Spring 2021

Affordable Care Act Insurance Coverage Gains in the Midwest: Evidence from the Dependent Coverage Provision

Sarah Herz
University of Northern Iowa

Recommended Citation

Affordable Care Act Insurance Coverage Gains in the Midwest: Evidence from the Dependent Coverage Provision

Sarah Herz

Abstract

This paper analyzes how the Affordable Care Act (ACA) Dependent Coverage Provision affected insurance coverage in the Midwestern region. The Dependent Coverage Provision allows individuals ages 19 to 25 to remain as dependents on parental health insurance plans. This provision was implemented to decrease the number of young adults who were uninsured. Using data from the American Community Survey spanning the years 2008-2013 and estimating difference-in-differences models, I test the impact of the policy implementation on health insurance coverage among a sample of Midwestern young adults. Under my preferred specification, which includes two-way fixed effects and controls for observable characteristics, I find that the policy led to a 5.63 percent increase in insurance coverage among young adults in the region. In an analysis of policy heterogeneity, I find that the Dependent Coverage Provision had the largest impact among Black males that were unemployed, a subgroup that likely had difficulty acquiring appropriate health insurance prior to the ACA. This study indicates that the Dependent Coverage Provision was effective in increasing the number of insured individuals.

1. Introduction

One of the goals of the Patient Protection and Affordable Care Act (ACA) was to increase the number of people with health insurance. To achieve this goal, the policy focuses on providing a wider range of affordable health insurance options. One of the major provisions of the ACA is the Dependent Coverage (aka Young Adult) Provision. This provision allows young adults to remain insured under parental health insurance plans until the age of 26. This includes all young adults regardless of health status, gender, race, marital status, etc. The provision includes individuals who no longer live with their parents, are not identified as a dependent on tax returns, or are not attending college/trade school. Before this provision, young adults who were not furthering their education were no longer eligible to remain under their parents' health insurance once they turned 19.

The ACA was signed into law in March of 2010, and the Young Adult Provision was implemented by September 23, 2010. According to the Centers for Medicare & Medicaid Services, many major insurance companies committed to implementation before this date, so spring graduates would not have a gap in coverage. Earlier studies have found that the Young Adult Provision was successful in decreasing the number of uninsured young adults in the U.S., but no prior study has focused primarily on the Midwestern region. It is important to study Midwestern families due to the large role that agriculture plays in their economy. Rosenbaum and Shin (2005, 1) and Zheng and Zimmer (2008, 268) each find that farmworkers are overwhelmingly more likely to be uninsured when compared to individuals working in other sectors. Studies from the Urban Institute find that workers in the agricultural industry are among the least likely to have health insurance (Garrett et al. 2001, 5). Hence, due to a heavy focus on agriculture within rural parts of the region, it is plausible that young adults in the Midwest are more at risk to be uninsured than those in other regions of the U.S.

In this paper, I test whether the ACA Dependent Coverage Provision led to insurance coverage gains among young adults in the Midwestern region. To answer this question, I rely on an identification strategy that compares pre- and post-policy insurance coverage among a treatment group (ages 23-25) to that of a control group (ages 28-30). To examine the effects of the policy on health insurance coverage, I use annual data from the 2008-2013 waves of the American Community Survey (ACS) and estimate difference-in-differences models that include both state and year fixed effects as well as other covariates. The results show that the ACA policy led to a 4.27 percentage point increase in insurance coverage among Midwestern young adults. Finally, in an analysis of heterogeneous policy effects, I find that the policy had the largest positive impact among Black males who were unemployed, a subgroup that likely struggled to find health insurance coverage prior to the ACA. These results suggest that the Dependent Coverage Provision was effective in increasing the number of young adults who have health insurance in the Midwest.

2. Literature Review

There are several papers examining how the ACA affected the U.S. population. According to Jung and Shrestha (2018), the ACA had an impact on college enrollment. Using data from the Survey of Income and Program Participation (SIPP), the authors find that the ACA Dependent Coverage Provision led to a 3-percentage point decline in college enrollment (53). Bailey and Chorniy (2016) study the impact of the ACA Dependent Coverage Provision on job-lock, a phenomenon in which individuals stay at a particular employer for health insurance reasons. They find no evidence that the ACA provision led to

increased labor market mobility, which is an indication that job-lock is not a major concern among young adults (620-621).

Other studies of the ACA Dependent Coverage Provision have found that the policy led to increases in insurance coverage as well as labor market disincentives. Both Akosa Antiwi et al. (2013) and Lenhart and Shrestha (2016) find that the Dependent Coverage Provision led to increases in insurance coverage among young adults, as well as subsequent decreases in labor supply in the ages 19 to 25. By becoming eligible to remain on parental health insurance plans, young adults could decide to either exit the labor market entirely or move from full-time to part-time employment because they no longer needed full-time employment to qualify for health insurance. Interestingly, utilizing time-use data, Lenhart and Shrestha (2017) find evidence that young adults worked less and watched television more following the ACA policy. Akosa Antiwi et al. (2013) find a sharp increase in the number of young adults insured and that young adults became less likely to work full-time following the ACA policy (15, 24).

Garrett and Gangopadhyaya (2016, 3) used data from the American Community Survey to examine the ACA's effectiveness by geographic location. Their results indicated that the ACA did decrease the number of uninsured individuals between 2010 and 2015. Specifically, their analysis shows that the ACA increased the number of insured individuals by an average of 3.46% from 2010 to 2015 in the Midwestern region (Iowa, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota) (Garrett and Gangopadhyaya, 2016, 8-9). Cantor et al. (2012) find further evidence of national-level health insurance coverage gains among young adults following passage of the ACA. Sommers et al. (2012) examine the effects of the Dependent Coverage Provision on insurance coverage using a treatment group of 19- to 25-year-olds and a control group of 26- to 30-year-old. (Sommers et al. 2012, 166). They found similar trends amongst both groups prior to the implementation of the policy (2005 to 2010) (168). They also found that the likelihood that a person had health insurance increased throughout each quarter in 2011 (implementation year) for the treatment group (169).

3. Data

This study uses publicly available data from the American Community Survey (ACS), an ongoing survey conducted yearly that collects information on the United States and its residents. The ACS data is ideal for this study because it contains information on whether individuals have health insurance, what age people became insured, what type of insurance they have, and multiple other demographic controls. As well as this, the ACS is appealing due to its large sample size, surveying approximately 3 million people per year (0.9% percent

of the U.S. population) (Lowe 2010, 2). The survey has been ongoing since 2005 and includes all states, American Indian reservations, Alaska Native villages, Hawaiian homelands in the U.S and Puerto Rico. About 250,000 household receive the paper survey through the mail each month.

The ACS data used in this study is obtained from the one-year Public Use Microdata Sample (PUMS). This study includes survey years 2008 to 2013, which covers a time before, during, and after implementation of the Dependent Coverage Provision. Given that the focus of this study is on insurance coverage in the Midwestern region of the U.S., the states included in the analysis are Iowa, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. Because the Young Adult Provision affects individuals ages 19 to 25, I restrict the data to include two age groups of people: 23-25 and 28-30. Individuals ages 23-25 are defined as the treatment group, e.g., individuals directly influenced by the policy, while the relatively older age group (ages 28-30) are defined as the control group. This treatment and control group definition exactly follows Abramowitz (2016) and is very similar to other papers studying the ACA Dependent Coverage Provision (Akosa Antiwi et al., 2013; Lenhart and Shrestha, 2017). The exclusion of people 26 to 27 years-old is to avoid any overlap from the policy implementation. I follow Abramowitz (2016) in the exclusion of those ages 26 to 27:

> The inclusion of these individuals might bias the results toward finding a negative effect of the provision on marriage rates if individuals delay marriage from the affected ages to older ages (Abramowitz 2016, 941).

Although marriage is not included as a variable in this model, it could play a factor in why someone might have insurance (married for health insurance prior to Dependent Coverage Provision). The treatment and control group definitions described above leave the analysis sample with 33,799 observations in the treatment group and 36,329 observations in the control group.

The analysis (discussed in greater detail in Section 4) controls for observable characteristics at both the individual and state levels such as age, gender (either Male or Female), race (either Black, White, or Other Race), education level (either Some College or High School Degree or Less), current college enrollment (either Currently Enrolled or Not Enrolled), employment status (either Employed, Unemployed, or Not in the Labor Force), and state-level unemployment rates.

Table 1 presents summary statistics of the data included in this study. The proportion with insurance coverage in the treatment group increased from 0.759 to 0.780 after the Young Adult Provision was implemented in 2010, while insurance coverage among the control group fell from 0.822 to 0.802. The proportion of males to females in the study are similar in both groups (0.510 vs 0.504). As expected, the control group is slightly older (on average) than the

treatment group. Individuals in the treatment group are slightly more likely to be Black or of another race, while those in the control group are more likely to be White. Overall, there is a much larger proportion of white individuals than Black individuals or those included in the other race category across both age groups. The Midwest is predominantly white, so this observation is not surprising.

Despite the significant age differences, the proportion of individuals having some college education is quite comparable across the two groups. This is a reflection that most often individuals make their college attendance decisions quite early in life (upon high school graduation), and there is only a small fraction of people who are non-traditional students enrolling in college at a later time. It is also not surprising that a higher percentage of the treatment group was currently enrolled in college than the control group. The treatment group includes younger individuals who are significantly more likely to still be continuing their education compared to the relatively older age range. The treatment group also has more individuals either unemployed or not in the labor force than the control group. This could also be explained by more individuals attending school, i.e., not actively looking for work, or natural unemployment that may occur during one's transition from college into the labor force. The control group has a higher proportion of employed individuals than the treatment group as this group is older and has had more time to find stable jobs.

Figure 1 displays the proportion of individuals with insurance coverage across time in both the treatment and control groups. Prior to the policy change in 2010, there is a noticeable gap between treatment and control groups regarding the likelihood of having health insurance. This is a reflection that prior to the ACA, young adults were an at-risk group to go without health insurance. Following the policy in 2010, there is a spike in insurance coverage among individuals in the treatment group between 2010 and 2011. Given that the young adult provision was not signed into law until May 10, 2010, and policy implementation did not take place until September 23, 2010, it is reasonable to expect policy effects to become noticeable in the years after the 2010 survey wave. From the figure, the control group appears to be unaffected by the change in policy; however, by 2014, the control group also exhibited gains in insurance coverage. This is likely due to other pillars of the ACA, i.e., the individual mandate, Medicaid expansion, etc. In the figure, the data is extended to include survey waves 2008-2018 to demonstrate how this policy was persistent into later periods, while the analysis to follow only includes the 2008-2013 survey waves.

4. Method

As mentioned previously, the data is separated into a treatment group (ages 23-25) and a control group (ages 28-30) to estimate how the Affordable Care Act Young Adult Provision affected insurance coverage in the Midwestern region. The descriptive statistics from Table 1 and Figure 1 imply that insurance coverage gains were observed among young adults in the Midwestern region. These results are merely descriptive and neither condition on observable characteristics of the sample nor control for unobservable characteristics.

To more formally test the impact of the ACA dependent coverage provision on insurance coverage in the Midwest, I estimate a difference-in-difference model. A difference-in-difference model is a common way to examine policy changes. Specifically, the model examines how a policy change impacts a treatment group. Much of this analysis is based on the identification strategy used in Abramowitz (2016). She uses data from the American Community Survey to examine how marriage rates were affected after the implementation of the Dependent Coverage Provision (Abramowitz 2016, 938). She uses a treatment group of individuals who were 23 to 25 years old (940). Her control group contained individuals who were 28 to 30 years old. In this case, the policy change was the Dependent Coverage Provision, and the treatment group is modeled like Abramowitz (2016), including individuals ages 23 to 25 years old. This model is denoted by Equation (1):

$$Y_{ist} = \beta_0 + \beta_1 Treat_i + \beta_2 X_{ist} + \delta_t Post_t * Treat_i + \lambda_1 Year_t + \lambda_2 State_s + \varepsilon_{ist}, \quad (1)$$

where $Post_t$ is an indicator for the post policy period (after 2009) and $Treat_i$ is an indicator equal to one if individual i falls into the treatment age bracket (23-25) and zero otherwise. This is similar to Hampton and Otto (2019) where they examine how Medicaid expansion impacted marriage. In the specification above, δ_t captures the intent-to-treat effect of the policy on insurance coverage. Variables age, gender, race, education, employment status, and state-level unemployment rates are controlled for by x_{ist}. To mitigate concerns of unobservable characteristics either across states or time, the model includes state and year fixed effects, denoted by $State_s$ and $Year_t$, respectively. Each model is estimated via ordinary least squares regression, with robust standard errors clustered at the state level.

5. Results

Table 2 shows estimates for the main difference-in-difference model outlined by Equation (1). Column 1 reports the results from a model that controls for state and year fixed effects only, while the results reported in Columns 2 and 3 include additional controls and state-specific linear time trends, respectively. The preferred specification is that of Column 2, which controls for state and year fixed effects and additional covariates (age, gender, race, education, employment status, and state-level unemployment rates). The coefficient of interest (δ_t) is found to be significant at the 1-percent level ($p < 0.01$) with an estimated magnitude of 0.0427, meaning that insurance coverage among Midwestern young adults increased by 4.27 percentage points after the policy was enacted. The estimated effect is robust to the inclusion and exclusion of additional controls, and Column 3 shows the robustness of the effect to the inclusion of state-specific linear time trends.

To describe the impact of other control variables on insurance coverage from column 2, age was found significant at the 5-percent level, and it has a positive coefficient of 0.043. Older individuals are more likely to have a full-time job that provides benefits, such as health insurance coverage, than young adults. Older individuals have also had more time to become married. Marriage provides many individuals an opportunity to gain health insurance through their spouses' employer-sponsored health insurance plans. Males are 5 percentage points less likely to have health insurance than females (omitted category) in this dataset. This is in line with earlier work by the Kaiser Family Foundation, who find that women are less likely than men to be uninsured. According to the Kaiser Family Foundation, women are more likely than men to qualify for Medicaid services and that is why more women are insured. Women, on average, have lower incomes and could be pregnant, which helps them qualify. Individuals who are Black are 10.75 percentage points less likely to have health insurance than whites (omitted category), and those who identify with the other race category are 11.57 percentage points less likely than whites. This is unsurprising because these racial groups are more at risk to be uninsured and were a main target group of the ACA as a whole. Individuals who had some college were 17.43 percentage points more likely to be insured than those without any college (omitted category). Those who have some college are, on average, more likely to obtain jobs with higher pay or other fringe benefits (such as health insurance coverage).

Employed individuals were 11.31 percentage points more likely to be insured than those who are not in the labor force (omitted category). Employer coverage is the driving factor behind this. Unemployed individuals were 9.92 percentage points less likely than those not in the labor force to have health insurance. Unemployed individuals are less likely to have the means to afford private health insurance and do not have the opportunity to be covered by an employer.

Some individuals not in the work force are students in college. Before the Dependent Coverage Provision, some insurance companies covered students still enrolled in school. This might explain why unemployed individuals are more likely than those not in the work force to not have health insurance.

Table 3 presents results testing for policy heterogeneity across both gender and race. Each model estimated in Table 4 includes both state and year fixed effects as well as the additional control variables discussed above. The ACA policy made men 5.40 percentage points more likely to obtain health insurance; women were 3.13 percentage points more likely following the policy. The male increase is substantially larger in magnitude than the female increase. This is unsurprising because, as previously mentioned, less men were insured prior to the implementation of the policy. Men are also more likely to work blue-collar jobs that might not provide employer-sponsored health insurance as a benefit.

Black and white individuals became more likely to have health insurance after the policy was implemented. Black individuals were 6.27 percentage points more likely, while white individuals were 4.38 more likely after the policy. The increase for Black individuals is larger in magnitude, which makes sense as the Black population had a higher percentage uninsured originally. The policy had no statistically significant impact on individuals in the Other Race category.

Table 4 reports results for further policy heterogeneity parsed on employment and education status. After the implementation, the proportion of unemployed individuals were 6.33 percentage points more likely to have health insurance and those not in the labor force were 5.33 more likely to have health insurance. Employed individuals were 3.62 percentage points more likely to have health insurance. Unemployed individuals and those not in the labor force do not have an opportunity to obtain health insurance through a benefit package like employed individuals do. That is why they are more heavily impacted by this policy. As expected, individuals not enrolled in school are also impacted by this policy more than those enrolled in school. Those not enrolled were 4.35 percentage points more likely to have health insurance, whereas enrolled individuals were only 3.25 percentage points more likely. Before the Dependent Coverage Provision, some insurance companies would allow enrolled students to stay on their parent's health insurance plans. Due to this, a larger portion of not enrolled individuals were affected by the policy.

6. Limitations

This study's focus is on the Midwestern Region. Data from Iowa, Minnesota, North Dakota, South Dakota, Nebraska, and Missouri were included. This set of states does not include all states that are defined as being a part of the Midwest. I excluded Illinois because the demographic is different than the six

states included. Chicago presents a demographic that is more similar to San Antonio, New York, and Los Angeles.

This study also examines only a region of the United States. Although other studies show that the Dependent Coverage Provision was effective overall, the results could be slightly different in other regions. The Midwest is primarily white, not as diverse as other areas, and has lower levels of poverty in comparison to other regions in the United States. Due to this, the Midwest region might have had higher rates of individuals with health insurance prior to the Dependent Coverage Provision.

This policy change took place shortly after the Great Recession of 2008. This recession increased the number of unemployed individuals. This could have led to an increase in uninsured individuals because previously employed individuals could have lost their employer provided health insurance. To factor in the effects of the recession I include state and year fixed effects. This should account for any "background noise" that could be taking place in that year or state that could affect the study. I also control for state-level unemployment rates, and I include state-specific linear time trends.

7. Conclusion

This study indicates that the Affordable Care Act Dependent Coverage Provision was effective in increasing the number of individuals under 26 who have health insurance in the Midwest region. The difference-in-differences model estimates the treatment effect being effective with young adults becoming 4.3 percentage points more likely to have health insurance following the implementation.

These results from the Midwest are consistent with earlier studies of the entire U.S. According to a 2013 study, not only did the policy increase the number of individuals 19- to 25- years old who have health insurance, but it also improved access to care (Sommers et al. 2013, 170). They state:

> We found a 2.3-percentage-point decline in the proportion of people who said they did not obtain care and a 4.0-percentage-point decline in the proportion of those who said they delayed getting care because of cost (Sommers et al. 2013, pg. 170).

This increase in access to care, in turn, could improve overall health. The increase in health insurance could also decrease the costs of unpaid medical bills.

It is important to continue to study the uninsured population in the U.S. going forward. The coronavirus outbreak has led to an increase in uninsured individuals. Many individuals lost their jobs and potentially health insurance

coverage (Tolbert et al. 2020, 1). Along with that, in recent years, the number of uninsured individuals has increased. The individual mandate was also removed under the Trump administration, which potentially contributed to the increase of uninsured individuals. Examining the repeal of the individual mandate is left for future research.

References

"About the American Community Survey." 2021. *United States Census Bureau* https://www.census.gov/programs-surveys/acs/about.html

Abramowitz, Joelle. 2016. "Saying, 'I Don't': The Effect of the Affordable Care Act Young Adult Provision on Marriage." *The Journal of Human Resources.* 51 (4): 934-960.

Akosa Antiwi, Yaa, Asoka S. Moriya, and Kosali Simon. 2013. "Effects of Federal Policy to Insure Young Adults: Evidence from the 2010 Affordable Care Act's Dependent-coverage Mandate." *American Economic Journal: Economic Policy,* 5 (4): 1-28

Alm James, and Leslie Whittington. 1999. "For Love or Money? The Impact of Income Taxes on Marriage." *Economica,* 66 (263): 297-316

Bailey, James, and Chorniy, Anna. 2016. "Employer-Provided Health Insurance and Job Mobility: Did The Affordable Care Act Reduce Job Lock?" *Contemporary Economic Policy* 34 (1): 173-83.

Becker, Gary. 1973. "A Theory of Marriage: Part I." *Journal of Political Economy,* 81 (4): 813-46.

Cantor, Joel, Alan Monheit, Derek DeLia, and Kristen Lloyd. 2012. "Early Impact of the Affordable Care Act on Health Insurance Coverage of Young Adults." *Health Services Research,* 47 (5): 1773-98.

Garrett, Bowen, Len M. Nichols, and Emily K. Greenman. 2001. *Workers without Health Insurance*. Research Report of the Urban Institute. Sept. 1. Available online at www. urban. org/UploadedPDF/310244_workershealthins. pdf (accessed April 9, 2004).

Garrett, Bowen and Anuj Gangopadhyaya. 2016. "Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?" *Urban Institute.*

Goldstein, Jacob. 2008. "Will You Marry Me for Health Insurance?" *Wall Street Journal Health Blog: Online,* April 9, https://www.wsj.com/articles/BL-HEB-2500.

Goodman, Michelle. 2008. "I Married for Health Insurance: Getting Married for Better Health Coverage and Other Tales from the Insurance Mess." *ABC News,* July 17. https://abcnews.go.com/Business/CareerManagement/story?id=5379923&page=1.

Hampton, Matt and Lenhart, Otto. 2019. "The Effect of the ACA Medicaid Expansion on Marriage Behavior" (September 9, 2019). Available at SSRN: https://ssrn.com/abstract=3450609 or http://dx.doi.org/10.2139/ssrn.3450609

Jung, Juergen, and Vinish Shrestha. 2018. "The Affordable Care Act and College Enrollment Decisions." *Economic Inquiry* 56 (4): 1980-2009.

Lenhart, Otto, and Vinish Shrestha. 2017. "The Effect of the Health Insurance Mandate on Labor Market Activity and Time Allocation: Evidence from the Federal Dependent Coverage Provision." *Forum for Health Economics & Policy*. Vol. 20. No. 1. De Gruyter.

Lichter, Daniel, Dine McLaughlin, and David Ribar. 2002. "Economic Restructuring and the Retreat from Marriage." *Social Science Research,* 31 (2): 230-56.

Lowe, Shelly. 2010. "American Community Survey Key Facts." *US Census Bureau,* https://www.census.gov/content/dam/Census/programs-surveys/acs/news/10ACS_keyfacts.pdf

Rosenbaum, Sara J., and Peter Shin. 2005. "Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care." hsrc.himmelfarb.gwu.edu

Sommers, Benjamin D., Thomas Buchmueller, Sandra L. Decker, Colleen Carey, and Richard Kronick. 2012. "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

Tolbert, Jennifer, Kendal Orgera, and Anthony Damico. 2020. "Key Facts about the Uninsured Population." *Kaiser Family Foundation.* https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

"Women's Health Insurance Coverage." *Kaiser Family Foundation.* 2021. https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage/

"Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Business." *Centers for Medicare & Medicaid Services.*
https://www.cms.gov/CCIIO/Resources/Files/adult_child_fact_sheet.

Zheng, Xiaoyong, and David M. Zimmer. 2008. "Farmers' Health Insurance and Access to Health Care." *American Journal of Agricultural Economics* 90 (1): 267-279.
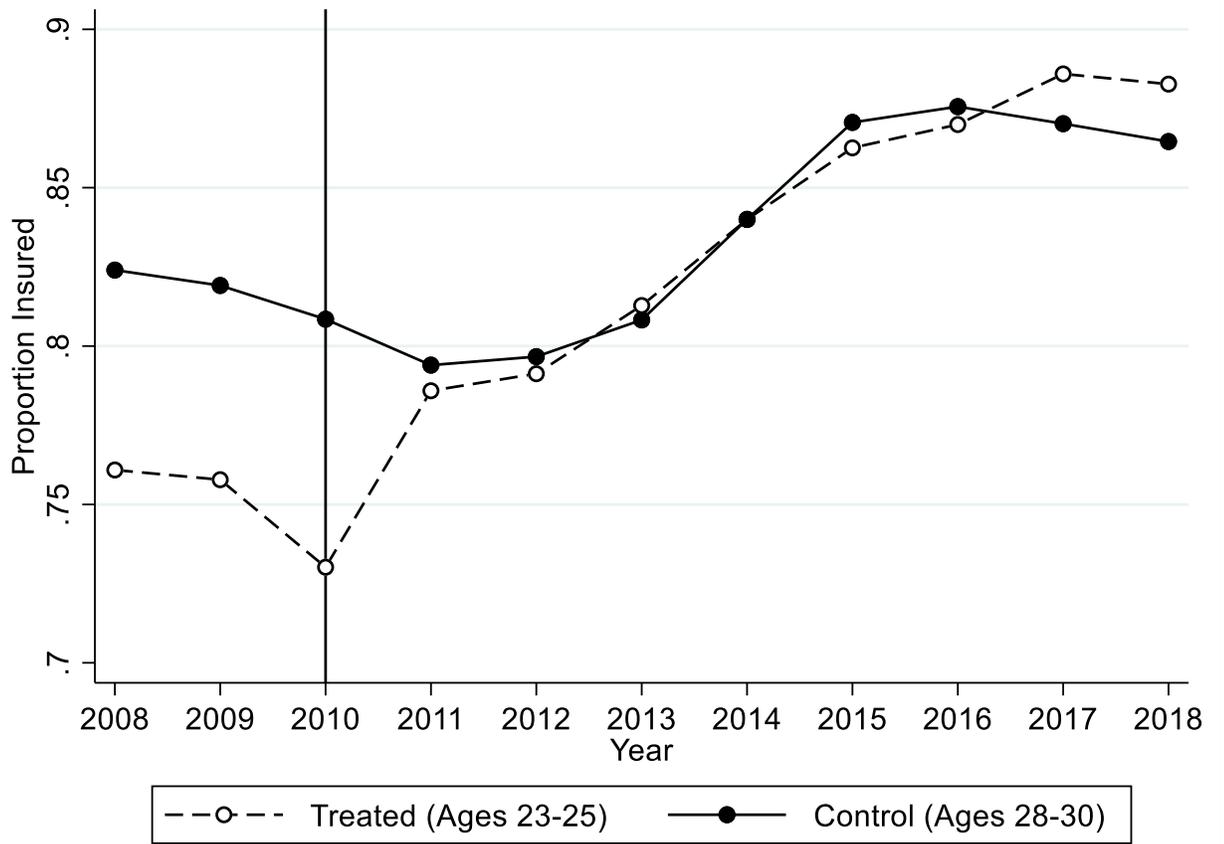
Figures and Tables

Figure 1

Proportion of Individuals with Health Insurance by Age Group and Calendar Year

Source: 2008-2013 1-year ACS data.

Table 1: Descriptive Statistics

Variable	Treatment (Ages 23-25)	Control (Ages 28-30)
Insurance Coverage		
Pre 2010	0.759	0.822
Post 2010	0.780	0.802
Demographic Characteristics		
Male	0.510	0.504
Age	24.010	29.008
Black	0.059	0.053
White	0.865	0.876
Other Race	0.076	0.071
Education		
Less than HS Degree	0.324	0.312
Some College	0.676	0.688
Currently Enrolled	0.237	0.120
Not Enrolled	0.763	0.880
Employment		
Employed	0.766	0.801
Unemployed	0.071	0.054
Not in Labor Force	0.162	0.145
Unemployment Rate	6.260	6.269
Observations	33,799	36,329

Table 2: Impact of Dependent Coverage Provision on Insurance Coverage

Dependent Variable: Insurance Coverage

	(1)	(2)	(3)
Treatment Effect	0.0407***	0.0427***	0.0428***
	(0.0049)	(0.0052)	(0.0052)
Age		0.0043**	0.0043**
		(0.0016)	(0.0016)
Male		-0.0499***	-0.0499***
		(0.0039)	(0.0039)
Black		-0.1075***	-0.1074***
		(0.0064)	(0.0063)
Other Race		-0.1157***	-0.1161***
		(0.0244)	(0.0244)
Some College		0.1743***	0.1743***
		(0.0147)	(0.0147)
Employed		0.1131***	0.1131***
		(0.0105)	(0.0105)
Unemployed		-0.0992***	-0.0991***
		(0.0135)	(0.0135)
State-Level Unemployment Rate		-0.0003	0.0017
		(0.0036)	(0.0024)
Fixed Effects	Yes	Yes	Yes
Additional Controls	No	Yes	Yes
State-Specific Linear Trends	No	No	Yes
Observations	70,128	70,128	70,128

Source: 2008-2013 1-year ACS data. Notes: Shown are coefficients estimated from the specification of the determinants of the probability of having health insurance. Each column presents results from a single regression outlined by Equation (1). Specifications include state and year fixed effects. Columns (2) and (3) include additional demographic controls, state-level unemployment rates, and state-specific linear time trends. All estimations are linear probability models with robust standard errors clustered at the state level. *** $p<0.01$, ** $p<0.05$, * $p<0.10$. Standard errors are in parenthesis.

Table 3: Heterogeneous Policy Effects on Insurance Coverage: Gender and Race

	Dependent Variable: Insurance Coverage				
	(1)	(2)	(3)	(4)	(5)
					Other
	Male	**Female**	**Black**	**White**	**Race**
Treatment Effect	0.0540***	0.0313***	0.0627**	0.0438***	0.0116
			(0.0212)		
	(0.0064)	(0.0052)		(0.0055)	(0.0385)
Fixed Effects	Yes	Yes	Yes	Yes	Yes
Additional Controls	Yes	Yes	Yes	Yes	Yes
Observations	35,548	34,580	3,911	61,065	5,152

Source: 2008-2013 1-year ACS data. Notes: Shown are coefficients estimated from the specification of the determinants of the probability of having health insurance among different demographic subgroups parsed by sex and race. Each column presents results from a single regression outlined by Equation (1). Specifications include state and year fixed effects as well as additional demographic controls and state-level unemployment rates. All estimations are linear probability models with robust standard errors clustered at the state level in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.10$.

**Table 4: Heterogeneous Policy Effects on Insurance Coverage:
Employment and College Enrollment Status**

	(1)	(2)	(3)	(4)	(5)
			Not in		
	Employed	Unemployed	Labor Force	Not Enrolled	Enrolled
Treatment Effect	0.0362***	0.0663**	0.0533*	0.0435***	0.0325*
	(0.0057)	(0.0238)	(0.0262)	(0.0086)	(0.0148)
Fixed Effects	Yes	Yes	Yes	Yes	Yes
Additional Controls	Yes	Yes	Yes	Yes	Yes
Observations	55,008	4,368	10,752	57,754	12,374

Dependent Variable: Insurance Coverage

Source: 2008-2013 1-year ACS data. Notes: Shown are coefficients estimated from the specification of the determinants of the probability of having health insurance among different subgroups parsed by employment and college enrollment status. Each column presents results from a single regression outlined by Equation (1). Specifications include state and year fixed effects as well as additional demographic controls and state-level unemployment rates. All estimations are linear probability models with robust standard errors clustered at the state level in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.10$