Ten Years of the Affordable Care Act: Major Gains and Ongoing Disparities

Prepared for:

The A-Mark Foundation

April 2020

Claremont Graduate University

UCLA CENTER FOR HEALTH POLICY RESEARCH

Ten Years of the Affordable Care Act: Major Gains and Ongoing Disparities

Gerald F. Kominski, PhD

Petra W. Rasmussen, MPH

Chengcheng Zhang, BA

Safia Hassan

Deborah Freund, PhD

UCLA Center for Health Policy Research
Health Economics and Evaluation Research Program
and
Claremont Graduate University

April 2020

Suggested Citation:
Kominski GF, Rasmussen PW, Zhang C, Hassan S, Freund D. April 2020. *Ten Years of the Affordable Care Act: Major Gains and Ongoing Disparities*. Los Angeles, Calif.: UCLA Center for Health Policy Research.

UCLA Center for Health Policy Research | 10960 Wilshire Blvd. | Suite 1550 | Los Angeles, CA 90024 | t: 310.794.0909 | f: 310.794.2686 | healthpolicy@ucla.edu

www.healthpolicy.ucla.edu

Contents

List of Exhibits

Executive Summary

The Patient Protection and Affordable Care Act (ACA) was enacted 10 years ago to expand health insurance coverage to significant portions of the population who fell through the cracks of our mix of private and public insurance programs in the United States. The coverage expansion provisions of the ACA were targeted primarily to three population groups with high rates of uninsurance: (1) low-income adults not otherwise eligible for Medicaid, (2) low- to middle-income individuals and families without employment-sponsored insurance (ESI) who were priced out of the individual market, and (3) young adults 18 and older who were no longer eligible for coverage through their parents' policies unless they were financially dependent (e.g., enrolled in college).

The ACA has produced significant reductions in the number and percentage of uninsured individuals. Nevertheless, important disparities (i.e., differences in insurance coverage) among the remaining uninsured continue, based on a number of factors, including Medicaid expansion status, race and ethnicity, occupation, and employment status. Disparities occur when not all individuals benefit equally from new policies such as the ACA. Understanding and reducing disparities in insurance coverage are still important goals, because certain population groups remain vulnerable or disadvantaged because of low income, poor health, or personal circumstances that make it more difficult to obtain and retain health insurance.

The primary goals of this report are: (1) to update information on the impacts of the ACA on rates of uninsurance, using the latest data available (from 2018), and (2) to examine disparities from a broad perspective, including some measures that have not received attention in previous studies. In this study, we used data from the American Community Survey, conducted annually by the U.S. Census Bureau, to examine annual changes from 2008 to 2018 in rates of uninsurance for various vulnerable population groups and to determine how those vulnerable groups have fared under the ACA. Specifically, we examined nine population characteristics that are associated with an increased likelihood of being uninsured:

(1) State Medicaid expansion status
(2) Education
(3) Housing
(4) Employment
(5) Citizenship
(6) English proficiency
(7) Race/ethnicity
(8) Age
(9) Type of insurance

We also stratified our analyses by income as a percentage of the federal poverty level (FPL) and by state decisions on Medicaid expansion for each of the population characteristics listed above. We defined three categories of income as percentages of the federal poverty level (FPL):

(1) low-income (i.e., below 100% FPL), (2) middle-income (100%–399% FPL), and (3) high-income (400% FPL or higher). The FPL for an individual in 2018 was $12,140; for a family of four, it was $25,100. We used 100% FPL rather than 138% as our cutoff point for the lowest income categories to account for the fact that individuals living in nonexpansion states can apply for subsidies to buy insurance in their ACA insurance exchange if their income is 100% FPL or higher. In expansion states, subsidies to buy insurance in the ACA insurance exchanges are limited to those with incomes of 138%-399% FPL. Therefore, rather than create a separate category for those with incomes from 100%-138% FPL, we combined this group with those with incomes of 139%-399% FPL.

Key Findings

Our major overall finding is that the ACA improved health insurance coverage within every population group we examined. However, some groups improved more than others, and important disparities remain. Furthermore, some groups have experienced erosion of coverage beginning in 2017, reversing the earlier gains from 2014 to 2016.

Our key findings for each of the population characteristics we examined are summarized below.

Medicaid Expansion Status
- Medicaid expansion states had similar improvements in coverage, regardless of when expansion occurred.
- Nonexpansion states improved less than expansion states but still had improved coverage for low-income individuals.
- Higher-income individuals saw small improvements in coverage but have had large increases in uninsurance since 2016.

Education
- Higher education is associated with substantially lower rates of uninsurance at every income level.

Housing
- Individuals whose homes lacked a basic necessity always had higher rates of uninsurance than those with complete housing, regardless of income level or state expansion status.

Employment
- Employed individuals always had the highest coverage rates, regardless of state expansion status.
- Employed individuals residing in nonexpansion states experienced smaller coverage gains than those in expansion states.
- Since 2008, individuals with incomes above 100% FPL who were not in the labor force (i.e., not seeking employment) had coverage rates very similar to the coverage rates of those who were employed.

Citizenship

- Coverage has improved regardless of citizenship status, but 1 in 3 noncitizens remains uninsured.
- Noncitizens have the highest uninsured rates across all income categories.
- Both citizens and noncitizens have higher uninsured rates in nonexpansion states across all income categories.

English Proficiency

- Lower levels of English proficiency are associated with higher rates of uninsurance, regardless of income level.
- Coverage for individuals at all levels of English proficiency improved more in expansion states than nonexpansion states.

Race/Ethnicity

- Uninsured rates decreased for all racial/ethnic groups, but Hispanics/Latinos and American Indians/Alaska Natives still have the highest uninsured rates.
- Among U.S. citizens, American Indians/Alaska Natives have a significantly higher uninsured rate than all other racial/ethnic groups.
- Noncitizen Hispanics/Latinos have higher uninsured rates than all other noncitizens, regardless of income.
- Differences in uninsured rates between racial/ethnic groups persist across all income groups, but disparities have diminished for some.
- Low-income individuals in expansion states had larger gains in coverage than those in nonexpansion states.

Age

- Everyone under age 65 has lower rates of uninsurance, but 19-25-year-olds have improved the most.
- Low-income individuals of all ages had the most dramatic coverage gains yet continue to have the highest uninsurance rates.
- Low-income individuals in expansion states had greater gains in coverage and lower uninsured rates than those in nonexpansion states across all age groups.

Type of Insurance

- Increased Medicaid enrollment has been primarily responsible for improved coverage among low- and middle-income individuals.
- High-income individuals had low rates of uninsurance and smaller improvements in coverage, but they have had larger reversals since 2016.

Chapter 1: Introduction

Study Purpose

The Patient Protection and Affordable Care Act (ACA) was enacted 10 years ago to expand health insurance coverage to significant portions of the population who fell through the cracks of the mix of private and public insurance programs in the U.S. The coverage expansion provisions of the ACA were targeted primarily at three population groups with high rates of uninsurance: (1) low-income adults not otherwise eligible for Medicaid, (2) low- to middle-income individuals and families without employment-sponsored insurance (ESI) who were priced out of the individual market, and (3) young adults no longer eligible for coverage through their parents.

The ACA has produced significant reductions in the number and percentage of uninsured individuals. Nevertheless, important disparities among the remaining uninsured continue, based on a number of factors, including Medicaid expansion status,[1] race and ethnicity,[2] occupation,[3] and employment status.[4] The primary goals of this report are: (1) to update information on the impacts of the ACA on rates of uninsurance, using the latest data available (from 2018), and (2) to examine disparities from a broad perspective, including some measures that have not received attention in previous studies.

Data and Methods

To achieve our study goals, we used data from the American Community Survey (ACS) from 2008 through 2018. The ACS is a federal survey conducted by the U.S. Census Bureau on an annual basis from December through January of each year. In total, there are approximately 3 million respondents each year. The ACS first began including questions regarding health insurance status in 2008, so we used data from the 11-year time period from 2008 to 2018 to permit analyses of: (1) the period prior to any ACA implementation (2008-2010), (2) the period after enactment but prior to major provisions being implemented in 2014 (2011-2013), (3) the Obama era post-ACA period (2014-2016), and (4) the Trump era post-ACA period (2017-2018).

---

[1] Courtemanche C, Marton J, Ukert B, Yelowitz A, Zapata D. 2017. Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Nonexpansion States. *Journal of Policy Analysis and Management* 36(1):178-210.

[2] Artiga S, Orgera K, Damico A. 2019. *Changes in Health Coverage by Race and Ethnicity Since Implementation of the ACA, 2013-2017*. Issue Brief. San Francisco, Calif.: Kaiser Family Foundation.

[3] Agarwal SD, Goldman AL, Sommers BD. 2019. Blue-Collar Workers Had Greatest Insurance Gains After ACA Implementation. *Health Affairs* 38(7):1140-1144.

[4] Berdahl TA, Moriya AS. 2018. Difference in Uninsurance Rates Between Full- and Part-Time Workers Declined in 2014. *Health Affairs* 37(10):1669-1672.

For our analyses, we excluded respondents who lived in group quarters. For most analyses, we focused on respondents ages 0 to 64, with the following exceptions: For our analysis looking at the uninsured rate by age groups in chapter 8, we included respondents of all ages. For our analyses by employment status in chapter 5 and education in chapter 3, we only included those ages 18 and older, because 18 is the age when people begin higher education, begin working, or both. For our analysis by English language proficiency in chapter 7, we included only respondents ages 5 to 64. We used survey weights to account for the complex survey design of the ACS.

Our primary outcome of interest was whether individuals were uninsured at the time of the survey. We examined annual estimates of the percentage of U.S. residents who were uninsured from 2008 (two years before the ACA was signed into law) until 2018 by various characteristics, including age, race/ethnicity, citizenship status, employment status, educational attainment, and housing. In some analyses, however, we focused on more limited comparisons — e.g., 2013 vs. 2018 — because the annual trends were less informative than the overall change between these two important pre- and post-ACA years.

In addition to examining trends over time, we also stratified our analyses by income as a percentage of the federal poverty level (FPL) and by state decisions on Medicaid expansion. We defined three categories of income as percentages of the federal poverty level (FPL): (1) below 100% FPL, (2) 100%–399% FPL, and (3) 400% FPL or higher. We chose to use 100% FPL rather than 138% as our cutoff point for the two lowest income categories to account for the fact that respondents in states that did not expand their Medicaid program (i.e., nonexpansion states) only had access to their state-based insurance exchange if their income was at least 100% FPL or higher.

In our analyses comparing Medicaid expansion with nonexpansion, we defined expansion states as those that expanded Medicaid eligibility in 2014, and nonexpansion states as those that had not expanded Medicaid eligibility as of 2018. In 2014, the following 22 states expanded their Medicaid programs: Arizona, Arkansas, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Michigan, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, and West Virginia. In 2018, there were 19 nonexpansion states: Alabama, Florida, Georgia, Idaho, Kansas, Maine, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming. Four states (California, Massachusetts, Minnesota, and Washington, plus the District of Columbia) expanded Medicaid eligibility prior to 2014, and 5 expanded after 2014 but before 2018 (Alaska, Indiana, Louisiana, Montana, and Pennsylvania). In chapter 2, we examine four categories of expansion status: pre-2014, 2014, post-2014, and never expanded. In chapters 3 through 10, we focus only on comparisons of states that expanded in 2014 versus nonexpansion states, because we found early and later expanders to be very similar to states that expanded in 2014.

In chapter 6, we examine individuals classified into one of the following five categories of citizenship:

 (1) U.S.-born citizen
(2) U.S. citizen born in Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands
(3) U.S. citizen born abroad to American parent(s)
(4) U.S. citizen by naturalization
(5) Not a U.S. citizen

The ACS does not distinguish between noncitizens who are lawfully present and undocumented immigrants, meaning that some of the individuals in the last group were eligible for coverage under certain provisions of the ACA, while others were not.

The ASC allows respondents to report multiple categories of uninsurance. Therefore, we employed the following hierarchy to create mutually exclusive and exhaustive categories of insurance: (1) uninsured, (2) Medicare, (3) ESI, (4) Medicaid, (5) individual market, and (6) other coverage.

When describing improvements in health insurance coverage, or reductions in uninsured rates, we calculated both *absolute* and *relative* rate changes. Absolute differences are defined as percentage point changes. For example, if the uninsured rate for adults went from 20% in 2014 to 10% in 2018, the absolute change would be (20-10) = 10 percentage points. However, large percentage point changes can be misleading when comparing improvements between groups that have very different starting points. A reduction of 10 percentage points in the rate of uninsurance for a group that started at 50% is quite different from a 10-percentage-point reduction for a group that started at 20%. Specifically, the relative change for the former is 10/50 = 20%, but it is 10/20 = 50% for the latter.

In this report, although we discuss both absolute and relative changes, we tend to focus on relative changes when discussing disparities, because large absolute reductions may mask the fact that disparities between population groups either have not changed or have actually increased. Specifically, unless groups with the highest rates of uninsurance have larger relative improvements over time than groups with the lowest rates, disparities have not diminished. Everyone may have improved, but the disparity between groups has not lessened.

Report Organization

The remaining chapters in this report provide analyses of trends in insurance coverage according to the following population characteristics:

State Medicaid expansion status
Education
Housing
Employment
Citizenship

English proficiency
Race/ethnicity
Age
Type of insurance

Finally, each chapter highlights the most important findings related to each topic area; therefore, the exhibits vary between chapters based on the findings.

Chapter 2: Medicaid Expansion Status

Key Findings

- Medicaid expansion states had similar improvements in coverage, regardless of when expansion occurred.
- Nonexpansion states improved less than expansion states but still had improved coverage for low-income individuals.
- Higher-income individuals have seen small improvements in coverage but large increases in uninsurance since 2016.

The expansion of Medicaid eligibility to previously ineligible adults and the establishment of uniform national eligibility criteria for such adults up to 138% FPL were major features of the ACA. When the ACA was enacted in 2010, states were required to expand their Medicaid programs or risk losing all federal funding for their existing Medicaid programs. The U.S. Supreme Court ruled this requirement unconstitutional in 2012, allowing states the option to expand their programs. The law also included provisions for states to implement early expansions, prior to those scheduled for 2014. As a result of these circumstances, states have followed a staggered timeline in implementing Medicaid expansions, with 4 states plus the District of Columbia expanding prior to 2014, 22 states expanding in 2014, 5 states expanding after 2014, and 19 states not expanded as of 2018. The list of states can be found in chapter 1.

A substantial number of studies have been conducted to date to examine the impacts of the Medicaid expansions on insurance coverage as well as other significant outcomes, including access to care and health status. This extensive body of research has been summarized recently in a comprehensive literature review conducted by the Kaiser Family Foundation.[1] As shown in Exhibit 2.1, expansion states as a group have achieved larger reductions in the rate of uninsured individuals compared to nonexpansion states. Expansion states had reductions of about 7 to 9 percentage points between 2013 and 2018 in the uninsured rate for those ages 0-64, compared to about 5 percentage points in nonexpansion states. The relative reduction was even greater in expansion states, because they started with lower uninsurance rates. For example, early expansion states achieved a 55.6% reduction in the uninsured population ages 0-64, while nonexpansion states experienced a 25.6% reduction.

Two other trends are worth noting. First, nonexpansion states have seen a 0.9 percentage point increase in their uninsured rates since 2016, while expansion state uninsured rates appear to be holding steady. Second, although early expanders have had the greatest overall reductions in

---

[1] Antonisse L, Garfield R, Rudowitz R, Guth M. 2019. *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review*. Issue Brief. San Francisco, Calif.: The Kaiser Family Foundation.

their uninsured rates, most of the improvement in those states has occurred since 2014, when the majority of other states expanded.

Exhibit 2.1. Uninsured Rates Among Those Ages 0-64 by Medicaid Expansion Status, 2008-2018
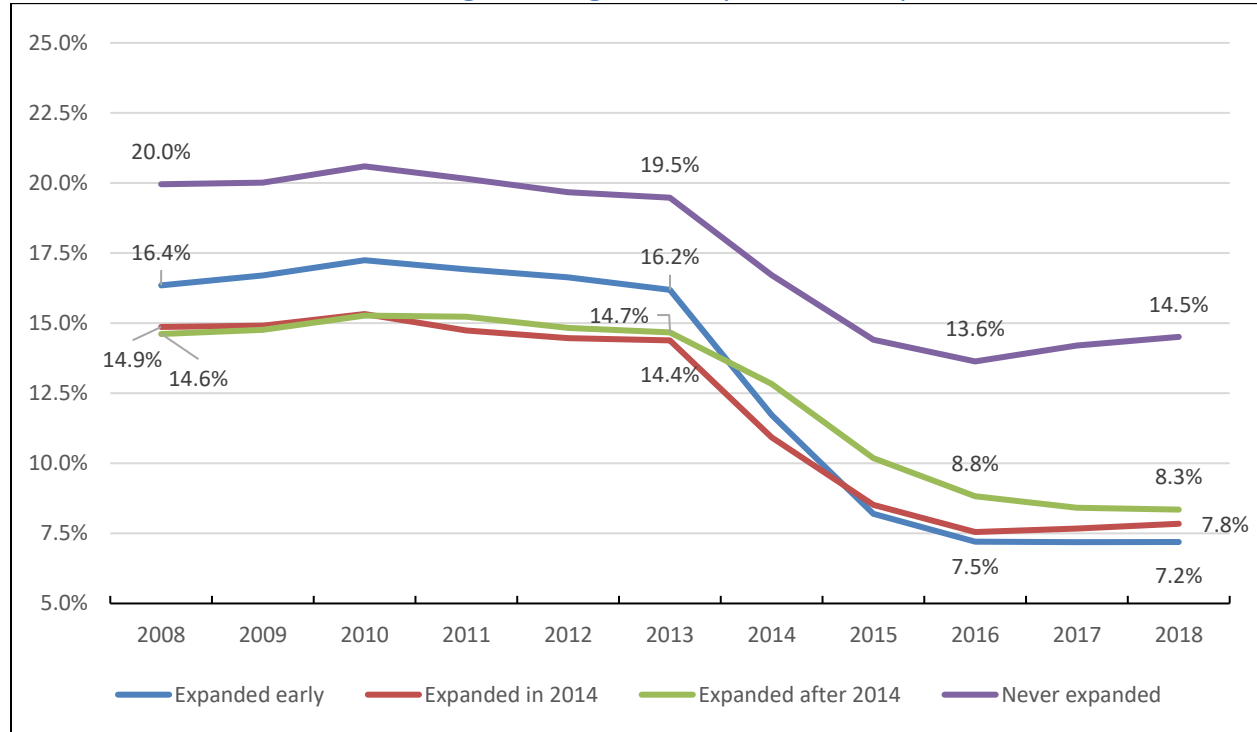
Source: Authors' analysis of American Community Survey data

Expansion States Achieved Similar Improvement in Coverage Among Low-Income Individuals Regardless of When Expansion Began

Exhibit 2.2 shows the impact of Medicaid expansion on low-income individuals, the primary group expected to benefit from Medicaid expansion. Similar to the aggregate trends in Exhibit 8.1, expansion states had very similar improvement in their rates of uninsurance, regardless of when expansion occurred. By 2018, all expansion states had uninsured rates between 11.3% and 12.6%. Notably, states that expanded after 2014 have achieved similar reductions to states that expanded earlier.

Nonexpansion states started with higher rates of uninsurance and improved less, in both absolute and relative terms. Nevertheless, nonexpansion states did experience an absolute reduction of 7.4% percentage points in the uninsured rate for individuals with incomes below 100% FPL between 2013 and 2018, which equals a *relative* reduction of 23.0% (Exhibit 2.2). This finding suggests that low-income individuals in nonexpansion states benefited from the ACA despite living in a nonexpansion state. This is most likely due to enhanced national awareness of Medicaid eligibility surrounding the implementation of ACA marketplaces in 2014. In separate analyses (summarized in Exhibit 10.2), we found that reductions in the rate of uninsurance for low-income individuals occurred almost entirely as a result of increased

enrollment in Medicaid starting in 2014 in both expansion and nonexpansion states. In nonexpansion states, increased enrollment in Medicaid most likely occurred because of increased attention to health insurance options related to the ACA, as well as concerns about the tax penalty of being uninsured resulting from the individual mandate (even though most low-income individuals were exempt from the mandate).

Exhibit 2.2. Uninsured Rates for Those Ages 0-64 With Incomes Below 100% FPL, by Medicaid Expansion Status, 2008-2018
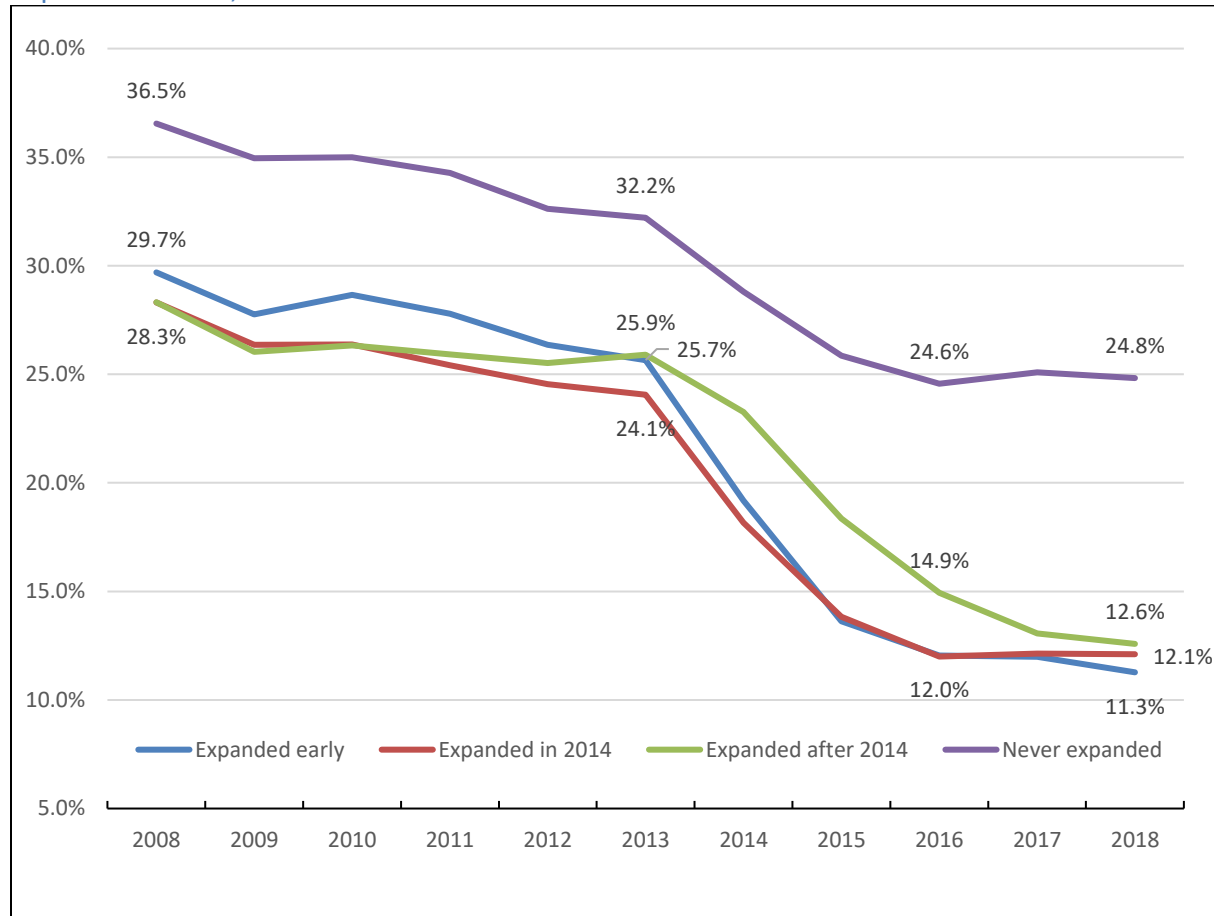
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Nonexpansion States Had Less Improvement in Coverage Among Middle-Income Individuals and Worsening Coverage Since 2016

Prior to 2013, expansion states had slightly lower rates of uninsurance among those with incomes of 100%-399% FPL, although early expansion states were more similar to nonexpansion states (Exhibit 2.3). Since 2013, expansion states have experienced greater reductions, and they had very similar rates in 2018, regardless of when expansion occurred. In contrast, nonexpansion states improved less since 2013, and since 2016 these states have

experienced noticeable increases in their rates of uninsurance – from 16.4% in 2016 to 17.8% in 2018.

Exhibit 2.3. Uninsured Rates for Those Ages 0-64 With Incomes 100%-399% FPL, by Medicaid Expansion Status, 2008-2018
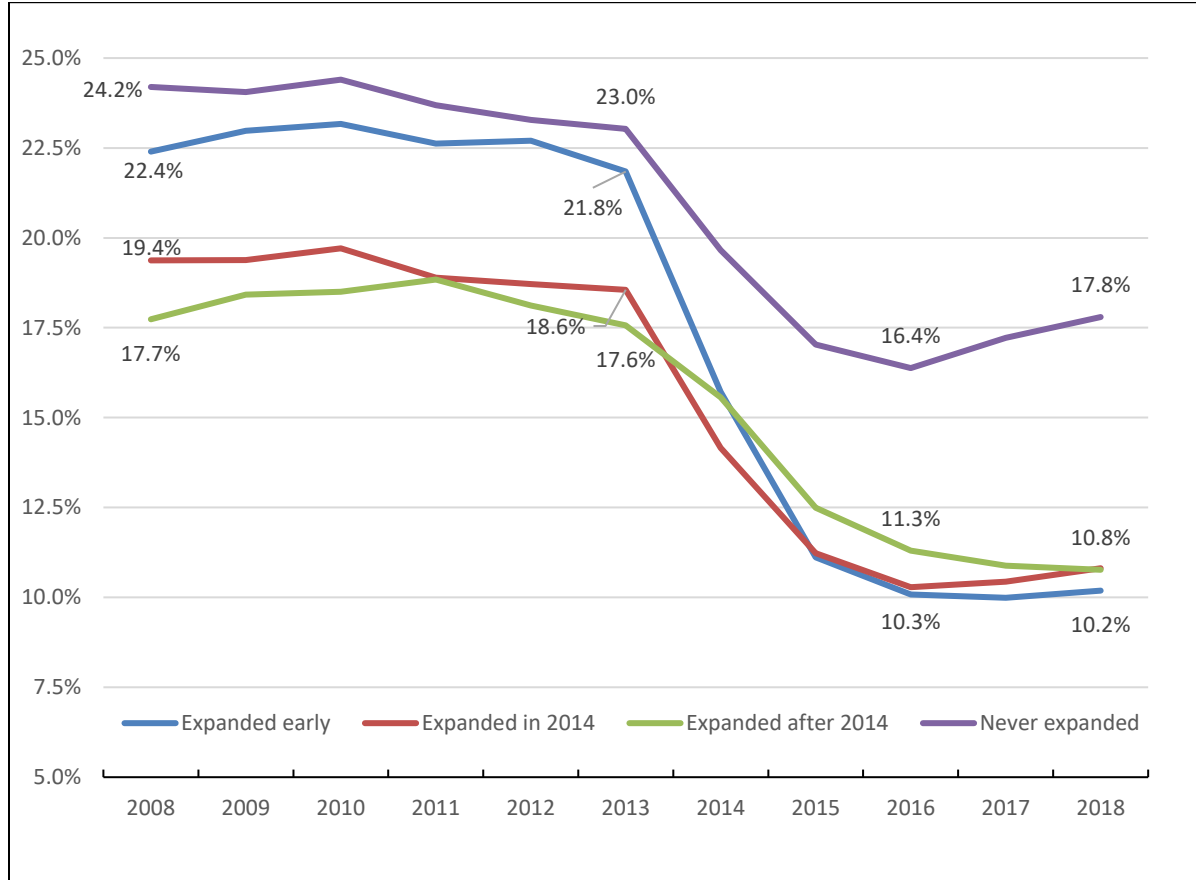
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Higher-Income Individuals Have Had Small Gains but Worsening Coverage Since 2016

Individuals with incomes of 400% FPL and above had relatively low rates of uninsurance prior to the ACA in both expansion and nonexpansion states (Exhibit 2.4). This income group also experienced small absolute reductions but large relative reductions in their rates of uninsurance after 2013, although the relative improvements were larger in expansion states. Most strikingly, this income group has shown the largest relative increases in rates of uninsurance since 2016. These reversals may be caused by several factors, including reduced affordability of insurance in the individual market, where this income group is not eligible for subsidies, and the repeal of the individual mandate tax penalty in 2017.

Exhibit 2.4. Uninsured Rates for Those Ages 0-64 With Incomes 400% FPL and Above, by Medicaid Expansion Status, 2008-2018
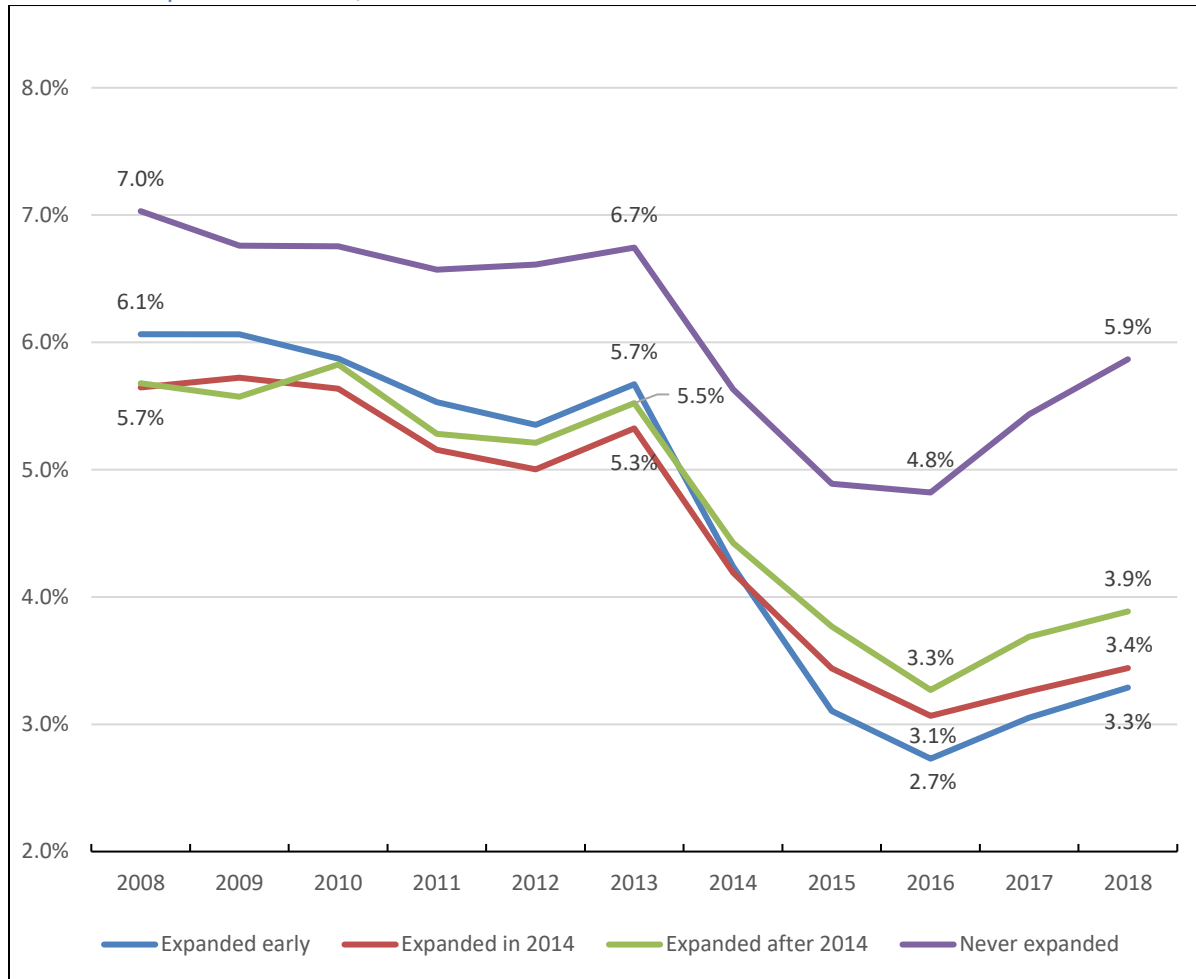
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Conclusions

Expansion states experienced larger reductions in their rates of uninsurance after full implementation of the ACA in 2014 compared to nonexpansion states. Expansion states reached very similar levels of uninsurance by 2018, regardless of when they started their Medicaid expansion. Nonexpansion states nevertheless saw reductions in their rates of uninsurance among those with incomes below 100% FPL, suggesting that the ACA had positive spillover effects for a portion of the Medicaid-eligible population in those states, despite their refusal to expand eligibility to all low-income adults. Expansion states achieved rates of uninsurance that were very similar for all individuals with incomes below 400% FPL, ranging from 10.2% to 12.6% in 2018. This finding suggests that the ACA has achieved greater equity in coverage between lower- and middle-income individuals, at least in expansion states. Finally, higher-income individuals had large relative improvements in their uninsurance rates between 2013 and 2016, but they have seen the largest reversals since 2016.

Chapter 3: Education

Key Finding

- Higher education is associated with substantially lower rates of uninsurance at every income level.

One overlooked disparity in evaluations of the ACA is the association between educational attainment and lack of insurance. Although the impact of education on earnings is well documented,[1] our findings suggest that education continues to have an important impact on the likelihood of being uninsured, regardless of income level. We found substantial differences by education level within each category of income. Specifically, lower levels of educational attainment are associated with higher rates of uninsurance, in both the pre- and post-ACA periods. Furthermore, differences in rates of uninsurance by education level have increased in the post-ACA period, indicating greater disparities based on educational attainment.

Higher Education Is Associated With Substantially Lower Rates of Uninsurance

Despite substantial reductions compared to 2013, those with incomes below 100% FPL continued to have the highest rates of uninsurance in 2018 (Exhibit 3.1). In 2013, individuals without a high school diploma were almost twice as likely to be uninsured as those with a graduate degree. Although all groups improved by 2018, the percentage difference between those without a high school diploma and those with a graduate degree actually increased compared to the pre-ACA period, indicating greater disparity. This finding suggests that relative changes in the rate of uninsurance, not just absolute percentage-point changes, are an important measure when examining disparities.

Because significant differences have been documented in the rate of uninsurance among low-income people in Medicaid expansion states versus nonexpansion states, we also examined the educational differences for those with incomes of less than 100% FPL in expansion and nonexpansion states. We observed the same pattern as that seen in Exhibit 3.1. Although expansion states had lower rates of uninsurance by education level in 2013 compared to nonexpansion states, both expansion and nonexpansion states had greater relative improvement among those with at least some college education by 2018, indicating greater disparity.

The educational differences observed among low- and middle-income people who are subsidy eligible under the ACA (100%-399% FPL) are even greater than the differences among those

---

[1] Vilorio D. 2016. Education Matters. *Career Outlook.* Washington, D.C.: U.S. Bureau of Labor Statistics.

who live below the poverty level. In 2013, those without a high school diploma were 3.7 times more likely to be uninsured than those with a graduate degree. This relative difference was slightly greater in 2018, despite improvements for every category of educational attainment between 2013 and 2018. Those with at least some college saw reductions of 38% to 40% in their rate of being insured, while those with a high school diploma had a 34% reduction, and those without a high school diploma had a 28% reduction.

Perhaps most surprising is that while absolute levels of uninsurance are lowest among those with the highest incomes, the relative differences by education level are greatest in this income group. In 2013, those without a high school diploma were almost 10 times more likely to be uninsured compared to those with a graduate degree, despite having incomes of at least 400% FPL. In 2018, this relative difference had not diminished, despite absolute reductions among every category of educational attainment.

Exhibit 3.1. Uninsured Rates for Those Ages 18-64 by Educational Attainment and Income, 2013 and 2018
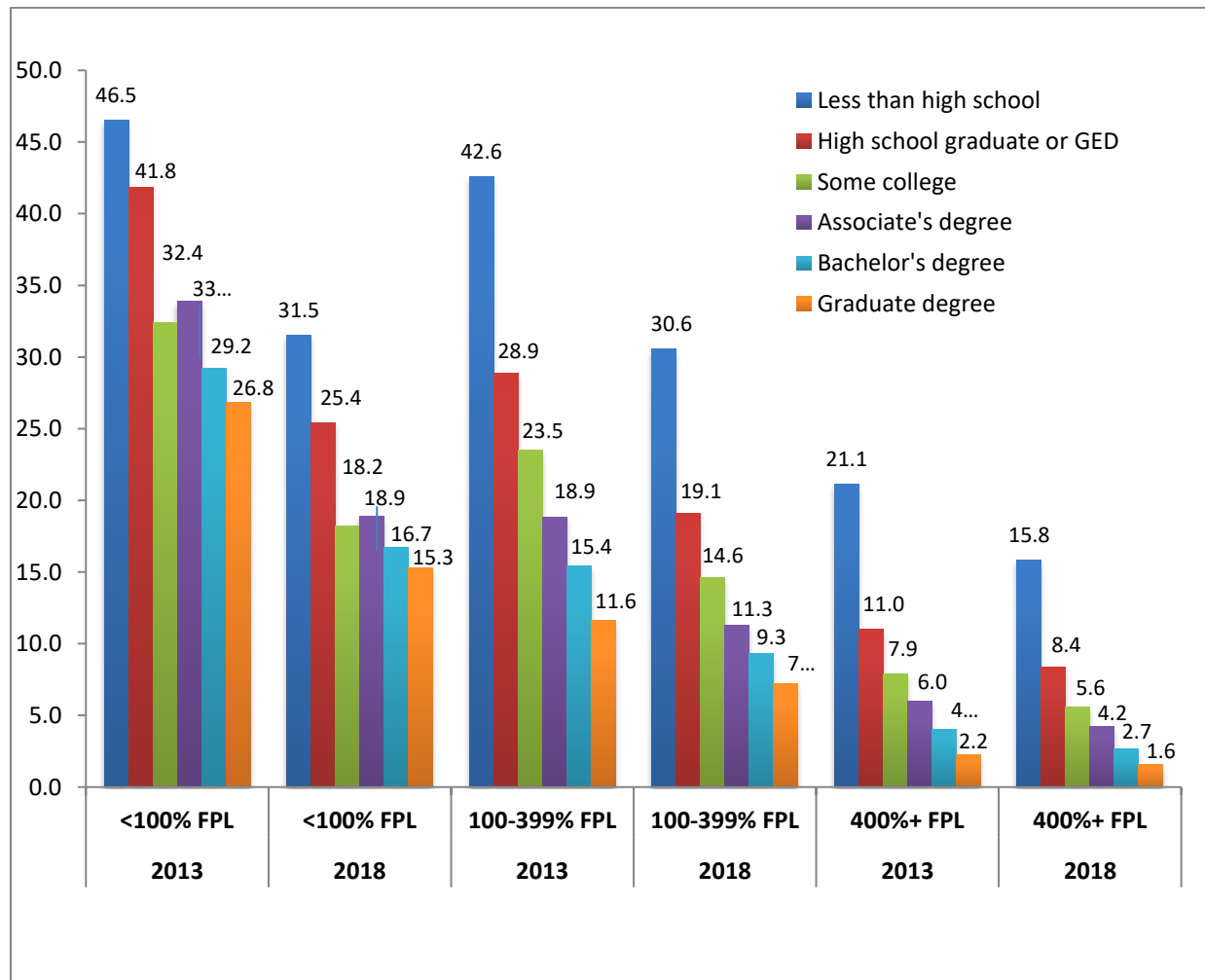
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Conclusions

Our findings suggest that educational attainment plays an important role in health insurance status independent of its impact on household income. And although the ACA has produced substantial reductions in the percentage of uninsured across both income categories and categories of educational attainment, disparities by education level persist and have not diminished as a result of the ACA. The reasons for these findings are not immediately obvious, but the findings certainly merit attention and further investigation. Educational attainment may be associated with other factors that make it difficult for individuals to obtain health insurance, even if health insurance is seemingly more affordable. At a minimum, our results certainly challenge the notion that affordability alone is the major determinant of being uninsured, especially in light of our findings that educational differences in rates of uninsurance are large at the lowest income levels and even greater at higher levels of income.

Chapter 4: Housing

Key Finding

- Individuals whose homes lacked a basic necessity always had higher rates of uninsurance than those with complete housing, regardless of income level or state expansion status.

Recent research has shown that there is an important relationship between housing and health outcomes,[1] and that improving housing quality and safety improves overall health. Individuals experiencing unstable housing and poor housing safety, defined in a variety of ways — including instability, an unsafe environment, water leaks, poor ventilation, and pest infestation — have poorer health. However, there is virtually no literature that focuses on the question of whether having stable and safe housing is related to the likelihood of having health insurance coverage. A study by Carroll et al. in 2017 assessed the extent to which housing instability is linked to insurance status in a preschool population. The study found that preschool-age children residing in unstable housing were 27% more likely than stably housed preschool-age children to have gaps in health insurance.[2]

We compared individuals ages 0-64 who had complete housing amenities with those whose housing lacked one basic necessity. Basic necessities are defined as these:

- Bathtub or shower
- Sink with a faucet
- Stove or range
- Refrigerator

Having Complete Housing Is Always Associated With Greater Health Insurance Coverage

Our findings suggest that having housing that lacks at least one basic necessity is associated with being uninsured. Prior to the implementation of the ACA's main coverage provisions, individuals whose housing lacked at least one basic necessity had higher rates of being uninsured than individuals with complete housing. While this disparity still exists after implementation of the ACA, rates of uninsurance have decreased for those whose incomes would qualify them for Medicaid coverage under Medicaid expansion or for individual market subsidies, both for those with complete housing and those whose housing lacks a basic necessity. But more importantly, large disparities in coverage persist.

---

[1] Taylor L. 2018. Housing and Health: An Overview of the Literature. Health Policy Brief. *Health Affair*. DOI: 10.1377/hpb20180313.396577.

[2] Carroll A et al. 2017. Housing Instability and Children's Health Insurance Gaps. *Academic Pediatrics* 17(7):732-738.

Overall, in a comparison of the pre-ACA implementation (2013) with the most recently available post-ACA implementation year (2018), the reduction in the uninsured rate was dramatic. However, individuals with homes that had all the basic necessities had lower uninsured rates and higher rates of decline in their uninsured rates in comparison to those lacking at least one basic necessity (Exhibit 4.1). Those having all the basic necessities had much lower rates of being uninsured than those whose housing lacked at least one basic necessity, regardless of income.

Among those living in homes missing at least one basic necessity, the rate of uninsurance declined in relative terms by 31.3% for individuals with incomes below 100% FPL, and by 33.0% among those with incomes of 100%–399% FPL. In comparison, those living in homes with all the basic necessities had better coverage rates in 2013, and their coverage rates improved more than the rates for those living without one basic necessity. Between 2013 and 2018, the uninsured rate for those in homes with all basic necessities declined by 38.0% for those with incomes below 100% FPL, and by 34.5% among those with incomes of 100%–399% FPL.

Exhibit 4.1. Uninsured Rates Among Those Ages 0-64 by Housing Status and Income, 2013 and 2018
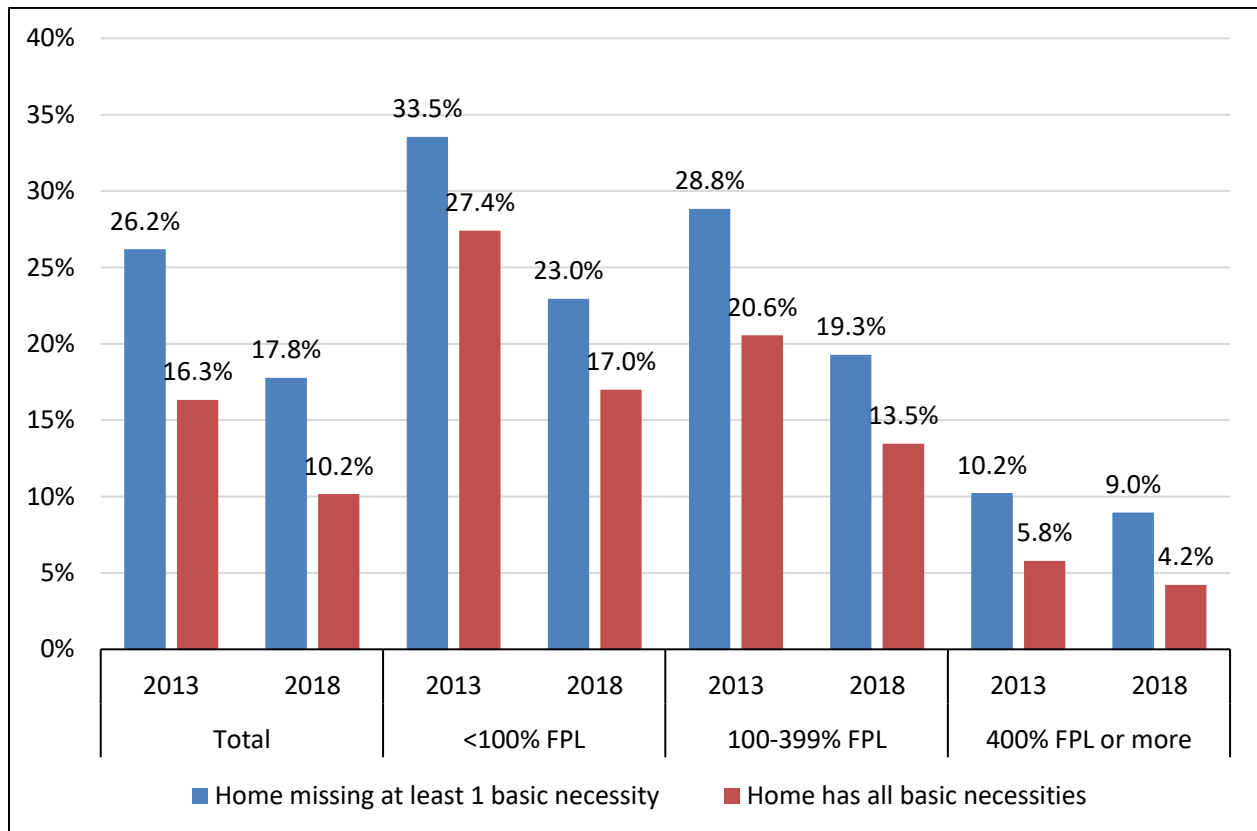
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Individuals with incomes of 400% FPL or greater started out with much lower rates of being uninsured than the other two income groups, regardless of their housing status. However, among this population, there were smaller relative declines in the uninsured rate. The rate declined 27.6% for those with all the basic necessities, and only 11.8% for those without at least one basic necessity. Thus, disparities still exist, as not all groups shared equally in the decline, and those that had full housing had lower uninsured rates than those that had a missing basic necessity.

We also compared the rates of being uninsured for each income group in states that expanded Medicaid in 2014 versus states that did not expand. Whether or not the individual or family had all the basic necessities, there was a larger percentage of decline in uninsured rates for all income groups in states that took part in the Medicaid expansion than in states that did not.

Conclusions

The relationship between housing insecurity and health insurance coverage has been a relatively unexplored topic. Though many health organizations — whether in the private, nonprofit, or government sectors — have begun to discuss and create interventions to tackle the social determinants of health, the role of housing as a variable that puts individuals at greater risk of being uninsured has never been highlighted. Our analyses demonstrate that individuals with housing issues, as measured by the lack of a basic necessity, are more likely to be uninsured than those without housing issues. The reasons why are not clear, though the finding may reflect a higher budgetary priority on housing and food than on health insurance. Further investigation is necessary to determine why individuals whose housing lacked at least one basic necessity and whose income was less than 100% FPL did not see a larger decrease in their uninsured rate, as they would be eligible for Medicaid in expansion states. More research will be needed to assess the relationship between insurance and housing.

Chapter 5: Employment

Key Findings

- Employed individuals always had the highest coverage rates, regardless of state expansion status.
- Employed individuals residing in nonexpansion states experienced smaller coverage gains than those in expansion states.
- Since 2008, individuals with incomes above 100% FPL who were not in the labor force (i.e., not seeking employment) had coverage rates very similar to the rates among those who were employed.

Employer-sponsored insurance (ESI) has been the largest source of coverage for the population in the U.S. since the late 1940s; in 2018, ESI covered 59.2% of those ages 19-64. ESI continues to be the predominant source of health insurance today, even with the passage of Medicare and Medicaid in 1965 and the Affordable Care Act in 2010. However, there has been a small but steady decline in ESI in recent decades.[1] Even with the passage of the ACA and the widely reported drop in the number of persons who remain uninsured, it is still important to assess the role of employment in providing health insurance coverage. The ACA requires employers with at least 50 full-time equivalent employees to provide health insurance to those working at least 30 hours per week. Because of this, one concern was that employers would cut work hours to reduce their health insurance expenses. However, recent studies have shown that the ACA has not resulted in large declines in ESI and has not caused "crowd-out," a phenomenon that occurs when the increased availability of government insurance results in lower enrollment in private insurance.[2]

Insurance Coverage Improved for Everyone, Regardless of Employment Status

As shown in Exhibit 5.1, the rate of insurance coverage improved for all adults ages 18-64 after 2013, regardless of employment status. Between 2008 and 2013, those who were unemployed (i.e., seeking employment) had uninsured rates that started at 48.8% and fell slowly to 44%. Over the same time period, those who were employed or not in the labor force (i.e., not seeking employment) had uninsured rates of a little more than 17% and 22%, respectively, figures that climbed a small amount by 2013. Clearly, employment had a major impact on insurance coverage prior to 2014, although 1 out of 6 workers remained uninsured.

---

[1] *Table HI-1, Health Insurance Coverage Status and Type of Coverage by Sex, Race, and Hispanic Origin: 1987 to 2005.* Historical Health Insurance Tables. Washington, D.C.: U.S. Census Bureau. https://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/original/orghihistt1.txt.
[2] Frean M, Gruber J, Sommers BD. 2017. Premium Subsidies, The Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act. *Journal of Health Economics* 53:72-86.

Following implementation of major provisions of the ACA in 2014, the uninsured rate for those who were unemployed dropped sharply, from 44.0% to 26.6%, by 2016 – a 39.5% reduction. Similarly, the uninsured rate for the employed and those not in the labor force declined by 39.8% and 37.2%, respectively. Among the unemployed, the uninsured rate dropped by 4.2 percentage points between 2010 and 2013 (from 48.2% to 44.0%). This is most likely due to the expansion of coverage to those ages 18-25; this issue is discussed more in chapter 9. Although the ACA has resulted in substantial coverage improvements for adults regardless of employment status, it has not reduced the relative disparity between the employed and the unemployed.

Exhibit 5.1. Uninsured Rates Among Those Ages 18-64 by Employment Status, 2008-2018
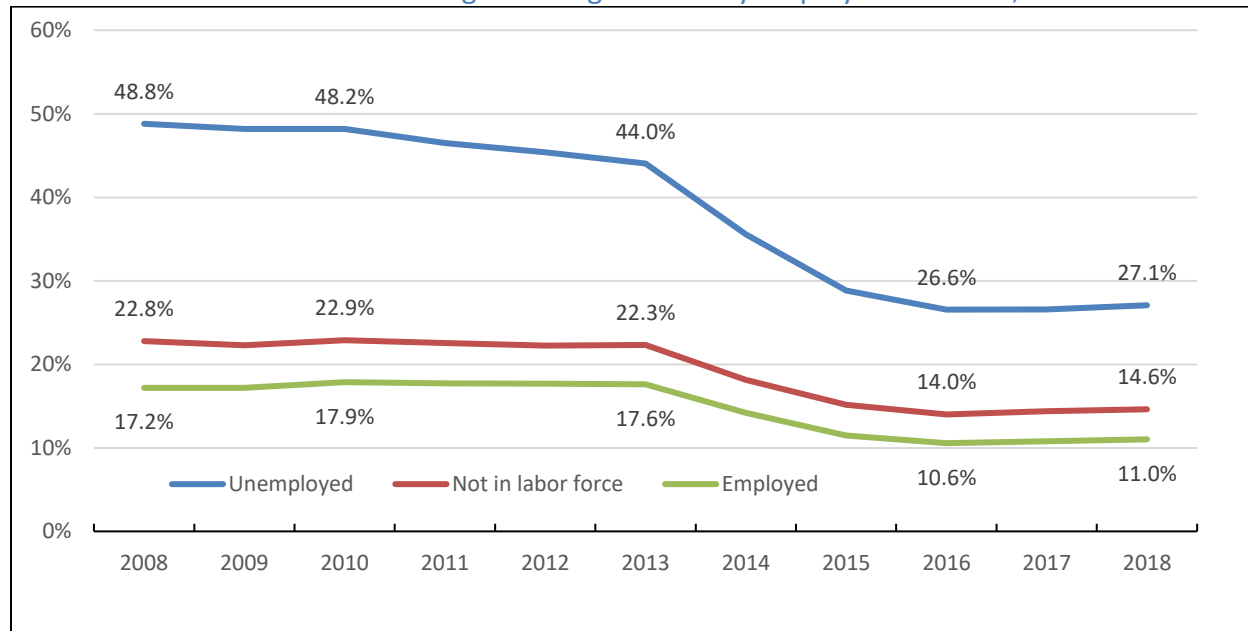
Source: Authors' analysis of American Community Survey data

Relationship of Employment to Coverage Varies Substantially by Income

Our analyses of the relationship between employment status and insurance coverage indicates considerable differences across income categories. For those whose incomes are less than 100% FPL, the ACA produced large improvements in insurance coverage after 2013 for all three categories of employment (Exhibit 5.2). The large disparities in the uninsured rates by employment status persist, but they are narrowed by the drop in percentage of unemployed individuals who are no longer uninsured — a drop by 2018 of almost 25 percentage points. However, a new and unexpected observation is also seen, with the somewhat surprising finding that those who were employed had higher uninsured rates than those who were not in the labor force. In 2018, those who were employed had an uninsurance rate of 25.8%, whereas those who were not in the labor force had a rate of 20.5%. This finding most likely reflects the impact of Medicaid expansion and the fact that low-income individuals are more likely to work part-time or for employers who do not offer health insurance coverage.

Exhibit 5.2. Uninsured Rates Among Those Ages 18-64 With Incomes Below 100% FPL, by Employment Status, 2008-2018
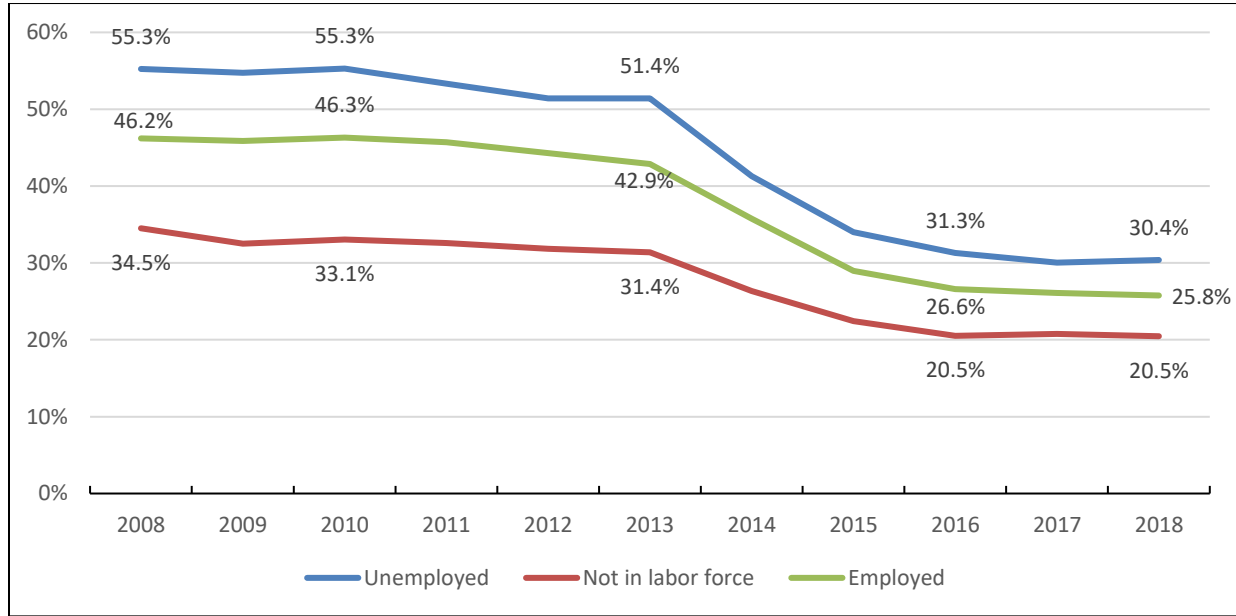
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Exhibit 5.3. Uninsured Rates Among Those Ages 18-64 With Incomes 100%-399% FPL, by Employment Status, 2008-2018
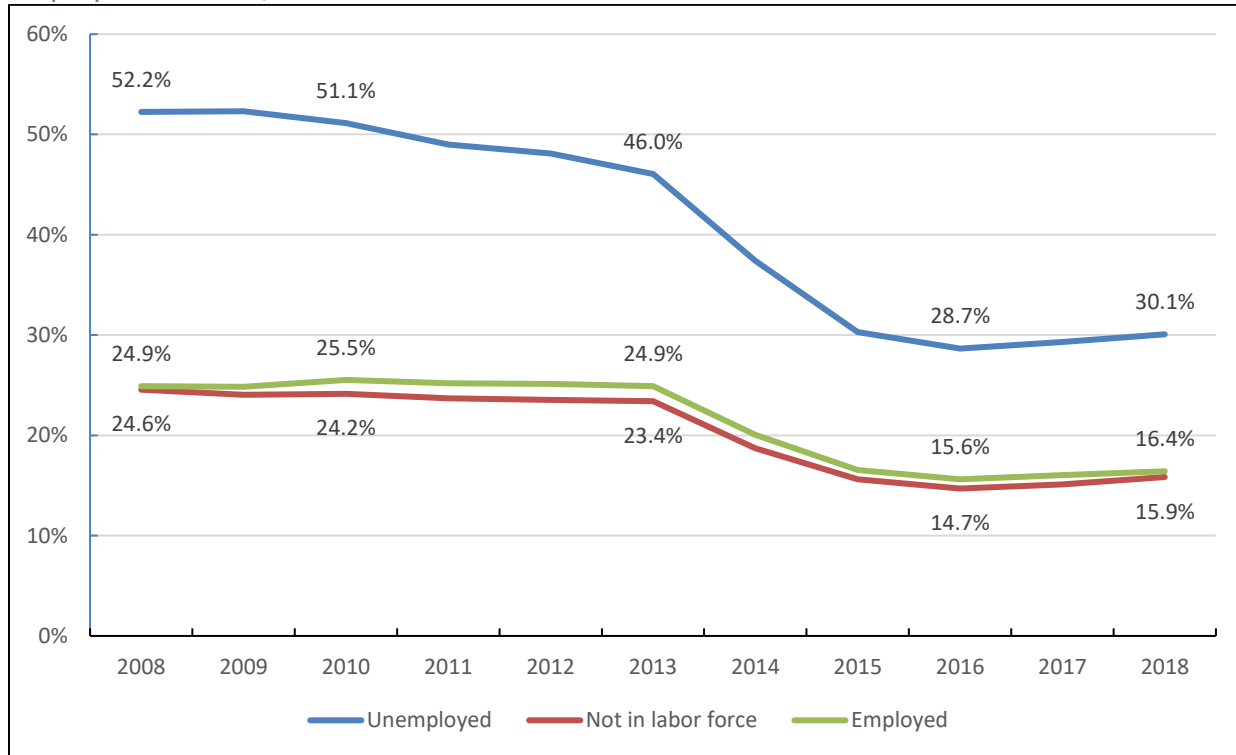
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Exhibit 5.4. Uninsured Rates for Those Ages 18-64 With Incomes 400% FPL and Above, by Employment Status, 2008-2018
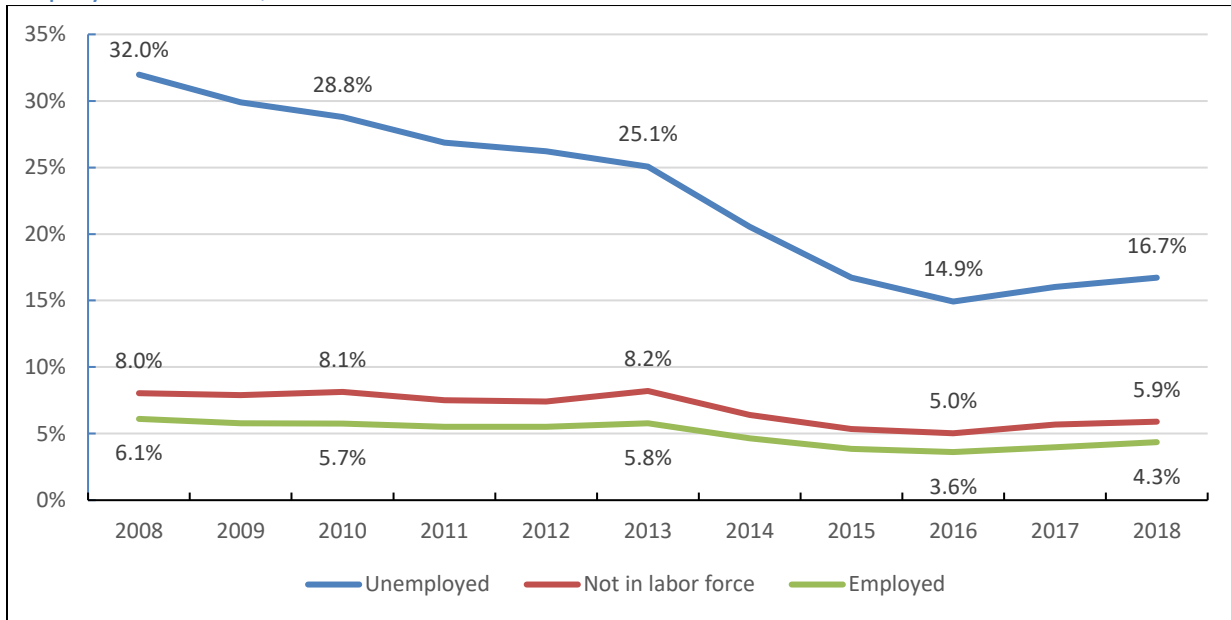
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

For Higher-Income Groups, the Unemployed Remain at Much Higher Risk of Being Uninsured

For higher-income groups (Exhibits 5.3 and 5.4), being unemployed is associated with much higher rates of uninsurance compared to those who are employed or not in the labor force. Furthermore, the largest gains in coverage occurred among the unemployed. These findings are in stark contrast to the results for those with incomes of less than 100% FPL, discussed above (Exhibit 5.2). In addition, those who are not in the labor force and those who are employed had virtually identical rates of coverage from 2008 to 2018. Both the employed and those not looking for work in the 100%-399% FPL group experienced a large decline in uninsured rates starting in 2014, dropping about 9 percentage points by 2018 (Exhibit 5.3). By comparison, for those with incomes of 400% FPL or higher, there were minimal changes in the coverage rate for those employed and those not in the labor force between 2008 and 2018 (Exhibit 5.4).

Nonexpansion States Have Higher Rates of Uninsurance, Regardless of Employment Status

Since 2008, the uninsured rates in nonexpansion states have been consistently higher than in expansion states, regardless of employment status (Exhibit 5.5). The unemployed living in expansion states were less likely to be uninsured in 2008 compared to the unemployed in nonexpansion states (45.0% versus 55.9%). As of 2018, despite lower rates of uninsurance

nationwide for the unemployed since 2013, the gap between expansion and nonexpansion states had widened for the unemployed (21.2% versus 41.0%).

Expansion states have also experienced larger relative reductions in uninsured rates among both the employed and those not in the labor force. Since 2013, expansion states had larger percentage point reductions in the uninsured rates than nonexpansion states – 6.6 versus 5.4 percentage points among the employed, and 10.3 versus 4.8 percentage points among those not in the workforce. Overall, the ACA has resulted in greater reductions in uninsured rates for adults living in expansion states, regardless of their employment status, compared to those living in nonexpansion states.

Exhibit 5.5. Uninsured Rates Among Those Ages 18-64 in Expansion vs. Nonexpansion States, by Employment Status, 2008-2018
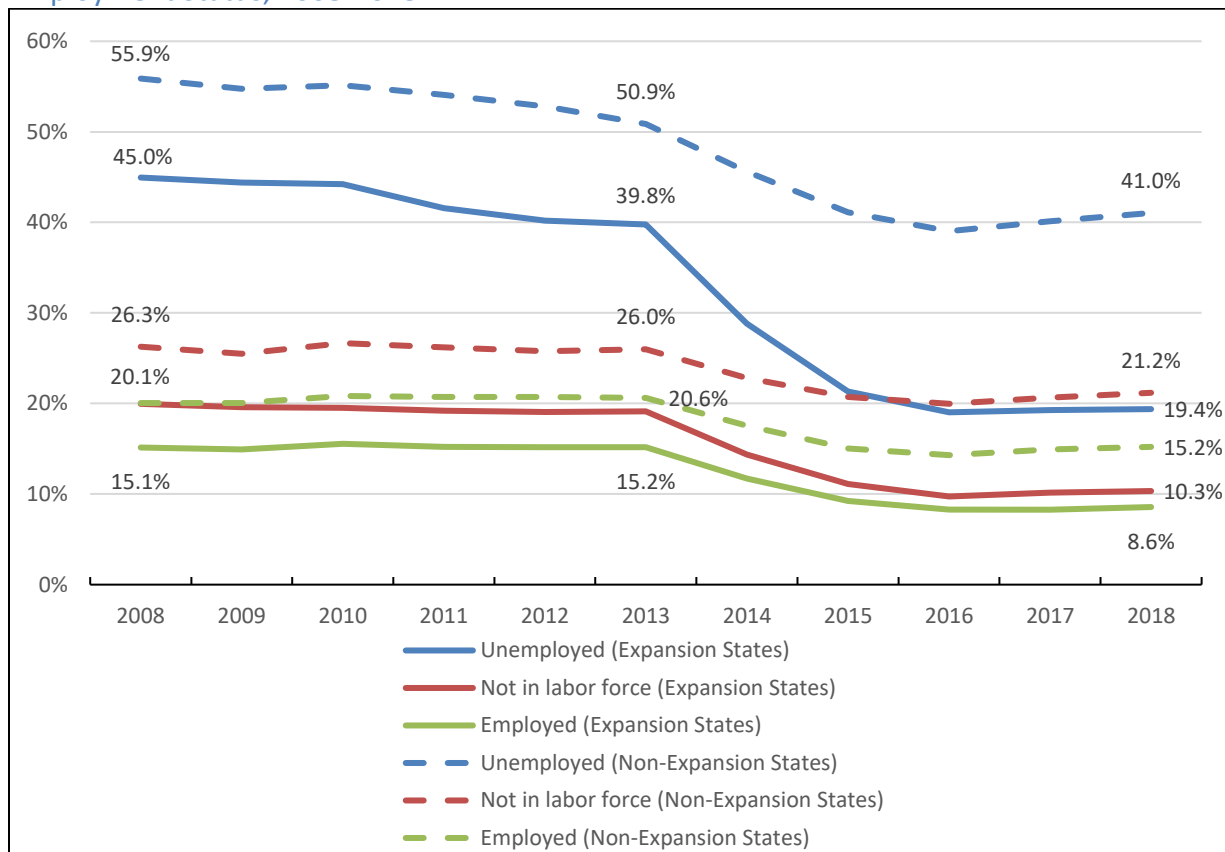
Note: Expansion states include only those that expanded in 2014; nonexpansion states are those that had not expanded as of 2018.
Source: Authors' analysis of American Community Survey data

Conclusions

Employment has continued to be a powerful determinant of uninsured rates following implementation of the ACA. One interesting finding from our analysis is that among individuals with incomes below 100% FPL, those who were not in the labor force had uninsured rates lower

than those who were employed. There are multiple possible reasons for this finding, including Medicaid eligibility, higher likelihood of working for employers who don't offer coverage, and higher likelihood of working part-time. Others have reported that individuals who work part-time had a large decline in being uninsured during the first year of the ACA, so part-time employment may not play a major role.[3] Because our results show considerable differences in patterns and impacts of ESI across income categories, drawing broad conclusions about the role of ESI in providing insurance coverage is difficult without acknowledging these differential effects by income status. These are issues that certainly merit further exploration.

Another important impact of the ACA on ESI is the requirement that ESI must include dependent coverage that allows adult children to remain on a parent's employment-based health insurance coverage until age 26. This provision of the ACA greatly increased the percentage of individuals with insurance coverage, as shown in other studies.[4] This issue is discussed further in chapter 9 of this report.

ESI has been the predominant form of insurance coverage in the U.S. for decades; despite its declining role, it continues to be the primary source of coverage for a majority of the nation's population. Until the U.S. finds an alternative mechanism for health care financing, health insurance trends by employment status must continue to be closely monitored.

---

[3] Berdahl TA, Moriya AS. 2018. Difference in Uninsurance Rates Between Full- and Part-Time Workers Declined in 2014. *Health Affairs* 37(10):1669-1672.
[4] Sommers BD et al. 2013. The Affordable Care Act Has Led to Significant Gains in Health Insurance and Access to Care for Young Adults. *Health Affairs* 32(1):165-174.

Chapter 6: Citizenship

Key Findings

- Coverage has improved regardless of citizenship status, but 1 in 3 noncitizens remains uninsured.
- Noncitizens have the highest uninsured rates across all income categories.
- Citizens and noncitizens both have higher uninsured rates in nonexpansion states across all income categories.

Eligibility for both Medicaid and individual market premium subsidies differs by citizenship status. Undocumented immigrants were excluded from all options for expanded coverage under the ACA. They are not eligible for enrollment through the Medicaid expansions, they are not eligible for subsidies through the health insurance marketplaces, and they cannot buy insurance through the marketplaces without subsidies. Although undocumented individuals are not eligible for full Medicaid benefits, six states (California, Illinois, Massachusetts, New York, Oregon, and Washington) and the District of Columbia have expanded Medicaid enrollment to undocumented children using state-only funds that do not qualify for federal matching funds. California recently expanded Medicaid coverage to all 18-25-year-olds, regardless of immigration status. For noncitizens, the American Community Survey does not distinguish between documented and undocumented residents, so our analysis of noncitizens includes both.

For lawfully present noncitizens, Medicaid eligibility differs by state. In most states, lawfully present residents who are not citizens are not eligible for Medicaid coverage for the first five years they are in the U.S., although some states have removed this five-year waiting period for Medicaid eligibility. Therefore, because of different eligibility rules for citizens and noncitizens, the ACA may have different impacts based on citizenship status.

In this chapter, we were also interested in examining differences in uninsured rates among U.S. citizens based on their nativity — namely, citizens born in the U.S. versus those who were born in U.S. territories or born outside the U.S. to American parents, or who are naturalized citizens.

Coverage Has Improved Regardless of Citizenship Status, but 1 in 3 Noncitizens Remains Uninsured

Over time, noncitizens have consistently had the highest uninsured rate in the country. In 2013, prior to the implementation of the ACA's main coverage provisions in 2014, the uninsured rate among noncitizens was 48.1% — more than 3.5 times the uninsured rate among U.S.-born citizens (Exhibit 6.1). Under the ACA, the uninsured rate for noncitizens dropped by 15.3 percentage points. Still, one-third (32.8%) of noncitizens were uninsured in 2018, and

noncitizens were much more likely to be uninsured than citizens (between 8.4% and 12.1% of citizens were uninsured in 2018).

Exhibit 6.1. Uninsured Rates Among Those Ages 0-64 by Citizenship Status, 2008-2018
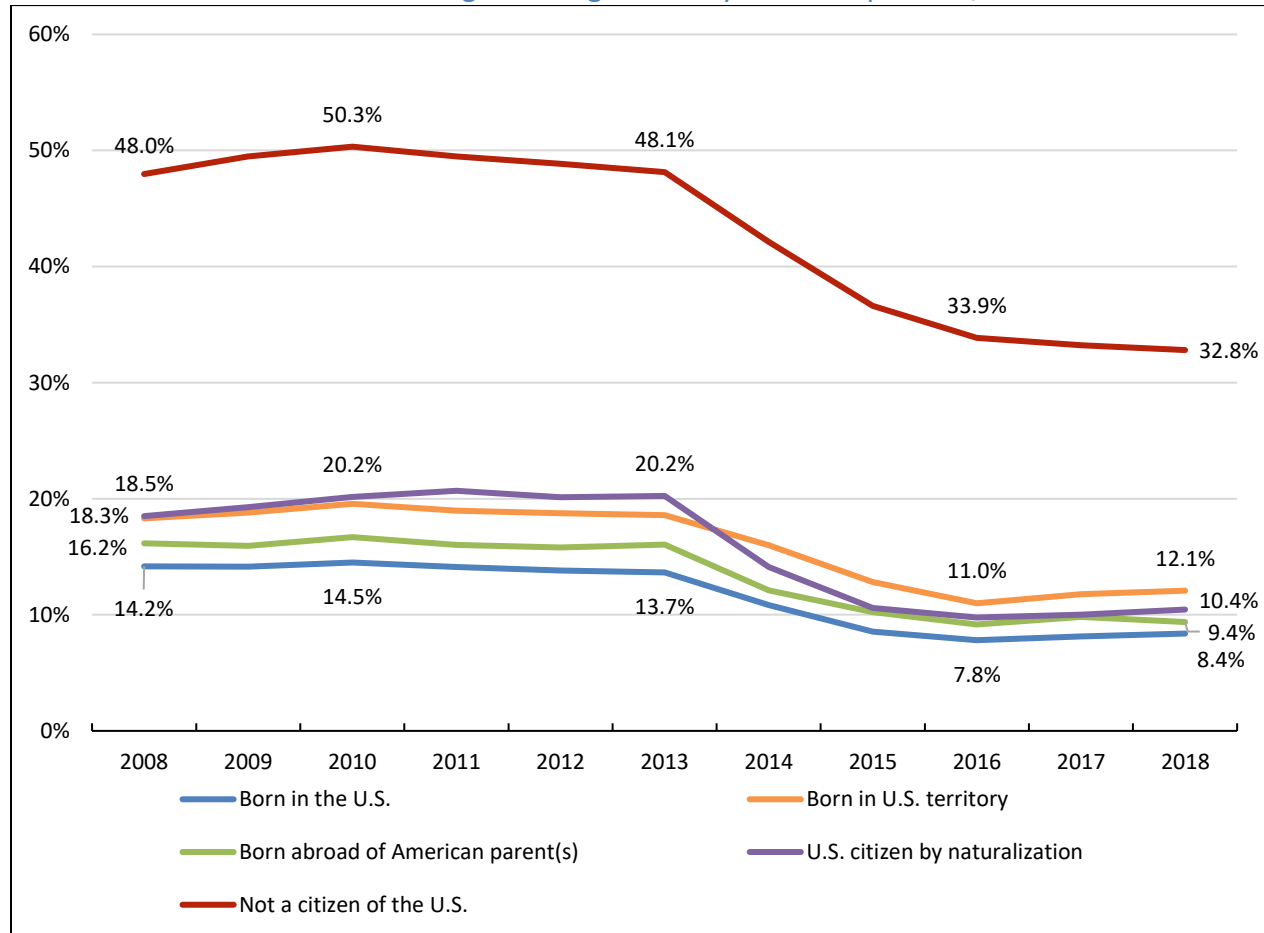
Source: Authors' analysis of American Community Survey data

Noncitizens Have Highest Uninsured Rates Across All Income Categories

In 2008, among U.S. citizens with incomes below 100% FPL, uninsured rates for citizens ranged from 25.2% to 37.8% (Exhibit 6.2). By 2018, the uninsured rates for citizens declined substantially and ranged between 11% and 18.4%. A similar trend occurred among those with incomes of 100%-399% FPL. Among individuals with incomes of 400% FPL and above, however, there were minimal differences in uninsured rates of citizens either prior to or following the implementation of the ACA. As expected, across all categories of citizenship, those with incomes of 400% FPL and above had the lowest uninsured rates. Even noncitizens in this group were uninsured at levels similar to those of citizens with lower incomes, suggesting that income plays an important role in mitigating the risk of being uninsured for noncitizens.

Exhibit 6.2. Uninsured Rates Among Those Ages 0-64 by Citizenship Status and Income, 2008-2018
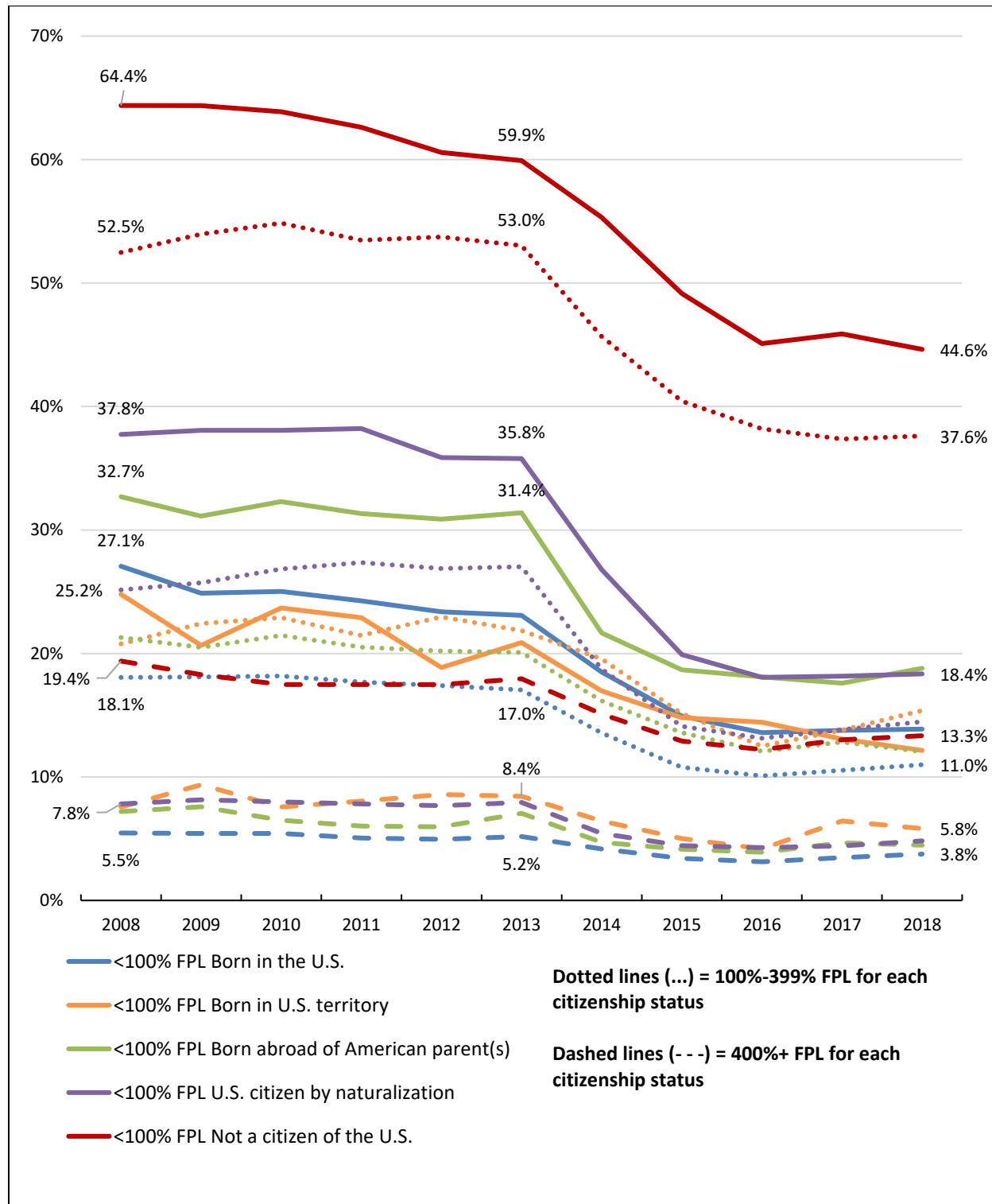
Legend:
- —— <100% FPL Born in the U.S.
- —— <100% FPL Born in U.S. territory
- —— <100% FPL Born abroad of American parent(s)
- —— <100% FPL U.S. citizen by naturalization
- —— <100% FPL Not a citizen of the U.S.

Dotted lines (…) = 100%-399% FPL for each citizenship status

Dashed lines (- - -) = 400%+ FPL for each citizenship status

Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Both Citizens and Noncitizens Have Higher Uninsured Rates in Nonexpansion States Across All Income Categories

In expansion states, residents with incomes below 100% FPL had significantly lower uninsured rates in 2018 than in 2013 (Exhibit 6.3). While about 1 in 5 U.S.-born citizens (20.3%) was uninsured in 2013, the uninsured rate decreased by more than half in 2018, to 9.1%. Similar declines in the uninsured rates occurred between 2013 and 2018 for all other U.S. citizen groups. Differences between categories of U.S. citizens continued to exist in 2018, particularly between U.S.-born and naturalized citizens. For noncitizens, the uninsured rate also declined by more than 25 percentage points, from 53.5% in 2013 to 39% in 2018.

In nonexpansion states, declines in the uninsured rate among low-income residents were not as significant, and gaps widened compared to expansion states (Exhibit 6.3). Across all groups of U.S. citizens, more than 1 in 5 residents of nonexpansion states remained uninsured in 2018, at rates that were between 1.7 and 3.2 times higher than the rates among residents of expansion states. Noncitizens fared the worst in these states, with more than 60% being uninsured in 2018 — 1.57 times the uninsured rate of noncitizens in expansion states.

Exhibit 6.3. Uninsured Rates Among Those Ages 0-64 With Incomes Below 100% FPL, by Year, Medicaid Expansion Status, and Citizenship Status, 2013 and 2018
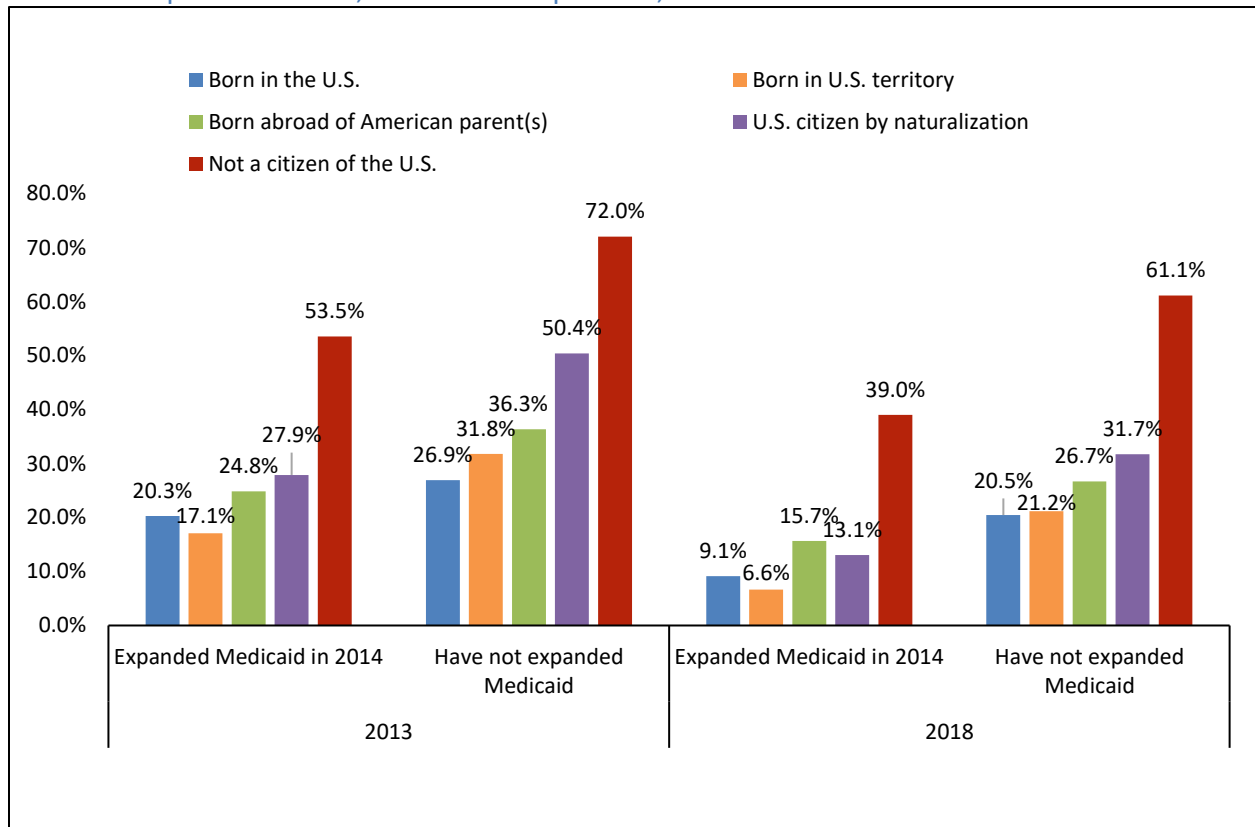
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Among those with incomes of 100%-399% FPL, similar trends to those seen in the low-income population are evident (Exhibit 6.4). Within citizenship status groups, the uninsured rates in 2018 were between 1.52 and 1.86 times higher in nonexpansion states compared to states that expanded in 2014. These relative differences grew larger between 2013 and 2018, mostly because of greater reductions in uninsured rates for citizens in expansion states.

Exhibit 6.4. Uninsured Rates Among Those Ages 0-64 With Incomes 100%-399% FPL, by Year, Medicaid Expansion Status, and Citizenship Status, 2013 and 2018
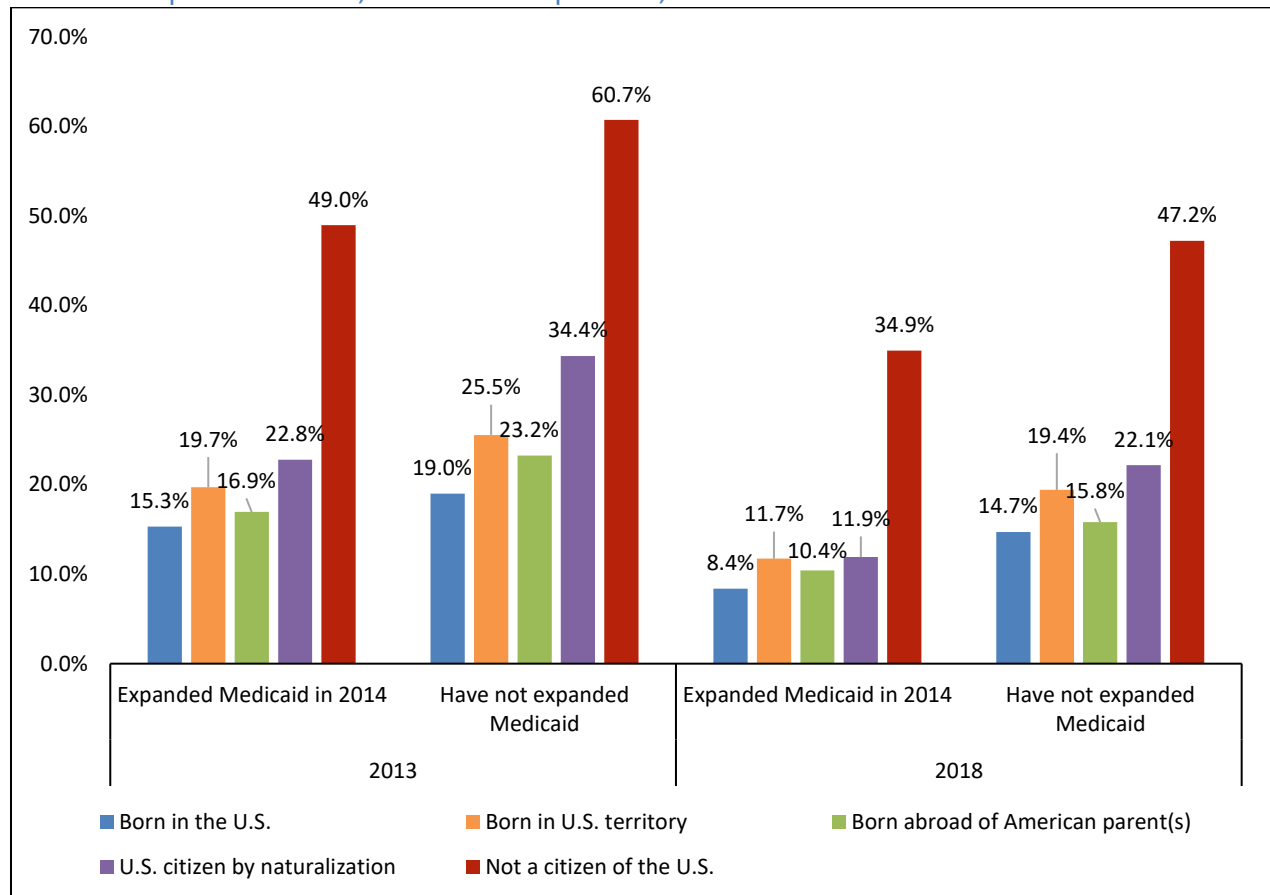
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

For individuals with the highest incomes (400% FPL or higher), uninsured rates were lower in states that expanded Medicaid, regardless of citizenship status (Exhibit 6.5). Within citizenship status groups, the uninsured rates in 2018 were 1.42 to 2.25 times higher in nonexpansion states. Again, these relative differences increased between 2013 and 2018 because expansion states had larger reductions in their uninsured rates.

Exhibit 6.5. Uninsured Rates Among Those Ages 0-64 With Incomes 400% or More FPL, by Year, Medicaid Expansion Status, and Citizenship Status, 2013 and 2018
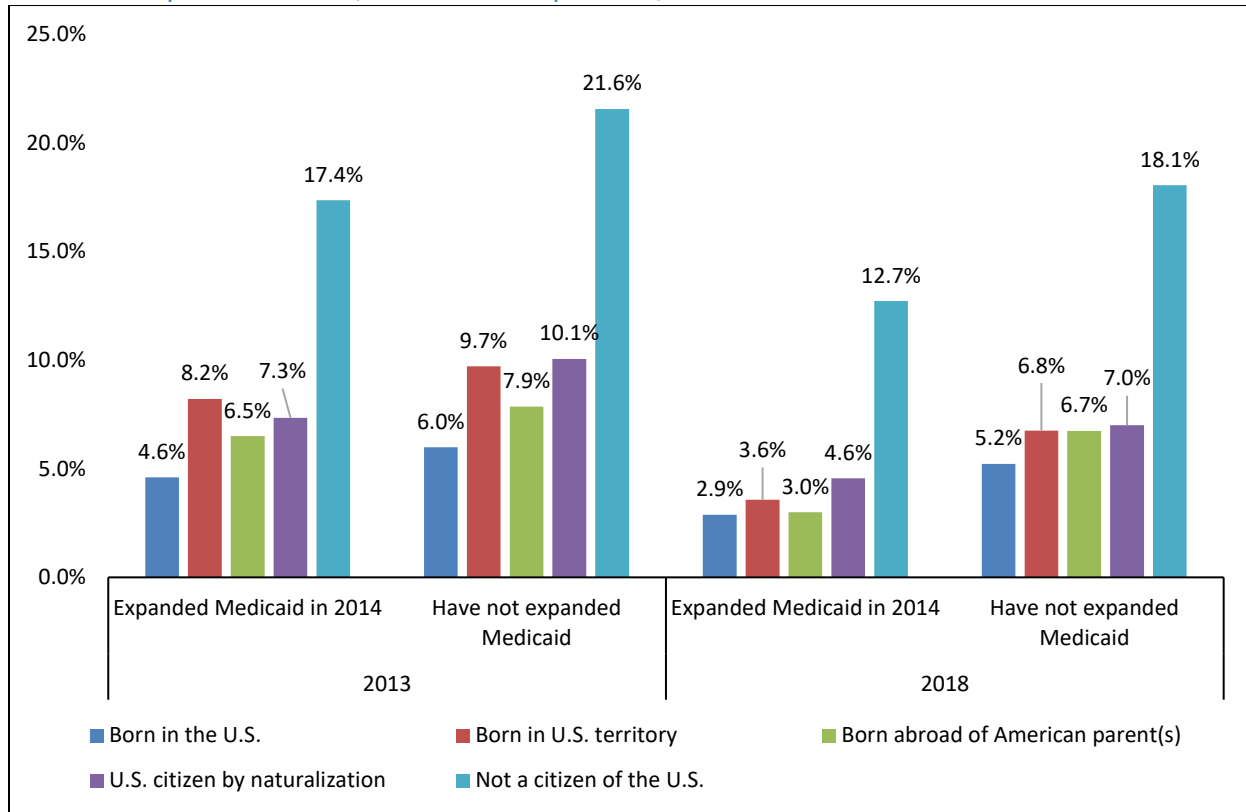
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Conclusions

The ACA has narrowed gaps that previously were quite large among citizens based on place of birth. However, while noncitizens have gained coverage under the ACA, they continue to have the highest uninsured rate in the country. A recent policy implemented by the Trump administration in 2020, referred to as the "public charge" rule, may exacerbate this issue in the future, even for lawfully present citizens. This rule, which is still being challenged in the courts, allows immigration officials to consider individuals' use of public programs, such as Medicaid, in their decision to grant citizenship. The rule will potentially make it harder for immigrants who have needed, and have been eligible for, public programs to eventually become citizens. This policy may deter otherwise eligible noncitizens from enrolling in Medicaid and other public programs.

Some states, on the other hand, are working to make coverage more accessible to noncitizens. In California, for example, a law passed in 2019 allows undocumented young adults to enroll in Medicaid coverage. These new federal policies and different state support for noncitizens will likely lead to greater disparities in coverage between states. Future research should continue to track insurance coverage trends by citizenship status.

Chapter 7: English Proficiency

Key Findings

- Lower levels of English proficiency are associated with higher rates of uninsurance, regardless of income level.
- Coverage for individuals at all levels of English proficiency improved more in expansion states than nonexpansion states.

Racial and ethnic disparities in insurance have been well documented,[1] although only a few studies focus on whether an individual's level of English proficiency is related to the likelihood of being uninsured. A low level of English proficiency can be a barrier to navigating health insurance. One study reported that children in non–English-speaking households are more likely to lack health insurance.[2] Another study demonstrated that a lack of English proficiency increases the likelihood of being uninsured, especially for Latinos.[3]

Individuals Who Do Not Speak English at All or Not Well Had the Highest Rates of Uninsurance at Every Income Level

Those with the least English proficiency had the highest rates of uninsurance from 2008 to 2018. For individuals who did not speak English, the uninsured rate was 67% before the implementation of the ACA, which was 4.41 times greater than the rate among those who speak English very well (Exhibit 7.1). After the ACA went into effect, the uninsured rates decreased among all levels of English proficiency. For example, the rate of uninsurance decreased 16.0 percentage points from 2013 to 2018 among those with the lowest level of English proficiency. However, in 2018, individuals who do not speak English still had the highest rate of uninsurance compared to other levels of English proficiency, and they were 5.15 times more likely to be uninsured than those who speak English very well.

---

[1] Artiga S, Stephens J, Damico A. 2015. *The Impact of the Coverage Gap in States Not Expanding Medicaid by Race and Ethnicity.* Disparities Policy: Issue Brief. Menlo Park, Calif.: The Henry J. Kaiser Family Foundation.

[2] Yu SM, Huang ZJ, Schwalberg RH, Nyman RM. 2015. Parental English Proficiency and Children's Health Services Access. *American Journal of Public Health* 96(8):1449-1455.

[3] Alegría M, Cao Z, McGuire TG, Ojeda VD, Sribney B., Woo M, Takeuchi D. 2006. Health Insurance Coverage for Vulnerable Populations: Contrasting Asian Americans and Latinos in the United States. *Inquiry* 43(3):231-254.

Exhibit 7.1. Uninsured Rates Among Those Ages 5-64 by Level of English Proficiency, 2008-2018
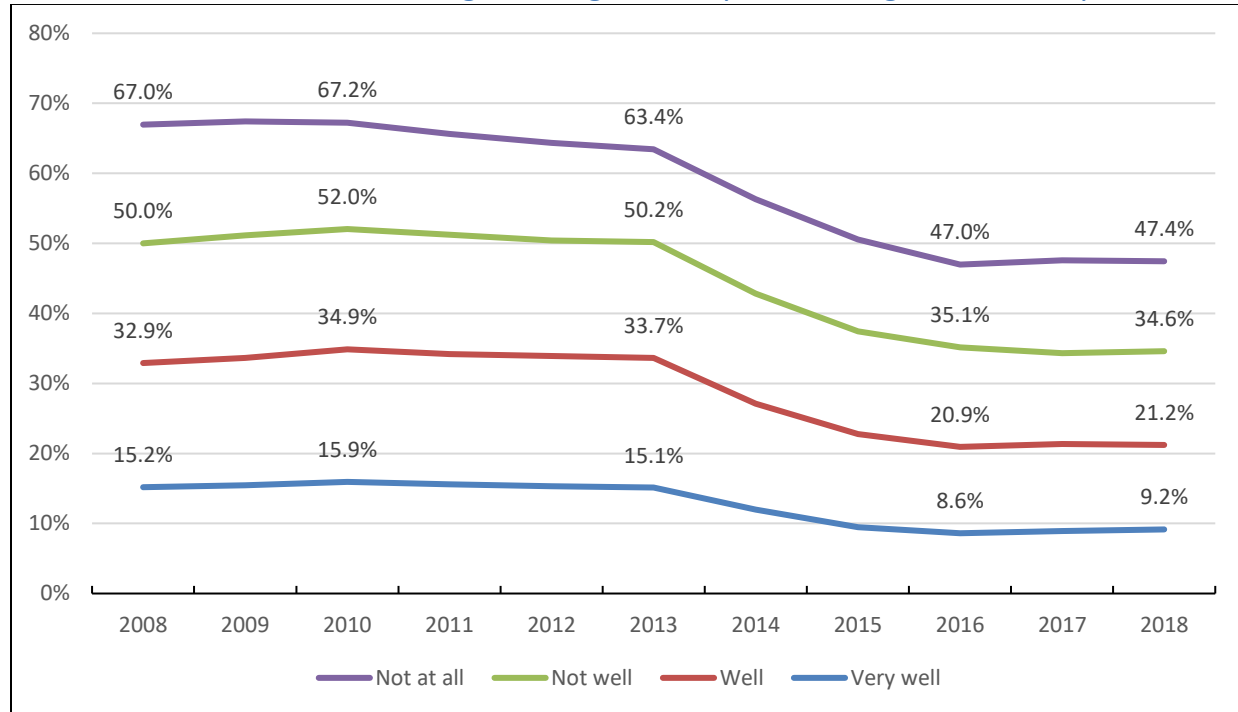
Source: Authors' analysis of American Community Survey data

Exhibit 7.2. Uninsured Rates Among Those Ages 5-64 by Level of English Proficiency and Income, 2013 and 2018
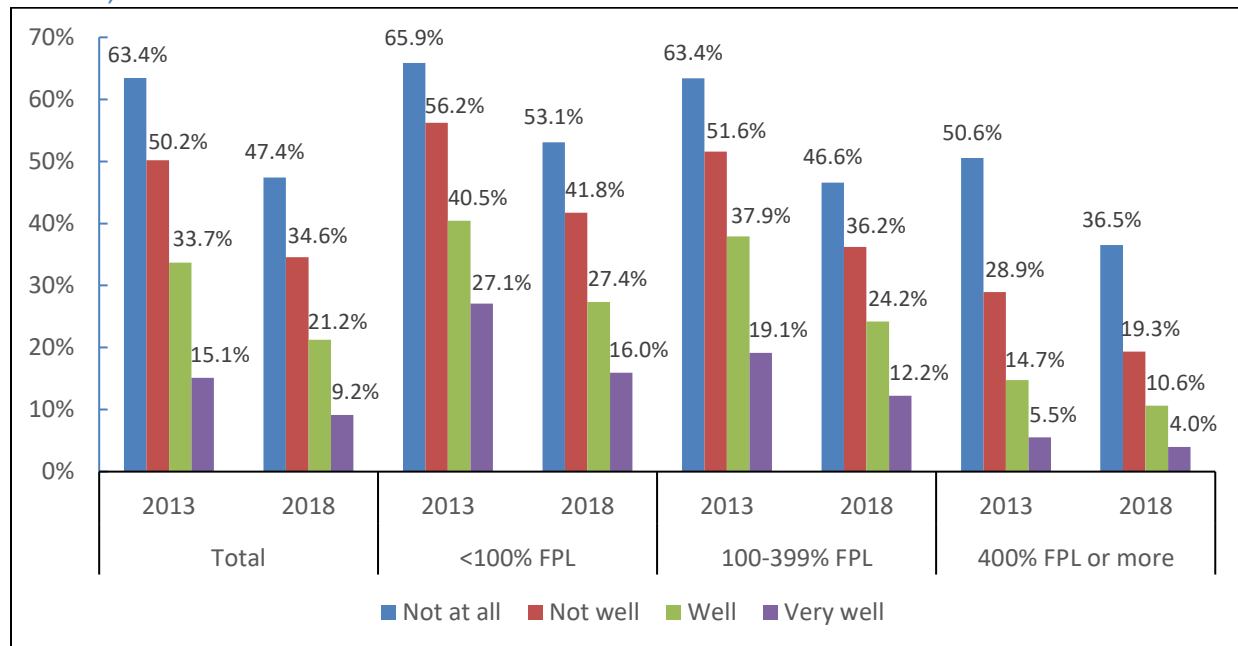
Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Individuals with incomes less than 100% FPL had the highest uninsured rates before the implementation of the ACA (Exhibit 7.2). The uninsured rates at every level of English profiency decreased after the ACA went into effect. By 2018, those with incomes less than 100% FPL continued to have the highest rate of uninsurance compared to other income groups, regardless of level of English proficiency. For example, even among those who speak English very well, those with incomes less than 100% FPL still had the highest uninsured rate (16.0%) compared to those whose incomes were 100%-399% FPL (12.2%) and those with incomes above 400% FPL (4.0%).

Exhibit 7.3. Uninsured Rates Among Those Ages 5-64 by Medicaid Expansion Status and Level of English Proficiency, 2013 and 2018
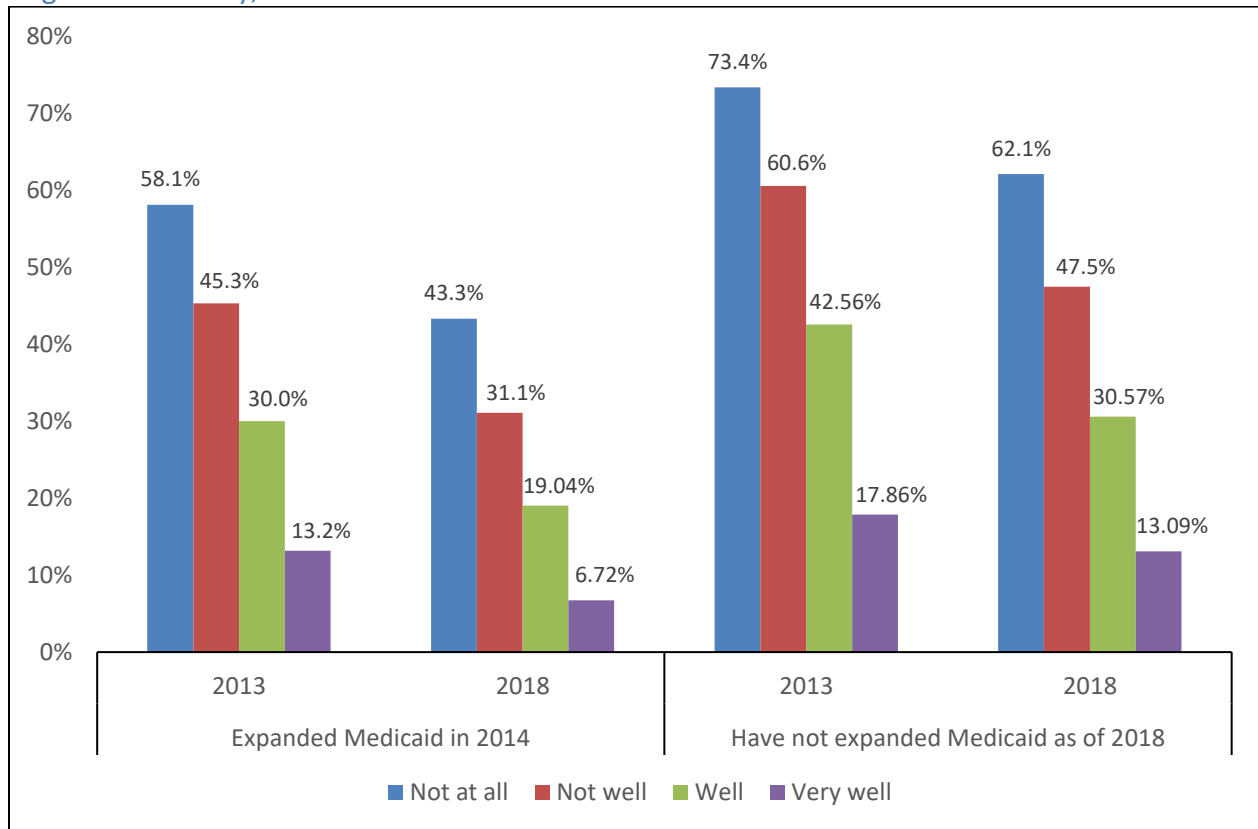
Source: Authors' analysis of American Community Survey data

Uninsured Rates Declined More in Expansion States Than Nonexpansion States for All Levels of English Proficiency

Individuals who live in expansion states had lower rates of uninsurance before and after the ACA was enacted than those who live in nonexpansion states, regardless of level of English proficiency (Exhibit 7.3). There were larger percentage point declines in uninsured rates in expansion states compared to nonexpansion states. In both expansion and nonexpansion states, the relative improvement in coverage was greater for individuals with higher levels of English proficiency, resulting in greater disparities based on language in 2018 than in 2013.

Conclusions

An individual's level of English proficiency impacts the ability to attain insurance. The ACA has made significant reductions in the rate of uninsurance at levels of English proficiency across income levels. However, disparities in health coverage by different levels of English proficiency persist, especially for individuals with incomes less than 100% FPL, and these disparities appear to have increased in relative terms under the ACA. English proficiency is linked to place of birth, race, and ethnicity. Lower levels of English proficiency may compound the challenge faced by foreign-born Latinos and Asians in obtaining health insurance.[4] Health care literacy is a challenge even for native speakers of English, much less for those for whom English is a second language. We need to understand better how policies in different states that offer information about health insurance in different languages may impact the levels of uninsurance experienced by those who do not speak English well.

---

[4] Perkins J. 2003. *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities.* Kaiser Commission on Medicaid and the Uninsured.

Chapter 8: Race/Ethnicity

Key Findings

- Uninsured rates decreased for all racial/ethnic groups, but Hispanics/Latinos and American Indians/Alaska Natives still have the highest uninsured rates.
- Among U.S. citizens, American Indians/Alaska Natives have a significantly higher uninsured rate than all other racial/ethnic groups.
- Noncitizen Hispanics/Latinos have higher uninsured rates than all other noncitizens, regardless of income.
- Differences in uninsured rates between racial/ethnic groups persist across all income groups, but disparities have diminished for some.
- Low-income individuals in expansion states had larger gains in coverage than those in nonexpansion states.

Prior to the implementation of the ACA's main coverage provisions in 2014, disparities among the different racial groups regarding insurance coverage were well documented.[1] The provisions of the ACA, including subsidized marketplace coverage and state Medicaid eligibility expansion, were designed to reduce these variations and expand health insurance coverage to more individuals.[2] A recent study that focused on population subgroups reported the elimination of disparities in coverage between whites and Asian Americans, Native Hawaiians, and Pacific Islanders under the ACA.[3] Other research comparing changes in insurance coverage among low-income, nonelderly adults found a widening of racial/ethnic disparities between Hispanics and whites and a non–statistically significant narrowing of disparities for blacks or African Americans and other races compared to whites.[4]

In this chapter, we discuss trends in the uninsured rates of different racial/ethnic groups and compare the differences in coverage based on all income levels, citizenship status, and state Medicaid expansion decisions before and after the ACA. Individuals were grouped into one of seven categories based on their self-reported race and ethnicity. All respondents who reported being of Hispanic, Latino, or Spanish origin were put into one group. The rest were categorized into one of the following groups: (1) white, (2) black or African American, (3) American Indian or Alaska Native, (4) Asian, (5) Native Hawaiian or Pacific Islander, or (6) other race.

---

[1] Courtemanche C, Marton J, Ukert B, Yelowitz A, Zapata D, Fazlul I. 2019. The Three-Year Impact of the Affordable Care Act on Disparities in Insurance Coverage. *Health Services Research* 54:307-316.

[2] Koh HK, Graham G, Glied SA. 2011. Reducing Racial and Ethnic Disparities: The Action Plan from the Department of Health and Human Services. *Health Affairs* 30(10):1822-1829.

[3] Park JJ, Humble S, Sommers BD, Colditz GA, Epstein AM, Koh HK. 2018. Health Insurance for Asian Americans, Native Hawaiians, and Pacific Islanders Under the Affordable Care Act. *JAMA Internal Medicine* 178(8):1128-1129.

[4] Yue D, Rasmussen PW, Ponce NA. 2018. Racial/Ethnic Differential Effects of Medicaid Expansion on Health Care Access. *Health Services Research* 53(5):3640-3656.

Individuals who indicated more than one race were placed into the "other race" category. We also examined the uninsured rates by racial/ethnic groups stratified by citizenship. We looked at both citizens (including those who were born in the U.S., U.S. territories, and abroad of American parent(s), as well as naturalized U.S. citizens) and noncitizens residing in the United States. Noncitizens include both documented and undocumented immigrants.

Uninsured Rates Decreased for All Racial/Ethnic Groups, but Hispanics/Latinos and American Indians/Alaska Natives Still Have the Highest Rates

Following the implementation of the ACA's main coverage provisions in 2014, the uninsured rate dropped for all racial/ethnic groups (Exhibit 8.1). However, Hispanics/Latinos and American Indians/Alaska Natives had higher uninsured rates both before and after the ACA. In 2013, American Indians/Alaska Natives had the highest rate of uninsurance at 30.3%, and the uninsured rate for Hispanics/Latinos was only slightly lower, at 29.8%. The third-highest uninsured rate in 2013 was among black or African American individuals (18.6%), but this was more than 10 percentage points lower than the uninsured rate among Hispanics/Latinos. By comparison, non-Hispanic whites had the lowest uninsured rate that year, at 12.2%.

Exhibit 8.1. Uninsured Rates Among Those Ages 0-64 by Race/Ethnicity, 2008-2018
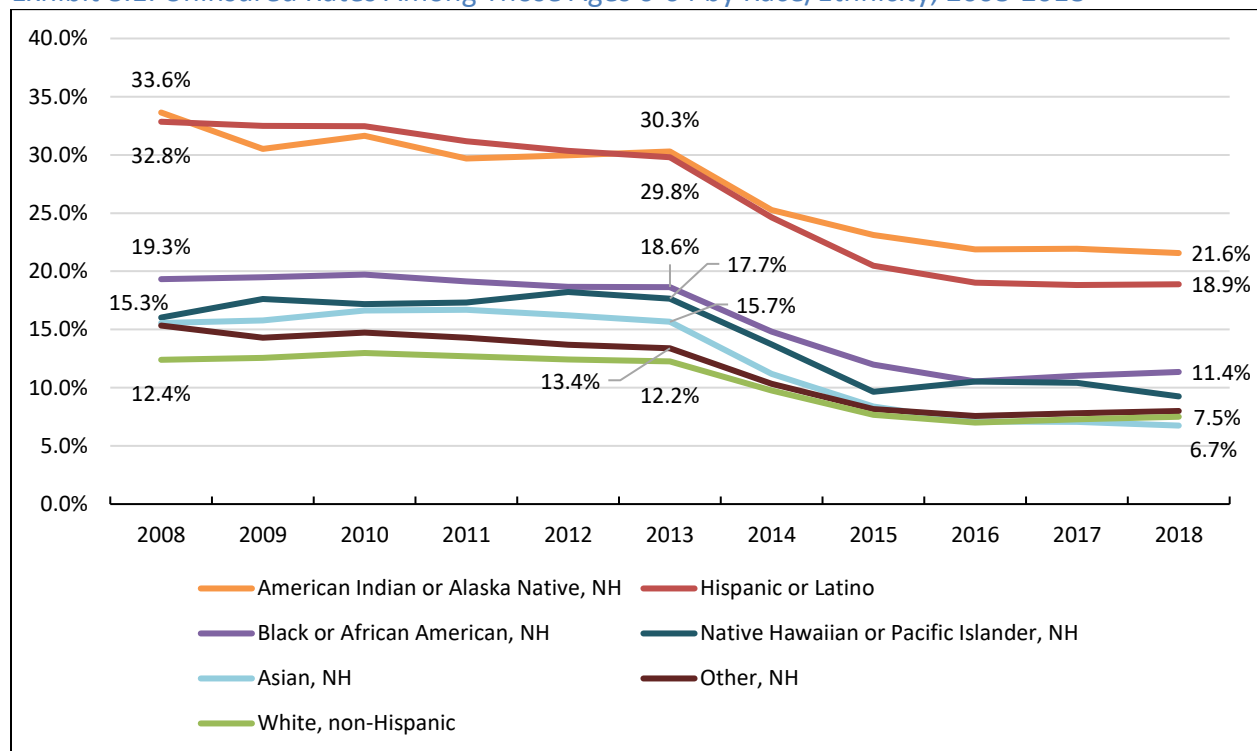
Note: NH = Non-Hispanic

Source: Authors' analysis of American Community Survey data

After the implementation of ACA, the uninsured rate for all racial/ethnic groups showed a substantial reduction. For example, the uninsured rates for Hispanics/Latinos and American Indians/Alaska Natives decreased by 10.9 and 8.7 percentage points, respectively, between 2013 and 2018. Asians also saw significant improvements in coverage after 2013, with a 9 percentage point reduction in uninsurance between 2013 and 2018. As a result, Asians displaced non-Hispanic whites as the group with the the lowest uninsurance rate. However, American Indians/Alaska Natives still had the highest uninsured rate and saw less of a gain than Hispanics/Latinos over that time period.

Among U.S. Citizens, American Indians/Alaska Natives Have a Significantly Higher Uninsured Rate Than All Other Groups

Looking specifically at U.S. citizens, the uninsured rate by racial/ethnic group followed a similar time trend to that seen among all U.S. residents. However, Hispanic/Latino citizens had a lower uninsured rate than the overall estimate both before and after the implementation of the ACA's main coverage provisions (Exhibit 8.2). While the overall uninsured rate for Hispanics/Latinos was 29.8% in 2013 and 18.9% in 2018 (Exhibit 8.1), it was lower among those who were citizens, at 19.5% in 2013 and 11.9% in 2018 (Exhibit 8.2).

Exhibit 8.2. Uninsured Rates Among Citizens Ages 0-64 by Race/Ethnicity, 2008-2018
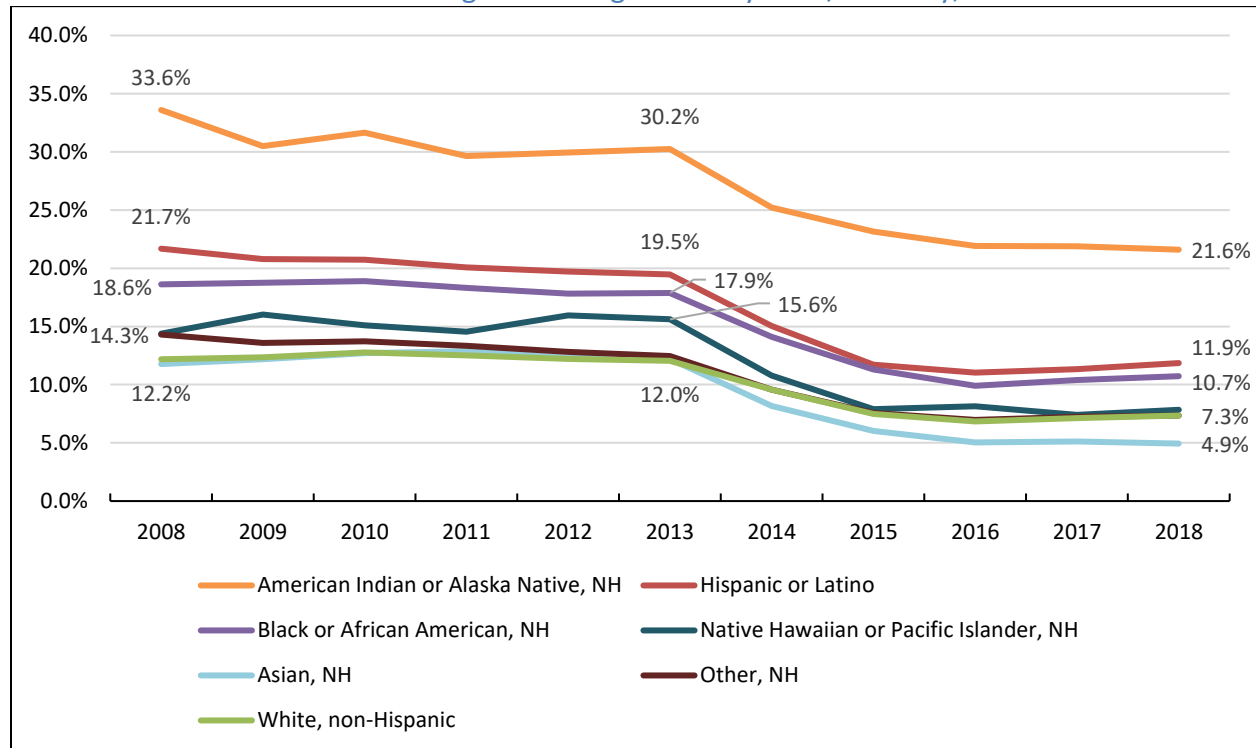
Note: NH = Non-Hispanic
Source: Authors' analysis of American Community Survey data

Citizens who identified as American Indian/Alaska Native continue to have the highest uninsured rate of any racial/ethnic group, across all years. The trend for other racial/ethnic

groups was similar to that seen in the overall analysis. Again, Asian citizens had a similar uninsured rate to white citizens prior to the implementation of the ACA, but they have had the lowest uninsured rate since 2013.

Noncitizen Hispanics/Latinos Have Higher Uninsured Rates Than All Other Noncitizens, Regardless of Income

Among noncitizens exclusively, Hispanics/Latinos had the highest uninsured rate both before and after the enactment of the ACA's main coverage provisions, regardless of income (Exhibit 8.3). For example, 70.3% of noncitizen Hispanics/Latinos with incomes below 100% FPL were uninsured in 2013 — an uninsured rate that was 32.4 percentage points higher than the rates for all other racial/ethnic groups combined.

By 2018, there were substantial reductions in the uninsured rates among all racial/ethnic groups and across all levels of income. However, noncitizen Hispanics/Latinos continued to be uninsured at a higher rate than all other racial/ethnic groups, at 27.0% versus 15.8%.

Exhibit 8.3. Uninsured Rates Among Noncitizens by Race/Ethnicity and Income, 2013 and 2018

Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Exhibit 8.4. Uninsured Rate Among Those Ages 0-64 by Race/Ethnicity and Income, 2013 and 2018

Total

2013
- American Indian or Alaska Native, NH: 30.3%
- Hispanic or Latino: 29.8%
- Black or African American, NH: 18.6%
- Native Hawaiian or Pacific Islander, NH: 17.7%
- Asian, NH: 15.7%
- Other, NH: 13.4%
- White, non-Hispanic: 12.2%

2018
- American Indian or Alaska Native, NH: 21.6%
- Hispanic or Latino: 18.9%
- Black or African American, NH: 11.4%
- Native Hawaiian or Pacific Islander, NH: 9.3%
- Asian, NH: 6.7%
- Other, NH: 8.0%
- White, non-Hispanic: 7.5%

<100% FPL

2013
- American Indian or Alaska Native, NH: 36.9%
- Hispanic or Latino: 34.7%
- Black or African American, NH: 23.4%
- Native Hawaiian or Pacific Islander, NH: 27.0%
- Asian, NH: 27.3%
- Other, NH: 18.6%
- White, non-Hispanic: 25.9%

2018
- American Indian or Alaska Native, NH: 24.7%
- Hispanic or Latino: 23.3%
- Black or African American, NH: 14.6%
- Native Hawaiian or Pacific Islander, NH: 13.6%
- Asian, NH: 14.6%
- Other, NH: 11.0%
- White, non-Hispanic: 15.2%

100-399% FPL

2013
- American Indian or Alaska Native, NH: 30.7%
- Hispanic or Latino: 33.0%
- Black or African American, NH: 20.0%
- Native Hawaiian or Pacific Islander, NH: 18.2%
- Asian, NH: 22.3%
- Other, NH: 16.0%
- White, non-Hispanic: 16.2%

2018
- American Indian or Alaska Native, NH: 23.3%
- Hispanic or Latino: 21.4%
- Black or African American, NH: 12.4%
- Native Hawaiian or Pacific Islander, NH: 10.0%
- Asian, NH: 9.6%
- Other, NH: 10.2%
- White, non-Hispanic: 10.5%

400% FPL or more

2013
- American Indian or Alaska Native, NH: 18.0%
- Hispanic or Latino: 12.4%
- Black or African American, NH: 9.0%
- Native Hawaiian or Pacific Islander, NH: 8.4%
- Asian, NH: 6.6%
- Other, NH: 6.4%
- White, non-Hispanic: 4.6%

2018
- American Indian or Alaska Native, NH: 13.8%
- Hispanic or Latino: 8.9%
- Black or African American, NH: 6.2%
- Native Hawaiian or Pacific Islander, NH: 5.4%
- Asian, NH: 3.1%
- Other, NH: 4.1%
- White, non-Hispanic: 3.4%

Legend:
- American Indian or Alaska Native, NH
- Hispanic or Latino
- Black or African American, NH
- Native Hawaiian or Pacific Islander, NH
- Asian, NH
- Other, NH
- White, non-Hispanic

Notes: FPL = federal poverty level. NH = Non-Hispanic
Source: Authors' analysis of American Community Survey data

Differences in Uninsured Rates Between Racial/Ethnic Groups Persist Across All Income Levels, But Disparities Have Diminished for Some

In 2018, substantial differences in uninsured rates between racial/ethnic groups remained across all income categories (Exhibit 8.4). Although there were improvements between 2013 and 2018 in their uninsured rates, American Indians/Alaska Natives had the highest rates of uninsurance in 2018 at all income levels, with Hispanics/Latinos reporting similarly high uninsured rates at all income levels. In contrast, non-Hispanic whites, Asians, African Americans, Native Hawaiian/Pacific Islanders, and other races/ethnicities had similar uninsured rates in 2018 after stratifying by income level. This finding indicates that at least some portion of the disparities in rates of uninsurance is attributable to income differences related to race/ethnicity.

Low-Income Individuals in Expansion States Had Larger Gains in Coverage Than Those in Nonexpansion States

In expansion states, American Indians/Alaska Natives had the highest rate of uninsurance in both 2013 and 2018, followed by Hispanics/Latinos (Exhibit 8.5). However, all racial/ethnic groups in these states experienced a significant reduction in their uninsured rates between 2013 and 2018. By comparison, the decline in the uninsured rate was less significant in nonexpansion states for all groups. In 2018, the coverage rates in nonexpansion states were similar to those seen in expansion states in 2013.

Exhibit 8.5. Uninsured Rates Among Those Ages 0-64 With Incomes Below 100% FPL, by Race/Ethnicity and Medicaid Expansion Status, 2013 and 2018
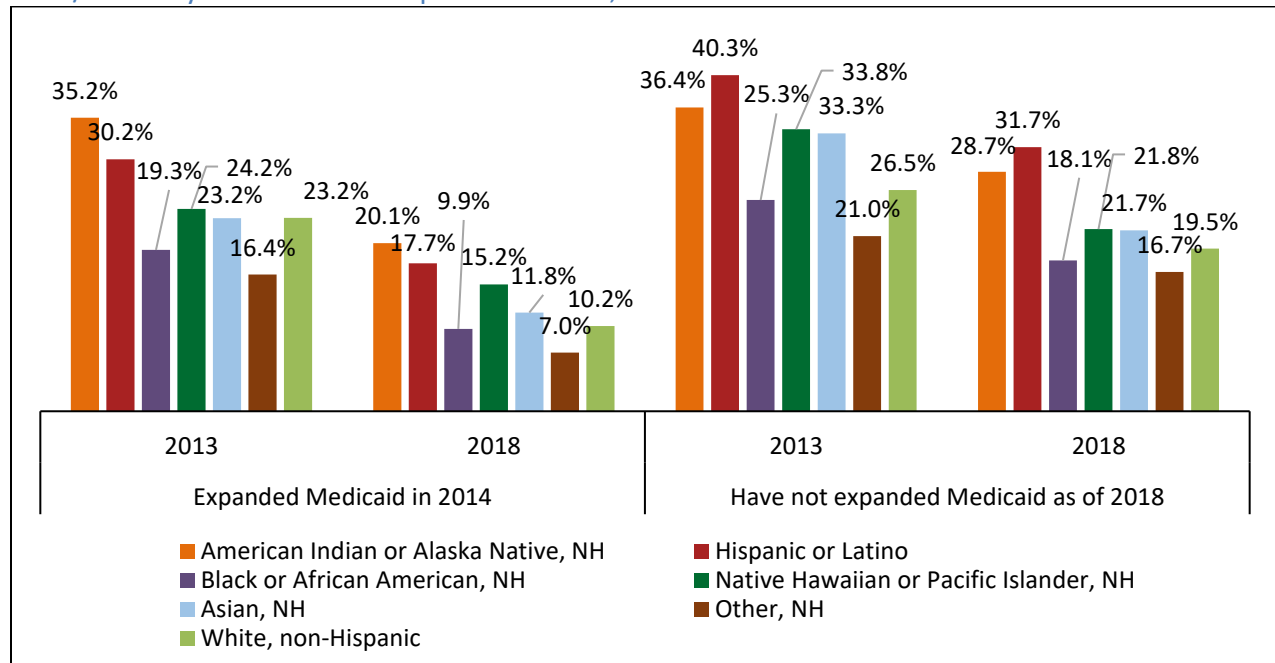
Note: FPL = federal poverty level. NH = Non-Hispanic
Source: Authors' analysis of American Community Survey data

Conclusions

Although the ACA has produced large gains in coverage, Hispanics/Latinos as well as American Indians/Alaska Natives continued to have the highest uninsured rates as of 2018, although this is somewhat mitigated for Hispanics/Latinos when looking only at U.S. citizens. Across all income levels, noncitizen Hispanics/Latinos have much higher rates of uninsurance than other racial groups, both prior to and following the implementation of the ACA's main coverage provisions. Our results indicate that disparities in health insurance coverage by different racial/ethnic groups persist, especially for American Indians/Alaska Natives, individuals with incomes less than 100% FPL, and noncitizen Hispanics/Latinos.

One interesting result is that as of 2018, white, Asian, and African American populations had very similar rates of uninsurance after controlling for level of income, and the differences between these groups have been reduced since 2013 under the ACA. Our findings suggest that the ACA has made considerable progress toward achieving one of its major goals: namely, to improve the equity of health insurance coverage regardless of income or racial/ethnic identity.

Chapter 9: Age

Key Findings

- Everyone under age 65 has lower rates of uninsurance, but 19-25-year-olds have improved the most.
- Low-income individuals of all ages had the most dramatic coverage gains yet continue to have the highest uninsurance rates.
- Low-income individuals in expansion states had greater gains in coverage and lower uninsured rates than those in nonexpansion states across all age groups.

One of the earliest and most popular provisions of the ACA was the dependent coverage expansion. Implemented in September 2010, the provision required all health insurance plans to allow young adults to stay on their parents' insurance until age 26, regardless of their living situation and their marital, student, or financial status.[1] Prior to the ACA, many insurers allowed young adults to stay on their parents' policies up to age 23 if they were financially dependent (e.g., in college or unemployed and living at home), but insurers were not required to offer this coverage. The ACA did not increase health insurance rates for seniors to the same degree that it did for the other age demographics, as virtually all individuals ages 65 and older are covered under Medicare. The ACA has benefited seniors by lowering the cost of prescription drugs, providing access to free preventive services, and combating Medicare fraud.[2] But the ACA was designed primarily to improve insurance coverage for those under age 65.

## Everyone Under Age 65 Had Lower Rates of Uninsurance, but 19-25-Year-Olds Improved the Most

In 2016, uninsured rates were at an all-time low for individuals of all ages. Since 2016, uninsurance rates have slightly increased for every age group, except for older adults (Exhibit 9.1). Individuals ages 19 to 25 have experienced the most dramatic coverage gains, with an 18 percentage point decrease in their uninsured rate from 2010 to 2018. Furthermore, coverage disparities by age have narrowed, especially for the 19-25-year-old age group: In 2009, those ages 19–25 had an uninsurance rate 6.4 percentage points higher than that of 26–34-year-olds; in 2018, the difference in uninsurance rates between these two age groups was 0.8 percentage points.

---

[1] Chen W. 2018. Young Adults' Selection and Use of Dependent Coverage Under the Affordable Care Act. *Frontiers in Public Health* (6):3.

[2] *How the Affordable Care Act Helps Seniors*. May 17, 2018. Medicare Policy Papers. Washington, D.C.: National Committee to Preserve Social Security and Medicare. Retrieved from https://www.ncpssm.org/documents/general-archives-2012/how-the-affordable-care-act-helps-seniors.

Exhibit 9.1. Uninsured Rates by Age Category, 2008-2018
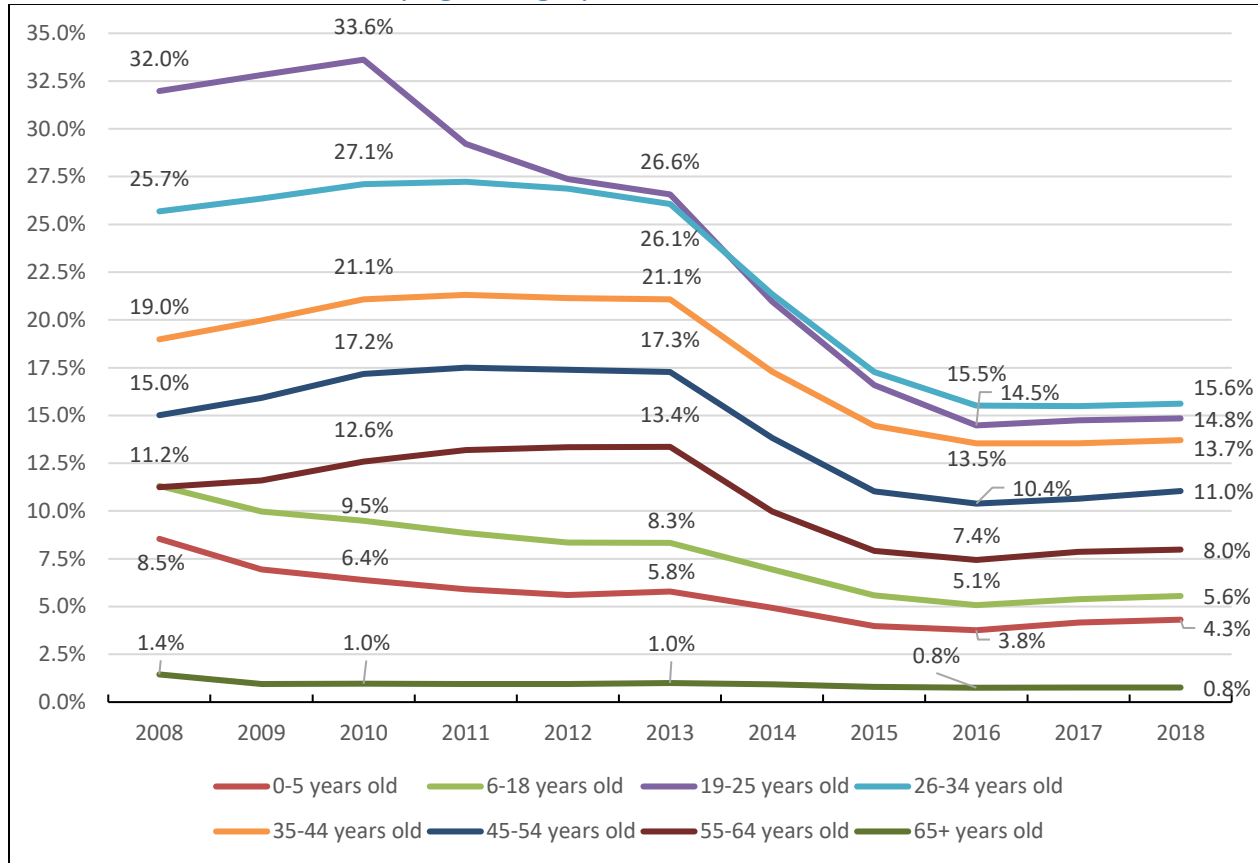
Note: FPL = federal poverty level
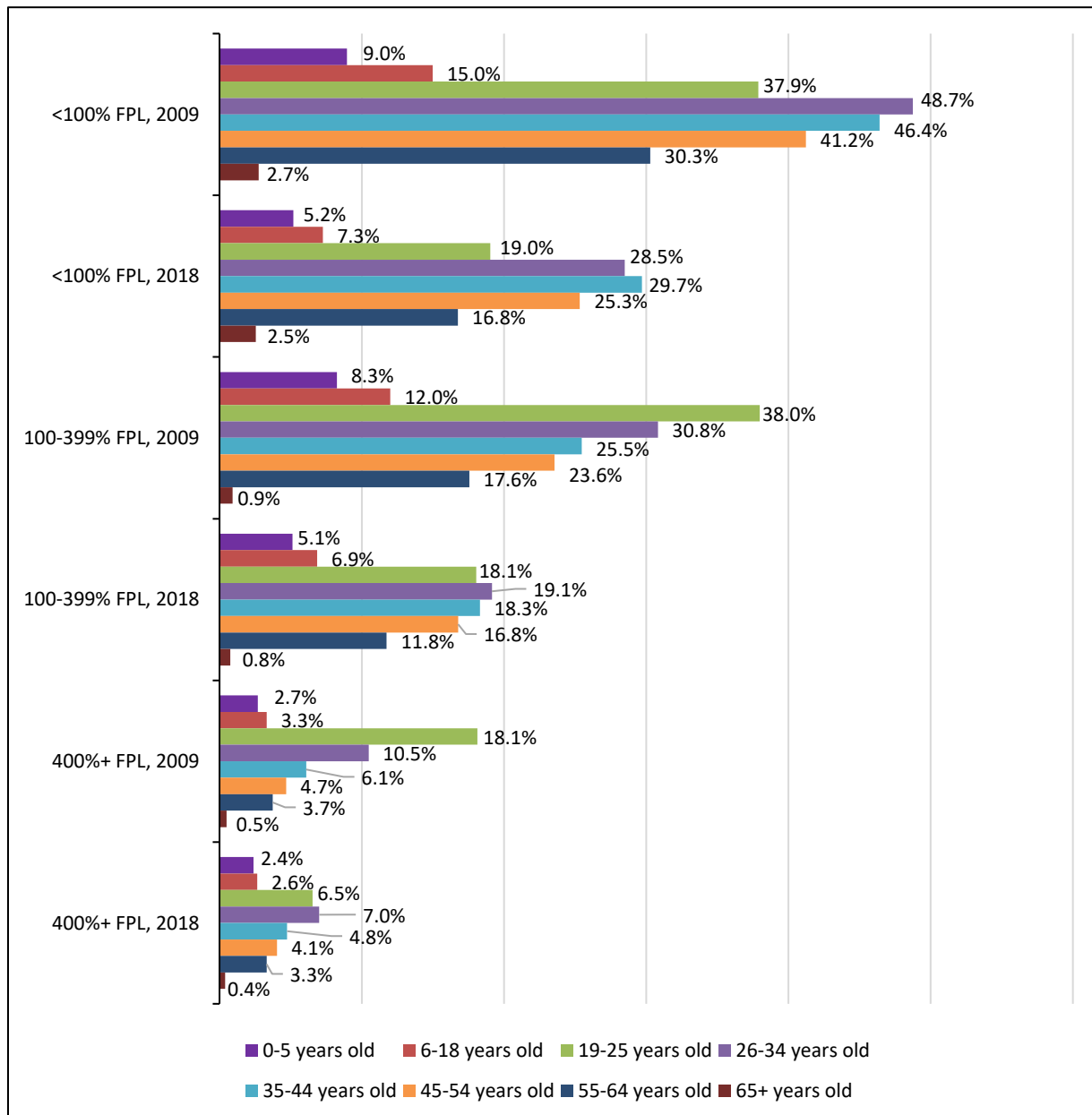Source: Authors' analysis of American Community Survey data

Low-Income Individuals of All Ages Had the Most Dramatic Coverage Gains, Yet They Continue To Have The Highest Uninsurance Rates

Despite major reductions in uninsured rates, age disparities in insurance coverage by socioeconomic status persist. Individuals with incomes less than 100% FPL have experienced the most dramatic gains in insurance coverage, yet they continue to have the highest rates of uninsurance. From 2009 to 2018, 26-34-year-olds with incomes less than 100% FPL had a 20.2 percentage point reduction in their uninsurance rates – the largest reduction of any age group across all income categories (Exhibit 9.2). Over the same time period, the highest reductions in uninsurance for those with incomes of 100%-300% FPL and 400% or more FPL were for 19-25-year-olds, who experienced uninsurance rate reductions of 19.9 percentage points and 11.6 percentage points, respectively.

Although individuals of lower socioeconomic status experienced substantially larger coverage gains, they continue to have the highest uninsurance rates. The highest uninsurance rate in 2018 for individuals with incomes below 100% FPL was 29.7% for 35-44-year-olds (Exhibit 9.2).

In the same year, the highest uninsurance rates for individuals with incomes of 100%-300% FPL and 400% FPL or above were 19.1% and 7.0%, respectively, for individuals ages 26-34 (Exhibit 9.2). There is a 22.7 percentage point difference in the highest uninsurance rates for individuals with incomes of 400% FPL and above and those with incomes of less than 100% FPL, indicating that coverage disparities by age and income still exist in the post-ACA period.

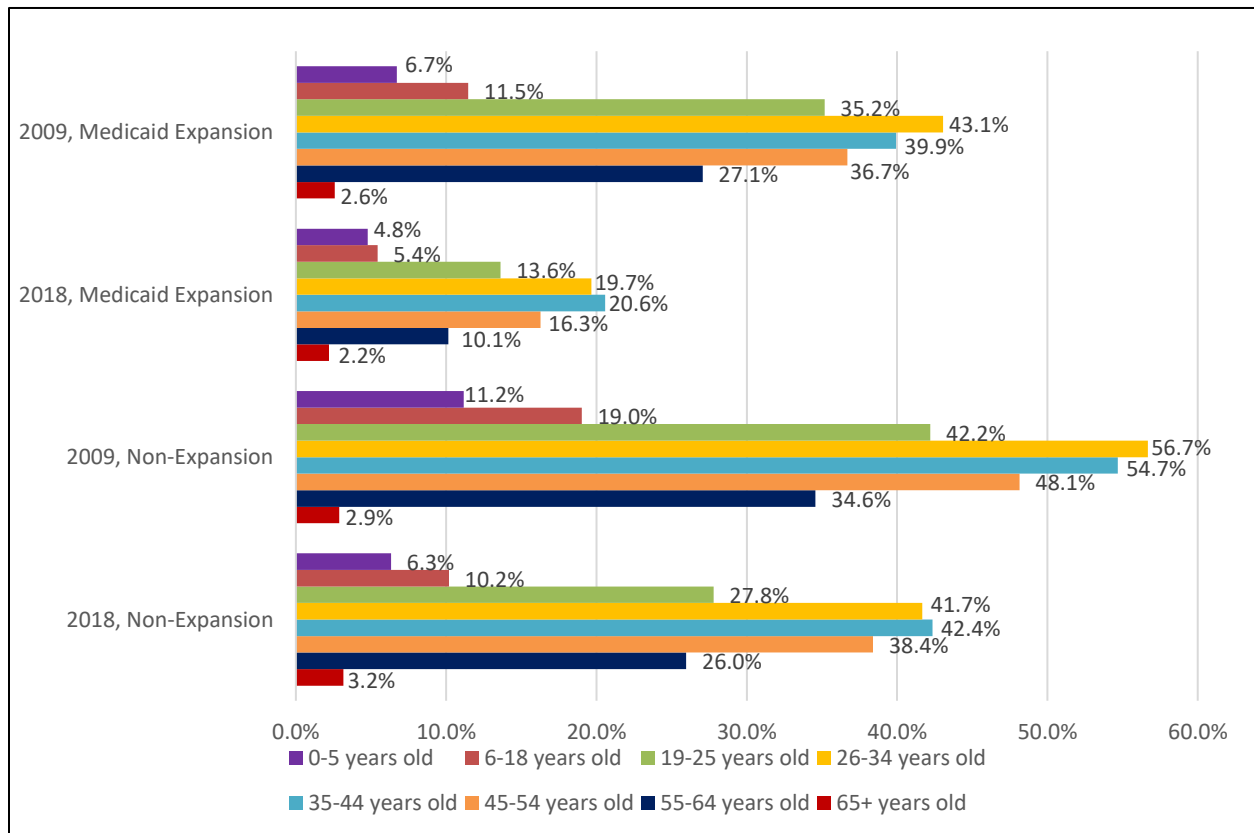## Exhibit 9.2. Uninsured Rates by Age and Income, 2009 and 2018

Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Low-Income Individuals in Expansion States Had Greater Gains in Coverage and Lower Uninsured Rates Than Those in Nonexpansion States Across All Age Groups

Low-income individuals in expansion states had greater gains in insurance coverage and lower rates of uninsurance compared to individuals in nonexpansion states between 2009 and 2018. In expansion states, the largest reduction in uninsurance was for 26-34-year-olds with incomes below 100% FPL; this group experienced a 23.4 percentage point reduction from 2009 to 2018 (Exhibit 9.3). In 2018, the highest uninsurance rate for individuals in expansion states was 20.6%, for those ages 35-44. In nonexpansion states, the largest reduction in uninsurance was 15.0 percentage points for individuals ages 26-34 with incomes below 100% FPL. The highest uninsurance rate in 2018 in nonexpansion states was 42.4% for those ages 35-44 with incomes below 100% FPL (Exhibit 9.3). Individuals with incomes below 100% FPL in expansion states experienced larger gains in coverage than individuals in nonexpansion states. Regardless of state expansion status, those with the lowest incomes still have the highest uninsurance rates.

Exhibit 9.3. Uninsured Rates for Individuals With Incomes Below 100% FPL, by Age and Medicaid Expansion Status, 2009 and 2018

Note: FPL = federal poverty level
Source: Authors' analysis of American Community Survey data

Conclusions

Our findings reveal that the ACA has substantially increased insurance coverage for individuals of all ages, with 19-25-year-olds experiencing the largest gains in coverage. However, uninsurance rates for those with incomes below 100% FPL continue to be drastically higher in comparison to those with higher incomes and to those in expansion states. Although the ACA has increased insurance rates for all individuals, disparities by age and income are still large.

Chapter 10: Type of Insurance

Key Findings

- Increased Medicaid enrollment has been primarily responsible for improved coverage among low- and middle-income individuals.
- High-income individuals have had lower rates of uninsurance and smaller improvements in coverage but larger reversals since 2016.

The ACA was clearly intended to reduce rates of uninsurance through increased enrollment in: (1) Medicaid, (2) newly established insurance exchanges within the individual insurance market, and (3) employment-sponsored insurance (ESI). In chapter 5, we analyzed the relationship between employment status and uninsurance rates. In this chapter, we analyze changes in the composition of insurance coverage and examine how the substantial reductions in rates of uninsurance since 2013 have changed the type of insurance coverage in which individuals are enrolled.

Low- and Middle-Income Individuals Gained Coverage Primarily Through Increased Enrollment in Medicaid

Medicaid enrollment among those ages 0-64 increased throughout most of the decade from 2008 to 2017, but showed a slight decline in 2018 (Exhibit 10.1). The ACA has clearly had an impact, although Medicaid enrollment increased substantially (from 13.9% to 18.4%) between 2008 and 2013, most likely due to ongoing impacts of the Great Recession. The individual insurance market also showed a large relative increase but small absolute increase in enrollment between 2013 and 2016 (6.2% to 8.2%), but declined to 7.3% in 2018. As indicated in the note below Exhibit 10.1, enrollment in the ESI market increased between 2013 and 2018, rising from 56.6% to 59.2%.

The type of insurance coverage held by individuals in the U.S. varies considerably based on income, as shown in Exhibits 10.2 and 10.3. For those with incomes below 100% FPL, Medicaid has long been the predominant type of coverage; it is even more prevalent under the ACA, increasing from 50.8% in 2013 to 58.5% in 2018 (Exhibit 10.2). The increased enrollments in Medicaid and (to a lesser extent) in ESI and the individual market have contributed to the substantial reduction in rates of uninsurance among those with the lowest incomes.

Exhibit 10.1. Type of Insurance Coverage for Individuals Ages 0-64, 2008-2018
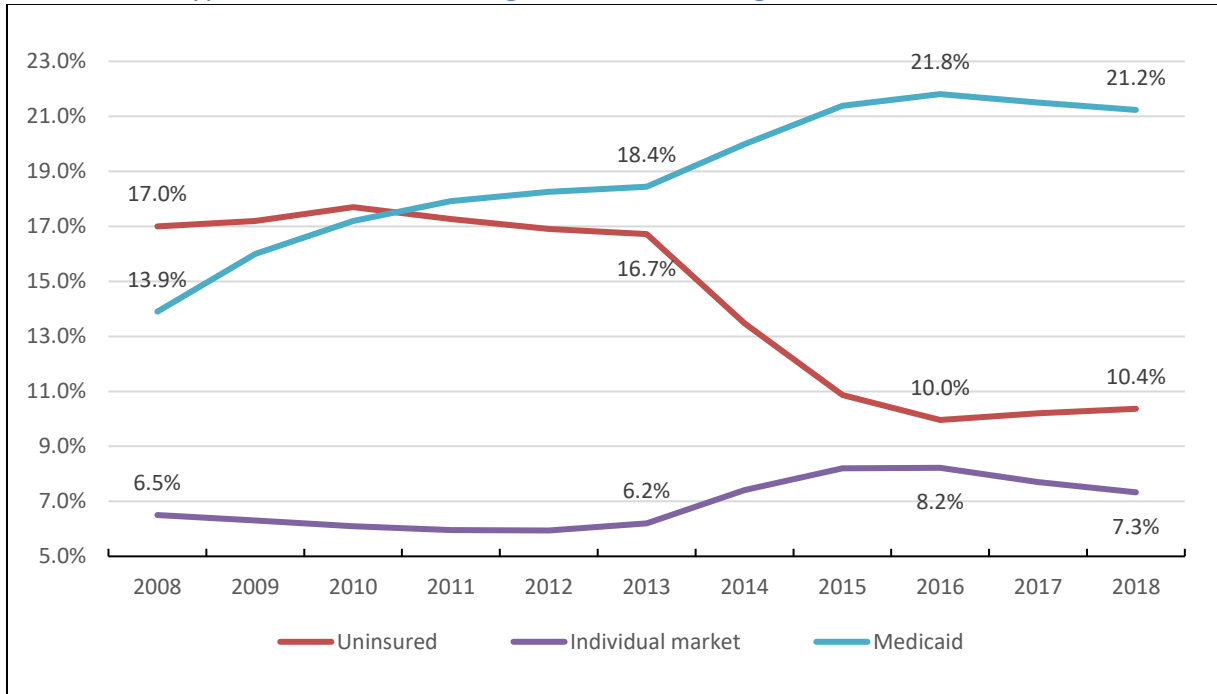
Notes: Employer-sponsored insurance (ESI) covered 60.9% of the 0-64 population in 2008, 56.6% in 2013, and 59.2% in 2018. These figures were excluded to prevent distortion of the exhibit's scale. Medicaid and Medicare enrollment are combined in this analysis, but Medicare enrollment was relatively constant during this period.
Source: Authors' analysis of American Community Survey data

Exhibit 10.2. Type of Insurance Coverage for Those Ages 0-64 With Incomes Below 100% FPL, 2008-2018
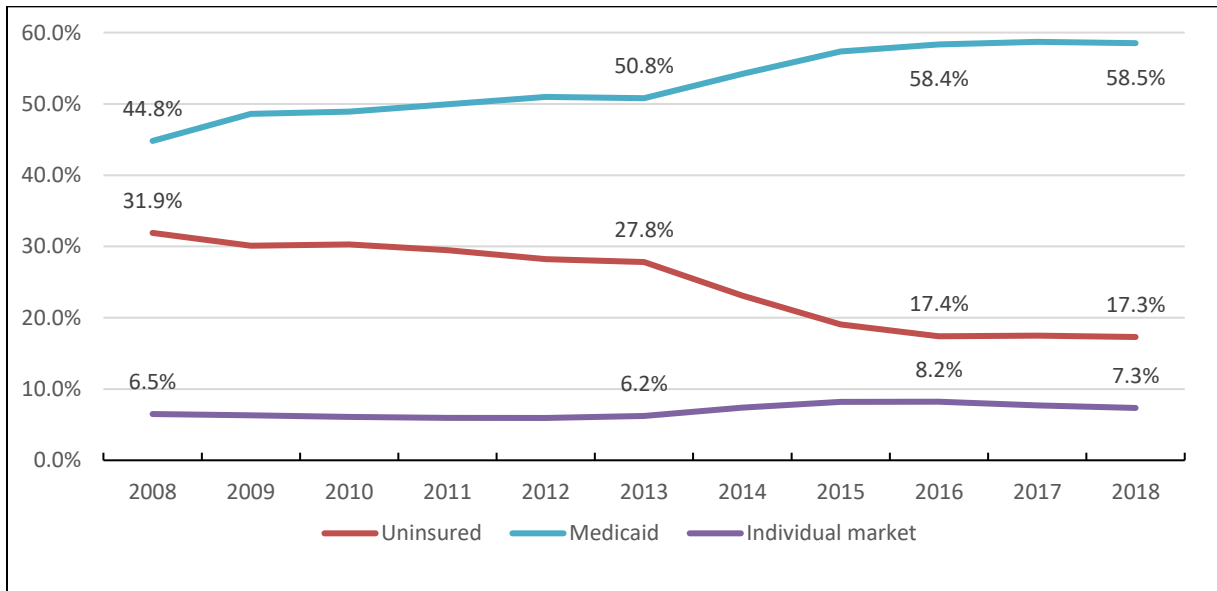
Notes: FPL = federal poverty level
Employer-sponsored insurance (ESI) covered 16.6% of the 0-64 population with incomes below 100% FPL in 2008, 15.3% in 2013, and 16.9% in 2018.
Source: Authors' analysis of American Community Survey data

For individuals with incomes of 100%-399% FPL, increased enrollment in Medicaid also played a major role in reducing their rates of uninsurance, along with increased enrollment in the individual market (Exhibit 10.3). This is somewhat surprising, because even in expansion states, Medicaid eligibility for newly eligible adults extends only up to 138% FPL. This income group also experienced reduced enrollment in the individual market and higher rates of uninsurance since 2016. In addition, as indicated in the note for Exhibit 10.3, this group experienced a slight overall decline in ESI between 2008 and 2018, decreasing from 55.8% to 51.9%.

Exhibit 10.3. Type of Insurance Coverage for Those Ages 0-64 With Incomes of 100%-399% FPL, 2008-2018
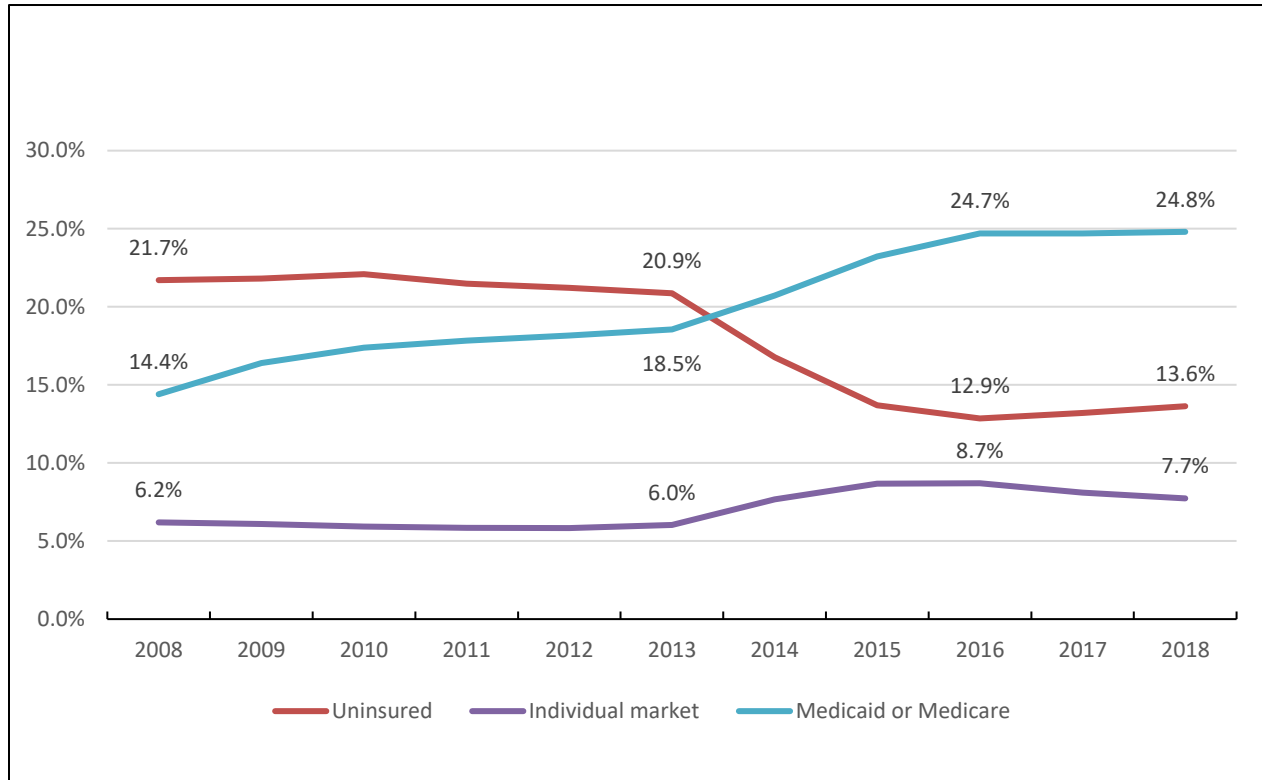
Notes: FPL = Federal poverty level
Employer-sponsored insurance (ESI) covered 55.8% of the 0-64 population with incomes of 100%-399% FPL in 2008, 52.4% in 2013, and 51.9% in 2018.
Source: Authors' analysis of American Community Survey data

Since 2008, ESI Has Remained Constant for Four out of Five High-Income Individuals

Although not shown here, our analysis of individuals with incomes of 400% FPL and above indicated remarkable stability during the period from 2008 to 2018. ESI is by far the most predominant form of insurance for this income group and has been essentially constant, ranging between 81.4% and 82.4% for this entire period. Enrollment in the individual market increased from 6.0% in 2013 to 8.7% in 2016, then declined to 7.7% in 2018. The rate of uninsurance for this income group declined from 5.9% in 2013 to 3.6% in 2016, but then rose to

4.3% in 2018. Clearly, the ACA — which was intended to target benefits to those below 400% FPL and to leave the ESI large-group market largely intact — has had minimal impact on the insurance coverage of those with higher incomes.

Conclusions

As intended, the ACA has substantially reduced rates of uninsurance through increased enrollment in state Medicaid, even in nonexpansion states, and — to a lesser extent — has increased enrollment in the individual insurance market. Of course, since our focus was solely on changes in enrollment rates, our study does not measure the financial benefit accruing to those who now receive subsidies to enroll in the individual market.

Overall, the ESI market remained relatively stable between 2008 and 2018. There are many potential explanations and offsetting trends that may account for this, including the ongoing recovery from the Great Recession and increasing minimum wage rates through the country, as well as requirements under the ACA for large employers to provide coverage for full-time employees or pay a tax penalty. What is clear, however, is that the ACA has not led to a significant displacement of ESI; the substantial growth in Medicaid enrollment and the growth in the individual market have not come at the expense of substantial reductions in ESI enrollment.

Finally, our analysis of differences in type of insurance coverage by income group reinforces the conclusion that there are persistent disparities in insurance coverage based primarily on income. Those with low incomes rely predominantly on public programs, those with high incomes rely almost exclusively on ESI, and those in the middle rely on both but are increasingly reliant on public programs.

UCLA CENTER FOR
HEALTH POLICY RESEARCH

Claremont
Graduate
University

The views expressed in this report
are those of the authors and do not
necessarily represent those of the
UCLA Center for Health Policy
Research, the Regents of the
University of California, or
collaborating organizations or funders.

The UCLA Center
for Health Policy Research
is affiliated with the
UCLA Fielding School of Public Health
and the UCLA School of Public Affairs.

Phone: 310-794-0909
Fax: 310-794-2686
Email: chpr@ucla.edu
www.healthpolicy.ucla.edu

UCLA Center for Health Policy Research | 10960 Wilshire Blvd. | Suite 1550 | Los Angeles, CA 90024 | t: 310.794.0909 | f: 310.794.2686 | healthpolicy@ucla.edu

www.healthpolicy.ucla.edu