ACA Implementation—Monitoring and Tracking

Declining Health Insurance in Low-Income Working Families and Small Businesses

April 2012

John Holahan and Vicki Chen
The Urban Institute

Robert Wood Johnson Foundation

Urban Institute

EXECUTIVE SUMMARY

Employer-sponsored insurance (ESI) rates are lower for low-income individuals and small businesses relative to high-income individuals and larger businesses. Similarly, the declines in ESI in the past decade have been greater for low-income than high-income families and greater for small firms than large firms. In this brief, we show that even high-income people in small firms have experienced relatively large declines in ESI. Similarly, low-income people working in large firms have also experienced large declines in employer-sponsored coverage. We also show that higher-income people in larger firms have experienced relatively small declines in ESI. These trends are important because rate of ESI is closely tied to the rate of uninsurance. The Affordable Care Act (ACA) has attempted to address the coverage problems of both low-income families and small businesses. We conclude that the provisions of the ACA are well targeted and that monitoring health coverage changes of low-income individuals and small businesses will be important.

INTRODUCTION

This brief examines the trends in ESI for low-income working families and small businesses over the last decade. The Affordable Care Act (ACA) targets both small businesses and low-income families, the former with the opportunity for new purchasing options and the latter with financial assistance to purchase health insurance. The majority of the uninsured in the United States are in families with at least one full-time worker.[1] In addition, low-income workers have lower rates of ESI and higher uninsurance rates than high-income workers.[2] Similarly, the likelihood of having ESI is lower and uninsurance rates are higher among those working in small firms than among those working in larger firms.[3] In this brief we focus on whether declines in health insurance coverage among workers and their families are a low-income problem, a small business problem, or both. Is coverage declining for low-income workers in large firms as well as small ones; is it declining for high-income workers in small businesses as well as low-income workers?

BACKGROUND

The ACA has mechanisms for providing assistance to low-income individuals, both through the Medicaid expansion and the provision of subsidies for the purchase of private coverage through nongroup exchanges. These subsidies are not available, however, to low-income workers (or their family members) who have an affordable offer of employer insurance. After January 1, 2014, those with incomes above Medicaid eligibility levels but below 400 percent of the federal poverty level (FPL) will potentially be eligible for premium subsidies that decrease as incomes increase. Specifically, those with incomes below 138 percent of the FPL pay no more than 2 percent of their income for exchange-based coverage. The percentage of income an individual would pay then increases as income increases, reaching 9.5 percent of income for those with incomes between 300 and 400 percent of the FPL.

Under the ACA, Medicaid eligibility will be extended to those with incomes up to 138 percent of the FPL, and they will be eligible for public coverage at little to no cost. Foreign born individuals in this income category with less than five years legal residence will be eligible for exchange-based subsidies instead of Medicaid however, until five years of legal residence has been reached.

Small business owners have new options under health reform as well. The smallest firms with the lowest wage employees are offered tax credits both before and after 2014 to offset a portion of their contributions to their workers' health insurance coverage. For employers that choose to provide such coverage, Small Business Health Options Program (SHOP) exchanges will be developed that will reduce the administrative costs of health insurance for firms with 100 or fewer workers.[4] Beginning

in 2017, states can choose to allow larger employers to purchase coverage through exchanges.

For small employers that do offer health insurance coverage, the ACA:

- requires that workers offered family coverage be allowed to include their children up to age 26 in those policies;
- limits waiting periods to no more than 90 days;
- prohibits the use of dollar limits on lifetime benefits and phases in prohibitions on dollar limits for annual benefits; and
- requires the provision of a list of preventive services with no cost-sharing requirements.

Starting in 2014, small group health insurance plans must meet essential benefits requirements, follow the rating limits in the law (i.e., 3:1 age bands, and up to 1.5:1 rating for those using tobacco), and be provided on a guaranteed issue basis with no pre-existing condition exclusions. Firms with more than 50 workers will be required to pay a penalty if any of their full-time workers obtain subsidies in the exchange due to the absence of adequate and affordable coverage at their workplace.

While not the focus of this brief, several studies have explored whether declines in ESI are due to changes in offer rates or employee take-up of those offers. McMorrow, Blumberg, and Buettgens[5] analyzed the Medical Expenditure Panel Survey (MEPS) and showed that between 2000 and 2009, employer offers of coverage declined the most for the smallest firms (fewer than 10 workers) and the least for the largest firms. Further, the declines in employer offers were greater in firms with low-wage employees than in firms with higher-wage employees. Table 1 updates these results with 2010 data; the overall results are unchanged. Clemans-Cope and Garrett,[6] using the February and March Supplements of the Current Population Survey (CPS), showed that between 2000 and 2005, employee take-up fell most for the lowest income workers. They also found that take-up rates fell in all firm sizes. A study by the State Health Access Data Assistance Center, using several years of the CPS, showed a decline between 1999-2000 and 2008-2009 in the percentage of employers offering coverage.[7] It also showed that employee contributions increased as a share of premiums both for individual and family coverage, likely affecting take-up rates.[8] The Kaiser Family Foundation and Health Research and Educational Trust (HRET) have shown that eligibility for employer-sponsored insurance is greater in higher-wage firms than lower-wage firms,[9] using 2011 Kaiser/HRET Survey of Employer-Sponsored Health Benefits. They have shown that most workers take up

TABLE 1. Percentage of Private-Sector Establishments that Offer Health Insurance, by Firm Size and Wage: 2000-2010

	Total	Fewer than 10 Employees	10-24 Employees	25-99 Employees	100-999 Employees	1,000+ Employees
All Firms						
2000	59.3%	39.6%	69.3%	84.5%	95.0%	99.2%
2010	53.8%	31.8%	60.9%	80.6%	94.9%	99.5%
Percentage Change:	-9.3%	-19.7%	-12.1%	-4.6%	-0.1%	0.3%
Firms in Which 50% or More of Employees Are Low Wage						
2000	42.5%	25.4%	46.3%	73.5%	94.2%	96.4%
2010	40.5%	16.6%	33.4%	60.0%	89.5%	99.0%
Percentage Change:	-4.7%	-34.6%	-27.9%	-18.4%	-5.0%	2.7%
Firms in Which Fewer than 50% of Employees Are Low Wage						
2000	64.7%	50.2%	83.4%	92.4%	96.9%	99.4%
2010	61.2%	40.1%	75.8%	90.9%	98.1%	99.7%
Percentage Change:	-5.4%	-20.1%	-9.1%	-1.6%	1.2%	0.3%

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2000 and 2010 Medical Expenditure Panel Survey—Insurance Component (Rockville, MD: Agency for Healthcare Research and Quality, July 2011).

coverage but that take-up also varies with firm wage level. Firms with a higher proportion of higher wage workers are more likely to have high take-up rates than firms with large numbers of low-wage workers (83 percent versus 71 percent).[10] Vistnes and colleagues use the Medicaid Expenditure Panel Survey-Insurance Component (MEPS-IC) to examined changes in ESI rates between 2000 and 2008.[11] They found that coverage rates declined regardless of firm size. In small firms, the decline in coverage was caused by reductions in both offer and take-up rates. In larger firms, offer rates were unchanged but coverage declined because of falling take up rates.[12]

METHODS

We use data from the CPS, a cross-sectional survey, based on the entire civilian non-institutionalized population, with a sample size of 95,958 households (204,983 individuals) in 2011.[13] The CPS is the most frequently cited national survey on Americans' health insurance.[14] Its strengths and weaknesses have been widely documented. [15,16] The analysis uses CPS data and does not adjust for underreporting of coverage in Medicaid or the Children's Health Insurance Program. While such an adjustment is important for improving accuracy of coverage levels at a point in time, there is no reason to believe it has much of an effect on the estimates of change over time by income and firm size.

We use the health insurance unit (HIU) as the unit of analysis for determining family-level "ACA-relevant" modified adjusted gross income (MAGI). An HIU includes members of the nuclear family who can be covered under one health insurance policy (i.e., policyholder, spouse, children under age 19, and full-time students under age 23).[17] Use of HIUs in determining family-level MAGI leads to results that differ from those obtained when household income is used, because the latter includes the income of all relatives and unrelated individuals living together. The income of the HIU more accurately reflects the income available to individuals when purchasing private insurance or determining eligibility for public programs.

Using MAGI as the income unit is consistent with provisions of the ACA, which will use MAGI to determine Medicaid and exchange subsidy eligibility across the nation. At present, rules for counting income and resources for current, pre-ACA Medicaid eligibility vary from state to state and from group to group. To construct an adjusted version of MAGI using data from the CPS that are appropriate to the ACA, we deduct public assistance income, Supplemental Security Income, child support, veteran benefits, worker's compensation, and child care expenses from total income. Unlike the standard definition of MAGI, we do not deduct social security benefits from total income in order to be consistent with the most recent legislation.

For this analysis, we examine health insurance coverage by income and by size of firm. All members of the HIU, including spouses and dependents regardless of work status, were grouped under the firm size of the worker employed by the largest firm in the HIU. This decision is based on data from the CPS that shows that, in families with two workers, the worker in the largest-sized firm is more likely to cover the entire family under his/her policy than a policy offered by a spouse's smaller firm.[18] This hierarchy affects only families with two full-time workers who work in different sized firms.

RESULTS

As shown in Table 2, the majority (75 percent) of non-elderly Americans are in families with at least one-full-time worker (200.5 million out of 266.0 million). Not surprisingly, the overwhelming share of those with ESI—a disproportionate share, in fact—are in families with at least one full-time worker, since part-time workers are significantly less likely than full-time workers to be offered insurance coverage.[19] (HIUs with no workers can have ESI because they receive coverage from someone outside the household or are retirees.) In this brief, we focus on families with at least one full-time worker and their dependents, and all of the data shown going forward include only those units. In this brief, we focus on families with at least one full-time worker and their dependents, and all of the data shown going forward include only those units. (In this brief we use families and HIVs interchangeably.)

Figure 1 shows the decline over the last decade of health insurance coverage of workers and their dependents at various income levels. The data show that higher income

people in HIUs with at least one full-time worker have higher rates of ESI than their low-income counterparts. For example, in 2010, 90 percent of those with incomes at 800 percent of the FPL or higher had ESI. In contrast, only 29 percent of those with income below 138 percent of the FPL had ESI.

Figure 1 also shows a sharp decline in coverage over the period in families with at least one full-time worker. For all income groups, ESI fell by 6 percentage points, from 77 percent in 2000 to 71 percent in 2010, or by 10 percent. The figure also shows that the declines in coverage were greatest for the two lowest income groups. The lowest income group, those with incomes below 138 percent of the FPL, had a decline in ESI from 38 percent to 29 percent, a 24 percent decline. The next higher income group, with incomes from 138 to 249 percent of the FPL, had a decline in ESI from 67 percent to 57 percent, a 15 percent decline. ESI barely declined for the two highest income groups, by 2 and 3 percent respectively. This suggests that the decline in ESI has been particularly severe for low-income families. This would follow from the difficulty in shifting the rising costs of health insurance onto low-wage workers which causes employers to drop coverage or increase employee contributions, causing many employees to cease taking up employer offers. However, the distribution of low-wage workers by employer size bears examining.

Small firms employ far more low-income workers as a share of their overall workforce than do larger firms (shown in table 4).[20] This raises the possibility that the low and falling rate of ESI among low-income workers could be related to the extra challenges small employers face in providing insurance to their workers. Small businesses face high administrative costs per covered worker and often lack the expertise to search the market for the best coverage options. Until the full ACA reforms take effect in 2014, small-group coverage is usually still subject to medical underwriting, making it considerably more expensive for small groups with unhealthy members to purchase coverage. These challenges, combined with a disproportionately low-income workforce that cannot directly absorb more of the cost of coverage, are generally presumed to be the sources of low ESI coverage rates among workers in small firms.[21] Figure 2 illustrates these lower rates of coverage. While the rate of ESI for all full-time workers and their dependents was 71 percent in 2010, it was only 33 percent in firms with fewer than 10 workers, and 57 percent in firms with between 10 and 99 workers. In contrast, larger firms have far higher rates of ESI. The declines in ESI over the past decade were also greatest in small firms. ESI rates fell by 23 percent (from 43 to 33 percent) for workers and their dependents in firms with fewer than 10 workers and by 12 percent (from 65 to 57 percent) for workers and their dependents in firms with 10 to 99 workers; workers and dependents in large firms had much smaller coverage declines.

In table 3, we explore the relative importance of income and firm size in explaining these coverage declines. Table 3 shows ESI by both income and firm size for 2000 and 2010; intermediate years are not shown. The panel on the left clearly shows the sharper decline in ESI for low-income people than for higher income people (same as figure 1). Going across the top row, it is clear that small firms have experienced larger declines in ESI than large firms (same as figure 2). But the table also reveals that the declines in coverage among low-income workers and their families hold true regardless of firm size. In the smallest

TABLE 2. Distribution of Select Health Insurance Coverages by Work Status for 2010

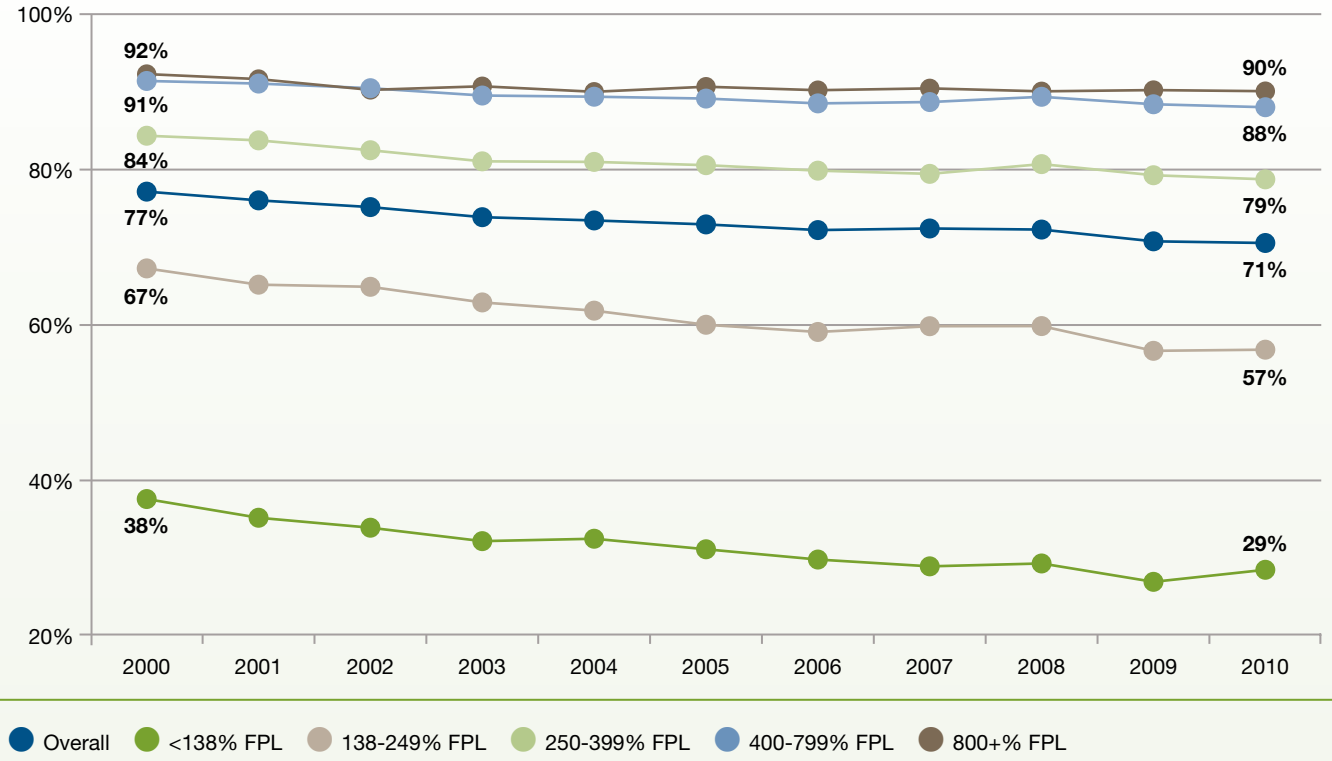
		FAMILY COMPOSITION					
	Total	No Workers		Only Part-Time Workers		At least 1 Full-Time Worker	
	#[1]	#[1]	%	#[1]	%	#[1]	%
Overall	266.0	40.7	15.3%	24.9	9.3%	200.5	75.4%
ESI Coverage	156.2	7.5	4.8%	7.3	4.7%	141.4	90.5%
Uninsured	49.1	11.6	23.7%	7.7	15.7%	29.8	60.6%

Source: Urban Institute, 2011. Based on data from the 2011 ASEC Supplement to the Current Population Survey.

[1]In millions of people

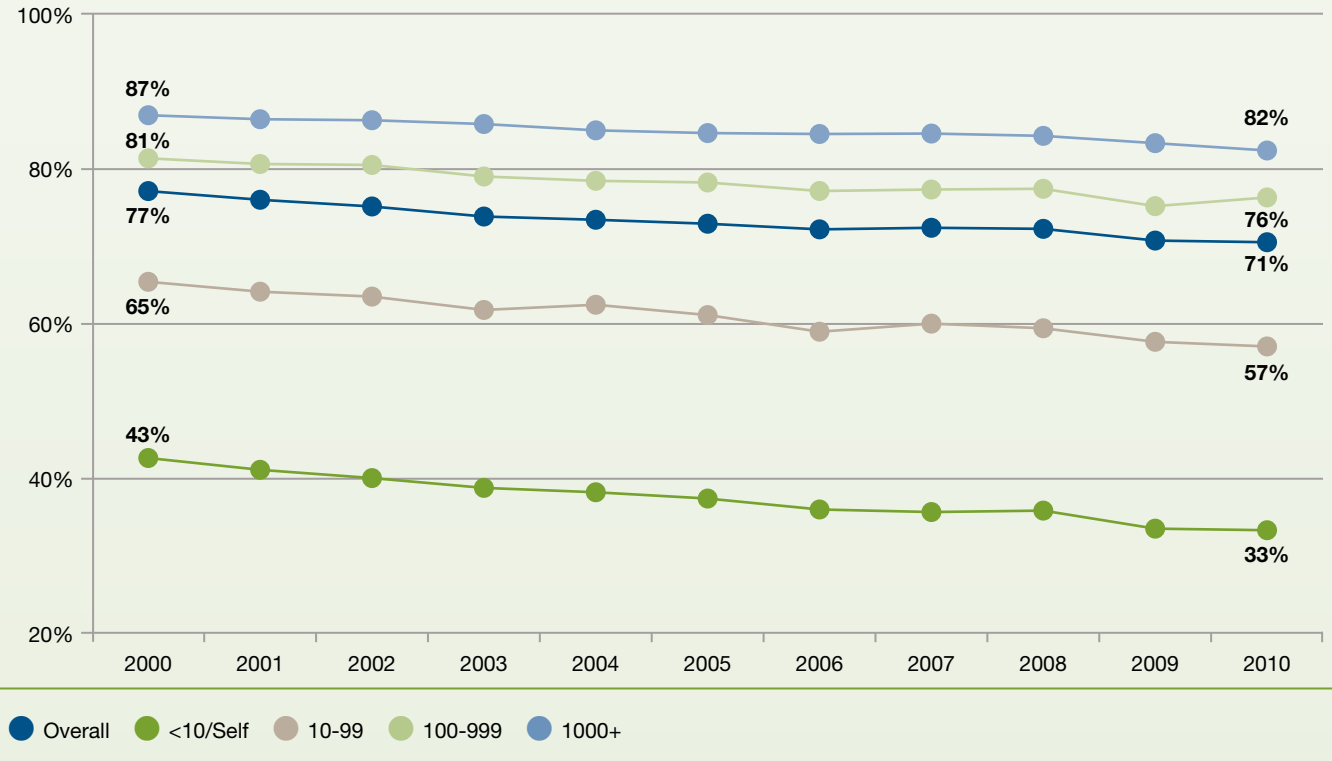
Note: Excludes persons aged 65 and older and those in the Armed Forces. All HIU members are grouped together under the worker employed by the largest firm. MAGI is used as the income unit.

FIGURE 1. **Percentage of Workers and Dependents Covered by ESI, by Income Group**



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

FIGURE 2. **Percentage of Workers and Dependents Covered by ESI, by Firm Size**



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

firms, the rates of ESI for those with incomes below 138 percent of the FPL fell from 22 percent to 14 percent, a 36 percent drop. For those with incomes between 138 and 249 percent of the FPL, the rate of ESI fell from 37 percent to 29 percent, a 22 percent drop. But low-income workers in large firms saw similar declines. For workers in firms with more than 1,000 workers, ESI fell from 47 percent to 39 percent among those with income below 138 percent of the FPL (a 17 percent decline), and from 78 percent to 68 percent for those with income between 138 and 249 percent of the FPL (a 13 percent decline). Thus, low-income workers and their families have experienced substantial declines in coverage regardless of firm size, although the declines were greatest among those employed by smaller firms. Although employer offers of insurance coverage in large firms do not appear to have dropped,[22] required employee contributions have been rising,[23] which in turn led to a drop in take-up rates among those least able to afford it.

Among employees of smaller firms, both those with fewer than 10 workers and those with 10 to 99 workers, there is a sharp decline in ESI regardless of income. Low-income workers in small firms saw sharp declines in coverage, but even those with income above 800 percent of the FPL saw a decline in ESI from 66 percent to 57 percent (a 14 percent decline) in the smallest firms. In firms with between10 and 99 workers, the decline for employees with income at or above 800 percent of the FPL was from 88 percent to 83 percent (a 6 percent decline). Thus, even employees with high incomes in smaller firms have had problems maintaining health insurance coverage over the last decade.

In contrast, higher income employees of firms with more than 100 workers have fared relatively well. This is illustrated in the bottom right-hand side of Table 3, where rates of ESI remain over 90 percent and have declined only slightly over the decade. This suggests that the ACA targeted benefits well—providing subsidies to low-income people and increasing health insurance options for small firms. Those who are least affected by the ACA—highest income workers in large firms—have not been seeing substantial declines in health insurance coverage. Appendix 1 provides a similar table on the changes in coverage for workers only. There is little difference in the pattern of changes over time for all of the income groups and firm sizes.

TABLE 3. The Number and Share of Full-Time Workers and Their Dependents with ESI Coverage by Firm Size and Income, 2000 and 2010

					SIZE OF FIRM															
	All Firms				Fewer than 10 Employees				10-99 Employees				100-999 Employees				1,000+ Employees			
	2000		2010		2000		2010		2000		2010		2000		2010		2000		2010	
	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%
Income	158.0	77%	141.4[a]	71%*	9.6	43%	8.3[a]	33%*	24.0	65%	21.0[a]	57%*	32.8	81%	27.5[a]	76%*	91.7	87%	84.6[a]	82%*
<138% FPL	11.1	38%	8.9[a]	29%*	1.3	22%	1.1[b]	14%*	2.5	32%	1.9[a]	24%*	2.5	45%	1.8[a]	38%*	4.8	47%	4.1[a]	39%*
138-249% FPL	27.9	67%	22.9[a]	57%*	2.1	37%	1.7[a]	29%*	5.5	58%	4.6[a]	48%*	6.4	74%	4.9[a]	64%*	13.9	78%	11.8[a]	68%*
250-399 %FPL	41.7	84%	36.4[a]	79%*	2.4	53%	2.1[a]	44%*	6.8	77%	5.9[a]	70%*	9.0	88%	7.7[a]	83%*	23.5	91%	20.7[a]	87%*
400-799% FPL	55.8	91%	52.0[a]	88%*	2.3	59%	2.2	54%*	6.7	86%	6.2[a]	80%*	11.1	93%	9.8[a]	91%*	35.6	96%	33.7[a]	93%*
800+% FPL	21.5	92%	21.3	90%*	1.4	66%	1.1[a]	57%*	2.5	88%	2.3[b]	83%*	3.8	95%	3.4[a]	92%*	13.8	96%	14.4[a]	95%*

Source: Urban Institute, 2011. Based on data from the 2001 and 2011 ASEC Supplement to the Current Population Survey.

[1]In millions of people

Note: Excludes persons aged 65 and older and those in the Armed Forces. All HIU members are grouped together under the worker employed by the largest firm. MAGI is used as the income unit.

** Indicates change in percent of people is statistically significant (at the 95% confidence level).*

 # Indicates change in percent of people is statistically significant (at the 90% confidence level).

[a] Indicates change in numbers of people is statistically significant (at the 95% confidence level).

[b] Indicates change in numbers of people is statistically significant (at the 90% confidence level).

TABLE 4. Change in the Number of Full-Time Workers and Their Dependents by Firm Size and Income, 2000 and 2010

				SIZE OF FIRM											
	All Firms			Fewer than 10 Employees			10-99 Employees			100-999 Employees			1,000+ Employees		
	2000	2010		2000	2010		2000	2010		2000	2010		2000	2010	
	#[1]	#[1]	Δ	#[1]	#[1]	Δ	#[1]	#[1]	Δ	#[1]	#[1]	Δ	#[1]	#[1]	Δ
Income	204.8	200.5	-4.3[a]	22.4	25.0	2.6[a]	36.7	36.7	0.0	40.2	36.1	-4.2[a]	105.4	102.6	-2.8[a]
<138% FPL	29.5	31.3	1.8[a]	6.2	8.1	2.0[a]	7.6	8.1	0.5[b]	5.5	4.7	-0.8[a]	10.2	10.3	0.1
138-249% FPL	41.5	40.4	-1.2[a]	5.7	5.9	0.1	9.4	9.5	0.1	8.5	7.6	-0.9[a]	17.8	17.3	-0.5
250-399 %FPL	49.5	46.2	-3.3[a]	4.5	4.8	0.4[a]	8.9	8.4	-0.5[a]	10.3	9.3	-1.0[a]	25.8	23.7	-2.2[a]
400-799% FPL	61.0	59.0	-2.0[a]	4.0	4.2	0.2	7.9	7.8	0.0	11.9	10.8	-1.2[a]	37.2	36.2	-1.0[a]
800+% FPL	23.3	23.6	0.3	2.1	2.0	-0.1	2.9	2.8	-0.1	4.0	3.7	-0.3[a]	14.3	15.1	0.8[a]

Source: Urban Institute, 2011. Based on data from the 2001 and 2011 ASEC Supplement to the Current Population Survey.

[1] In millions of people

Note: Excludes persons aged 65 and older and those in the Armed Forces. All HIU members are grouped together under the worker employed by the largest firm. MAGI is used as the income unit.

[a] Indicates change in numbers of people is statistically significant (at the 95% confidence level).

[b] Indicates change in numbers of people is statistically significant (at the 90% confidence level).

Table 4 shows changes in the number of workers and their dependents by firm size and by income over the past decade. Comparing 2000 to 2010 is somewhat problematic because 2000 was a year with a very strong economy while in 2010, the country was just emerging from a deep recession. As a result, the overall number of workers and their dependents declined by 4.3 million over the period. Surprisingly, the number of those in working families with incomes below 138 percent of the FPL increased by 1.8 million (about 6 percent), while the number in each of the other income categories either fell or was unchanged. The number in the smallest firms increased by 2.6 million (about 12 percent) and the number in firms with between 10 and 99 workers was unchanged, while there were declines in the number of workers in the two larger firm categories. Thus, the population changes that have occurred in the past decade are increasing the relative share of the income and firm size groups where coverage has been declining the most.

DISCUSSION

The ACA will go far to address the coverage problems for low-income families and for those with workers in small firms through the Medicaid expansion, premium subsidies, and the SHOP exchanges. For example, Table 3 shows that 8.9 million full-time workers and dependents could enroll in Medicaid;[24] this would lower employer costs substantially, disproportionately for small firms but also for larger firms with many low-wage workers. Table 3 shows that there are 29.3 million Americans with ESI coverage and with at least one family member working in a firm with fewer than 100 workers. Their firms could all benefit from SHOP exchanges. Another 35 million workers[25] who have family members working in larger firms might have access to SHOP exchange coverage and its benefits beginning in 2014, depending upon the choices made by their small employers (not shown).

It will be important to monitor the changes in health insurance coverage for both low-income families and for smaller businesses. In analyzing of the potential impact of the ACA, Urban Institute researchers have estimated that, for the nonelderly individuals in families with at least

one worker in a small firm (fewer than 50 employees), the uninsured rate would decline from 23.8 percent to 11 percent.[26] For families with no small firm worker but at least one worker in a medium-size firm (50-99 employees), the uninsured rate would decline from 13.9 percent to 6.1 percent. These coverage gains are due to increased coverage by Medicaid and increased coverage in the nongroup market. For both firm sizes, there is little change in ESI coverage but many small firms could purchase coverage through SHOP exchanges, which could reduce premium prices.

Despite all of the ACA provisions that will lower health care coverage costs for small firms and provide less expensive coverage options for low-income families, small firms will continue to offer coverage at lower rates than large firms. They will still face somewhat higher administrative costs (although they will be lower than today's) and will be more likely to have a lower-wage workforce, which makes it harder to shift the cost of coverage onto workers. Much of the effect of these continued lower offer rates on workers and their dependents will be ameliorated by the reforms in the nongroup market such as the income-related subsidies, guaranteed issue, and the absence of health status rating. The Medicaid expansion will also provide coverage options for low-income workers that should lower costs for small firms. All of these provisions should make it easier for small firms to be more competitive in hiring than today, when many workers have strong incentives to seek employment in large firms because of the availability and price of health insurance coverage. The ACA will increase the likelihood of coverage for low-income workers and for small businesses and should substantially change the trends described in this brief.

APPENDIX 1. The Number and Share of Full-Time Workers Only with ESI Coverage by Firm Size and Income, 2000 and 2010

	SIZE OF FIRM																			
	All Firms				Fewer than 10 Employees				10-99 Employees				100-999 Employees				1,000+ Employees			
	2000		2010		2000		2010		2000		2010		2000		2010		2000		2010	
	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%	#[1]	%
All Income	106.4	79%	93.9[a]	74%*	6.2	44%	5.4[a]	36%*	15.9	68%	13.9[a]	61%*	21.9	83%	18.3[a]	79%*	62.3	88%	56.3[a]	84%
<138% FPL	5.8	39%	4.6[a]	31%*	0.7	23%	0.6[b]	15%*	1.3	34%	1.1[a]	28%*	1.3	47%	0.9[a]	39%*	2.5	48%	2.1[a]	41%
138-249% FPL	16.2	66%	13.4[a]	57%*	1.3	36%	1.0[a]	29%*	3.3	57%	2.8[a]	48%*	3.7	74%	2.8[a]	66%*	7.9	77%	6.8[a]	68%
250-399 %FPL	27.2	83%	23.3[a]	78%*	1.6	52%	1.4[b]	43%*	4.6	76%	3.9[a]	70%*	5.9	87%	5.0[a]	83%*	15.1	91%	13.0[a]	87%
400-799% FPL	40.6	91%	36.7[a]	88%*	1.7	59%	1.6	54%*	4.9	85%	4.5[a]	80%*	8.2	93%	7.0[a]	91%*	25.9	95%	23.6[a]	93%
800+% FPL	16.5	93%	15.9[a]	91%*	0.9	63%	0.8	56%*	1.8	89%	1.6[a]	85%*	2.9	96%	2.5[a]	92%*	10.9	97%	10.9	95%

Source: Urban Institute, 2011. Based on data from the 2001 and 2011 ASEC Supplement to the Current Population Survey.

[1] In millions of people

Note: Excludes persons aged 65 and older and those in the Armed Forces. All HIU members are grouped together under the worker employed by the largest firm. MAGI is used as the income unit.

** Indicates change in percent of people is statistically significant (at the 95% confidence level).*

 # Indicates change in percent of people is statistically significant (at the 90% confidence level).

[a] Indicates change in numbers of people is statistically significant (at the 95% confidence level).

[b] Indicates change in numbers of people is statistically significant (at the 90% confidence level).

ENDNOTES

1. John Holahan. "The 2007–09 Recession And Health Insurance Coverage." *Health Affairs* 30(1) (2010): 145-152.

2. Ibid.; Fredric Blavin, Linda J. Blumberg, Matthew Buettgens, John Holahan, and Stacey McMorrow.. "How Choices In Exchange Design For States Could Affect Insurance Premiums And Levels Of Coverage." *Health Affairs* 31(2) (2012): 290-298.

3. Stacey McMorrow, Linda Blumberg, and Matthew Buettgens. "The Effects of Health Reform on Small Businesses and Their Workers." (Washington, DC: The Urban Institute report prepared for the Robert Wood Johnson Foundation, June 2011).

4. States may choose to define small employers (and the associated eligibility for purchasing coverage in the state's SHOP exchange) as those with 50 or fewer workers until 2016; however, the definition must change to 100 or fewer workers after 2016.

5. McMorrow et al. "The Effects of Health Reform on Businesses and Their Workers"; Linda Blumberg,"The High Cost of Small Business Health Insurance: Limited Options, Limited Coverage," testimony before the US House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, October 20, 2009.

6. Lisa Clemans-Cope and Bowen Garrett, "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005," Issue Paper (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2006); Jessica Vistnes, Alice Zawacki, Kosali Simon, and Amy Taylor, "Declines in Employer-Sponsored Insurance between 2000 and 2008: Examining the Components of Coverage by Firm Size," *Health Services Research* (January 2012). DOI: 10.1111/j.1475-6773.2011.01368.x.

7. State Health Access Data Assistance Center and Robert Wood Johnson Foundation. *State-Level Trends in Employer-Sponsored Health Insurance: A State-by-State Analysis* (June 2011).

8. Ibid.

9. The Kaiser Family Foundation and Health Research and Educational Trust. "Employee Coverage, Eligibility, and Participation," In *Employer Health Benefits, 2011 Annual Survey*.

10. Ibid.

11. Vistnes at al., "Declines in Employer-Sponsored Insurance between 2000 and 2008."

12. Ibid.

13. In 2011, the Census Bureau revised its health coverage imputation methodology for those who did not respond to health insurance questions. Previously, dependent coverage assignments were limited only to the policyholder's spouse and/or children. The revisions now allow all members in the household to be assigned dependent coverage, thus the increase in the imputed number of dependents with coverage more accurately reflects individual reporting. These revisions were reflected in the calendar year 2010 CPS Annual Social and Economic (ASEC) data, and revised extracts were released for the 1999 to 2009 data years allowing a methodologically consistent trend to be examined from 1999 to 2010. Overall, the new editing process has led to a 0.6 percentage point decrease in the number of uninsured in 2009.

14. U.S. Census Bureau.,. "Current Population Survey, 2011 Annual Social and Economic (ASEC) Supplement," (2011), http://www.census.gov/apsd/techdoc/cps/cpsmar11.pdf.

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

16. Genevieve Kenney, John Holahan, and Len Nichols, "Toward a More Reliable Federal Survey for Tracking Health Insurance Coverage and Access," *Health Services Research*. 41(3 Pt 1) (2006): 918–945; Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, DC: U.S. Census Bureau, 2007), http://www.census.gov/prod/2007pubs/p60-233.pdf.

17. Under the Affordable Care Act, family coverage was extended to allow the inclusion of dependent members up to the age of 26, beginning in late September 2010. Despite this change, the HIU definition remains the same.

18. Data from the CPS ASEC 2010 show that among families with two workers employed in firms of different sizes, the policyholder was the worker employed in the larger firm in 66 percent of families, and the policyholder was the worker employed in the smaller firm only in 18 percent of families. In the remaining 26 percent of families, both workers were policyholders. We were then unable to determine under which policy the dependents were covered under. These data are not shown.

19. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. *2010 Medical Expenditure Panel Survey—Insurance Component.* (Rockville, MD: Agency for Healthcare Research and Quality, July 2011).

20. As shown in table 4, 56 percent of the family members in HIUs associated with the smallest employers have incomes below 250 percent of the FPL ((8.1+5.9)/25.0), compared with only 27 percent of those associated with the largest ((10.3+17.3)/102.6).

21. Blumberg "The High Cost of Small Business Health Insurance: Limited Options, Limited Coverage."

22. See table 1, which shows an increase of 0.3 percent in health insurance offers by firms larger than 1000 employees. Taken from Agency for Healthcare Research and Quality, Center for Financing, Access, Cost Trends, 2000 and 2010 Medical Expenditure Panel Survey—Insurance Component.

23. Vistnes et al., "Declines in Employer-Sponsored Insurance between 2000 and 2008."

24. These 8.9 million workers are not all uninsured today. Some are already eligible for and enrolled in Medicaid/Children's Health Insurance Program, while others have other sources of coverage. All, however, will be Medicaid eligible as of January 1, 2014.

25. These workers and their dependents were those who worked for a smaller firm but were assigned to the larger firms of the family in the analysis. These workers, and their spouses and dependents, might have access to SHOP exchange coverage and its benefits beginning in 2014, even if the spouse worked for a larger firm.

26. McMorrow et al., "The Effects of Health Reform on Businesses and Their Workers"; Matthew Buettgens, Bowen Garrett, and John Holahan, "America Under the Affordable Care Act," (Washington, DC: The Urban Institute, 2010).