

Health Care Coverage, Access, and Affordability for Children and Parents: New Estimates from March 2016

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At a Glance

- Between mid-2013 and March 2016, the share of parents and children with health insurance coverage increased 6.0 and 1.5 percentage points, respectively.
- Children who had uninsured parents in March 2016 were much more likely to be uninsured than were children with insured parents.
- The share of parents and children who have had a routine checkup in the past 12 months increased, and fewer parents are having problems affording health care for themselves and their children.
- Barriers to covering parents who remained uninsured in March 2016 include ineligibility for financial assistance and limited awareness of ACA coverage provisions.

The key health insurance coverage provisions of the Affordable Care Act (ACA) were primarily targeted toward low- and moderate-income nonelderly adults (those ages 18 to 64), who historically have had the highest uninsurance rates of any group (Blavin et al. 2012). Parents living with dependent children were among those expected to benefit from those provisions (Aizer and Grogger 2003; Busch and Duchovny 2005; Hamersma and Kim 2009; McMorro et al. 2016), which have the potential for positive spillover effects on children's coverage and health care access and on families' financial well-being (Davidoff et al. 2003; Dubay and Kenney 2003; Finkelstein et al. 2012).

A previous analysis of June 2013 through September 2015 data from the Urban Institute's Health Reform Monitoring Survey (HRMS) found that parents, and to a lesser extent, children, experienced gains in coverage following the implementation of the ACA's major coverage provisions (Karpman, Gates, and Kenney 2016). Several federal surveys have found similar gains in coverage for children since 2013 (Alker and Chester 2015; Cohen, Martinez, and Zammitti 2016; Gates et al. 2016; Lukanen, Schwehr, and Fried 2016; Smith and Medalia 2015). Such gains appear in large part to be caused by increased participation of children who are eligible for Medicaid and the Children's Health Insurance Program, or CHIP (Kenney et al. 2016).

What We Did

We use data from several rounds of the HRMS, including questions from the HRMS child supplement (HRMS-Kids), to assess changes in coverage, access, and affordability for nonelderly parents ages 18 to 64 and children age 17 and under. In each round of the HRMS, approximately 7,500 nonelderly adults complete the survey. The HRMS-Kids was added to the HRMS in the second quarter of 2013 to ask questions about a randomly selected child in respondents' households, yielding information on approximately 2,400 children each round. Our definition of parents, which

is based on information provided in the HRMS-Kids, includes all parents and other legal guardians living with a dependent child age 17 or under. In some cases, adults who are not parents or guardians (e.g., other relatives or nonrelatives) respond to the HRMS-Kids questions on behalf of a randomly selected child in the household. Those cases are excluded from analyses of parents and guardians but are included in analyses of outcomes for children.¹

We examine changes in coverage between mid-2013, just before the first open enrollment period under the ACA, and March 2016.² Data from June and September 2013 are pooled to increase the precision of our mid-2013 estimates. March 2016 data are not pooled with data from other rounds of the survey, because additional data collected after the third open enrollment period are not yet available.

We consider both coverage at the time of the survey and whether parents and children were insured for all 12 months before the survey.³ We also assess how the uninsurance rate of children varied by the coverage status of parents reporting on their behalf in June/September 2013 and March 2016. Although these estimates of children's uninsurance rates by parental coverage status reflect only the coverage status of the parent who responds to the survey, they serve as a useful proxy for the coverage status of all parents because other data indicate that, among parents living together in 2014, only about 9 percent were in households in which one parent had coverage and the other was uninsured.⁴

Next, we examine changes in health care access and affordability between June/September 2013 and March 2016. Our measures of access include whether parents and children have a usual source of care; whether they have had a routine checkup in the past 12 months; and whether they have had trouble finding a doctor in the past 12 months. For children, trouble finding a doctor includes difficulty finding a general doctor, specialist, or dentist who would see them. For parents, the question about trouble finding a doctor or other health care provider does not specify the type of provider.

When examining measures of health care affordability, we focus on whether parents did not get one of the following types of care in the past 12 months because they could not afford it: prescription drugs, medical care, general doctor care, specialist care, tests, treatment, follow-up care, or mental health care or counseling. We also focus on problems paying family medical bills in the past 12 months and problems paying a child's medical bills in the past 12 months, and we assess whether the respondent is very or somewhat confident his or her child could get health care if he or she needed it.⁵

Each round of the HRMS and HRMS-Kids is weighted to be nationally representative. We use these weights and regression adjustment to control for differences in the demographic and socioeconomic characteristics of the respondents and their children across the different rounds of the survey.⁶ This allows us to remove any variation in coverage, access, and affordability caused by changes in the observable characteristics of people responding to the survey over time. However, the basic patterns shown for the regression-adjusted measures are similar to those based solely on simple weighted estimates.⁷ We emphasize statistically significant changes in coverage and other outcomes over time, defined as differences that are significantly different from zero at the 5 percent level or lower. We provide a 95 percent confidence interval (CI) for key estimates.

Though HRMS estimates capture changes in outcomes since June/September 2013, the estimates do not reflect the effects of some important ACA provisions (such as the ability to keep dependents on health plans until age 26, early state Medicaid expansions, and the maintenance of eligibility provision for children) that were implemented before 2013. In addition, these estimates

will reflect changes beyond the effects of the ACA because they do not control for long-term trends in health insurance coverage, access, and affordability that predate the ACA, changes in the business cycle, or other factors.

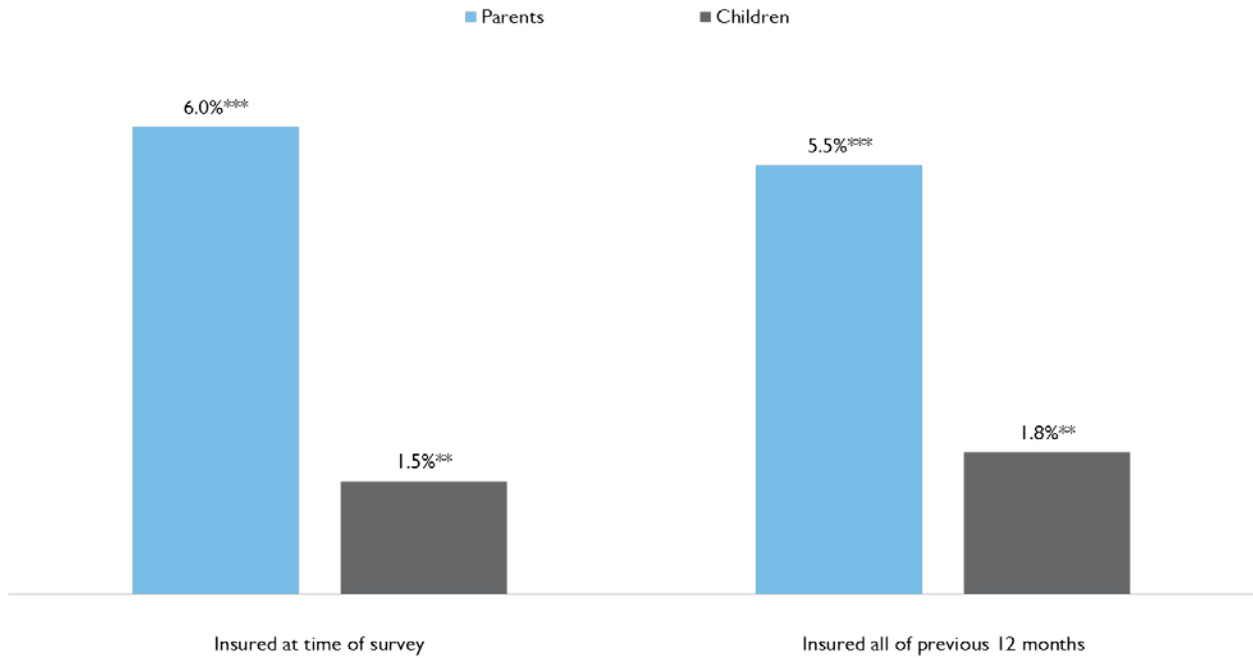
In addition to reporting changes in coverage, access, and affordability over time, we examine the characteristics of the remaining uninsured parents in March 2016, including their income distribution with respect to the federal poverty level (FPL) and whether they live in a state that expanded Medicaid by January 1, 2016.⁸ Although this information is indicative of the potential access to financial assistance under the ACA among these parents, we cannot use it to determine which parents are eligible for Medicaid or Marketplace premium subsidies for several reasons. First, some of these parents may be immigrants who are not eligible for any financial assistance to obtain coverage. Others may be ineligible for Marketplace subsidies because of an affordable offer of employer-based coverage. In addition, the income measure used in the HRMS is not the same as the measure of modified adjusted gross income used to determine eligibility for Medicaid and Marketplace tax credits. Finally, some uninsured parents with incomes at or below 138 percent of FPL may qualify for Medicaid under pre-ACA eligibility categories.

We conclude by examining whether the remaining uninsured parents have looked for information about health plans available through the Marketplace, how much those with incomes below 400 percent of FPL have heard about Marketplace premium subsidies, and whether uninsured parents know the correct amount of the tax penalty for not having coverage in 2016.⁹

What We Found

Between June/September 2013 and March 2016, parents and children experienced gains in coverage and were more likely to be insured for a full year. We find a 6.0 percentage-point increase (95% CI [4.9, 7.2]) in the share of parents with coverage and a 1.5 percentage-point increase (95% CI [0.2, 2.7]) in the share of children with coverage between June/September 2013 and March 2016 (figure 1).¹⁰ During this period, there were similar patterns with respect to changes in full-year coverage, with parents 5.5 percentage points and children 1.8 percentage points more likely to have been insured for all 12 of the preceding months. Despite the larger gains for parents, children were still more likely to have coverage than parents in March 2016 (appendix table 1).

Figure 1. Percentage-Point Increase in Health Insurance Coverage for Parents Ages 18 to 64 and Children Age 17 and Under between June/September 2013 and March 2016



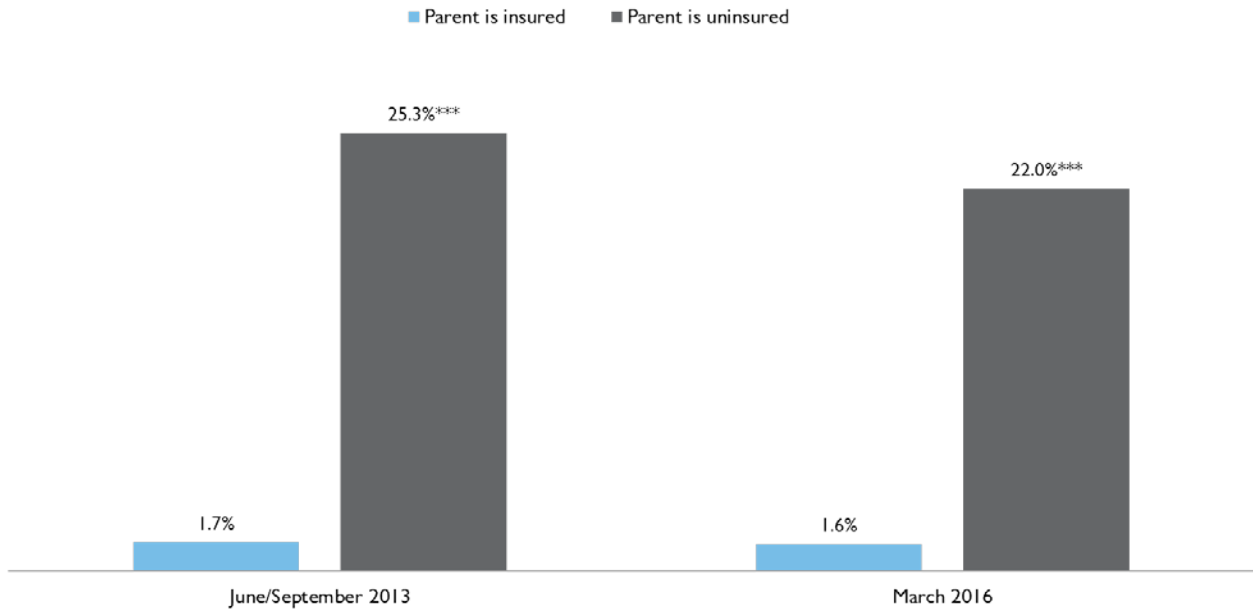
Source: Health Reform Monitoring Survey, quarters 2-3 2013 and quarter 1 2016.

Note: Estimates are regression adjusted.

*** Estimate differs significantly from zero at the .10/.05/.01 level, using two-tailed tests.

Children who had uninsured parents in March 2016 were much more likely to be uninsured than children with insured parents. Although children were less likely to have an uninsured parent in March 2016 relative to June/September 2013, those with an uninsured parent remained much more likely to be uninsured compared to children with an insured parent (figure 2).¹¹ In March 2016, we found a 22.0 percent uninsurance rate for children whose parents were uninsured compared with a 1.6 percent uninsurance rate for children whose parents were insured.

Figure 2. Share of Children Age 17 and Under Who Are Uninsured, by their Parents' Coverage Status, June/September 2013 and March 2016



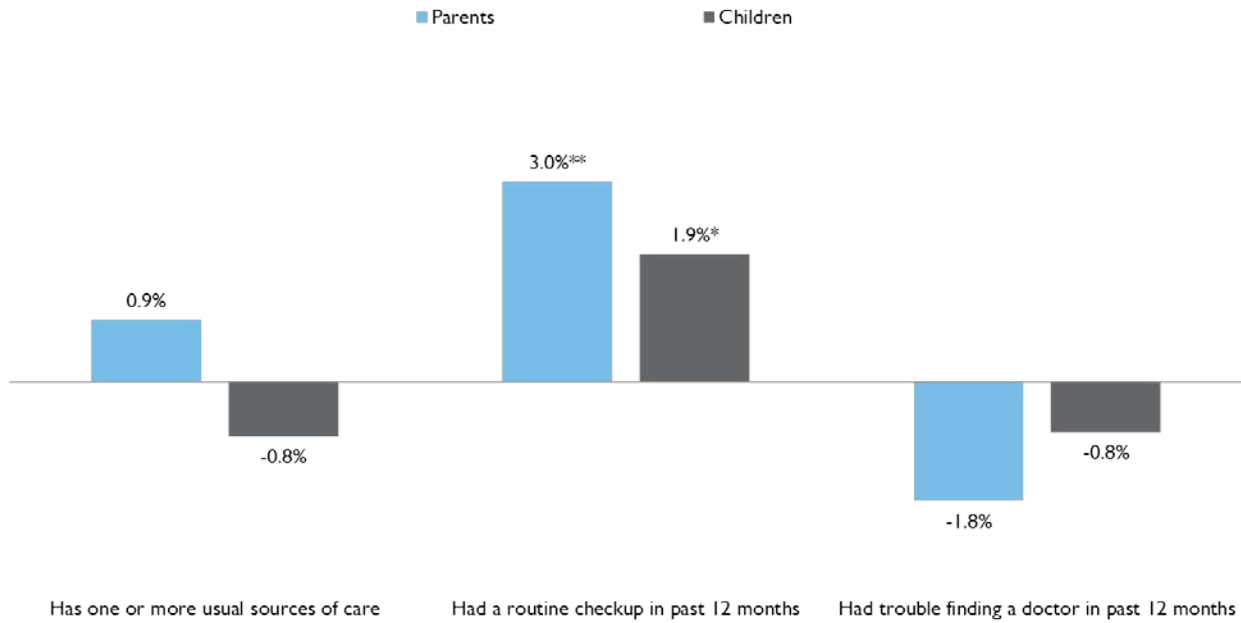
Source: Health Reform Monitoring Survey, quarters 2–3 2013 and quarter 1 2016.

Notes: Estimates exclude responses from those who are not parents or guardians. Estimates are not regression adjusted. See the text for further information on the estimated uninsurance rates for children by parental coverage status.

*** Estimate differs significantly from children with an insured parent at the 0.01 level, using a two-tailed test.

More parents and children are getting routine checkups. The share of parents who have had a routine checkup in the past 12 months increased 3.0 percentage points (95% CI [0.6, 5.4]) between June/September 2013 and March 2016, and the share of children who have had a routine checkup in the past 12 months increased 1.9 percentage points, though the latter estimate is only significant at the 0.10 level (figure 3). For both groups, there was no statistically significant change in the percentage that had a usual source of care or in the percentage that has had trouble finding a doctor, though more access problems were reported for parents than for children. As of March 2016, more than 9 in 10 children and nearly three-quarters of parents reported a usual source of care, and about one in 5 parents (19.2 percent) and one in 10 children (9.6 percent) had difficulty finding a doctor in the previous year (appendix table 1).

Figure 3. Percentage-Point Change in Health Care Access for Parents Ages 18 to 64 and Children Age 17 and Under between June/September 2013 and March 2016



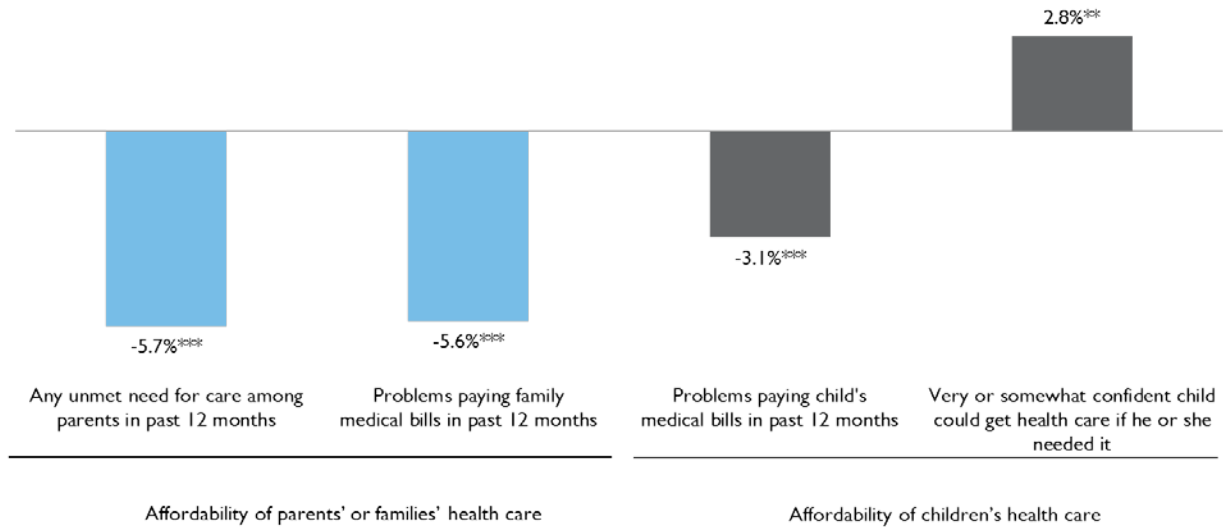
Source: Health Reform Monitoring Survey, quarters 2-3 2013 and quarter 1 2016.

Notes: Estimates are regression adjusted. "Trouble finding a doctor" for children includes difficulty finding a general doctor, specialist, or dentist.

^{**} *p* < 0.01; ^{*} *p* < 0.05. Estimate differs significantly from zero at the 0.10/0.05/0.01 levels, using two-tailed tests.

Parents are reporting fewer health care affordability problems. There were gains in reported health care affordability as reflected in several indicators. The share of parents who had an unmet need for care because of affordability reasons in the past 12 months fell 5.7 percentage points (95% CI [4.0, 7.4]) between June/September 2013 and March 2016 (figure 4).¹² There was a 5.6 percentage-point decline (95% CI [3.0, 8.1]) in the share of parents reporting problems paying family medical bills and a 3.1 percentage-point decline (95% CI [1.1, 5.1]) in the share of adults reporting problems paying a child's medical bills. Respondents were also 2.8 percentage points (95% CI [0.5, 5.0]) more likely to say they were confident that their child could get health care if he or she needed it. However, many parents, particularly those who are uninsured (data not shown), still struggled to afford health care, with 25.0 percent reporting an unmet need for care and 21.1 percent reporting problems paying family medical bills in March 2016 (appendix table 1).

Figure 4. Percentage-Point Change in Health Care Affordability and Perceptions of Parents Ages 18 to 64 and Children Age 17 and Under between June/September 2013 and March 2016



Source: Health Reform Monitoring Survey, quarters 2–3 2013 and quarter 1 2016.

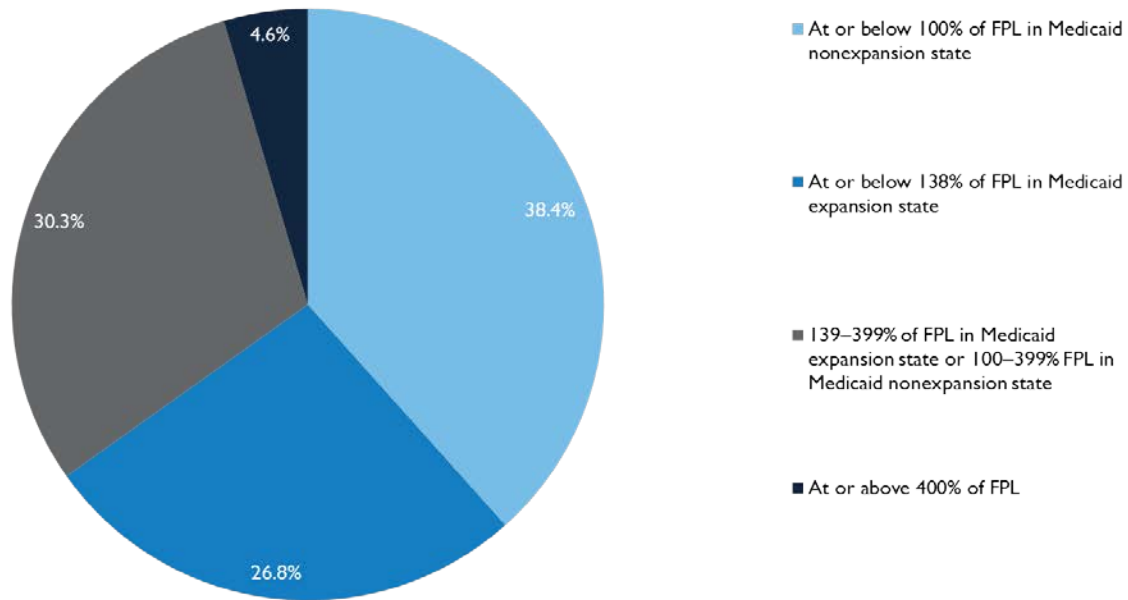
Notes: Estimates are regression adjusted. Unmet needs for care include prescription drugs, medical care, general doctor care, specialist care, tests, treatment, or follow-up care, and mental health care or counseling. Problems paying child's medical bills in past 12 months and confidence in child's ability to get needed health care include responses from those who are not parents or guardians.

*** Estimate differs significantly from zero at the 0.10/0.05/0.01 levels, using two-tailed tests.

Nearly two in five uninsured parents had incomes below 100 percent of FPL and lived in a state that did not expand Medicaid. Nearly two in five (38.4 percent) parents who remained uninsured in March 2016 had incomes below 100 percent of FPL and lived in a state that had not expanded Medicaid as of January 2016 (figure 5). Many of these parents fall into a coverage gap because their incomes are too low to qualify for Marketplace premium subsidies but too high to qualify for Medicaid (Blumberg et al. 2016). In the states that did not expand Medicaid by January 2016, the median income eligibility threshold for parents is only 42 percent of FPL (Kaiser Commission on Medicaid and the Uninsured 2016).

Another 26.8 percent of uninsured parents have incomes at or below 138 percent of FPL and live in states that have expanded Medicaid. These parents are in the income range targeted by the ACA's Medicaid expansion though, as discussed, they may not qualify for Medicaid because of their immigration status or because the income measure available on the survey does not align with the income measure used to determine eligibility. Thirty percent of the uninsured parents appear to have incomes that would make them potentially eligible for Marketplace subsidies, but some may not qualify because of the affordability test used to determine subsidy eligibility or because of immigration requirements. Only 4.6 percent of uninsured parents have incomes above 400 percent of FPL, making them unlikely to be eligible for financial assistance to buy coverage under the ACA.

Figure 5. Family Income and State Medicaid Expansion Status of Remaining Uninsured Parents Ages 18 to 64, March 2016

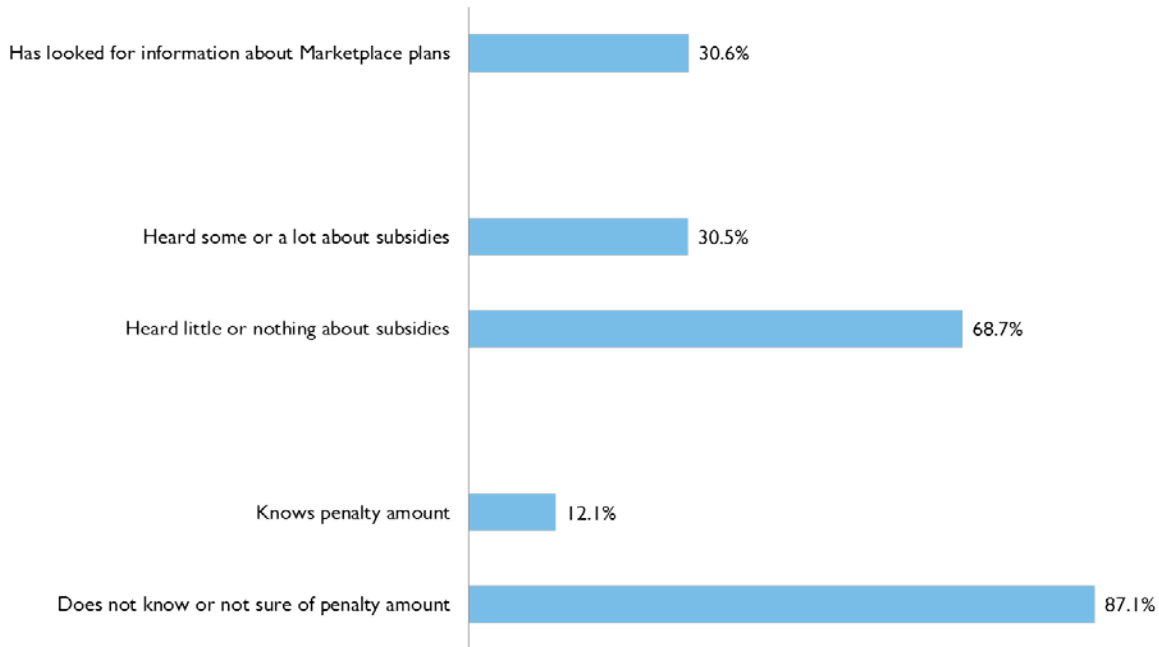


Source: Health Reform Monitoring Survey, quarter 1 2016.

Notes: FPL = federal poverty level. Medicaid expansion states include those that expanded Medicaid by January 1, 2016.

Few remaining uninsured parents have looked for coverage in the ACA’s Marketplaces or were aware of premium subsidies or the amount of the tax penalty for being uninsured. About 30.6 percent of parents who were uninsured in March 2016 reported looking for information about health plans available through the health insurance Marketplaces (figure 6). In addition, uninsured parents reported low levels of awareness of other key ACA coverage provisions. Just 30.5 percent of uninsured parents with incomes below 400 percent of FPL reported having heard some or a lot about the Marketplace premium subsidies. Furthermore, most uninsured parents were unsure of the amount of the tax penalty for not having coverage. Only 12.1 percent of uninsured parents knew the correct amount of the tax penalty that would be assessed in 2017 for not having had coverage in 2016. Another 14.3 percent underestimated the amount, 4.4 percent overestimated the amount, 68.4 percent were not sure, and 0.8 percent did not respond to the question (data not shown). Although many of the remaining uninsured parents are likely to be exempt from the penalty because (a) their incomes are below the tax filing threshold, (b) their premiums would be considered unaffordable relative to their income, or (c) they have incomes below 138 percent of FPL and live in a state that did not expand Medicaid, greater awareness of the penalty amount could spur some uninsured parents to seek out coverage.

Figure 6. Experience with Marketplaces and Awareness of ACA Provisions Among Uninsured Parents Ages 18 to 64, March 2016



Source: Health Reform Monitoring Survey, quarter 1 2016.

Note: Question about awareness of subsidies only asked of those with incomes below 400 percent of the federal poverty level. Estimates not shown for the share of adults who did not respond to questions about use of the Marketplaces, awareness of subsidies, or knowledge of the penalty amount.

What It Means

Parents and children experienced improvements in coverage, receipt of routine checkups over the course of a year, and several measures of health care affordability between June/September 2013, just before the implementation of the ACA's key coverage provisions, and March 2016, just after the completion of the third open enrollment period. We also found a strong association between the coverage status of parents and children: a child was over 20 percentage points more likely to be without coverage when his or her parent was without coverage. It also appears that the levels of coverage, access, and affordability were relatively stable between late 2015 and early 2016; the findings in this brief echo findings reported in a previous analysis of changes through September 2015 (Karpman, Gates, and Kenney 2015).

A significant share of parents who remained uninsured in March 2016 were unlikely to be eligible for financial assistance to obtain coverage, including nearly two in five who were poor and lived in a state that had not expanded Medicaid. Other uninsured parents may be ineligible for Medicaid or Marketplace coverage because of their immigration status or may be eligible for and aware of Marketplace subsidies but still find that coverage unaffordable. In the absence of additional federal and state action to expand Medicaid eligibility, increase the subsidies available for coverage, or enact other related policy changes, the potential for continued gains in coverage will depend on targeted outreach efforts to the remaining uninsured who are eligible for financial assistance but reported little awareness of the ACA's coverage provisions.

Potential strategies to reach the remaining uninsured parents and children who have the greatest potential to enroll in coverage—those who qualify for either Medicaid, CHIP, or the most generous premium subsidies—include outreach and enrollment assistance through public schools, nonhealth public benefit programs, places of employment, family courts, and support programs for single parents (Blumberg et al. 2016). Other studies suggest that parent mentors can play an important role in helping other parents obtain coverage for their children (Flores et al. 2016). These and other outreach strategies may promote further coverage gains by increasing the rate at which eligible parents and children take advantage of the financial assistance available to them through Medicaid, CHIP, and the Marketplaces. The rising rates of participation among children eligible for Medicaid or CHIP—which increased nationally from 81.7 percent in 2008 to 91.0 percent in 2014 along with persistent variation in participation rates across states (Kenney et al. 2016)—underscore the opportunities for further progress in covering the parents and children who remained uninsured in March 2016.

Appendix Table 1. Coverage, Access, and Affordability for Parents Ages 18 to 64 and Children Age 17 and Under, June/September 2013 through March 2016

| | June/September 2013 | March 2016 |
|---|---------------------|------------|
| Parents | | |
| <i>Coverage</i> | | |
| Insured at time of survey | 83.3% | 89.3%*** |
| Insured all of past 12 months | 75.0% | 80.5%*** |
| Uninsured all of past 12 months | 13.1% | 8.0%*** |
| Insured for part but not all of past 12 months | 11.3% | 11.3% |
| <i>Access</i> | | |
| Has one or more usual sources of care | 71.9% | 72.8% |
| Had a routine checkup in past 12 months | 59.6% | 62.6%** |
| Had trouble finding a doctor in past 12 months | 21.0% | 19.2% |
| <i>Affordability</i> | | |
| Any unmet need for care in past 12 months | 30.7% | 25.0%*** |
| Problems paying family medical bills in past 12 months | 26.7% | 21.1%*** |
| Children | | |
| <i>Coverage</i> | | |
| Insured at time of survey | 94.6% | 96.1%** |
| Insured all of past 12 months | 87.8% | 89.6%** |
| Uninsured all of past 12 months | 3.4% | 1.6%*** |
| Insured for part but not all of past 12 months | 8.1% | 8.2% |
| <i>Access</i> | | |
| Has one or more usual sources of care | 92.1% | 91.3% |
| Had a routine checkup in past 12 months | 82.2% | 84.1%* |
| Had trouble finding a doctor in past 12 months | 10.4% | 9.6% |
| <i>Affordability</i> | | |
| Any unmet need for care in past 12 months | 13.0% | 14.2% |
| Problems paying child's medical bills in past 12 months | 13.2% | 10.1%*** |
| Very or somewhat confident child could get health care if he or she needed it | 92.9% | 95.6%** |

Source: Health Reform Monitoring Survey, quarters 2–3 2013 and quarter 1 2016.

Notes: Estimates are regression adjusted. Estimates are not shown for those who did not report coverage status in the past 12 months. “Trouble finding a doctor” for children includes difficulty finding a general doctor, specialist, or dentist. “Unmet needs for care” for parents include prescription drugs, medical care, general doctor care, specialist care, tests, treatment, or follow-up care, and mental health care or counseling. “Unmet needs for care” for children include prescription drugs, medical care, general doctor care, specialist care, tests, treatment, or follow-up care, mental health care or counseling, and eyeglasses or vision care.

*/**/*** Estimate differs significantly from June/September 2013 at the 0.10/0.05/0.01 levels, using two-tailed tests.

References

- Aizer, Anna, and Jeffrey Grogger. 2003. [*Parental Medicaid Expansions and Health Insurance Coverage*](#). Working Paper 9907. Cambridge, MA: National Bureau of Economic Research.
- Alker, Joan, and Alisa Chester. 2015. [*“Children’s Health Insurance Rates in 2014: ACA Results in Significant Improvements.”*](#) Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families.
- Blavin, Fredric, John Holahan, Genevieve M. Kenney, and Vicki Chen. 2012. [*A Decade of Coverage Losses: Implications for the Affordable Care Act*](#). Washington, DC: Urban Institute.
- Blumberg, Linda J., Michael Karpman, Matthew Buettgens, and Patricia Solleveld. 2016. [*Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us about How to Reach Them?*](#) Washington, DC: Urban Institute.
- Busch, Susan H., and Noelia Duchovny. 2005. [*“Family Coverage Expansions: Impact on Insurance Coverage and Health Care Utilization of Parents.”*](#) *Journal of Health Economics* 24 (5): 876–90.
- Cohen, Robin A., Michael E. Martinez, and Emily P. Zammitti. 2016. [*Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2015*](#). Hyattsville, MD: National Center for Health Statistics.
- Davidoff, Amy, Lisa Dubay, Genevieve M. Kenney, and Alshadye Yemane. 2003. [*“The Effect of Parents’ Insurance Coverage on Access to Care for Low-income Children.”*](#) *Inquiry* 40: 254–68.
- Dubay, Lisa, and Genevieve M. Kenney. 2003. [*“Expanding Public Health Insurance to Parents: Effects on Children’s Coverage under Medicaid.”*](#) *Health Services Research* 38 (5): 1283–1301.
- Finkelstein, Amy, Sarah Taubman, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, Katherine Baicker, and the Oregon Health Study Group. 2012. [*“The Oregon Health Insurance Experiment: Evidence from the First Year.”*](#) *Quarterly Journal of Economics* 127 (3): 1057–1106.
- Flores, Glenn, Hua Lin, Candy Walker, Michael Lee, Janet M. Currie, Rick Allgeyer, Marco Fierro, Monica Henry, Alberto Portillo, and Kenneth Massey. 2016. [*“Parent Mentors and Insuring Uninsured Children: A Randomized Controlled Trial.”*](#) *Pediatrics* 137 (4): e20153519. DOI: 10.1542/peds.2015-3519.
- Gates, Jason A., Michael Karpman, Genevieve M. Kenney, and Stacey McMorro. 2016. [*Uninsurance among Children, 1997–2015: Long-Term Trends and Recent Patterns*](#). Washington, DC: Urban Institute.
- Hamersma, Sarah, and Matthew Kim. 2009. [*“The Effect of Parental Medicaid Expansions on Job Mobility.”*](#) *Journal of Health Economics* 28 (4): 761–70.
- Kaiser Commission on Medicaid and the Uninsured. 2016. [*Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women*](#). Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- Karpman, Michael, Jason Gates, and Genevieve M. Kenney. 2016. [*Time for a Checkup: Changes in Health Insurance Coverage, Health Care Access and Affordability, and Plan Satisfaction among Parents and Children between 2013 and 2015*](#). Washington, DC: Urban Institute.
- Kenney, Genevieve M., Jennifer M. Haley, Clare Wang Pan, Victoria Lynch, and Matthew Buettgens. 2016. [*Children’s Coverage Climb Continues: Eligibility and Participation under the ACA*](#). Washington, DC: Urban Institute.
- Lukanen, Elizabeth, Natalie Schwehr, and Brett Fried. 2016. [*State-Level Trends in Children’s Health Insurance Coverage, 2016*](#). Minneapolis, MN: State Health Access Data Assistance Center.

McMorrow, Stacey, Genevieve M. Kenney, Sharon K. Long, and Dana E. Goin. 2016. [“Medicaid Expansions from 1997 to 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Parents.”](#) *Health Services Research* doi: 10.1111/1475-6773.12432.

Smith, Jessica C., and Carla Medalia. 2015. [Health Insurance Coverage in the United States, 2014](#). Washington, DC: US Census Bureau.

State Health Access Data Assistance Center. 2013. [Comparing Federal Government Surveys that Count the Uninsured](#). Princeton, NJ: Robert Wood Johnson Foundation.

About the Series

This brief is part of a series drawing on the HRMS, a survey of the nonelderly population that explores the value of cutting-edge Internet-based survey methods to monitor the ACA before data from federal government surveys are available. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation and the Urban Institute. This brief was funded by the David and Lucile Packard Foundation and funding from an anonymous donor. It draws on the HRMS-Kids, which was conducted in partnership with the Center for Children and Families at Georgetown University and is currently funded by the David and Lucile Packard Foundation. The authors are grateful to Sharon Long, Douglas Wissoker, Nathaniel Anderson, Lisa Clemans-Cope, Lisa Dubai, Joan Alker, Tricia Brooks, and Liane Wong for their input on the HRMS-Kids.

For more information on the HRMS and for other briefs in this series, visit www.urban.org/hrms.

About the Authors

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The authors gratefully acknowledge the suggestions and assistance of Stephen Zuckerman.

Notes

¹ In the March 2016 HRMS, 94.1 percent of adults reporting on behalf of children were parents or guardians.

² We focus on estimated changes in coverage because estimates of the level of coverage often vary across surveys because of differences in survey design (State Health Access Data Assistance Center 2013). In some rounds of the survey, the interview month starts a few days before or lasts a few days after the target month.

³ We focus on estimated changes in coverage because estimates of the level of coverage often vary across surveys because of differences in survey design (State Health Access Data Assistance Center 2013). In some rounds of the survey, the interview month starts a few days before or lasts a few days after the target month.

⁴ Authors’ tabulations of 2014 National Health Interview Survey data. Among single parents, the coverage status reported reflects that of the parent who is living with the child at the time of the survey.

⁵ Estimates of the share of adults reporting problems paying a child’s medical bills and reporting confidence the child could get needed health care include responses from adults who are not the child’s parent or guardian.

⁶ We control for the variables used in poststratification of both the KnowledgePanel (the nationally representative Internet panel maintained by GfK Custom Research from which HRMS samples are drawn) and the HRMS, including gender, age, race/ethnicity, language, education, marital status, presence of children in the household, household income, family income, homeownership status, Internet access, urban/rural status, and region. We also control for citizenship

status and participation in the previous quarter's survey. For children, we include all of the control variables for respondents as well as controls for the child's gender, age, and race/ethnicity, and for the number of children in the household.

⁷ In presenting the regression-adjusted estimates, we use the predicted rate of each measure in each quarter or set of pooled quarters for the same nationally representative population. For this analysis, we base the nationally representative sample on survey respondents for the four most recent rounds of the survey for quarters 1 and 3 to match the current timing of the HRMS. The nationally representative sample includes parents from the third quarter of 2014, the first and third quarters of 2015, and the first quarter of 2016 when examining changes in outcomes for parents. It includes children from the third quarter of 2014, the first and third quarters of 2015, and the first quarter of 2016 when examining changes in outcomes for children. The basic patterns shown for the regression-adjusted measures are similar to those based solely on simple weighted estimates.

⁸ States expanding Medicaid by January 1, 2016, are AK, AZ, AR, CA, CO, CT, DE, DC, HI, IL, IN, IA, KY, MD, MA, MI, MN, MT, NH, NV, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV. Several of those states, including CA, CT, DC, and MN, expanded Medicaid under the ACA before 2013. Among nonexpansion states, WI has used state funding to expand eligibility to nonelderly adults with incomes up to 100 percent of FPL, and LA expanded eligibility for Medicaid in June 2016.

⁹ The correct answer to the survey question was "higher of \$695 per adult or 2.5 percent of household income." Other potential responses were: "the higher of \$95 per adult or 1 percent of household income," "the higher of \$325 per adult or 2 percent of household income," "the higher of \$1,095 per adult or 3.5 percent of household income," and "I am not sure."

¹⁰ Because of differences in survey design and coverage editing processes, HRMS estimates of the levels of uninsurance are typically below the levels reported in other surveys.

¹¹ These estimates of the children's uninsurance rate by their parents' coverage status in June/September 2013 and March 2016 are not regression adjusted.

¹² We did not find statistically significant changes in the share of children with unmet needs for any of the following types of care because of affordability reasons: prescription drugs, medical care, general doctor care, specialist care, tests, treatment, or follow-up care, mental health care or counseling, or eyeglasses or vision care.