-income groups. Among the higher-income population, ESI declined by approximately 3 percentage points for all groups, and Medicaid/CHIP increased by 1 percentage point among children and remained constant at under 1 percent for adults. Overall, the uninsurance rate increased by approximately 1 percentage point for parents and by 2 percentage points for adults without dependent children, and remained constant for children. In 2010, the vast majority of the high-income population was covered by ESI. However, the uninsurance rate among adults without dependent children (7 percent) was approximately twice as high as the uninsurance rates among parents and children.

Decomposing the Change in Health Insurance Coverage

Figure 5 shows changes in the income distribution over the past decade. From 2000 to 2010, the total nonelderly population increased from 245 million to 266 million people. During the same period, the number of nonelderly with income below 138 percent of FPL increased by 22.5 million, whereas the number of individuals in the two higher-income groups combined decreased by 1.6 million. In addition, the number of individuals in the below 138 percent of the FPL group steadily rose between 2000 and 2003, remained relatively constant from 2004 to 2007, and began a steady rise again in 2008 and onward due to the recession. Overall, in 2000, 25 percent of nonelderly Americans had income below 138 percent of the FPL, compared to 31 percent in 2010. In addition, between 2000 and 2007 there were modest increases in the number of individuals with incomes above 138 percent in most years. However, the number of individuals in the higher-income groups started to decrease substantially in 2008.

As indicated above, from 2000 to 2010, the proportion of the population covered by ESI decreased by 10.6 percentage points, from 69.3 percent to 58.8 percent; the proportion covered by Medicaid grew by 6.0 percentage points, from 8.4 percent to 14.4 percent; and the proportion uninsured increased by 3.7 percentage points, from 14.8 percent to 18.5 percent. These changes represent a 13.6 million decline in the number of nonelderly with ESI, an increase of 17.6 million covered by Medicaid/CHIP, and an increase of 12.9 million uninsured. The results in table 1 suggest that 35 percent of the overall decline in ESI is attributable to changes in income distribution, whereas the majority of the decline appears to be attributable to other factors, such as rising premiums, that could reduce ESI coverage rates within each income group. Using the same decomposition method, we also find that approximately 22 percent of the increase in Medicaid and half of the increase in uninsurance rates are attributable to changes in the income distribution.

Table 1 also highlights how the shifting income distribution had different effects on adults and children. For instance, 77 percent of the increase in the proportion of children covered by Medicaid/CHIP is attributable to factors other than the economy, such as eligibility expansions and policies that promote enrollment and retention, compared to 64 percent among parents and 60 percent among adults without dependent children. Medicaid/CHIP policy changes also likely explain how the overall proportion of uninsured children declined by 1.1 percentage points over the decade, despite macroeconomic forces putting upward pressure on the uninsurance rate.

DISCUSSION

This analysis has shown that there was a notable deterioration in ESI among all nonelderly groups and an increase in uninsurance rates for adults without dependent children and parents over the past decade. These trends persist across both periods of recession and recovery, and among all income groups, with more pronounced deterioration among Americans with income below 400 percent of the FPL, who will be most affected by key provisions of the ACA. It appears that Medicaid and CHIP have been particularly effective at reducing the number of uninsured children, even during the recent economic downturn, but, due to more restrictive eligibility, they have not prevented increases in the number of uninsured parents and other adults.

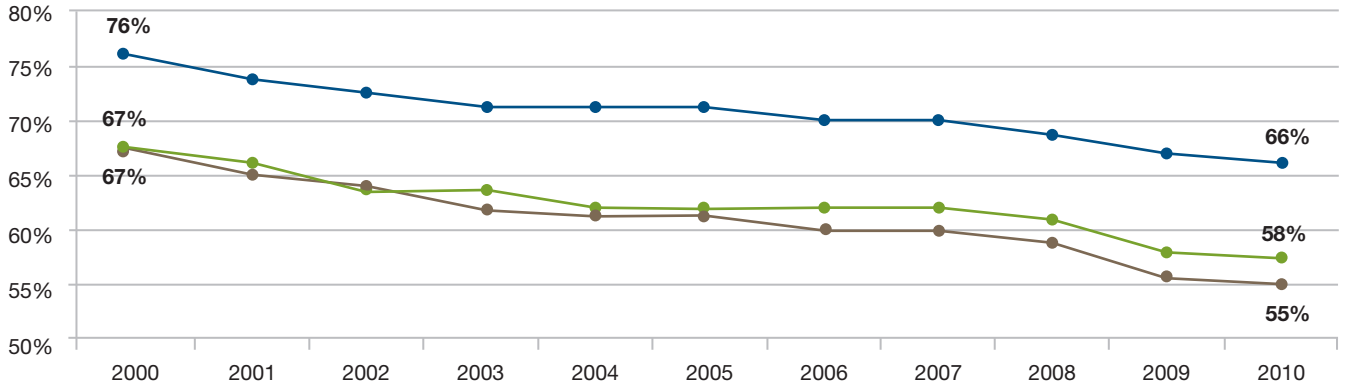
Our results indicate that both parents and adults without dependent children stand to gain the most from the ACA's Medicaid eligibility expansion and subsidized coverage available through the newly established health insurance exchanges. Among those with income below 138 percent of FPL, just over 20 percent of both adult groups currently have ESI coverage and over 40 percent are uninsured, many of whom will become newly eligible for Medicaid coverage. Among those with income between 138 and 400 percent of FPL, 72 percent of parents and 59 percent of adults without dependent children currently have ESI, and 17 percent of parents and 26 percent of adults without dependent children are uninsured. While a portion of the uninsured population in the 138 to 400 percent of FPL income band will not be eligible for exchange subsidies by virtue of having access to an offer of ESI that is deemed affordable, many will be able to gain access to subsidized coverage in the exchange.

Our results also show that large numbers of people have moved into the lower end of the income distribution over the past decade. The lower-income population is less likely to have ESI and more likely to be uninsured; therefore, some of the overall decline in ESI is attributable to the fact that the country was in a recession at the end of the decade. However, throughout the decade, even during more prosperous periods, we have seen a steady deterioration in ESI among all income groups, especially among those in the middle-income category. This suggests that the deterioration in ESI and the rise in uninsurance over the decade cannot solely be attributable to macroeconomic trends. Secular declines in ESI could be attributable to a host of factors, such as premiums rising faster than wages; shifts in the nature of workers' jobs, away from high-offer industries (e.g., manufacturing) toward low-offer industries (e.g., services); and population migration to regions, the South and West, that tend to have lower than average ESI offer rates (Holahan 2011).

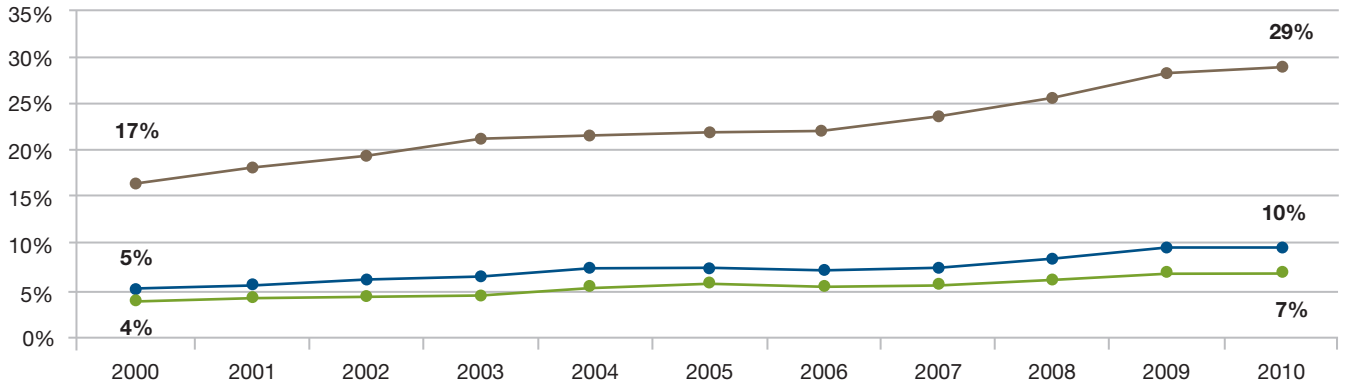
The past decade saw an increase in the nation's uninsured of nearly 13 million, of which as much as half appears to be driven by secular changes that have led to declines in ESI and that would have led to even greater increases in uninsurance had Medicaid/CHIP not expanded to cover more children and adults. Therefore, if the coverage-related provisions of the ACA are not implemented, the number of uninsured can be expected to continue to grow significantly in the coming years.[23]

FIGURE 1: **Coverage Among the Nonelderly Population, Overall**

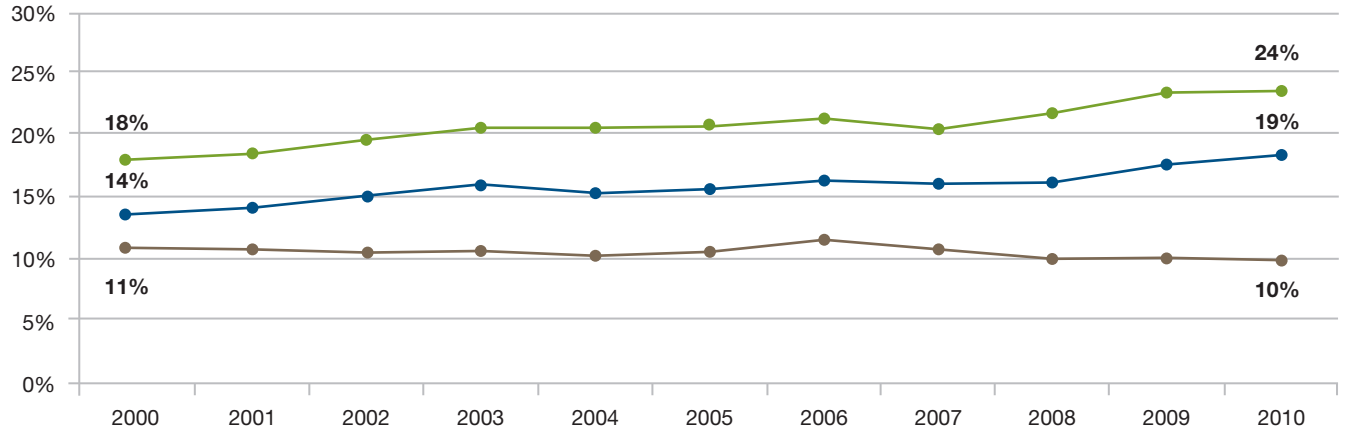
1.A: Percentage of Parents, Adults without Dependent Children, and Children with ESI, 2000-2010



1.B: Percentage of Parents, Adults without Dependent Children, and Children with Medicaid, 2000-2010



1.C: Percentage of Parents, Adults without Dependent Children, and Children without Health Insurance, 2000-2010

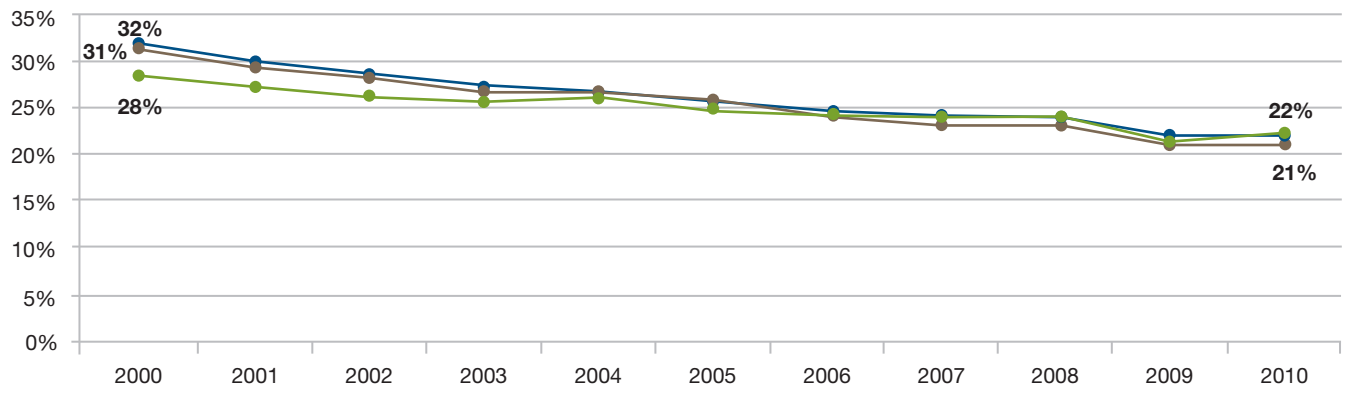


Parents Childless Adults Children

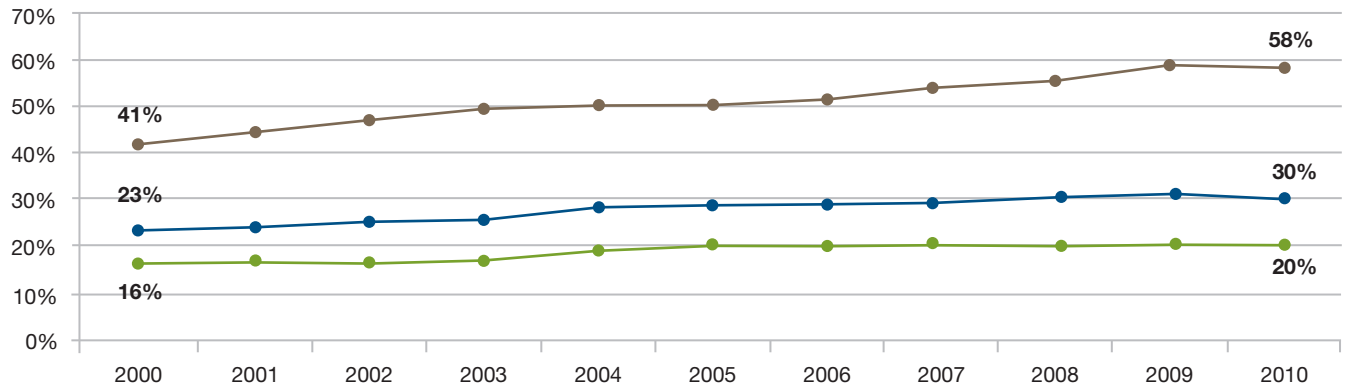
Urban Institute, 2011. Based on data from the 2001-2011 ASEC Supplement to the Current Population Surveys.

FIGURE 2: **Coverage Among the Nonelderly Population, <138 Percent FPL**

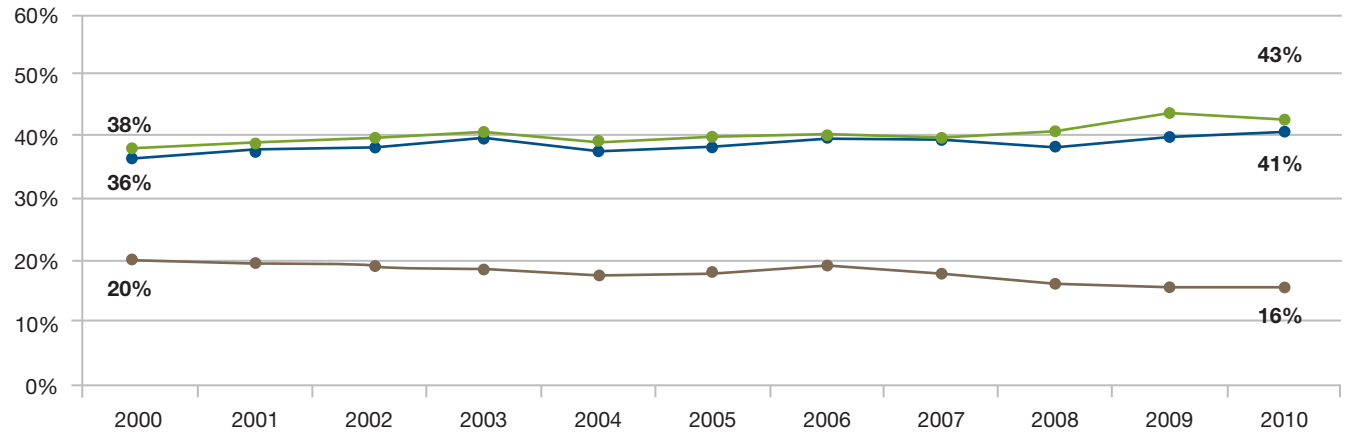
2.A: Percentage of Parents, Adults without Dependent Children, and Children with ESI, 2000-2010 CPS



2.B: Percentage of Parents, Adults without Dependent Children, and Children with Medicaid, 2000-2010 CPS



2.C: Percentage of Parents, Adults without Dependent Children, and Children without Health Insurance, 2000-2010

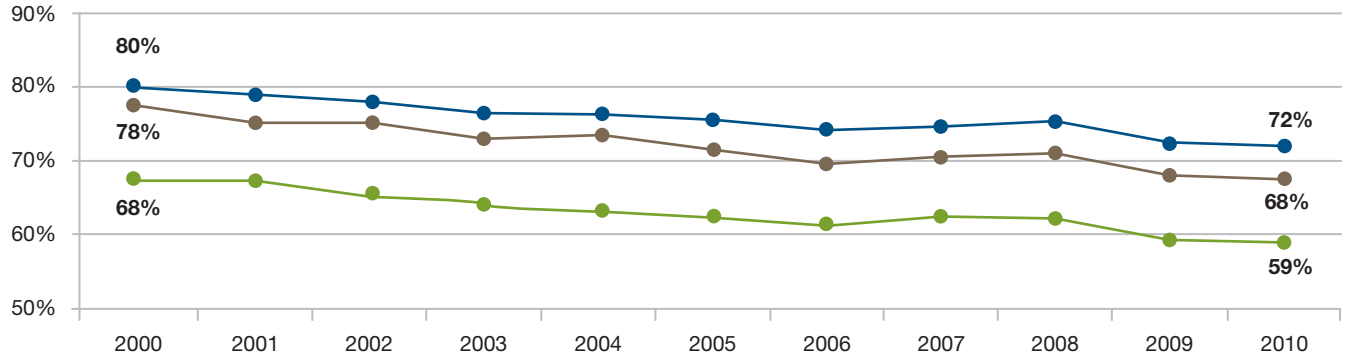


Parents Childless Adults Children

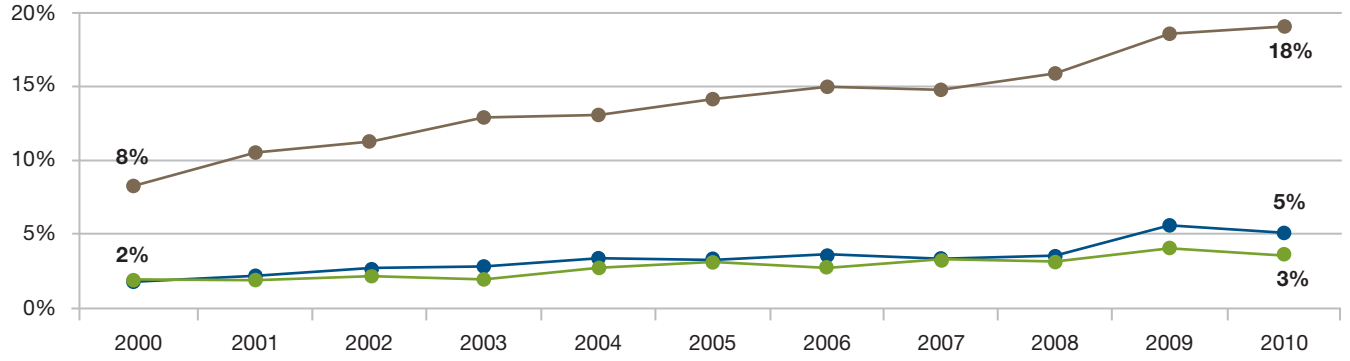
Urban Institute, 2011. Based on data from the 2001-2011 ASEC Supplement to the Current Population Surveys.

FIGURE 3: **Coverage Among the Nonelderly Population, 138 to 400 Percent FPL**

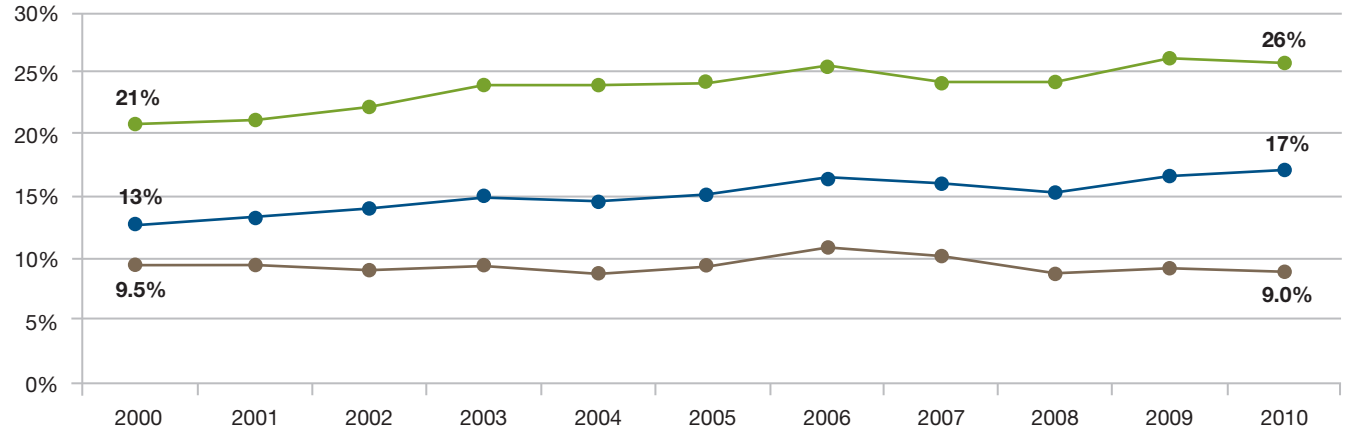
3.A: Percentage of Parents, Adults without Dependent Children, and Children with ESI, 2000-2010 CPS



3.B: Percentage of Parents, Adults without Dependent Children, and Children with Medicaid, 2000-2010 CPS



3.C: Percentage of Parents, Adults without Dependent Children, and Children without Health Insurance, 2000-2010

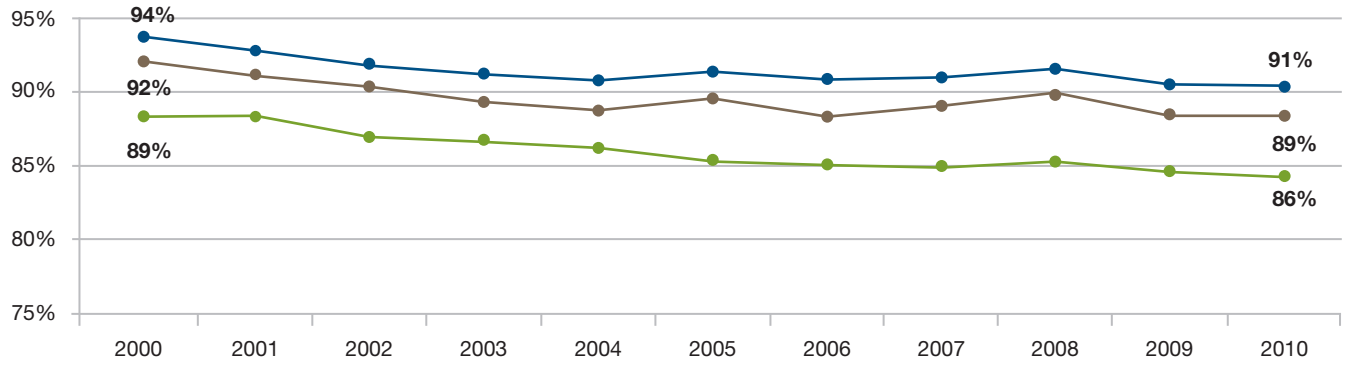


Parents Childless Adults Children

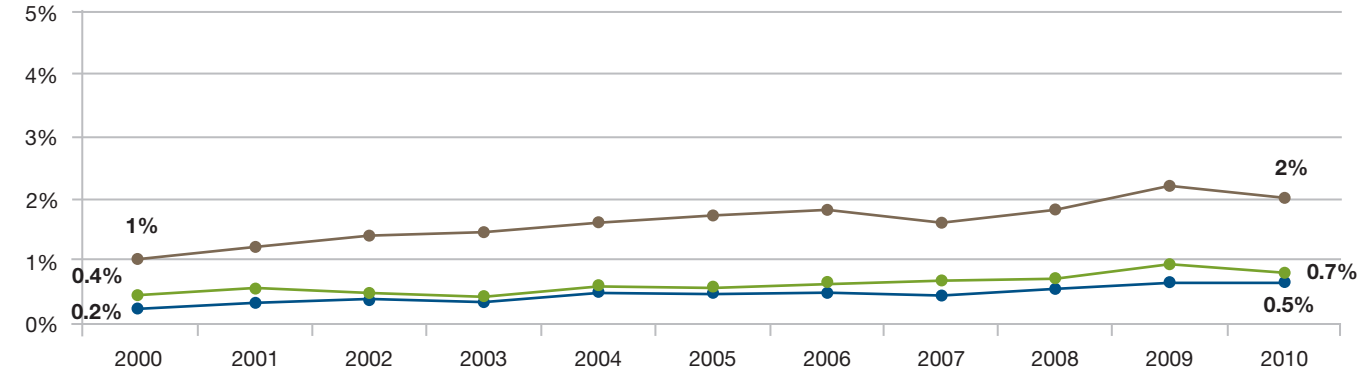
Urban Institute, 2011. Based on data from the 2001-2011 ASEC Supplement to the Current Population Surveys.

FIGURE 4: **Coverage Among the Nonelderly Population, 400 Percent + FPL**

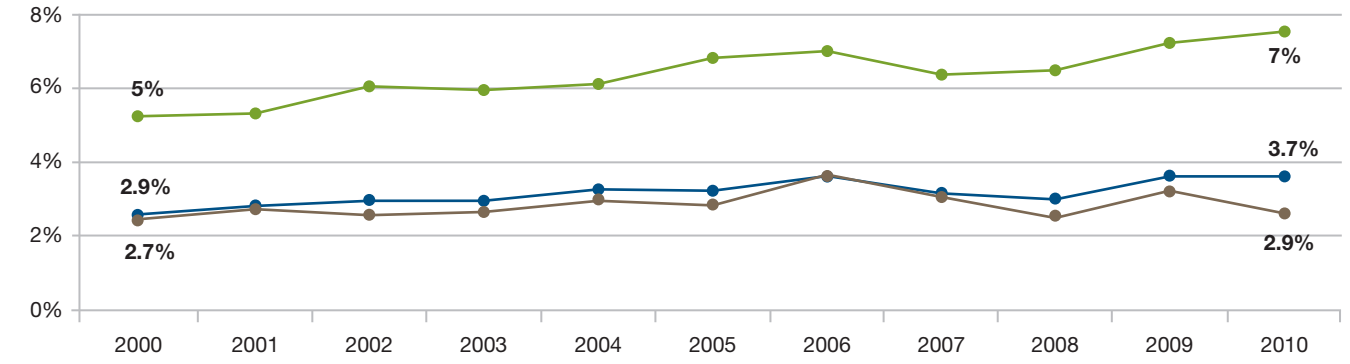
4.A: Percentage of Parents, Adults without Dependent Children, and Children with ESI, 2000-2010 CPS



4.B: Percentage of Parents, Adults without Dependent Children, and Children with Medicaid, 2000-2010 CPS



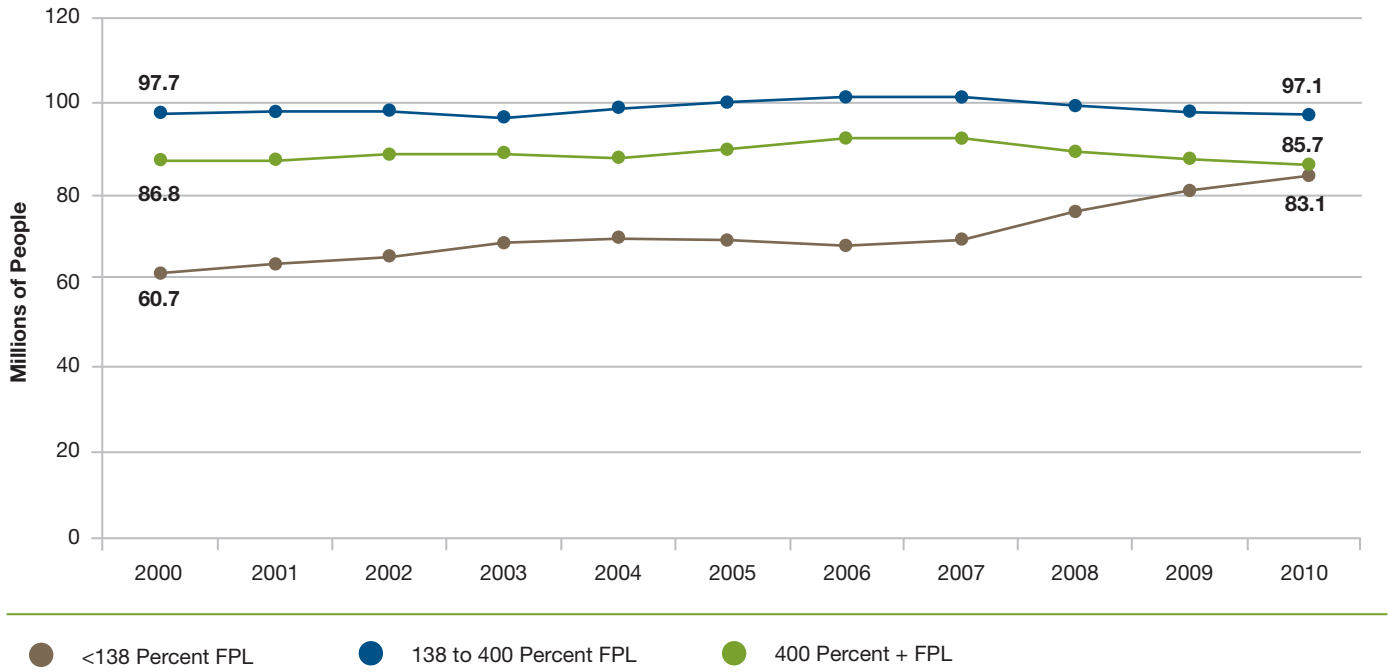
4.C: Percentage of Parents, Adults without Dependent Children, and Children without Health Insurance, 2000-2010



Parents Childless Adults Children

Urban Institute, 2011. Based on data from the 2001-2011 ASEC Supplement to the Current Population Surveys.

FIGURE 5: Change in Number of People by Income Group, 2000-2010



Urban Institute, 2011. Based on data from the 2001-2011 ASEC Supplement to the Current Population Surveys.

TABLE 1: Decomposing the Change in Health Insurance Coverage, 2000 to 2010

	2000	2010	Total Change	Change Attributable to Economy	Change Attributable to Other Factors
Overall					
ESI	69.3%	58.8%	-10.6%	-3.7%	-6.7%
Medicaid	8.4%	14.4%	6.0%	1.3%	4.4%
Uninsured	14.8%	18.5%	3.7%	1.8%	1.8%
Parents Adults					
ESI	75.7%	65.5%	-10.2%	-3.4%	-6.5%
Medicaid	5.3%	9.7%	4.5%	1.4%	2.8%
Uninsured	13.7%	18.5%	4.8%	1.7%	3.0%
Adults without Dependent Children					
ESI	67.3%	57.6%	-9.6%	-3.7%	-5.8%
Medicaid	4.5%	7.3%	2.8%	1.0%	1.6%
Uninsured	18.2%	23.9%	5.7%	2.0%	3.6%
Children					
ESI	66.7%	55.0%	-11.6%	-3.3%	-8.2%
Medicaid	16.5%	29.1%	12.6%	2.3%	9.7%
Uninsured	11.1%	10.0%	-1.1%	0.8%	-1.6%

Urban Institute, 2011. Based on data from the 2001-2011 ASEC Supplement to the Current Population Surveys.

ENDNOTES

1 The nonexchange nongroup and small-group markets are also subject to these new regulations.

2 Exemptions will be granted for the incarcerated, American Indians, financial hardship, religious objections, those without coverage for less than three months, undocumented immigrants, and those with incomes below the tax filing threshold.

3 Author tabulations from the 2010 Current Population Survey.

4 Martha Heberlein, Tricia Brooks, and Jocelyn Guyer, *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011. January 2011. Kaiser Family Foundation report available at http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf publications/about medicaid/holding steady, looking ahead.pdf.*

5 Matthew Buettgens, Bowen Garrett, and John Holahan, *America Under the Affordable Care Act. Urban Institute report prepared for the Robert Wood Johnson Foundation. December 2010.*

6 J. Vistnes, A. Zawack, K. Simon, and A. Taylor,. *Declines in Employer Sponsored Insurance between 2000 and 2008: Examining the Components of Coverage by Firm Size.* Health Services Research. 2012. doi: 10.1111/j.1475-6773.2011.01368.x.

7 C. Schoen, K. Stremikis, S. K. H. How, and S. R. Collins, *State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits. The Commonwealth Fund, December 2010.*

8 D. Cutler, "Employee Costs and the Decline in Health Insurance Coverage." *Frontiers in Health Policy Research, 6(3) (2003), 27–53.*

9 John Holahan and Vicki Chen, *Changes in Health Insurance in the Great Recession, 2007-2010. December 2011. Kaiser Family Foundation report available at http://www.kff.org/uninsured/upload/8264.pdf.*

10 State Health Access Data Assistance Center and Robert Wood Johnson Foundation, "State-Level Trends in Employer-Sponsored Health Insurance: A State-by-State Analysis." June 2011. Available at http://www.shadac.org/files/shadac/publications/ESI_Trends_Jun2011.pdf

11 Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey. 2010. Employee Benefit Research Institute Issue Brief #347 available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2010_No347_Uninsured1.pdf*

12 All estimates are based on the Census's revised imputation methodology. In 2011, the Census revised its health coverage imputation methodology for those who did not respond to health insurance questions. The revisions address the differences between the way health insurance coverage is collected in the CPS and the way it is imputed. For example, previously, dependent coverage assignments were limited only to the policyholder's spouse and children. The revisions now allow all members of the household to be assigned dependent coverage; thus the increase in the imputed number of dependents with coverage more accurately reflects individual reporting.

13 U.S. Census Bureau, "Current Population Survey, 2011 Annual Social and Economic (ASEC) Supplement." 2011. [October 20, 2011]. Available at http://www.census.gov/apsd/techdoc/cps/cpsmar11.pdf.

14 G. Kenney, J. Holahan, and L. Nichols, "Toward a more reliable federal survey for tracking health insurance coverage and access." *Health Service Research. 2006;41(3 Pt 1):918–45; C. DeNavas-Walt, B. D. Proctor, and J. Smith, Income, poverty, and health insurance coverage in the United States: 2006 [Internet]. (Washington, DC: US Census Bureau, August 2007) [cited Nov. 9, 2010]. Available at http://www.census.gov/prod/2007pubs/p60-233.pdf.*

15 State Health Access Data Assistance Center and Robert Wood Johnson Foundation, "Comparing Federal Government Surveys that Count Uninsured People in America." 2008. Available at http://www.rwjf.org/files/research/082608shadac.census.pdf

16 M. Davern, J. A. Klerman, J. Ziegenfuss, V. Lynch, D. Baugh, and G. Greenberg, "A partially corrected estimate of Medicaid enrollment and uninsurance: results from an imputational model developed off linked survey and administrative data." *Journal of Economic and Social Measurement* 2009; 34(4):219–40.

17 K. T. Call, G. Davidson A. S. Sommers, R. Feldman, P. Farseth, and T. Rockwood, "Uncovering the missing Medicaid cases and assessing their bias for estimates of the uninsured. *Inquiry* Winter 2001/2002;38(4): 396–408.

18 For the current Medicaid-eligible population, rules for counting income and resources vary from state to state and from group to group.

19 As a sensitivity analysis, we found that the deduction of veterans' benefits, child care expenses, and public assistance income had a negligible effect on the income distribution. The deduction of Social Security benefits changes the income distribution by approximately 2 percentage points.

20 We also explored using tax units as the unit of analysis, as it is unclear whether tax units or HIUs will determine eligibility for Medicaid and exchange subsidies. However, there are only minor differences between the two definitions. In the 2009 CPS, approximately 86 percent of observations had their HIU perfectly line up with the tax unit, 11 percent of cases had the whole HIU encompassed by a larger tax-filing unit, and 3 percent had the whole HIU contain more than one tax-filing unit. In addition, the income distribution is similar across both definitions.

21 Children are defined as any persons 18 years of age or younger. Parents are identified as adults aged 19 to 64 who have their own children under age 18 in their HIU. Adults without dependent children are adults aged 19 to 64 who do not live with dependent children under age 19.

22 The ESI differential between parents and children is mitigated within a given income group.

23 Bowen Garrett, Matthew Buettgens, Lan Doan, Irene Headen, and John Holahan, "The Cost of Failure to Enact Health Reform: 2010–2020 (Updated)." Urban Institute report prepared for the Robert Wood Johnson Foundation.