To: Cheryl Strange, Secretary of the Washington State Department of Social and Health Services
From: Affordable Care Analysts (Brooks Bolsinger, Kelsey Figone, Basil Hariri)
Re: Health insurance coverage grows from 2009 to 2019
Date: 12 March, 2021

Executive Summary

Uninsured individuals tend to have worse health outcomes and inadvertently raise the cost of healthcare for everyone, as providers absorb the cost of their care (Institute, 2002). It is in the public interest to increase health insurance coverage rates to reduce these issues. This analysis examines several aspects of changes in health insurance coverage rates from 2009 to 2019. First and foremost, overall American health insurance coverage rates increased over the ten year period. These increases in coverage rates were shared by all racial groups; however, some racial groups saw larger growth than others. Additionally, states that implemented an expansion of Medicaid as part of the Affordable Care Act (ACA) prior to 2019 tended to see larger increases in coverage than those that did not. This analysis recommends further study to determine causality between the ACA's Medicaid expansion provision and coverage increases, more nuanced racial disaggregation, and subsequent policy intervention to capitalize on the successes of the past decade.

Introduction

The past ten years have seen numerous changes to the landscape of health insurance in the United States. The passage of the Affordable Care Act (ACA) in 2009 started numerous policy debates about how to effectively provide health insurance coverage to Americans.

While the ACA was built to provide a market-based system of universal access to health insurance to Americans, several parts of the bill - particularly the individual mandate - were politically controversial (White, 2010; Nikpay, 2020). After attempts to repeal the legislation entirely fell short in Congress, efforts to pass legislation rendering the individual mandate irrelevant, preventing Medicaid expansion, and limiting open enrollment were aimed at discouraging usage of the ACA. One of these efforts was realized by the Supreme Court in *National Federation of Independent Business v. Sebelius*, which ruled it optional for states to expand Medicaid coverage (Nikpay, 2020). This ruling meant that some individuals were too wealthy to be eligible for Medicaid, but not eligible for the ACA. Responses to those initiatives, in turn, led to attempts to ensure fidelity of the enrollment periods and marketplaces established by the ACA.

As a backdrop to the evolving nature of health insurance coverage in the United States, racial disparities in access to health care and health insurance are well documented, and have persisted over the past ten years (Williams 2000).

In light of the numerous changes in health care policy in the United States, this report aims to analyze how health insurance coverage rates have changed between the years of 2009-2019 by answering the following research questions:

- How has health insurance coverage increased or decreased in the decade between 2009 and 2019?
- Are any changes experienced differently between people of different races?

- Is there a correlation between Medicaid expansion as part of the ACA and changes in healthcare coverage rates?

This analysis examines changes to coverage rates overall, as well as for public and private insurance, between 2009 and 2019. In addition, it also analyzes how these changes impacted coverage rates based on race, and based on whether or not states chose to expand Medicaid in the aftermath of the ACA's enactment.

Data

In order to examine these questions, this analysis uses full American Community Survey (ACS) data from 2009 and 2019 downloaded from IPUMS USA. The ACS is an annual demographics survey conducted by the United States Census Bureau containing approximately 3 million observations in each year. The survey is modeled after the decennial census and includes several questions on health insurance coverage. Despite changes in health insurance coverage variables between years, IPUMS ensures the compatibility of the variables used in this analysis between different survey years. This report analyzed variables using the full sample size of approximately 6.2 million observations in Stata, a statistical software package.

Specific variables analyzed include 2009 and 2019:

- Binary variable for health insurance coverage of any type[1],
- State of residence
- Race

This analysis also disaggregated health insurance coverage by state-specific Medicaid expansion data from the Kaiser Family Foundation (2021). A binary variable was created to group states according to their expansion status, to examine if health insurance coverage changed more for states who expanded Medicaid prior to 2019. States that had adopted and implemented an expansion by 2019 were categorized as "Did adopt/implement Medicaid expansion." States categorized as "Did not adopt/implement Medicaid expansion" were those that (1) did not adopt Medicaid expansion, or (2) adopted the expansion but had not implemented it before 2019.

Analysis

Overall Health Insurance Coverage

Given the politicized nature of the national health insurance debate, the existing level of health insurance coverage was surprising. . In 2009, 87% of the ACS sample had health insurance coverage.[2] ACS data is intentionally nationally representative and, by extrapolating the proportion to the U.S. population at that time, approximately 267 million people out of 307M had health insurance coverage (The World Bank, 2019). In contrast, 92% of the 2019 ACS sample had health insurance coverage (see Figure 1).[3]

[1] Having coverage through the Indian Health Service is not considered "With health insurance coverage" under this or any of the variables, as such coverage is not always comprehensive.
[2] With standard error = .0001925
[3] With a standard error of .00015.

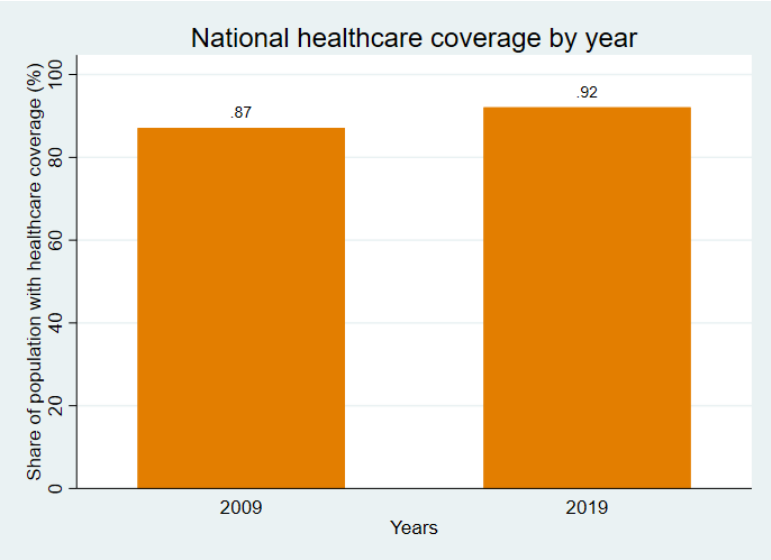

Figure 1

By extrapolating this proportion to the U.S. population in 2019, approximately 301.98 million people of 328.24 million people in the U.S. had coverage. This is an increase in 35.09 million people insured from 2009-2019, indicating that coverage increased faster than the rate of population growth (an increase in 21.47 million people over the same time period).

The analysis shows with high confidence that healthcare coverage rates increased by 4.98% from 2009 to 2019.[4] This is consistent with the trends of overall health insurance coverage year-by-year for the relevant time period, shown in Figure 2.

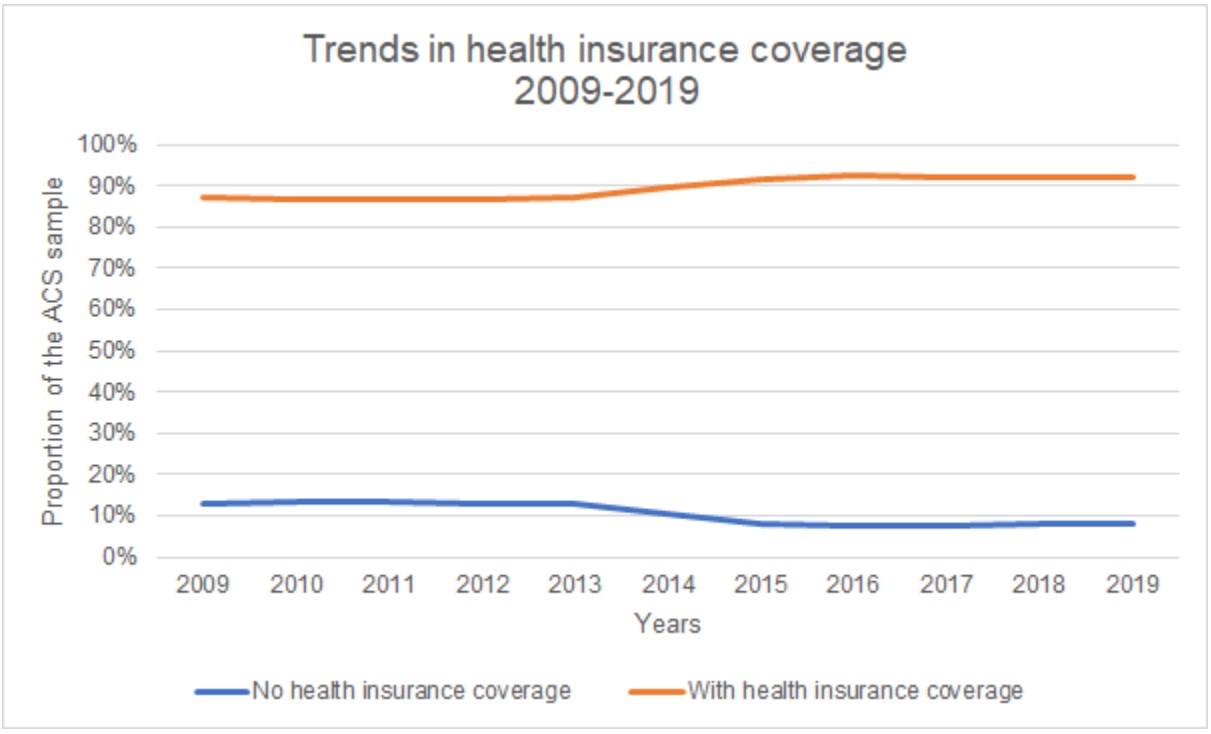

Figure 2

[4] P-value<.001 at a 1% significance level. All hypothesis tests conducted for this analysis used a 1% significance level, as all conclusions were found to be significant at that level due to the very large sample size.

Health Insurance Coverage Increases by Race

The increase in overall healthcare coverage noted above was shared by all races (as defined by the Census Bureau). This analysis shows that while every racial group experienced an increase in healthcare coverage, they did not increase in coverage at equal rates. From 2009 to 2019, 3.17% more Japanese Americans became fully covered, the smallest gains of any race (though perhaps less movement was possible for this racial group, considering they already had the highest coverage in 2009). White American coverage grew at a smaller than average pace as well, growing at just under 4.19%. In the same time period, 6.38% of Black Americans.[5] See Figure 3 for a broader look at how health insurance coverage changed by race.

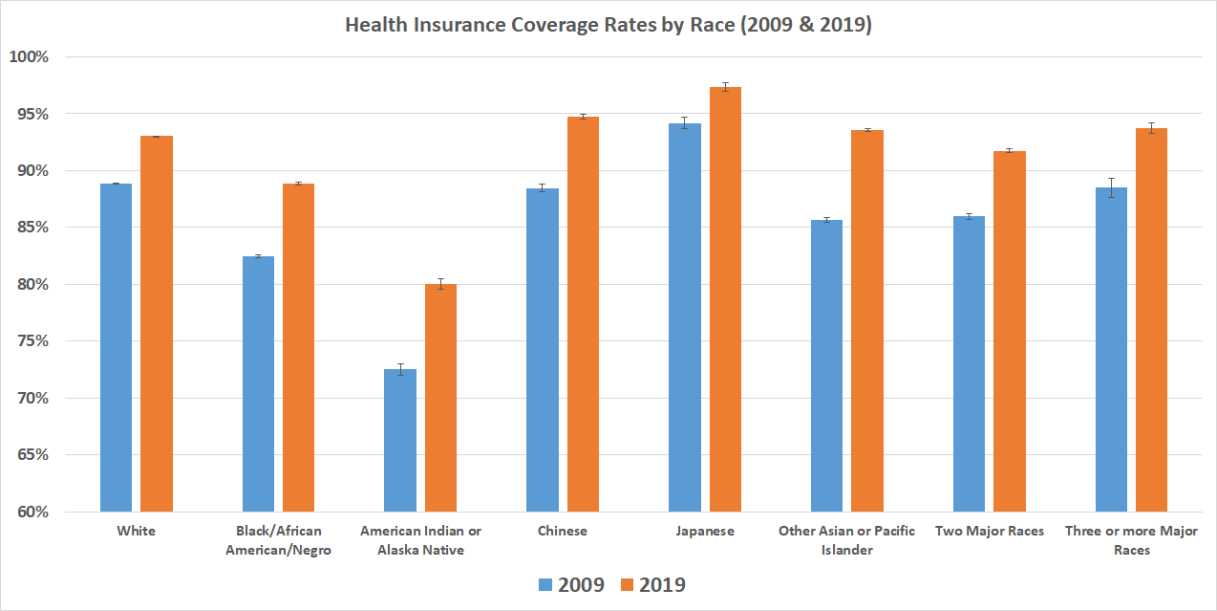

Figure 3

Health Insurance Coverage Increases by State Medicaid Expansion

This analysis examines the healthcare coverage rates of states that expanded Medicaid (i.e. adopted and implemented the expansion before 2019) and those that have not. While both sets of states increased coverage rates from 2009 to 2019, states that expanded Medicaid saw larger increases than those that did not. Coverage rates in states that expanded grew by 5.6% as opposed to 4% in states that did not expand.[6] While expanded Medicaid access could be the driver of the additional increase in coverage in these states, this analysis does not examine or prove a causal relationship between these variables.

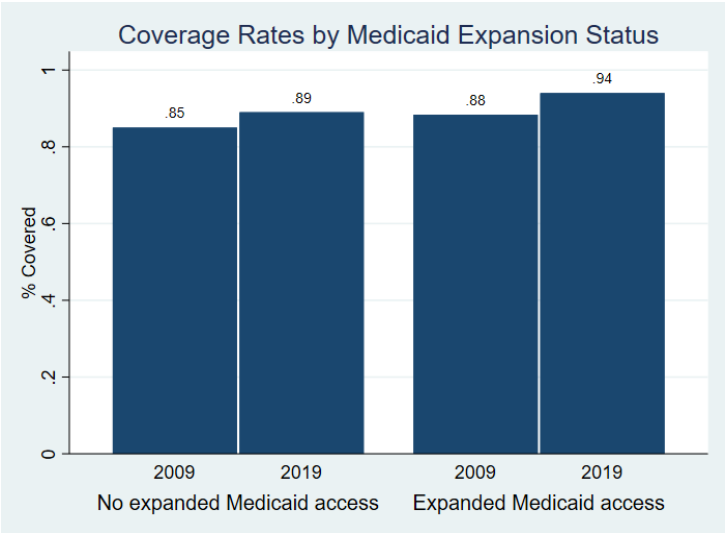

Figure 4

[5]Hypothesis testing of each racial group's coverage by year found with high confidence that these increases are significant, with p-values < .001

[6]There is strong evidence that these rates are significantly different, with $p < .001$

Limitations

There are several limitations to this analysis:

Causality

This analysis does not attempt to establish causality. The time period of 2009-2019 was chosen specifically because it bounds the passage, implementation, and subsequent adjustments to the Affordable Care Act. Nevertheless, attributing any of the observed changes to the Affordable Care Act is outside the scope of this analysis.

COVID-19 Pandemic

Policy implications of this analysis may also have limited application in the coming years. The COVID-19 pandemic is an enduring public health crisis that began in February 2020. It is too early to draw any conclusions with confidence, but it is likely that the pandemic will shape public opinion on health insurance coverage in some way. It is likely that the proportions of public and private health insurance coverage changed dramatically in 2020, as businesses contracted or closed and more people flocked to their state exchanges. Additionally, some states began implementing Medicaid expansion through the ACA in 2019 and 2020 (Kaiser Family Foundation, 2021). This expansion may have increased overall health insurance coverage; in contrast, the reduction of the individual mandate penalty to $0 in 2019 may have decreased overall health insurance coverage as some individuals lost coverage through their employers and potentially did not sign up for the public option.

American Indian and Alaska Natives

Indian Health Service (IHS) coverage is considered "No health insurance coverage" in the ACS. Therefore, the increase in coverage for American Indians and Alaska Natives may be underrepresented. More of these racial groups may have gained IHS between 2009 and 2019, and a type of IHS that could be constituted as full health insurance coverage, but that cannot be captured by ACS data.

"Other Race"

The "Other Race" category was excluded in the analysis of race. This is because the "Other Race" category is not consistently defined. Respondents self-select into this category, leading to uncertainty in the size and composition of this category between 2009 and 2019. When initially included in the analysis this category showed the greatest increase in coverage, likely as a result of uncertainty in the categorization.

Other variables for analysis

Disaggregating health insurance coverage along other demographic characteristics would be a fruitful addition to this analysis. For example, health insurance needs vary greatly by age. Further analysis might explore whether or not increasing age correlated with a greater increase in coverage over the ten-year period.

Policy Implications

Health care coverage has increased for Americans of all racial groups, but significant disparities still persist: Black and American Indian or Alaskan Native populations still have the lowest rates of coverage. These data suggest that the health insurance system in the United States is still inequitable, and policy makers should utilize this information to work towards improving

coverage rates among the most marginalized populations. One particular way Congress could work to improve this coverage gap would be to allocate funds for further policy research as to understand the reasons behind this disparity. Is this disparity due to lack of access to equitable health care? Are there financial barriers that continue to persist? Is there cultural skepticism towards the health care or health insurance system? Or are there other unknown factors that policy makers should be aware of when crafting more equitable insurance policies?

Overall increases in health insurance rates have also plateaued. While this plateau is at a high overall level, policy makers should continue to monitor future changes. Our analysis showed that while overall coverage can increase, it did not always increase uniformly by geography or race; policy makers should examine ways to strengthen existing policy and explore new legislation that can ensure the fidelity and reliability of the health insurance system.

In addition, while health insurance rates rose across all states regardless of Medicaid expansion, the states that enacted Medicaid expansion saw more substantial increases in coverage. Despite the absence of a defined causal relationship, policymakers should consider Medicaid expansion as a potential option to expand access to coverage if they believe it necessary.

Conclusion

Health insurance stands as one of the most widely debated issues in modern American society. This analysis showed that, from 2009 to 2019, American health insurance coverage rates increased both in general and for every racial group. It also found that states that expanded Medicaid as part of the Affordable Care Act saw larger increases in coverage than states that did not. Despite inferential limitations surrounding causality, the COVID-19 pandemic, and census racial categorizations, this analysis provides direction for future healthcare research and policymaking with respect to racial equity and Medicaid expansion.

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