

Effects of the Affordable Care Act's Medicaid Expansion Provision on the Uninsured Rate: A State-by-State Analysis

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Abstract

The Affordable Care Act (ACA), also known as Obamacare, is a reform of the United States health care system passed by Congress in 2010. The goal is to increase the number of insured citizens and reduce the cost of health care. The major provisions include the individual mandate, Medicaid expansion, extension of coverage of insurance plans that offer dependent coverage, and reduction of inefficiency in Medicare spending. This analysis addresses the following: How has the Medicaid expansion provision of the ACA affected the uninsured rate? How does the change in the uninsured rate differ between expansion and non-expansion states? What other variables can explain the variation in the uninsured rate across states? This study combines data from three different sources: the Kaiser Family Foundation, the American Community Survey, and the U.S. Census Bureau. Data is analyzed for the years 2013 (pre-Medicaid expansion) and 2014 (post-Medicaid expansion). Statistical analysis and econometric methods, particularly multiple regression, are used to predict the effects of the ACA on the uninsured rate. My findings reveal that the Medicaid expansion provision has had a significant impact in reducing the number of uninsured citizens. Overall, states that expanded Medicaid indicated successful outcomes, with southern expansion showing even greater health coverage outcomes.

Introduction

The Patient Protection and Affordable Care Act (PPACA), commonly referred to as the Affordable Care Act (ACA), is a reform of the health care system in the United States passed into law by Congress in 2010. Also known as Obamacare,

the ACA was conceived by the Obama Administration and bears similarities to the state of Massachusetts' health care reform in 2006. The primary objectives of the ACA include reducing the amount of uninsured citizens, reducing the costs of health care, and improving the quality of health care. The current mixed system (private and government-provided health insurance) remains intact, but with pervasive alterations. The components of the ACA were met with considerable controversy. In particular, the individual mandate (the legal requirement to have health insurance) and Medicaid expansion provisions were heavily scrutinized and nearly halted the ACA's passage entirely. Many Americans and politicians view the individual mandate as unconstitutional; however, the individual mandate was upheld by the Supreme Court in 2012 (Clemmitt 2012). The state of Wisconsin did not accept the Medicaid expansion and the available federal dollars. However, additional state funds were allocated to BadgerCare Plus, the state's Medicaid program. The ACA also forces states to reimburse insurance companies for the fee that they charge to handle people insured by Medicaid. Texas, Louisiana, and Kansas filed a lawsuit that challenged this fee and Wisconsin, Nebraska, and Indiana followed suit. The Medicaid expansion provision was intended to be a national program, but the Supreme Court's 2012 ruling enabled Medicaid expansion to be left to each individual state's discretion. The ACA's implementation includes numerous stages, with some provisions effective since 2010, some of the most significant effective since 2014, and others in effect in 2020. The major provisions, or components, include the requirement by law to carry health insurance (effective 2014), Medicaid expansion (effective 2014), the extension of coverage of insurance plans that offer dependent coverage (effective 2010), and the reduction of inefficiency in Medicare spending.

The ACA is the United States' attempt to provide health coverage for everyone while simultaneously making health care affordable for citizens and the United States government. To achieve this, every citizen is required by law to have a health insurance plan, or they must pay a fee (the individual mandate). This is essentially a tax that will force everyone to pay for health care whether they have health insurance or not. This provision of the ACA was modeled after the Massachusetts insurance expansion bill in 2007. This bill contained a health insurance mandate and insurance exchange, which showed success in health insurance coverage outcomes.

In addition to comparing expansion and non-expansion states, this study also highlights the different outcomes for southern and non-southern states. This can be useful for policymakers, since southern states tend to have lower incomes and higher rates of poverty, both of which are incorporated into this study. The Medicaid expansion provision was designed to benefit states with higher uninsured rates and lower incomes, so outcomes of states with these characteristics can be observed.

The findings of this study suggest that Medicaid expansion can account for the differences in the resulting uninsured rate amongst states, and states that expanded Medicaid demonstrated greater success in providing more citizens with health coverage. States in the South have seen even greater benefits from expanding Medicaid. This study primarily focuses on the effects of the Medicaid expansion provision on the uninsured rate from 2013 to 2014. Econometric methods and, more specifically, regression analysis is used to determine the relationship, magnitude, and significance that the Medicaid expansion provision and other variables appear to have on the uninsured rate. Additionally, this report compares outcomes of expansion and non-expansion states in multiple categories.

Literature Review

The ACA is a relatively new policy that will take time to be fully implemented and reveal its effect on health care. However, numerous short-term studies have been conducted and used to analyze the ACA's effects on health-related outcomes. The following studies have suggested that states that expanded Medicaid had significantly greater decreases in the uninsured rate, improved access to health care, higher subsidized exchanges enrollment, and greater self-assessed health.

Courtemanche et al. (2015) examined the impacts of the fully implemented ACA on first-year health insurance coverage, access to health care, utilizations of preventative care, and self-assessed health. The main data was gathered from the Behavioral Risk Factor Surveillance System, due to its large amount of observations and broad range of questions on health insurance and health care. They sampled adults ages 18–64 from 2011 to 2014. A differences-in-differences-in-differences model was used to examine the Medicaid and non-Medicaid components separately.

Courtemanche et al. (2015) estimated the influence that the ACA had on the insured rate with and without Medicaid expansion. They found that the fully implemented ACA (states that expanded Medicaid) increased the rate of insured by an average of 4.6 percentage points compared to an average increase of 2.5 percentage points in states that did not expand Medicaid. Furthermore, the rate of insured reached a maximum increase of 7.7 percentage points due to the fully implemented ACA in states that had the largest existing uninsured rates, and a maximum increase of 3.6 percentage points from effects of the ACA without Medicaid expansion. According to this study, the non-Medicaid expansion components increased the insured rate by 2.5 percentage points on average, while the expansion component generated an additional 2.1 percentage points increase, yielding 4.6 percentage points in expansion states.

Additionally, Courtemanche et al. (2015) suggested that the ACA produced better primary care access, increased utilization of preventative services, decreased forgone care due to cost, and improved self-assessed health. According to this study, a state that fully implements the ACA is expected to have an increase of 3.7 percentage points of citizens having a primary doctor, a decrease of 4.8 percentage points of forgone health care due to cost, and a 1.5 percentage point increase in citizens reporting excellent health.

Richardson and Yilmazer (2013) estimated the change in insurance coverage by state due to the ACA, through the two main channels of Medicaid expansion and subsidized state health insurance exchanges. Richardson and Yilmazer (2013) gathered data from the 2010 Current Population Survey, which was used to indicate the health care coverage in states at the time the ACA was passed. The effect of states choosing to opt out of the Medicaid expansion was tested as well.

Findings by Richardson and Yilmazer (2013) estimated the expansion and subsidized exchanges component produced an 8 percent and 10 percent increase in the rate of insured, respectively. The Medicaid expansion and subsidized exchanges were positively correlated, suggesting that expansion states received greater gains in insurance coverage through subsidized exchanges.

Richardson and Yilmazer (2013) also discussed the impact of the Supreme Court's ruling that allowed each state to decide whether to expand Medicaid. As reported by Richardson and Yilmazer (2013), if Florida had expanded Medicaid, an additional

12 percent and 14 percent would have been covered by Medicaid and state exchanges, respectively.

Wong et al. (2015) studied the changes in health care use among young adults after the expansion of dependent insurance coverage in 2010. More specifically, it focused on the changes in routine care and usual sources of care due to the previously mentioned dependent provision. Wong et al. (2015) gathered data from the Medical Expenditure Panel Survey (MEPS) from 2006 to 2012 to evaluate trends in the use of primary care, and focused solely on young adults ages 19–35 years old. Wong et al. (2015) began by pooling data from the 2006 to 2012 MEPS, and used logistic modeling to estimate the likelihood that young adults with a usual source of care routinely visited their provider.

The results of their analysis revealed that from 2006 to 2012, there was an increase of 7.2 percent of young adults who received routine health care. They also found that the coverage of young adults increased from 75.5 percent in 2006 to 77.4 percent in 2012.

The studies discussed above focused on multiple health-related outcomes in addition to the Medicaid expansion provision. Courtemanche et al. (2015) considered all provisions of the ACA, while Richardson and Yilmazer (2013) confined their analysis of the change in the uninsured rate to a couple of components of the ACA. In this study, the Medicaid expansion provision is the primary focus; however, other factors are considered and modeled when determining the effects on the uninsured rate. Additionally, this study compares expansion and non-expansion states amongst multiple state categories.

Data and Methodology

Data Description

This study utilizes data from the following three sources to analyze the uninsured rates across the United States pre- and post-Medicaid expansion, for the years 2013 and 2014.

The first data source is the Kaiser Family Foundation (KFF), a non-profit organization that focuses on U.S. health issues. The KFF provides national and individual state data. The following variables were constructed using data from the KFF website: *employer provided insurance*, *Medicaid expansion*, *insured by Medicaid*, and *Medicaid eligibility*.

The next data source is the U.S. Census Bureau and the American Community Survey. The U.S. Census Bureau provides data concerning numerous business- and economic-related categories. The American Community Survey is part of the U.S. Census Bureau, which conducts surveys on population, geographic, housing, and economic data. The U.S. Census Bureau was used to define which states are southern states and construct the variable *South*. The data for the variables *median household income* and *senior citizen* were collected from the American Community Survey.

The third data source is the Bureau of Labor Statistics (BLS), which collects data on labor market activity, working conditions, and price fluctuations. The BLS was used to collect data on the state unemployment rates.

Description of Variables

The following variables (excluding year) contain state-specific data on all 50 states and Washington, DC, from the years 2013 and 2014.

Uninsured Rate: *Uninsured rate* is the dependent variable, expressed as a percentage of uninsured people in each state.

Year: *Year* indicates the time (year) of all other variables. *Year* is a dummy variable, coded with a 0 for 2013 and a 1 for 2014.

Employer-Provided Health Insurance: This is a percentage of all types of “providers.” Providers include employer provided (this variable), Medicaid, Medicare, non-group, other public, and uninsured.

Senior Citizen: This is a percent of the total population that is at least 65 years old.

South: *South* is a binary dummy variable, set equal to 1 if a state is in the southern United States and set equal to 0 if the state is not in the southern United States. The southern states are Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

Medicaid Eligibility: *Medicaid eligibility* indicates the state’s income requirement to qualify for Medicaid relative to the Medicaid expansion level of 133 percent of the Federal Poverty Line (FPL). This is a dichotomous variable; states with a level equal to or greater than 133 percent of the FPL are set equal to 1 and states with a level lower than the 133 percent FPL are set equal to 0.

Median Household Income: This is the median household income in each state.

Unemployment Rate: The *unemployment rate* as a percentage of the labor force.

Medicaid Expansion: This is a binary dummy variable set equal to 1 if a state expanded Medicaid as of January 2016, and set equal to 0 if a state did not expand Medicaid. January 2016 was used because it is the most recent data available and the year this study was conducted. The states’ expansion decisions, apart from the states that were initially decided, are not believed to have changed their decision since 2014.

Percent Insured by Medicaid: This is a percent of the total population insured by Medicaid.

Table 1. Summary statistics.

Variable	Mean	Number of observations	Minimum	Maximum	Units
<i>Uninsured Rate</i>	10.95% (3.58%)	102	3%	20%	Percentage
<i>Year</i>	50%	102	0	1	0 = 2013 1 = 2014
<i>Employer-Provided Health Insurance</i>	50.51% (5.51%)	102	37%	61%	Percentage
<i>Senior Citizen</i>	14.55% (1.78%)	102	8.90%	19.10%	Percentage
<i>South</i>	29.41%	102	0	1	1 = South, 0 = Not South
<i>Medicaid Eligibility</i>	37.25%	102	0	1	1 = \geq 133% of the FPL 0 = < 133% of the FPL
<i>Median Household Income</i>	53,830.74 (8,854.59)	102	39,031	74,149	Dollars
<i>Unemployment Rate</i>	5.87% (1.37%)	102	2.70%	8.80%	Percentage
<i>Medicaid Expansion</i>	62.74%	102	0	1	1 = Expansion, 0 = No Expansion
<i>Percent Insured by Medicaid</i>	17.55% (4.31%)	102	9%	29%	Percentage

Note: Standard deviations are listed in parentheses below the mean values. The descriptive statistics indicate the average uninsured rate to be about 10 percent, ranging from 3 percent (Massachusetts in 2013) to 20 percent (Texas in 2013). The mean for Medicaid expansion (about 63 percent) shows that a majority of states (32) decided to expand Medicaid. Also note the average for employer-provided insurance, indicating that just over half of the population receives health insurance through their employers.

Empirical Framework

The following baseline economic model shows the dependent variable (uninsured rate), and its explanatory variables. The expected sign of the estimated regression coefficients are shown in table 2.

$$UI = \beta_0 + \beta_1 Y_{i,t} + \beta_2 EPHI_{i,t} + \beta_3 Sr_{i,t} + \beta_4 Sth_{i,t} + \beta_5 ME_{i,t} + \beta_6 MHI_{i,t} + \beta_7 UE_{i,t} + \beta_8 MX_{i,t} + \beta_9 MI_{i,t} + U_i$$

where “i” is a state and “t” is a time index which represents 2013 or 2014.

Figure 1. Economic Model.

Table 2. Expected sign of coefficients.

Variable	Expected Sign
<i>Year (Y)</i>	Uncertain
<i>Employer Provided Health Insurance (EPHI)</i>	Negative
<i>Senior Citizen (Sr)</i>	Negative
<i>South (Sth)</i>	Positive
<i>Medicaid Eligibility (ME)</i>	Negative
<i>Median Household Income (MHI)</i>	Negative
<i>Unemployment Rate (UE)</i>	Uncertain
<i>Medicaid Expansion (MX)</i>	Negative
<i>Percent Insured by Medicaid (MI)</i>	Negative

Year: This captures any other changes in the *uninsured rate* that are not the results of independent variables included in the model.

Employer Provided Health Insurance: People who have health insurance coverage through their employer will already be insured. Richardson and Yilmazer (2013) found that states with higher percentages of *EPHI* had lower *uninsured rates*.

Senior Citizen: A greater portion of the population being comprised of senior citizens is expected to decrease the *uninsured rate* because many will have health insurance through Medicare.

South: States in the *South* are expected to have a greater *uninsured rate*, due to preexisting uninsured rates and resistance to Medicaid expansion. For the year 2013, southern states had an average uninsured rate of 14.5 percent, and non-southern states 11.3 percent.

Medicaid Eligibility: States with *Medicaid eligibility* greater than or equal to 133 percent of the Federal Poverty Line are expected to have greater enrollment and fewer uninsured.

Median Household Income: A greater *median household income* is expected to decrease the *uninsured rate*, since health care will be more affordable.

Unemployment Rate: A higher *unemployment rate* could be correlated with more or fewer people having health insurance coverage. People who are unemployed may be insured because they qualify for Medicaid. On the other hand, fewer people will have health insurance through their provider, and health care will be less affordable.

Medicaid Expansion: Previous studies done by Courtemanche et al. (2015) and Richardson and Yilmazer (2013) have found that states that expanded Medicaid showed greater decrease in the *uninsured rate* than states that did not expand Medicaid.

Percent Insured by Medicaid: States with a higher preexisting percent of people insured by Medicaid are expected to have a lower *uninsured rate*.

Results and Discussion
Regression Model Analysis

The regression model listed below is created using data from pre- and post-Medicaid expansion for the years 2013 and 2014. The log-transformation is used on *median household income* for the purpose of percentage interpretation (as opposed to a unit change in dollars). Furthermore, in order to capture whether there is a significant change in *uninsured rates* between 2013 and 2014 in expansion and non-expansion states, the interaction term between a dummy variable for year and that for *Medicaid expansion* is included.

Table 3. Regression results.

Variable	Model 1	Model 2
<i>Year</i>	-0.0099* (-1.94)	-0.0156** (-2.04)
<i>Employer-Provided Health Insurance</i>	-.6577*** (-12.50)	-.3964*** (-6.04)
<i>Senior Citizen</i>	-.6002*** (-6.10)	-.6833*** (-4.64)
<i>South</i>	-.0011 (-0.26)	-.0056 (-.87)
<i>Medicaid Eligibility</i>	-.0081 (-1.42)	—————
<i>Median Household Income</i>	.0113 (.74)	-.0053 (-.23)
<i>Unemployment Rate</i>	.4532*** (3.16)	.0432 (.21)
<i>Medicaid Expansion</i>	-.0029 (-.57)	-.0136* (-1.83)
<i>Percent Insured by Medicaid</i>	-.5866*** (-9.91)	—————
<i>Year * Medicaid Expansion</i>	.0013 (0.17)	-.0137 (-1.44)
Number of observations	102	102
Adjusted R ²	.8153	.6151

Note: t-statistics are in parentheses. ***, ** and * represent statistical significance at the 1%, 5% and 10% levels, respectively.

The results of regression for model 1, which includes all variables, indicate that the variables *year*, *employer-provided health insurance*, *senior citizen*, *unemployment rate*, and *percent insured by Medicaid* are statistically significant. Model 2 was created using an interaction term of variables *year*, and *Medicaid expansion* was added to determine the effect of *Medicaid expansion* from the years 2013 and 2014, which is the focus of this report. Model 2 excludes the variables *Medicaid eligibility* and *percent insured by Medicaid* due to a moderately strong correlation between the two variables and *Medicaid expansion*. In this model, the interaction term with *year* and *Medicaid expansion* still holds insignificant, but the sign is as expected and can explain significant variance in the *uninsured rate* in a state that adopts the Medicaid expansion. The greater magnitude and now statistically significant *Medicaid expansion* imply that the variations of *Medicaid expansion* in 2014 can be partly explained by *Medicaid eligibility* and *percent insured by Medicaid*. Specifically, states that adopted *Medicaid expansion* in 2014 experienced on average a 1.3 percentage point reduction in *uninsured rates*.

Generally, the correlation between the independent variables and *uninsured rates* are in agreement with economic intuition (table 2). All of the variables except *unemployment rate* have a negative relationship with the *uninsured rate*; that is, an increase in one of these variables is associated with a decrease in the *uninsured rate*, ceteris paribus. Southern states were expected to have higher *uninsured rates* on average, due to resistance to *Medicaid expansion*. However, southern expansion states achieved an average decrease in the *uninsured rate* of 20.03 percent, greater than the average mean decrease of 16.73 percent for all expansion states.

Other significant variables from model 2 include percentage of *senior citizens* and percentage of *employer-provided health insurance*. A 1 percentage point increase in *senior citizens* is associated with a .68 percentage point decrease in *uninsured rate*. Similarly, a 1 percentage point increase in *employer-provided health insurance* is correlated with a .40 percentage point decrease in *uninsured rate*.

In summary, the findings suggest that the Medicaid expansion from 2013 to 2014 has lowered uninsured rates amongst states. Other factors, such as employer-provided health insurance and percentage of senior citizens appear to be statistically and economically significant determinants of a state's uninsured rate.

State Comparisons in the Change in the Uninsured Rate

The following tables describe comparisons in the change in the uninsured rate from 2013 to 2014 for specified subsets of the data set. The data were categorized and organized based on the case of interest. Then, the states' changes in the uninsured rate were calculated as the change from 2013 to 2014. These changes were then averaged within each category.

Table 4 considers all states, and compares the average change among states that expanded Medicaid and states that did not expand Medicaid. Table 5 only examines southern states, and shows the average change among expansion and non-expansion states. Table 6 categorizes states by the preexisting (2013) level of the uninsured rate. Low, average, and high were the three categories assigned to states. Low represents an uninsured rate less than the sample average (less than .11), average is from .11 to .14, and high is between .15 and .20. The low and average groups are compared to each other, as well as the low and high groups.

A t-test of equal means was used to determine if the average differences in the changes in uninsured rate between particular groups is statistically significant at the 95 percent confidence level.

Table 4. All states: Medicaid expansion and non-Medicaid expansion.

All States Comparison**	Average Change in the Uninsured Rate (2013–2014)	Number of Observations
Medicaid Expansion States	-16.73%	32
Non-Expansion States	-22.85%	19

Note: **Statistically significant at the 95% confidence level (t-statistic = 2.4275).

Table 5. Southern states: Medicaid expansion and non-Medicaid expansion.

Southern States Comparison**	Average Change in the Uninsured Rate (2013–2014)	Number of Observations
Expansion States	-20.03%	6
Non-Expansion States	-22.87%	10

Note: **Statistically significant at the 95% confidence level (t-statistic = 3.4169).

Table 6. States with low, average, and high preexisting uninsured rates.

Low and Average Preexisting Uninsured Rates Comparison**	Average Change in the Uninsured Rate (2013–2014)	Percentage That Expanded Medicaid	Number of Observations
Low Preexisting Uninsured Rate	-10.42%	70.59%	17
Average Preexisting Uninsured Rate	-24.88%	72.22%	18
Low and High Preexisting Uninsured Rates Comparison	Average Change in the Uninsured Rate (2013–2014)	Percentage That Expanded Medicaid	Number of Observations
Low Preexisting Uninsured Rate	-10.42%	70.59%	17
High Preexisting Uninsured Rate	-21.53%	43.75%	16

Note: **Statistically significant at the 95% confidence level (t-statistic = 2.3380).

Table 4 indicates that non-expansion states, on average, displayed a slightly greater decrease. These results do not support the notion that expansion states have had better outcomes; nonetheless, this could be contributed to a combination of other factors, such as percentage of senior citizens and other variables outside of the model, which also influence the uninsured rate.

Table 5 shows that Medicaid expansion provision had more substantial effects in the southern states. This effect can be attributed to factors such as larger preexisting uninsured rates, higher poverty rates, and a larger exposure of the population to the new Medicaid eligibility level.

Table 6 indicates that states with average levels of preexisting uninsured rates saw the largest changes, with an average decrease of about 25 percent. States with low preexisting uninsured rates experienced the smallest changes. The average and high groups had a similar average decrease. However, only 44 percent of states within the high category expanded Medicaid compared to 72 percent in the average category. If more states within the high category would have expanded Medicaid, it is likely that the average decrease would have been even greater for states with high preexisting uninsured rates.

Conclusions

The Medicaid expansion provision has played a vital role in health insurance coverage outcomes. States that opted to expand Medicaid have shown evidence of greater health insurance outcome, with southern expansion states experiencing more dramatic effects. Other economically significant factors that can explain the variation in the uninsured rate amongst states include the amount of employer-provided insurance and the percentage of senior citizens.

A notable find is the potential impact of Medicaid expansion in the South. Southern expansion states had a greater average decrease from 2013 to 2014 than the average for all expansion states. States with high preexisting uninsured rates (many of which are southern states) displayed significant results due to expansion. The Medicaid expansion provision has exhibited success in achieving one of the core goals of the Affordable Care Act; it has enabled millions of Americans to have access to health insurance and coverage for medical services.

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