Obamacare Reduces Racial Disparities in Health Coverage

By Algernon Austin

The 2014 implementation of the Affordable Care Act (ACA), also known as Obamacare, has had a promising start in providing health insurance for all Americans. All racial groups have experienced substantial increases in their health insurance coverage. Before the ACA was enacted, people of color were much more likely to be uninsured than Whites. Obamacare has reduced these disparities and has essentially eliminated the difference between the uninsured rates of Asian Americans and Whites and of Black and White children. Yet evidence from Massachusetts' health insurance reform—a model for the Affordable Care Act—suggests that Obamacare is not going to completely eliminate racial and ethnic inequalities in health insurance coverage. Only a more extensive expansion of government-sponsored health insurance is likely to achieve that goal.

This issue brief finds:

- *Disparities in uninsured rates between Asian Americans and Whites and between Black and White children were eliminated in 2014.*
- *Health insurance coverage for people of color increased primarily due to increases in private insurance; for Whites, coverage increased primarily because of increases in government insurance.*
- *The growth in health insurance enrollment in 2014 might have been 25 percent greater if all states had expanded Medicaid under Obamacare.*
- *The evidence from Massachusetts' health insurance reform—a model for Obamacare—suggests that the Affordable Care Act will lower uninsured rates for all, but racial and ethnic disparities in health insurance coverage between White and non-White populations will remain.*
- *A significant expansion of Medicaid or Medicare could eliminate all racial and ethnic disparities in health insurance coverage.*

Health and Wealth Benefits of Health Insurance

As one might imagine, for all people a lack of health insurance is associated with worse health outcomes. The uninsured are less likely to receive needed care for preventable and chronic conditions. They are also more likely to postpone care and to forego needed prescriptions due to cost. For these reasons, the uninsured are sicker and more likely to die prematurely than the insured. [1]

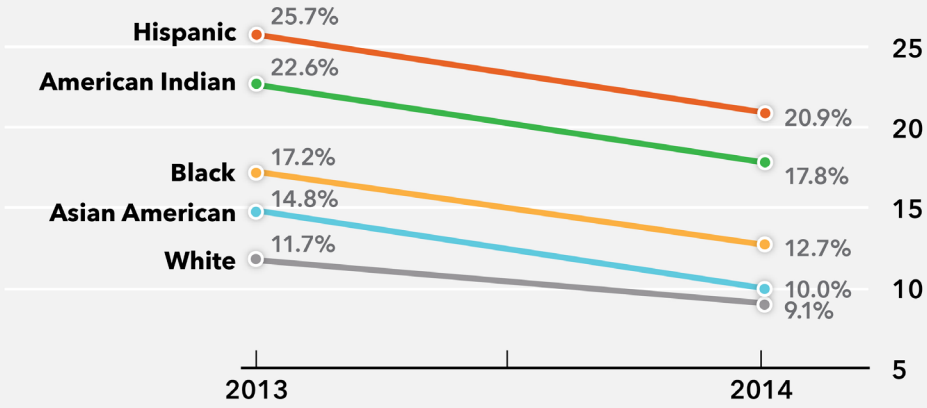
The lack of health insurance also puts an individual's wealth at risk. Uninsured low- and moderate-income adults are twice as likely as the insured to use up their savings or go into debt because of medical bills. The Kaiser Family Foundation reports:

> *In 2014, nearly a third (32 percent) of uninsured adults said they were carrying medical debt. Medical debts contribute to over half (52 percent) of debt collections actions that appear on consumer credit*

reports in the United States and contribute to almost half of all bankruptcies in the United States. Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.[2]

The stress of being unable to pay medical bills affects uninsured adults' job performance, family relationships, and ability to sleep.[3] This stress can lead to lower earnings and worse health outcomes, causing a downward spiral.

Figure A.
Percent of People Uninsured by Race, 2013 and 2014
(Under 65 years old)



Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

The high uninsured rates of Hispanics, Blacks, Asian Americans and American Indians, are therefore a contributing factor in the health and wealth disparities between people of color and Whites. When people of color need medical treatment, they are less likely to be able to afford it because they are less likely to have medical insurance and more likely to be low- or moderate-income.[4] Reports from Latinos and Blacks suggest that they are more likely than Whites to go without medical care because of the cost.[5] If Latinos and Blacks do obtain treatment, they are more likely to fall into debt because of their higher uninsured rates and lower incomes. For example, research on wealth disparities in Boston found that Latinos and Blacks are nearly twice as likely as Whites to have medical debt.[6]

Affordable Care Act Narrows Health Insurance Disparities

2014 was a successful year for the Affordable Care Act. The Census Bureau estimates that nearly 9 million individuals gained health insurance in 2014.[7] The Affordable Care Act has not only reduced the percentage of all racial groups lacking health insurance, it has also reduced disparities in health-insurance coverage between Whites and people of color.

Uninsured rates change in response to economic conditions, demographic shifts, and public policy. We cannot say precisely what portion of the decline in the uninsured rates is due to the policy change of the Affordable Care Act; however, the majority of the change in these rates in 2014 is probably due to the ACA because the drop, which occurred after the Act's implementation, was *several times greater* than any other yearly reduction on record.[8] The unprecedented policy change that is Obamacare is the most reasonable explanation for this dramatic decline.

As Figure A illustrates, all major racial and ethnic groups saw a reduction in their uninsured rate from 2013 to 2014. The reduction for America's racial and ethnic minorities was almost double the reduction for non-Hispanic Whites, which narrowed the uninsured-

rate disparity between people of color and Whites (Table 1). Most notably, the disparity between Asian Americans' higher uninsured rate and the Whites' lower one was essentially eliminated in 2014, dropping from a gap of more than 3 percentage points in 2013 to less than 1 percentage point in 2014. In this brief, uninsured rates within one percentage point of each other are considered to be equivalent.[9] For African Americans, the gap between their higher uninsured rate and that of Whites was 5.5 percentage points in 2013, falling to 3.6 percentage points in 2014. For American Indians,[10] the disparity with Whites dropped from 10.9 percentage points in 2013 to 8.7 points in 2014. For Hispanics, the uninsured rate dropped considerably, but this group still has the largest disparity with Whites, 11.8 percentage points. This large disparity is due, in part, to the relatively large share of the Hispanic population that is made up of unauthorized immigrants, who are ineligible for Medicaid and ACA benefits.[11]

Table 1.
Percent of People Uninsured by Race, 2013 and 2014
(Under 65 years old)

	Uninsured Rate			Difference from the White Uninsured Rate	
	2013	2014	Change 2013 to 2014	2013	2014
All	15.3%	12.0%	-3.3	3.6	2.9
White	11.7%	9.1%	-2.6	--	--
Hispanic	25.7%	20.9%	-4.8	14.0	11.8
Black	17.2%	12.7%	-4.5	5.5	3.6
Asian	14.8%	10.0%	-4.8	3.1	0.9
American Indian	22.6%	17.8%	-4.8	10.9	8.7

Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

These changes, which are largely due to the Affordable Care Act, show that it is possible to create policies that benefit all Americans. No racial or ethnic group was excluded. Whites and all other groups increased their health insurance coverage. People of color had higher uninsured rates than Whites in 2013, and they received a larger benefit from the ACA; this has helped to narrow the gaps between these groups. This policy approaches the ideal for the nation in that it provides universal benefits to all and simultaneously reduces racial and ethnic disparities.

Obamacare Eliminates Three Racial Disparities

It is rare for a racial disparity to be eliminated, but the Affordable Care Act has done so. The ACA has succeeded in eliminating the uninsured gap between Asian Americans and Whites, as discussed above. It has also eliminated the disparity in uninsured rates between Black and White children, and between Asian American and White adult males.

Children's Uninsured Rates

Since the late 1990s, the uninsured rate for children has been declining because of Medicaid and the Children's Health Insurance Program (CHIP) which was established in 1997. CHIP provided states with federal assistance to create programs for children from families with incomes that were too high to qualify for Medicaid but too low to enable them to afford private health insurance. From 1997 to 2012, the uninsured rate for children was cut in half.[12] Even in the immediate wake of the Great Recession, from 2008 to 2010, when the nonelderly adult uninsured

rate was increasing, the children's uninsured rate decreased.[13] This trend produced a widening gap between the lower uninsured rate for children and the higher uninsured rate for nonelderly adults. However, the decline in the children's uninsured rate stalled in 2013. There was no significant reduction in the children's uninsured rate from 2012 to 2013, even though there had been significant reductions most of the prior years, including every year from 2008 to 2012.[14]

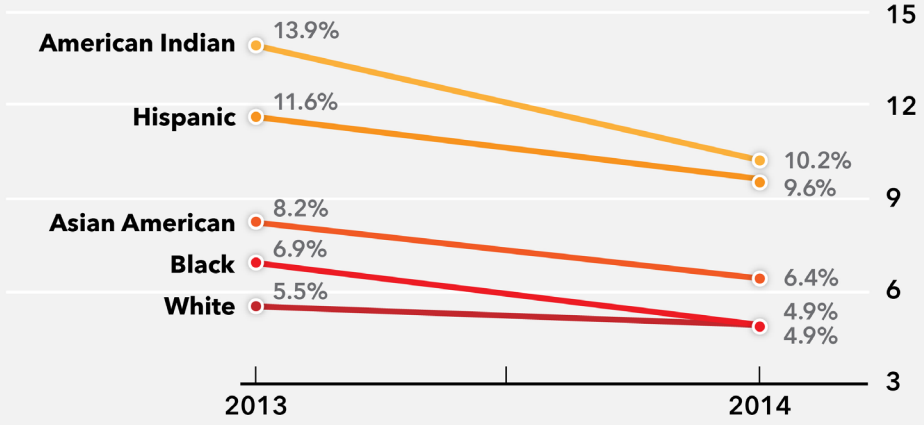
Table 2.
Percent of Children Uninsured by Race, 2013 and 2014

(Under 19 years old)

	2013	2014	Change 2013 to 2014	Difference from the White Uninsured Rate 2013	Difference from the White Uninsured Rate 2014
All	7.5%	6.2%	-1.3	2.0	1.3
White	5.5%	4.9%	-0.6	--	--
Hispanic	11.6%	9.6%	-2.0	6.1	4.7
Black	6.9%	4.9%	-2.0	1.4	0.0
Asian	8.2%	6.4%	-1.8	2.7	1.5
American Indian	13.9%	10.2%	-3.7	8.4	5.3

Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

Figure B.
Percent of Children Uninsured by Race, 2013 and 2014 (Under 19 years old)

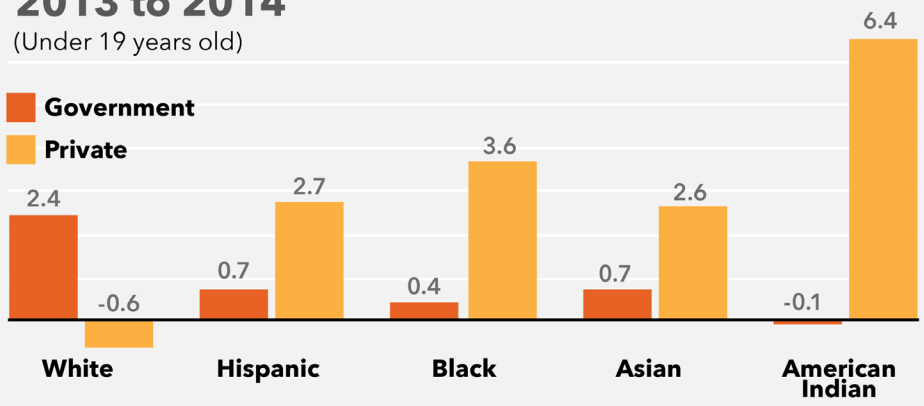


Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

Because of the success of Medicaid and CHIP, health policy analysts predicted that the Affordable Care Act would lead to further reductions in the uninsured rate for children.[15] Policies like the ACA that increase the enrollment of adults in health insurance lead to increases in the enrollment of their children. Additionally, many uninsured children who were eligible for Medicaid or CHIP before the ACA gained coverage after ACA implementation because of increased awareness, outreach, and enrollment efforts.[16] The ACA also changed some policies to increase the enrollment of children in Medicaid or CHIP. Not only does the Act prevent states from lowering Medicaid and CHIP eligibility standards for children, it requires a "children's expansion" of Medicaid. All states must have a minimum Medicaid eligibility level for children of up to 138 percent of the federal poverty level. Because this eligibility level was higher than the standard in several states, in these states, children were moved from CHIP into Medicaid, which has lower costs and provides more comprehensive services. The ACA also increased federal funding to states for CHIP.[17]

Probably due to the long push to enroll low-income children, who are disproportionately non-White, in Medicaid and CHIP, the gaps in uninsured rates between Whites and non-Whites are smaller for children than for nonelderly adults. As with the groups as a whole, children of all racial and ethnic groups saw declines in their uninsured rates, but non-White children saw larger declines. These declines reduced the gaps for all children of color and totally eliminated the uninsured rate gap between Black-and White children (Figure B).

Figure C.
Percentage-Point Change in Children's Government and Private Insurance Coverage, 2013 to 2014
(Under 19 years old)



Note: The types of health insurance coverage are not mutually exclusive. Individuals may be covered by more than one type over the year. All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Author's calculations from Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

In 2013, the uninsured rate for Black children under 19 years old was 1.4 percentage points above the rate for White children (Table 2). Although both groups of children experienced reductions in their uninsured rates, in 2014 the Black rate declined faster, and the disparity was reduced to zero. Although the uninsured rates for White children and Black children both fell in 2014, the increase in their health insurance coverage came from different sources. For white children, the increase in coverage was mainly due to government insurance, while for Black children it was mainly due to private insurance. (It is important to note that, in any year, individuals may be covered by more than one type of insurance.) From 2013 to 2014, the government insurance rate for White children increased by 2.4 percentage points, while their private insurance coverage declined by 0.6 percentage points (Figure C and Appendix Table A-1). In contrast, Black children's private insurance coverage increased 3.6 percentage points, while their government insurance coverage increased only 0.4 percentage points.

The disparity in uninsured rates between Asian American and White children was also nearly eliminated (Figure B and Table 2). The disparity fell from 2.7 percentage points in 2013 to 1.5 points in 2014 (Figure B and Table 2). As with Black children, the increase in health insurance coverage for Asian American children was driven more by private insurance than by government insurance. The percentage point increase in private coverage for Asian American children from 2013 to 2014 was more than three times as large as the increase in government health insurance coverage (Figure C and Appendix Table A-1).

The difference in uninsured rates between Hispanic and White children fell from 6.1 percentage points to 4.7 points, and the inequality between American Indian and White children fell from 8.4 percentage points to 5.3 points (Figure B and Table 2). For these groups also, growth in private coverage was greater than growth in government coverage. American Indian children had the largest growth in private health insurance coverage—6.4 percentage points—and

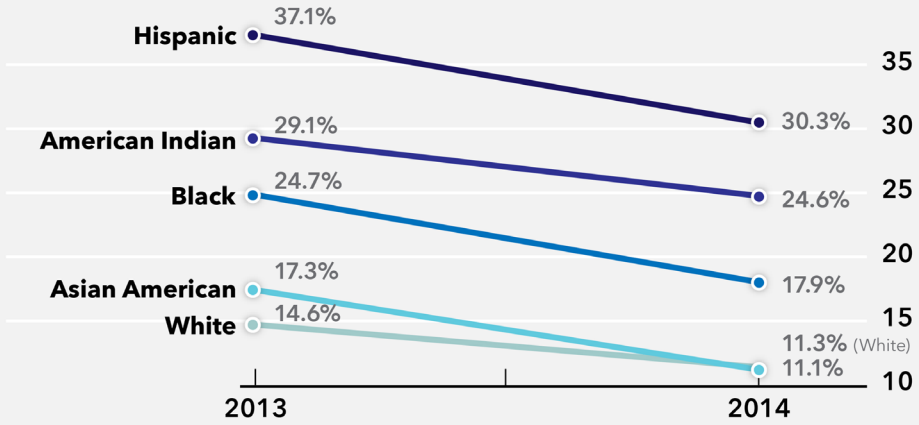
were the only group other than Whites to experience a decline in government health insurance coverage (Figure C and Appendix Table A-1).

All children of color saw a larger increase in private health insurance than in government insurance. There is reason to be concerned about this development since there are signs that insurance purchased through the health insurance exchanges is still too expensive for many people to maintain or to use to fully access all of the health care that they need. This issue is discussed further below.

Uninsured Rates for Men and Women

Obamacare has eliminated the uninsured-rate disparity between Asian American and White men, and it has nearly eliminated the disparity between Asian American and White women. In 2013, the Asian American uninsured rate for men ages 19 to 64 years was 2.7 percentage points higher than the White rate. In 2014, both rates declined, but the Asian American rate was now 0.2 percentage points below the White rate (Figure D and Table 3). In 2013, the Asian American rate for women ages 19 to 64 years was 3.7 percentage points higher than the White rate. In 2014, it was reduced to 1.5 percentage points

Figure D.
Percent of Men Uninsured by Race, 2013 to 2014 (19 to 64 years old)



Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Author's calculations from Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

Table 3.
Percent of Men and Women Uninsured by Race, 2013 to 2014
(19 to 64 years old)

	Men		Women		Change 2013 to 2014	
	2013	2014	2013	2014	Men	Women
All	20.0%	15.6%	17.0%	13.1%	-4.4	-3.9
White	14.6%	11.3%	12.9%	9.8%	-3.3	-3.1
Hispanic	37.1%	30.3%	30.8%	24.5%	-6.8	-6.3
Black	24.7%	17.9%	19.6%	14.8%	-6.8	-4.8
Asian	17.3%	11.1%	16.6%	11.3%	-6.2	-5.3
American Indian	29.1%	24.6%	26.1%	20.0%	-4.5	-6.1

Difference from the White Uninsured Rate

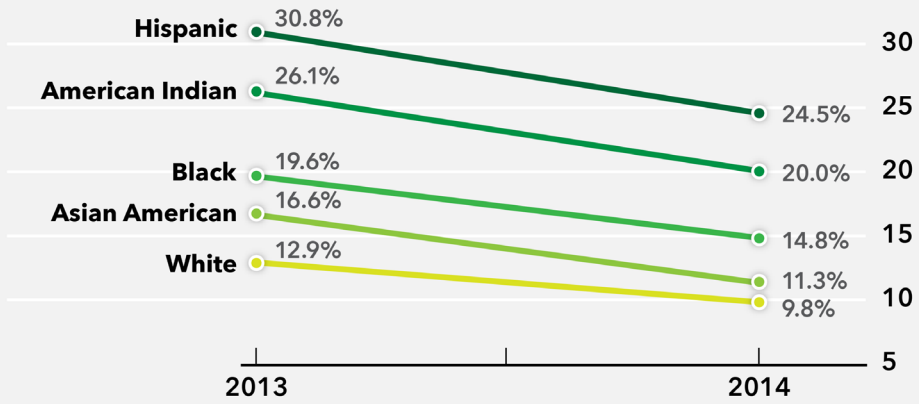
	Men		Women	
	2013	2014	2013	2014
Hispanic	22.5	19.0	17.9	14.7
Black	10.1	6.6	6.7	5.0
Asian	2.7	-0.2	3.7	1.5
American Indian	14.5	13.3	13.2	10.2

Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

(Figure E and Table 3).

This narrowing of the disparity between Asian American and White adults was due to uninsured rates falling more quickly for Asian American than White adults. While White adults saw similar increases in private and government insurance coverage, Asian American adults saw larger increases in private insurance coverage (see Appendix Table A-2).

Figure E.
Percent of Women Uninsured by Race, 2013 to 2014 (19 to 64 years old)



Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Author's calculations from Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

Although Hispanic men and women had the biggest reduction in their uninsured rates (the men tied with African American men), their disparities with Whites remain in the double digits and remain the largest disparities of the racial and ethnic groups by gender. In 2014, Hispanic men (19 to 64 years old) had an uninsured rate 19 percentage points higher than White men, and Hispanic women had a rate 14.7 percentage points above White women (Table 3).

American Indian men and women also had a double-digit disparity with Whites in 2014 despite a narrowing of the uninsured gap. In 2014, American Indian men's uninsured rate was 13.3 percentage points higher than that of White men. For American Indian women, the gap with White women in 2014 was 10.2 percentage points (Table 3).

The disparity in uninsured rates between Black and White men was 6.6 percentage points in 2014, having dropped from 10.1 percentage points in 2013. In 2014, the uninsured-rate disparity between Black and White women was 5 percentage points, having fallen from 6.7 percentage points in 2013 (Table 3).

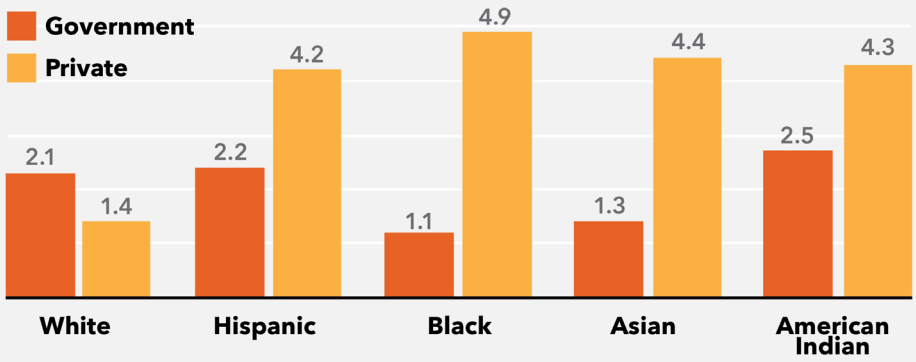
Private Health Insurance Dominates Coverage Gains for People of Color; Government Insurance Dominates Coverage Gains for Whites

While all of the major racial and ethnic groups experienced increases in their rates of health insurance coverage from 2013 to 2014, gains for people of color under 65 years old were primarily due to increases in private insurance coverage. For Whites in this age group, the opposite was true: gains in coverage were primarily due to increases in government insurance. Latinos, Blacks, Asian Americans, and American Indians all saw growth in their private insurance coverage of more than 4 percentage points (Figure F and Table 4). In contrast, for Whites, the increase in private insurance was only about a third of the increase for the non-White groups.

It is not clear what is behind this difference. Opposition to Obamacare may be one factor. Whites express the strongest opposition to Obamacare,[18] and consequently, they may seek out its benefits on the health insurance exchanges less than other groups.[19] Alternatively, there could be a "ceiling effect." Whites have the highest rate of health insurance coverage.[20] When the rate is high, it may be difficult to raise it even higher. Further research is necessary to understand this issue.

Figure F.
Percentage-Point Change in Government and Private Insurance Coverage, 2013 to 2014

(Under 65 years old)



Note: The types of health insurance coverage are not mutually exclusive. Individuals may be covered by more than one type over the year.All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.

Source: Author's calculations from Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

Table 4.
Percent of People with Government and Private Health Insurance by Race, 2013 to 2014

(Under 65 years old)

	Government		Private		Change 2013 to 2014	
	2013	2014	2013	2014	Government	Private
All	24.7	26.8	65.8	68.2	2.1	2.4
White	19.3	21.4	74.9	76.3	2.1	1.4
Hispanic	33.8	36.0	45.8	50.0	2.2	4.2
Black	37.3	38.4	51.6	56.5	1.1	4.9
Asian	18.5	19.8	72.3	76.7	1.3	4.4
American Indian	34.4	36.9	49.0	53.3	2.5	4.3

Note: The types of health insurance coverage are not mutually exclusive. Individuals may be covered by more than one type of insurance over the year. All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.

Source: Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

Whites experienced a gain of 2.1 percentage points in government insurance from 2013 to 2014 (Figure F and Table 4). This increase was squarely within the range of growth (from 1.1 to 2.5 percentage points) of the non-White groups. In contrast, whites had a 1.4 percentage-point increase in private insurance while all of the non-White groups had increases of more than 4 percentage points. African Americans had the smallest gain in government insurance—1.1 percentage points—and the biggest gain in private insurance—4.9 percentage points. The Hispanic increase in government insurance was 2.2 percentage points, and the increase in private insurance was 4.2 percentage points. American Indians had the biggest increase in government insurance—2.5 percentage points—and a 4.3 percentage-point increase in private insurance. Asian Americans had a 1.3 percentage-point increase in government insurance and a 4.4 percentage point increase in private insurance.

These findings suggest that Obamacare has been effective in reaching low-income Whites who are eligible for Medicaid in greater numbers due to the

"children's expansion" of Medicaid and the general expansion of Medicaid among adopting states. White children's increase in government insurance coverage was particularly strong relative to the other groups (Figure C).

In contrast, Blacks' growth in government insurance coverage is surprisingly low. Overall, Blacks had the lowest increase in government insurance of any group (Figure F). Given that this group is disproportionately low-income, this is not what one would expect. The fact that many southeastern states, states with large Black population shares, did not have a general expansion of Medicaid may be responsible for this situation.[21]

Estimating the Possible Impact of Full Medicaid Expansion in 2014

The Affordable Care Act expanded Medicaid to cover more low-income individuals, but the Supreme Court made the expansion optional for states. By January 1, 2014, 24 states and the District of Columbia had agreed to expand Medicaid. The Census Bureau reports that the uninsured rates for nonelderly adults declined more in the states that expanded Medicaid.[22]

In those states that did not expand Medicaid, the harmful effect was not felt uniformly across racial and ethnic groups. Blacks were more affected than other groups because many of the non-expansion states are in the southeast, an area with a disproportionate share of the Black population. Latinos and Asian Americans were affected less because they are underrepresented in the non-expansion states relative to their overall share of the population. Whites and American Indians are proportionally represented in the non-expansion states.[23]

As of September 2015, about 5.6 million adults living in the states that did not expand Medicaid were caught in a "coverage gap" or "assistance gap."[24] These individuals were not poor enough to receive Medicaid, but their income was not high enough for them to be eligible for subsidies in the ACA's health insurance marketplaces. Whites make up 48 percent (2.7 million people) of the adults in the coverage gap. Blacks make up 27 percent (1.5 million people), and Hispanics make up 21 percent (1.2 million people).[25]

Estimates of the coverage gap described above are based on the total number of adults potentially eligible for Medicaid if all states were to implement the expansion, but not everyone who was required to obtain health insurance or who was eligible for Medicaid obtained health insurance in 2014.[26] Therefore, it is also informative to estimate how many adults might not have obtained health insurance in 2014 specifically because of the non-expansion of Medicaid in half of the states. If one assumes that the size of the increase in health insurance coverage would have been the same in non-expansion states had they expanded Medicaid as it was in the states that actually did expand it, then one can gain a sense of the magnitude of the loss in health insurance coverage. Had all states expanded Medicaid, an additional 2 million Americans might have had health insurance in 2014, including about 1 million Whites, 400,000 Latinos, 300,000 Blacks, 10,000 Asian Americans, and 60,000 American Indians.[27]

The growth in health insurance enrollment might have been 25 percent greater if all states had expanded Medicaid. White enrollment might have been 30 percent greater; Hispanic enrollment, 15 percent greater; Black enrollment, 15 percent greater; Asian American enrollment, 1 percent greater; and American Indian enrollment, 20 percent greater.[28] For nearly all groups, these are not trivial figures. Even if potential growth in enrollment due to Medicaid expansion was half the size of these estimates, it would still have been a significant addition to health insurance enrollment in 2014. Hence, the failure to expand Medicaid in all states had significant costs for the health and wellbeing of a large number of Americans.

Will the Affordable Care Act Meet the Needs of People of Color?

While the Affordable Care Act has eliminated some racial disparities and reduced others, will it be able to provide equally low uninsured rates for all? The Affordable Care Act was modelled on Massachusetts' health insurance reform, which was established in 2006.[29] Thus, we can examine health insurance coverage in that state in recent years to predict what health insurance coverage might be like when Obamacare is a mature and well-established system. The two programs, while similar, are not the same however. The Massachusetts reform has greater potential to achieve universal coverage because Obamacare has had to contend with considerable political opposition and many states have refused to expand Medicaid, a key feature of the reform. The Massachusetts case, therefore, is likely the best-case scenario for Obamacare.

Table 5.
Average Massachusetts Uninsured Rates by Race and Age, 2008-2012

	White	Hispanic	Black	Asian	American Indian
Children	1.4%	2.3%	1.9%	1.2%	3.7%
Adults	4.5%	13.2%	9.5%	5.5%	9.8%
Elderly	0.2%	1.9%	1.7%	2.2%	0.6%

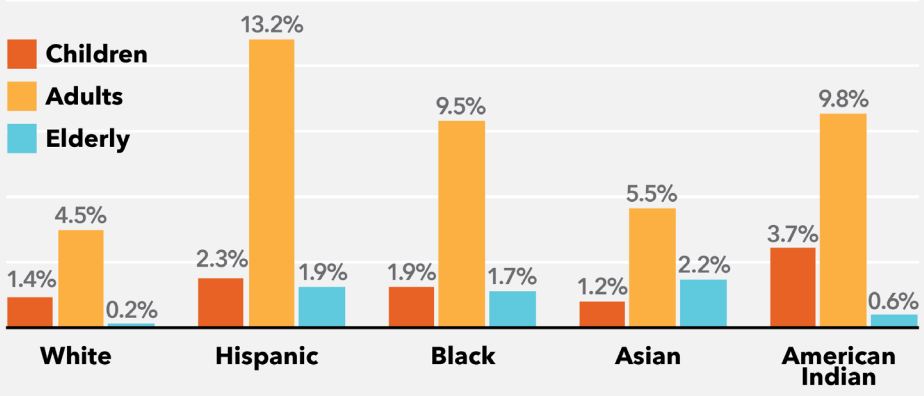
Difference from the White Uninsured Rate

	Hispanic	Black	Asian	American Indian
Children	0.9	0.5	-0.2	2.3
Adults	8.7	5.0	1.0	5.3
Elderly	1.7	1.5	2.0	0.4

Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics. "Children" are under 19 years old. "Adults" are 19 to 64 years old, and the "Elderly" are over 64 years old.

Source: Author's analysis of 2008 to 2012 American Community Survey data from IPUMS-USA, University of Minnesota, www.ipums.org.

Figure G.
Average Massachusetts Uninsured Rates by Race and Age, 2008-2012



Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics. "Children" are under 19 years old. "Adults" are 19 to 64 years old, and the "Elderly" are over 64 years old.

Source: Author's analysis of 2008 to 2012 American Community Survey data from IPUMS-USA, University of Minnesota, www.ipums.org.

The Kaiser Family Foundation reports that health insurance coverage has expanded significantly in Massachusetts since the health insurance reform.[30] In 2014, the state had the lowest uninsured rate in the country.[31] Yet the Kaiser Foundation found that low-income individuals are still more likely to be uninsured and the cost of health insurance still appears to be a burden for some.[32] Because people of color tend to have lower than average incomes, one would expect to see

higher uninsured rates among people of color in Massachusetts.

In this issue brief, pooled American Community Survey (ACS) data for 2008 through 2012 is used to determine if there are differences in uninsured rates by race and ethnicity in Massachusetts. Additionally, the analysis of the data was divided by age because children receive more government insurance coverage through Medicaid and CHIP (part of MassHealth in Massachusetts) and individuals 65 years old and over are eligible for Medicare.

The ACS data shows that, by state (including the District of Columbia), Massachusetts has the lowest uninsured rate overall.[33] Moreover, Massachusetts has relatively low uninsured rates for people of color generally. Yet the analysis also revealed some bad news: There continue to be racial and ethnic disparities in Massachusetts. There are smaller disparities, however among children. Over the years 2008 to 2012, there is no substantial difference among the uninsured rates for White, Hispanic, Black, and Asian American children (Figure G and Table 5). White, Black, and Asian American children have uninsured rates of less than 2 percent, and the rate for Hispanic children is only a little above 2 percent. The only substantial difference is for American Indian children, whose uninsured rate is 2.3 percentage points above the White rate. These findings suggest that Obamacare will be able to lower uninsured rates for children and eliminate most of the racial and ethnic disparities in insurance coverage for children.

Overall, nonelderly adults living in Massachusetts have the lowest uninsured rate (Appendix Table A-3). By race, however, the rate is low for all groups but not necessarily the lowest for each group by state. For Asian Americans, Massachusetts has the lowest rate. For Whites, the Massachusetts uninsured rate is statistically tied for the lowest with the District of Columbia. For American Indians, the District of Columbia is also the "state" with the lowest rate. Whites and American Indians in the District of Columbia have the highest educational attainment of their group by state,[34] and they are employed at a high rate in jobs that provide health insurance.[35] For Hispanics and Blacks, Hawaii has the lowest uninsured rate. Hawaii requires employers to provide health insurance for workers who work more than 20 hours per week.[36] While Massachusetts is not the lowest for each group, it is at least the second lowest for each group. Health insurance reform appears to have set the state of Massachusetts apart.

Even with this apparent success, significant inequalities in nonelderly adult uninsured rates remain in Massachusetts. The smallest difference is between Whites and Asian Americans (Figure G and Table 5). The Asian American uninsured rate is only 1 percentage point above the White rate. The Black rate is 5 percentage points higher than the White rate; the American Indian rate is 5.3 points higher; and the Hispanic rate is 8.7 points higher. These findings suggest that substantial racial disparities in health insurance coverage for nonelderly adults will remain under Obamacare.

Individuals 65 years old and over are eligible for Medicare. In this age group, all racial and ethnic groups have very low uninsured rates in Massachusetts. The highest uninsured rate is 2.2 percent for Asian Americans (Figure G and Table 5). This rate is 2 percentage points above the White rate. Hispanics and African Americans have a disparity with Whites of less than 2 percentage points. The American Indian rate is essentially equal to that of the Whites.

Health insurance reform in Massachusetts suggests that Obamacare will lower uninsured rates, but the rates of White and non-White populations will not be the same. Disparities will likely continue to be largest among nonelderly adults. In general, the lowest uninsured rates and the smallest disparities are likely to be among children and the elderly—the groups who receive the highest levels of government assistance.

More Government Insurance Would Work Better for People of Color

So far Obamacare has been a success, but it is not clear that it will continue to be so. In particular, there are reasons to worry about whether the Act can deliver truly affordable health insurance to all who are eligible. The White House has lowered its projections for health insurance enrollment in 2016.[37] Many states still have not expanded Medicaid. Although the law requires more employers to offer health insurance to their employees, evidence suggests that the rate of new employer-sponsored enrollment has been very low. For low-income workers, a health-insurance plan that reduces income by nearly 10 percent and then has a deductible of thousands of dollars is not an affordable plan.[38] Among those who look for insurance through the marketplaces, cost is also a major concern; many who fail to choose a plan cite the price of coverage as the reason.[39] Also, there are reports that some of those who have purchased health insurance through the marketplace may forgo care because of the high deductibles.[40] Even if Obamacare lowers the rate of increase in health insurance costs, in the context of stagnating or declining household incomes[41] any increase can be too big an increase for plans to remain affordable. Given that America's people of color are disproportionately low- and moderate-income, these affordability challenges disproportionately affect minority groups.

The evidence from Massachusetts suggests that more government assistance in providing health insurance should lower uninsured rates and reduce racial and ethnic disparities. The lowest uninsured rates and smallest racial and ethnic disparities in this state were for children, many of whom are covered by Medicaid or CHIP, and for the elderly, most of whom are covered by Medicare. These programs present pathways for increasing health insurance coverage and reducing racial and ethnic disparities.

The Affordable Care Act expanded Medicaid to 138 percent of the poverty level for adults, while in Massachusetts, Medicaid- and CHIP-covered children in families with incomes up to 300 percent of the federal poverty level.[42] Expanding Medicaid for all up to 300 percent of the poverty level is probably a better threshold for increasing coverage. The payroll processing company ADP found that there is very low enrollment in employer-sponsored health insurance among employees earning less than $45,000 a year.[43] A threshold of 300 percent of the poverty level would substantially reduce the number of employees earning less than $45,000 a year who need health insurance from their employer.

Although means-tested benefits like Medicaid are less costly than universal benefits, means-tested benefits tend to become stigmatized and get attacked. Another alternative for achieving high insurance coverage and low disparities between groups is to expand Medicare to cover all age groups. This would be a simple and powerful way to bring about very low uninsured rates and very small racial and ethnic disparities.

Appendix

Table A-1. Percent of Children with Government and Private Health Insurance by Race, 2013 to 2014

(Under 19 years old)

	Government		Private		Change 2013 to 2014	
	2013	2014	2013	2014	Government	Private
All	40.9	42.6	60.1	61.0	1.7	0.9
White	29.8	32.2	73.4	72.8	2.4	-0.6
Hispanic	56.4	57.1	39.9	42.6	0.7	2.7
Black	58.7	59.1	42.7	46.3	0.4	3.6
Asian	28.9	29.6	71.0	73.6	0.7	2.6
American Indian	50.5	50.4	43.7	50.1	-0.1	6.4

Note: The types of health insurance coverage are not mutually exclusive. Individuals may be covered by more than one type of insurance over the year. All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.

Source: Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

Table A-2. Percent of Adults with Government and Private Health Insurance by Race and Sex, 2013 to 2014 (19 to 64 years old)

Men

	Government		Private		Change 2013 to 2014	
	2013	2014	2013	2014	Government	Private
All	16.7	19.0	68.7	71.2	2.3	2.5
White	15.0	17.0	75.0	77.3	2.0	2.3
Hispanic	17.4	20.6	49.1	54.6	3.2	5.5
Black	25.4	27.3	55.3	61.0	1.9	5.7
Asian	13.7	15.3	73.6	79.0	1.6	5.4
American Indian	23.0	27.2	51.9	54.6	4.2	2.7

Women

	Government		Private		Change 2013 to 2014	
	2013	2014	2013	2014	Government	Private
All	19.5	21.7	68.3	71.1	2.2	2.8
White	16.3	18.4	75.8	77.7	2.1	1.9
Hispanic	23.6	27.3	49.4	54.0	3.7	4.6
Black	29.3	30.5	56.0	61.2	1.2	5.2
Asian	16.2	17.7	71.9	76.7	1.5	4.8
American Indian	27.6	30.4	52.1	55.8	2.8	3.7

Note: The types of health insurance coverage are not mutually exclusive. Individuals may be covered by more than one type of insurance over the year. All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.

Source: Current Population Survey, Annual Social and Economic Supplement, 2014 and 2015.

Appendix
(continued)

Table A-3.
Average Adult Uninsured Rates by State and Race, 2008-2012 (19 to 64 years old)

	All	White	Hispanic	Black	Asian	American Indian
Alabama	20.2%	16.3%	60.2%	24.4%	20.7%	26.2%
Alaska	23.5%	17.9%	28.0%	14.2%	29.4%	46.4%
Arizona	22.4%	15.0%	37.1%	21.2%	15.9%	34.4%
Arkansas	25.1%	22.4%	51.4%	27.6%	26.2%	29.7%
California	24.5%	14.2%	39.7%	20.6%	18.4%	26.7%
Colorado	19.7%	14.6%	39.1%	23.2%	18.3%	28.2%
Connecticut	12.7%	8.6%	31.1%	17.1%	13.4%	18.1%
Delaware	13.4%	10.6%	36.6%	13.4%	10.8%	20.2%
District Of Columbia	9.0%	4.3%	18.9%	11.1%	8.3%	5.7%
Florida	28.6%	21.0%	44.4%	32.9%	27.5%	33.2%
Georgia	25.7%	18.9%	61.2%	28.0%	30.0%	33.3%
Hawaii	9.3%	10.7%	10.9%	5.2%	7.6%	11.9%
Idaho	23.0%	20.0%	47.4%	26.1%	16.4%	35.7%
Illinois	19.0%	12.4%	40.4%	26.3%	18.5%	24.3%
Indiana	19.5%	17.0%	43.2%	27.2%	20.0%	28.9%
Iowa	12.5%	10.8%	39.1%	20.0%	14.7%	32.3%
Kansas	17.5%	13.6%	43.0%	25.0%	18.5%	29.7%
Kentucky	20.2%	18.7%	50.0%	26.1%	17.9%	27.9%
Louisiana	25.0%	19.4%	49.8%	32.4%	33.4%	32.9%
Maine	14.8%	14.6%	20.8%	11.4%	17.4%	21.3%
Maryland	14.9%	9.3%	46.4%	16.3%	16.3%	19.5%
Massachusetts	5.8%	4.5%	13.2%	9.5%	5.5%	9.8%
Michigan	17.1%	15.2%	31.6%	23.3%	14.9%	22.5%
Minnesota	11.3%	9.0%	38.4%	21.0%	13.6%	25.0%
Mississippi	24.8%	20.2%	58.6%	29.5%	32.2%	36.8%
Missouri	18.6%	16.4%	42.2%	27.0%	17.5%	30.9%
Montana	23.6%	21.0%	36.5%	53.2%	26.3%	50.4%
Nebraska	15.9%	12.4%	41.7%	27.3%	15.6%	40.7%
Nevada	27.1%	19.9%	44.8%	27.7%	21.1%	35.5%
New Hampshire	14.9%	14.2%	29.3%	30.5%	15.5%	24.7%
New Jersey	17.8%	10.5%	39.7%	20.0%	17.3%	35.0%
New Mexico	27.8%	17.3%	33.8%	19.0%	18.6%	49.1%
New York	16.2%	10.2%	31.6%	18.1%	20.8%	22.8%
North Carolina	22.6%	16.9%	61.5%	25.5%	21.6%	33.2%
North Dakota	13.1%	10.9%	31.9%	28.8%	8.9%	41.0%

Appendix
(continued)

Table A-3. (Continued)
Average Adult Uninsured Rates by State and Race, 2008-2012 (19 to 64 years old)

	All	White	Hispanic	Black	Asian	American Indian
North Dakota	13.1%	10.9%	31.9%	28.8%	8.9%	41.0%
Ohio	16.6%	14.9%	34.4%	24.4%	14.1%	21.8%
Oklahoma	25.7%	20.5%	53.4%	28.1%	24.9%	37.9%
Oregon	21.9%	18.7%	45.8%	24.4%	18.4%	34.1%
Pennsylvania	13.8%	11.6%	30.3%	20.7%	17.6%	19.8%
Rhode Island	15.7%	11.5%	38.0%	23.3%	20.4%	16.5%
South Carolina	23.4%	18.6%	60.3%	27.7%	24.2%	30.8%
South Dakota	16.4%	12.7%	35.1%	27.1%	16.8%	47.8%
Tennessee	20.1%	17.0%	59.7%	23.7%	21.8%	30.0%
Texas	30.5%	18.1%	48.5%	27.9%	24.8%	32.4%
Utah	18.8%	14.2%	47.6%	27.3%	14.0%	36.0%
Vermont	11.1%	10.5%	16.1%	21.3%	21.0%	21.4%
Virginia	16.5%	11.9%	41.8%	21.3%	18.6%	24.8%
Washington	18.7%	14.8%	45.2%	22.2%	17.2%	28.3%
West Virginia	21.4%	21.0%	32.7%	28.9%	19.5%	25.9%
Wisconsin	12.6%	10.2%	37.8%	20.8%	17.1%	24.4%
Wyoming	20.2%	18.1%	37.6%	20.2%	8.2%	40.1%

Note: All racial categories are single race and non-Hispanic except for "American Indian" which includes biracials, multiracials, and Hispanics.
Source: Author's analysis of 2008 to 2012 American Community Survey data from IPUMS-USA, University of Minnesota, www.ipums.org.

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    The difference in the size of the decline between expansion and non-expansion states extends beyond those eligible for Medicaid, suggesting that there are social and cultural factors (such as "welcome mat" factors) beyond the narrowly economic that affect the decision to enroll in health insurance.

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