Do people really have multiple health insurance plans?
Estimates of Nongroup Health Insurance in the American Community Survey

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ABSTRACT

This paper investigates the estimates of multiple types of coverage in the working-age adult population from the American Community Survey (ACS). Due to the costs associated with private health insurance and the eligibility restrictions associated with public coverage, it is unlikely that a person has multiple types of comprehensive coverage at a single point in time. This paper shows that ACS is capturing more information than just comprehensive health insurance coverage. The likelihood that a person has nongroup coverage and employer-based insurance goes up with income. For nongroup coverage and Medicaid, there were only small, but significant, marginal effects. One of the robust regression results is that the write-in option for people with multiple types of coverage is large. This suggests that the write-in option is part of the reason that ACS has higher nongroup insurance than other surveys.

Key words: American Community Survey, Health Insurance Coverage

[1] Congressional Research Service

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[3] This report is released to inform interested parties of ongoing research and to encourage discussion of work in progress. Any views expressed are those of the authors and not necessarily those of the U.S. Census Bureau or the Congressional Research Service.

INTRODUCTION

The major outcome of the Affordable Care Act [ACA; (PL111-148 2010)] is that almost all people will have health insurance coverage starting in 2014. To facilitate this, the ACA establishes health insurance exchanges. These exchanges have the function of certifying the value of health insurance plans and provide a web-portal for comparison shopping. Individuals can purchase nongroup health insurance from the exchanges, and small employers can buy insurance from small-group exchanges (Kaiser 2009). Low-income people that participate in the exchanges will receive a tax credit to offset the cost of premiums (Sommers and Rosenbaum 2011). ACA also changes the eligibility requirements for Medicaid; all people under 139 percent of the poverty line will be able to participate in Medicaid.

Survey data will be used to evaluate ACA's effects in 2014 and beyond. Evaluations concerning types of insurance and where a person obtains the insurance will be as important as evaluations of the people that remain uninsured. This is particularly true for estimates of the nongroup market and Medicaid, as both will likely expand under ACA. Currently, Medicaid and other means-tested health insurance coverage and nongroup health insurance coverage (i.e., individuals purchasing directly from an insurance company) are not captured well in surveys (Boudreaux, et al. 2011, Cantor, et al. 2007). Research suggests that survey data overestimate the number of people with nongroup insurance, underestimate the number of people with Medicaid, and in some cases confuse these types of insurance with other private or public coverage (Cantor, et al. 2007, Klerman, et al. 2009, Call, et al. 2008).

Household surveys may have increased collection problems for health insurance with the implementation of the exchanges and the expansion of Medicaid; survey respondents will have to distinguish not only between nongroup insurance, Medicaid, and other types of insurance, but also whether the nongroup insurance is subsidized. These issues raise questions about the usefulness of current survey data to evaluate the effects of ACA.

There are many ways to assess the validity of nongroup estimates; one way is to examine people who report nongroup insurance in combination with another type of insurance. Due to the costs associated with private health insurance (including nongroup insurance) and the restrictions

associated with public coverage, it is unlikely that a person would have nongroup insurance and another type of comprehensive insurance concurrently (Cantor, et al. 2007). This suggests that survey estimates of multiple types of coverage reflect more information than just comprehensive health insurance coverage. This additional information could lead to inaccurate estimates of nongroup insurance and other types of coverage.

The purpose of this study is to identify pathways to having nongroup insurance and one or more other types of coverage in the working-age population (aged 19-64) as a baseline for estimates of nongroup coverage in the future. We focus on the working-age population because working-age adults are the most likely to use the exchanges to purchase nongroup insurance. We identify adults with nongroup coverage alone and those who have it in combination with another type of coverage. This study uses data from the American Community Survey (ACS), because its large sample size allows us to examine this issue at the state level.

LITERATURE REVIEW

Some aspects of the measurement of health insurance coverage have been thoroughly investigated. For example, researchers have investigated the undercount of Medicaid participants in surveys; surveys tend to underestimate the size of the Medicaid population in comparison to administrative records (Klerman, et al. 2009). Other investigations of health insurance survey estimates include examining reporting patterns of respondents whose coverage status is known (Davern, et al. 2008, Call, et al. 2008), and comparisons of health insurance estimates from different national surveys (Turner and Boudreaux 2010).

Research on the nongroup market has largely focused on attempts to understand the role of nongroup insurance in the health insurance market, and to examine the accessibility and affordability of nongroup insurance (Kaiser 2010, Pauly and Lieberthal 2008, Pauly and Nichols 2002, Ziller, et al. 2004). Little research has focused specifically on survey measurement of the nongroup market. In one study of the nongroup market, Cantor and colleagues assessed estimates of the size of the nongroup market in New Jersey by comparing enrollment statistics from insurance carriers to estimates from household surveys. The study found that survey data overestimated the size of the nongroup market and misrepresented the composition of the

nongroup population (Cantor, et al. 2007).

Estimates of nongroup insurance in combination with another type of coverage have not been researched, as far as we know, for three reasons. One reason is that prior to the ACS, survey sample sizes were too small to examine this issue closely. The nongroup market is small in comparison to other insurance markets (Kaiser 2010), and it requires a survey with a large sample to examine the issue. A second reason is that some health insurance surveys ask the respondent the name and type of his or her health insurance plan. This method eliminates issues with multiple types of coverage because the survey administrator classifies the respondent's health plan (AHRQ 2009). A third reason is that the issue only recently became urgent with the passage of the ACA. The health insurance exchanges will induce new people to enter the nongroup insurance market; it is important that health insurance survey estimates not only accurately report uninsurance, but also specific types of health insurance.

This paper focuses on respondents who report nongroup insurance in combination with another type of coverage. Specifically, the paper focuses on three combinations: nongroup and employer-based insurance; nongroup and Medicaid or other means-tested public coverage (hereafter, Medicaid); nongroup and other private or public coverage. The nongroup and other private or public coverage category includes Medicare, TRICARE or other military health care, and VA Health Care, but it does not include employer-based insurance or Medicaid. Each of these combinations is of varying levels of concern for the accuracy of health insurance estimates, and different health insurance market issues and survey measurement issues affect each.

Nongroup insurance and employer-based insurance

Nongroup insurance can be comprehensive coverage, and having two comprehensive plans is redundant and cost prohibitive. In 2009, the average annual premium for nongroup insurance for single coverage was $2,985 and for family coverage it was $6,328 (Lemieux, J. 2009). A 2010 Kaiser Family Foundation survey found people with individual nongroup coverage report spending an average of $924 annually out-of-pocket health expenses; people with family nongroup coverage report spend an average of $2,688 annually for out-of-pocket health expenses (Claxton, et al. 2010). This unsubsidized dollar amount is expected to go up under ACA because

all health plans need to cover more services than before (Alliance For Health Reform 2011).

Employer-based insurance can be less cost-prohibitive than nongroup insurance, but it is unlikely that a person would purchase a comprehensive nongroup plan in addition to employer-based insurance. Among those with employer-based insurance, employees on average contribute $779 annually for single coverage and $3,515 annually for family coverage (Claxton, et al. 2010). Based on the costs of nongroup insurance and employer-based insurance, working-age people are unlikely to need and unwilling to pay the costs associated with more than one comprehensive health insurance plan.

While it seems illogical from a cost perspective for an individual to purchase both nongroup insurance and employer-based insurance, it is reasonable to believe that a person who has employer-based insurance could report both types of insurance. For example, a person who has employer-based insurance and also buys a separate dental plan or vision plan may report that he or she has both employer-based insurance and nongroup insurance. Some people who have nongroup insurance could also report both nongroup and employer-based insurance; a 2010 survey found that 45 percent of respondents said they purchase nongroup insurance because they are self-employed or a small business owner (Kaiser 2010). These examples indicate that surveys might capture information from respondents who have one type of comprehensive health insurance and either have one or more types of supplemental insurance, or who mistake their one type of coverage as fulfilling two health insurance categories.

Nongroup insurance and Medicaid or other means-tested public coverage

Medicaid and other types of public coverage are not cost prohibitive like private health insurance, but characteristics of the Medicaid program and other means-tested public programs do make it difficult for a person to have comprehensive public coverage and have additional comprehensive insurance such as nongroup insurance.

A person must be both categorically (until 2014) and financially eligible for Medicaid. The categorically eligible include children, parents, pregnant women, the elderly, and the disabled; financial eligibility varies according to categorical eligibility, but generally only low-income

people are financially eligible for Medicaid. The Medicaid financial restrictions make it unlikely that a Medicaid-eligible individual can reasonably afford nongroup insurance. In 2010, financial eligibility for parents across the states and D.C. ranged from 17 percent of the Federal Poverty Line (FPL) to 215 percent of the FPL. Financial eligibility for childless adults is even more restrictive; seven states offered Medicaid coverage to childless adults, and 18 states offered programs that are more limited than Medicaid to childless adults (Heberlein, et al. 2011).

These restrictions for parents and childless adults make it unlikely for working-age adults to have Medicaid or other state means-tested coverage and afford nongroup insurance, but surveys could capture one type of coverage masquerading as two types of coverage. According to the most recent Medicaid data, 46 states and D.C. have over half of their Medicaid population enrolled in Medicaid managed care organizations (MCOs) (Kaiser Commission on Medicaid and the Uninsured 2010). MCOs are networks of providers that receive a fixed capitation rate to provide Medicaid-covered services to each Medicaid enrollee. MCOs can look and function like private insurance plans, particularly if the MCO only serves Medicaid enrollees.

Research into whether Medicaid managed care enrollees misreport their Medicaid coverage suggests that managed care recipients do not underreport their Medicaid coverage more than fee for service Medicaid enrollees (Plotzke, Klerman and Davern 2010). One theory is that managed care enrollees spend more time in contact with Medicaid offices to set up their managed care plans compared to fee for service enrollees, thus the managed care enrollees are more aware that they have Medicaid (Call, et al. 2008). This body of research, however, does not examine reports of more than one type of coverage; Medicaid managed care enrollees who recognize their Medicaid coverage may also believe their Medicaid managed care coverage fulfills the nongroup insurance category.

Another issue that may confuse respondents about their type(s) of coverage is that there are state and local health insurance assistance programs for people with low incomes or disabilities other than Medicaid. These programs can look like Medicaid programs in that they are means-tested programs with a defined set of benefits, they are often locally- or community-based, and they are often only for people who do not have other insurance (Taylor, Cunningham and McKenzie

2006, Nakashian 2006). Respondents may find it confusing to report these programs, particularly if they receive a subsidy from the program to purchase their own insurance, or if they are given an opportunity to purchase a subsidized plan. Respondents may report this type of coverage as both nongroup insurance and Medicaid or other means-tested public coverage.

Nongroup insurance and other public or private insurance

Reports of nongroup insurance and other public or private insurance (in this study, Medicare, TRICARE or other military health care, or VA Health Care) are somewhat easier to envision. For example, most Medicare enrollees have the option to enroll in Medicare Advantage plans or to obtain Medigap policies. Medicare Advantage plans are comprehensive plans that take the place of fee for service Medicare and are offered by private insurance companies. Medigap policies are supplemental plans offered by private insurance companies that are intended to off-set some medical costs not covered by Medicare (Department of Health and Human Service 2011). Both types of coverage may lead to reporting both nongroup insurance in addition to Medicare.

Estimates of nongroup insurance and TRICARE or other military health care or VA Health Care are not a large concern because a small number of adults report these types of coverage. In 2009, 1.9 percent of working-age adults reported TRICARE or other military health care and 1.7 percent of working-age adults reported VA Health Care (authors' own calculations). In the case of people who report VA Health Care, it is very likely that these people actually have another type of insurance. The VA acknowledges that VA Health Care is not full and comprehensive health insurance, and it encourages its recipients to have additional health insurance coverage (United States Department of Veterans Affairs 2009).

The effects of ACS survey design

The health insurance question from the ACS has been scrutinized. Prior to including the health insurance question in the 2008 ACS, Census Bureau staff examined different versions of the question in a content test in 2006 (Nelson and Ericson 2007). The ACS gives reasonable estimates compared to other surveys (Turner and Boudreaux 2010) and it gives reasonable estimates for policymakers (Boudreaux, et al. 2011). Still, survey designs and processing issues

will affect health insurance estimates. This is particularly true for the ACS nongroup insurance estimates, which are higher than estimates from other national household surveys (Turner and Boudreaux 2010). There are several ways in which the ACS is different from other national household surveys that are likely to influence the health insurance estimates.

The ACS is the only national household survey with health insurance questions that uses a mail questionnaire (Turner and Boudreaux 2010). The ACS health insurance question is similar in design to health insurance questions in other national surveys (Turner and Boudreaux 2010), but in 2009, 52.7 percent of the civilian noninstitutionalized population responded to the survey through the mail instrument (authors' own calculations). In contrast, the Annual Social and Economic Supplement to the Current Population Survey (CPS ASEC) is conducted through telephone and in-person interviews, as is the Survey of Income and Program Participation (SIPP); the National Health Interview Survey (NHIS) is conducted solely through in-person interviews (U.S. Census Bureau 2011, National Health Interview Survey 2011, U.S. Census Bureau 2006).

While the ACS questions are similar in scope to other health insurance survey questions, there are slight differences in the questions that may affect responses. The ACS nongroup question asks whether the respondent has "Insurance purchased directly from an insurance company (by this person or another family member)." The CPS ASEC nongroup question specifies that the coverage should not be related to current or past employment (U.S. Census Bureau 2011), and the NHIS asks a series of questions about whether private insurance is employment related, or obtained through the workplace, before the respondent is asked if he or she has nongroup insurance (National Health Interview Survey 2011). Some researchers have suggested that the lack of specification in the ACS nongroup question might lead to some respondents misreporting nongroup insurance (Boudreaux, et al. 2011).

The ACS Medicaid or other means-tested public coverage question is more general than the CPS ASEC, NHIS, and SIPP questions, all of which capture Medicaid, the Children's Health Insurance Program (CHIP), and other government programs through separate questions. The more general Medicaid question in the ACS may lead to misreporting of Medicaid or other

means-tested public coverage (O'Hara 2008). Additionally, the ACS question does not include state-specific program names, whereas the CPS ASEC, NHIS, and SIPP do. Some researchers have suggested this increases underreporting of Medicaid, but whether it could increase reporting of more than one type of coverage is less clear (Boudreaux, et al. 2011).

The ACS allows respondents to "write-in" a type of health insurance. Health insurance analysts classify the write-in into one of the seven types of insurance unless the write-in indicates that the respondent does not have insurance. In the current process for coding the write-in responses, the analyst coding the responses does not know whether the respondent marked any other types of coverage. It is almost impossible for Census Bureau employees to know the type of insurance based on a plan name (e.g., Blue Cross Blue Shield), so these write-ins are categorized as nongroup insurance; the notable exceptions are recognizable plan names such as Medicaid plan names or Medicare plan names.

The result of this coding method is that respondents who write-in responses are more likely to have multiple types of coverage when the analyst cannot accurately classify the write-in response. While other surveys allow for "write-in" responses, this is a larger issue for the ACS compared to other household surveys. In 2009, 2.1 percent of working-age adults in the ACS wrote in a health insurance response, and 44.3 percent of those write-ins were classified as nongroup insurance (authors' own calculations). In contrast, only 0.1 percent of all CPS ASEC respondents wrote in a health insurance response in 2009 (personal communication with Census Bureau staff, 12 /15/ 2010).

DATA

This study uses data from the 2009 American Community Survey (ACS). The ACS's annual sample of approximately 3 million addresses nationwide provides demographic, social, economic and housing data for the nation, states and sub-state localities every year. The sample size is large enough to support state and sub-state estimates of nongroup insurance and multiple types of coverage. In addition to its robust sample, the ACS measures both household-level and person-level attributes, and features the demographic variables necessary to study the characteristics of people with nongroup insurance and one or more other types of coverage.

The ACS has included a question on health insurance coverage since 2008. The question asks respondents about their current health insurance coverage at the time of the survey and instructs them to mark "yes" or "no" to each of seven coverage categories. The coverage options are broadly defined as either public coverage or private health insurance. The private health insurance types are employer-based health insurance, direct-purchase health insurance (i.e., nongroup), and TRICARE or other military health coverage; the public coverage types are Medicare, Medicaid or other means-tested public coverage, and VA Health Care. Indian Health Service (IHS), one of the seven coverage categories, is not considered to be comprehensive health insurance because it does not cover a wide array of medical services (SHADAC 2005).

Respondents also have the option to write in a type of health insurance. During the editing process, the write-in responses are classified into one of the seven coverage categories unless the write-in indicates that the respondent does not have insurance. Respondents can have both public and private coverage (e.g., Medicare and employer-based insurance), and respondents who indicate that they have no health insurance coverage are considered uninsured. In this analysis, we look at all working-age people (aged 19-64) with nongroup insurance and one or more other types of coverage; specifically, working-age people who have nongroup insurance alone, nongroup insurance and employer-based insurance, nongroup insurance and Medicaid or other means-tested coverage, and nongroup insurance and other private or public coverage.

ACS coding, editing, and imputation procedures affect health insurance estimates. For example, missing responses to each coverage categories are assigned a "yes" or "no" response through editing and imputation. The process for classifying write-ins and the potential effects of that process were discussed earlier. To date, no one has examined how ACS coding, editing, and imputation procedures affect the estimates of multiple types of coverage which include nongroup insurance, and it is beyond the scope of this study to so. To avoid these concerns, this study uses the unedited ACS health insurance data with the one exception being the write-in responses that have been classified by Census Bureau analysts.

METHODOLOGY

To examine the characteristics of people who report both nongroup insurance and an additional source of coverage, we use the ACS data on health insurance to compare the characteristics of people with nongroup insurance alone to those with nongroup insurance in one of the following combinations: nongroup insurance and employer-based insurance; nongroup insurance and Medicaid; nongroup insurance and other private or public coverage (but not employer-based insurance or Medicaid).

We use unedited ACS health insurance data to mitigate the issue of ACS editing procedures being the source of a respondent having more than one type of coverage. Specifically, we use unedited ACS data that does not include any health insurance responses that were imputed through imputation procedures or assigned by logical coverage edits. We selectively edit the unedited data in the following ways: we drop all respondents from our analysis who left the health insurance items blank (i.e., the respondents who would have imputed health insurance coverage); if a person only checked "yes" to one or some types of coverage, all blank responses are assigned "no"; and we assign coverage based on write-in responses.

We adjust the replicate weights so that our newly weighted population that does not include any imputed health insurance responses is the same as the full-sample ACS population. We examine the unweighted frequencies of the regular ACS population and the unweighted frequencies of the selectively edited population used in this study to assess the differences between the two populations. We find few substantive differences between the two populations; the weighted uninsured rate among adults aged 19-64 in the full-sample ACS population is 20.8 percent and it is 21.8 percent when we drop the people that skipped the health insurance coverage section. This difference is statistically significant. We dropped 2.7 percent of the weighted full-sample ACS population (117,298 unweighted people, among them 60,656 adults aged 19-64 years) to create our reweighted population. The people we dropped had imputed health insurance coverage.

We present descriptive statistics of the characteristics of people with each combination of coverage to better understand how each population differs, and to examine how each population differs from the population that has nongroup insurance alone. We use average marginal effects

from a multinomial logit regression to examine the characteristics associated with people who report each combination of coverage. Consistent with our interest in understanding factors associated with reports of nongroup insurance and another type of coverage, we use one dependent variable that classifies respondents as having nongroup insurance alone or in combination with either employer-based insurance, Medicaid, or other private or public coverage.

The independent variables are characteristics of the respondents from the ACS. We include the following independent variables that describe individual characteristics of the respondents: sex; citizenship status (citizen, not a citizen); disability status (with a disability, no disability); whether the respondent wrote in a health insurance response; age (under 27, 27-34, 35-44, 45-54, 55-64); poverty status (under 100%, 100-138%, 139-199%, 200-299%, 300-399%, 400% or greater); education status (did not finish high school, high school diploma or GED, some college or associate's degree, bachelor's degree or higher); race and ethnicity (non-Hispanic White, non-Hispanic Black, non-Hispanic Other, Hispanic); employment status (employed full-time, employed part-time, unemployed, not in the labor force); marital status (married, widowed, divorced, separated, never married), and survey mode (mail, telephone interview, in-person interview). We use the following independent variables that describe the household characteristics of the respondents: metropolitan status (live in an urban area, live in a metropolitan area but not in the city, live in a micropolitan area, other); number of own children in the household (0, 1-2, 3 or more); whether the household receives food stamps; and whether someone in the household speaks a language other than English.

RESULTS

Nationwide, 12 million working-age adults have nongroup insurance alone and about 6 million people have nongroup insurance in combination with another type of insurance (Table 1). Among those with nongroup insurance in combination, about 5 million report having nongroup insurance and employer-based insurance (hereafter, nongroup/employer) and about 450,000 report nongroup insurance and Medicaid (hereafter, nongroup/Medicaid), and nearly 600,000 report nongroup insurance and other private or public coverage (hereafter, nongroup/other).

The levels of having nongroup insurance in combination with another type of coverage varied across the states and D.C. The range of nongroup coverage alone was 11.4 percent of working-age adults in North Dakota (not significantly different from South Dakota) to 3.6 percent in West Virginia (not significantly different from Alaska). The range of coverage for working-age adults with nongroup in combination was 7.1 percent in D.C. (not significantly different from Hawaii) to 2.3 percent in New Hampshire (not significantly different from Arizona and Vermont; Table 2).

Looking more closely at the share of each states' nongroup insurance population that has coverage in combination, we see that compared to the national average, 23 states had a larger share of their nongroup population in combination, 18 states had a smaller share of their nongroup population in combination, and 10 states did not have shares significantly different from the national average (Figure 1).

Nongroup/Employer

The tabular results in Table 1 show that 54.3 percent of the nongroup/employer population and 42.9 percent of the nongroup alone population report income 400 percent FPL and higher. The proportion of the population that is employed full-time is greater in the nongroup/employer population than it is in the nongroup alone population (73.6 percent and 51.8 percent, respectively). About 65 percent of the nongroup/employer population is married, whereas 54.2 percent of the nongroup alone population is married.

The average marginal effects from the logistic results, in Table 3, show that as income goes up the likelihood of nongroup/employer goes up. Compared to those who are employed full-time, those who are employed part-time or who are unemployed or not in the labor force are less likely to report nongroup/employer. Compared to those who are married, those who are widowed, divorced, or never married are less likely to report nongroup/employer. Compared to those who mailed in their responses, people who responded over the telephone were 18.3 percent more likely to have both types of coverage, and those whose information was collected during personal interviews were 9.0 percent more likely to have nongroup/employer. Compared to people without children, people with children are more likely to report nongroup/employer.

Nongroup/Medicaid

The tabular data show that 32.9 percent of the nongroup/Medicaid population has income below 100 percent FPL, compared to 13.3 percent of adults with nongroup insurance alone (Table 1). About 60 percent of the nongroup/Medicaid population is not in the labor force, compared to 26.4 percent of the nongroup alone population (Table 1). Nearly half of the nongroup/Medicaid population reports a disability, and only 5.5 percent of the nongroup alone population reports a disability (Table 1).

The regression results in Table 3 show that adults with income 400 percent FPL and higher are 1.6 percent less likely to report nongroup/Medicaid compared to adults with incomes below 100 percent FPL. Compared to those who are employed full-time, people not in the labor force are 2.3 percent more likely to report nongroup/Medicaid. Respondents who have a disability are 4.1 percent more likely to have nongroup/Medicaid than those who did not have a disability. Compared to those who respond via mail, adults who respond via telephone are 1.2 percent more likely to report nongroup/Medicaid. Respondents who lived in a household that participated in SNAP (formerly called the Food Stamps program) were 3.4 percent more likely to report nongroup/Medicaid than those who did not receive SNAP.

Nongroup/Other

Table 1 shows that the nongroup/other population has a much larger percent of adults age 55-64 than the nongroup alone population (62.4 percent and 24.4 percent, respectively). Nearly three-quarters of the nongroup/other population is not in the labor force, compared to the 26.4 percent of the nongroup alone population. Over half the nongroup/other population reports a disability, while only 5.5 percent of the nongroup alone population reports a disability. A larger percentage of the nongroup/other population does not live in a household with children (89.0 percent) compared to the nongroup alone population (69.5 percent).

The regression results in Table 3 show that being between the ages of 55 and 64 increases the likelihood that a person reports nongroup/other by 7.1 percent. The likelihood of having nongroup/other coverage increases among higher incomes compared to below 100 percent of

FPL. Compared to those who are employed full-time, people who are employed part-time and people who are not in the labor force are more likely to report nongroup/other. Those who are disabled are 6.8 percent more likely to report nongroup/other than those who are not disabled. Compared to those who respond via mail, those who respond by phone are 1.6 percent more likely to report nongroup/other.

Common Effects

Some results were common across all three combinations of coverage. One of these results is the relationship between reporting nongroup coverage in combination and with educational attainment. The regression results show that higher education status (bachelor's degree or higher) decreases the likelihood that a person reports nongroup in combination with another type of coverage. Compared to those who have less than a high school education, people with at least a bachelor's degree are 4.5 percent less likely to report nongroup/employer, and 3.3 percent less likely to report nongroup/Medicaid (although 4.5 and 3.3 percent are not statistically different). Respondents who have at least a bachelor's degree are 1.1 percent less likely to report nongroup/other compared to those who have less than a high school education (Table 3).

A second result shared across the combinations of coverage is that the percentage of non-Hispanic Blacks who reported each type of combination was greater then the percentage that reported nongroup alone (Table 1). The regression results show that non-Hispanic Blacks are 20.4 percent more likely to report nongroup/employer, 1.2 percent more likely to report nongroup/Medicaid, and 1.7 percent more likely to report nongroup/other compared to non-Hispanic Whites (although 1.2 percent is not significantly different from 1.7 percent; Table 3).

A third result is that having a write-in response was related to having nongroup insurance in combination is important. In the nongroup/employer population, 13.0 percent have a write-in; in the nongroup/Medicaid population, 35.1 percent have a write-in; in the nongroup/other population 25.2 percent have a write-in (Table 1). Among those in the nongroup/employer population and had a write-in, 566,372 people (87.1 percent of the nongroup/employer write-in population) wrote in nongroup insurance (Table 4). In the nongroup/Medicaid population, among the 156,237 with a write-in, 131,990 wrote in nongroup insurance (Table 4). In the

nongroup/other population, among the 148,424 with a write-in, 140,102 wrote in nongroup insurance (Table 4). Respondents with a write-in are 12.6 percent more likely to have nongroup/employer, 2.8 percent more likely to report nongroup/Medicaid, and 4.2 percent more likely to report nongroup/other compared to those who do not have a write-in (Table 3).

DISCUSSION

States: States have the option to design, implement, and run their own health insurance exchanges (within federal guidelines). In addition, while federal guidelines govern some aspects of the health insurance market, each state has a unique health insurance market based on the specific state rules that govern the private health insurance market, the make-up of the state's economy, as well as the state's decisions concerning its public coverage. State variation, for all types of coverage, is therefore expected; however, we did not expect state variation in multiple types of coverage given a coverage type. The results from this study show that there is substantial variation across the states and D.C. as to the percent of the population that reports nongroup coverage alone or in combination. Of those working-age adults who report nongroup coverage, we found that 21.6 percent of Colorado's adults who have nongroup insurance report that they have another type of health insurance coverage, while 55.4 percent of West Virginia's adults who report nongroup insurance report that they have another type of coverage. In terms of establishing a baseline for estimates for health insurance exchanges ACA, we need to know the characteristics of the people reporting nongroup coverage.

Nongroup/Employer: An important result of this study is that employer-based insurance is the main driver of having nongroup insurance in combination with another type of coverage; 84.3 percent of those with nongroup in combination have employer-based insurance. The results suggest that the people who report both nongroup insurance and employer-based insurance likely do have employer-based insurance. About three-quarters of this population are employed full-time, and they are likely to have an income greater than 300 percent FPL. These results corroborate the suspicion that employed people are reporting nongroup insurance that is not comprehensive coverage (e.g., single plan coverage such as dental insurance), or they are confused about their coverage, or they are misreporting because of ACS methodological issues. While this type of misreporting does not affect the aggregate estimates of health insurance

coverage status or general types of coverage (private or public), it does affect estimates of specific types of coverage, most notably, estimates of nongroup coverage.

Nongroup/Medicaid: Research has shown that survey respondents sometimes misreport nongroup coverage when they actually have Medicaid (Cantor, et al. 2008, Call, et al. 2008). Given this, we thought that some respondents would report both types of coverage when, in fact, they only have Medicaid. While the results of this study suggest that this does happen, this issue affects a small population; only 7.5 percent of the population with nongroup in combination reports nongroup insurance and Medicaid or other means-tested public coverage.

Nongroup/Other: This combination of coverage was the least concerning to us because of the combination types. The results of the study suggest that respondents with this combination are older, not in the labor force, and unlikely to live in a household with children. A closer examination of this population shows that Medicare is the predominant "other" type of insurance, and the study results corroborate this finding. While this combination certainly affects the nongroup coverage estimates, the combinations of coverage represented in this population are easy to explain and unlikely to be affected by ACA.

Survey Effects: We found several results that were common across the three combinations of coverage. The most striking result concerns the write-in responses. Having a write-in response was positively associated with each combination of coverage. This issue affects a small population, as only 2.1 percent of working-age adults write-in a response on the ACS, but it is a likely contributor to having nongroup insurance in combination (and possibly other types of multiple coverage). This is a methodological issue that could be addressed. Fixing this one aspect of the ACS could improve the estimates of multiple types of coverage, thus improving the health insurance estimates overall (and particularly for nongroup coverage).

We also saw across all groups that having a bachelor's degree compared to having less than a high school education makes you less likely to have each of the combinations. It is unclear what this indicates, particularly because the effect is not linear – having some college education or an Associate's degree does not have nearly the impact that having a bachelor's degree does;

educational attainment and labor force status do not explain this. For race groups, we saw that non-Hispanic Blacks are more likely to report all the combinations than non-Hispanic Whites. We failed to find a cross-effect that explained this anomalous result; we thought that race/ethnicity would be a small factor when controlling for income.

Limitations: A limitation of this study has to do with how surveys ask questions about health insurance. When health insurance estimates are produced, it is assumed that the estimates are for coverage that provides full and comprehensive health benefits. The estimates are not intended to produce estimates of supplemental coverage or single-service coverage; however, national household surveys do not ask whether health insurance plans are comprehensive.

Conclusion: It is important to examine the issue of multiple types of coverage to be able to produce useful estimates of coverage for a baseline now, and to measure the effects of ACA. This is particularly important for the nongroup market, which is likely to expand under ACA and is not currently measured well. The results of this study show that while the population who reports nongroup coverage in combination is small, the population seems to misreport coverage, which affects health insurance estimates. This is particularly important for nongroup insurance in combination with employer-based insurance, and less important for nongroup insurance with other types of coverage, including Medicaid.

The results also suggest that some of this multiple coverage could be mitigated with changes to how write-in results are classified. The results of this study suggest that write-in responses contribute to having nongroup coverage in combination, and particularly contribute to the nongroup part of that combination. Looking into the how the write-ins are classified could not only improve estimates of coverage for multiple coverage, but also improve estimates of nongroup coverage, and thus improve the results to be better used to measure the effects of ACA.

TABLES AND FIGURES

Table 1. Demographic characteristics of adults (age 19-64) who have nongroup insurance alone or in combination with another type of coverage: 2009

Universe: U.S. Civilian Noninstitutionalized Population Age 19-64

	Percentage with Nongroup Insurance				Percentage with Nongroup & Employer-based Insurance		Percentage with Nongroup & Medicaid[1]		Percentage with Nongroup & Other Private or Public Coverage[2]	
	Alone		In Combination							
	Estimate	MOE[3]	Estimate	MOE[3]	Estimate	MOE[3]	Estimate	MOE[3]	Estimate	MOE[3]
Total population (numbers in thousands)	12,010	66	5,913	58	4,986	54	445	11	590	12
Individual characteristics										
Sex										
Female	51.9	0.16	51.2	0.26	50.8	0.28	58.3	1.23	50.1	1.05
Male	48.1	0.16	48.8	0.26	49.2	0.28	41.7	1.23	49.9	1.05
Age										
Under 27 years	20.3	0.23	11.3	0.25	12.1	0.28	14.6	0.99	3.2	0.39
27-34 years	13.4	0.18	12.2	0.25	13.3	0.30	12.7	0.94	2.9	0.46
35-44 years	18.4	0.21	20.7	0.33	22.4	0.36	17.9	1.05	8.1	0.61
45-54 years	23.6	0.21	27.4	0.26	28.0	0.33	25.8	0.95	23.3	0.84
55-64 years	24.4	0.25	28.4	0.35	24.3	0.35	28.8	1.27	62.4	1.00
Race and Hispanic Origin										
White, not Hispanic or Latino	78.1	0.26	68.3	0.35	67.7	0.38	51.8	1.33	81.0	0.86
Black, not Hispanic or Latino	5.4	0.13	14.6	0.28	14.5	0.30	25.4	1.22	10.4	0.71
Some other race, not Hispanic or Latino	8.2	0.16	6.3	0.18	6.6	0.21	7.2	0.81	2.7	0.36
Hispanic or Latino (any race)	8.2	0.18	10.9	0.28	11.2	0.33	15.6	1.12	5.9	0.51
Citizenship Status										
Not a U.S. citizen	7.3	0.13	5.0	0.18	5.3	0.21	7.7	0.84	1.0	0.21
U.S. Citizen	92.7	0.13	95.0	0.18	94.7	0.21	92.3	0.84	99.0	0.21
Disability Status										
Not disabled	94.5	0.10	84.6	0.21	91.4	0.18	53.6	1.27	46.5	0.9
Disabled	5.5	0.10	15.4	0.21	8.6	0.18	46.4	1.27	53.5	0.9
Educational Attainment										
Less than high school graduate	5.3	0.12	8.1	0.18	6.3	0.18	26.1	1.22	12.2	0.59
High school graduate	21.4	0.20	25.4	0.36	23.9	0.38	33.7	1.18	32.8	0.92
Some college or Associate's degree	34.4	0.25	34.9	0.38	35.5	0.41	28.6	1.07	34.4	0.92
Bachelor's degree or more	38.9	0.25	31.6	0.35	34.3	0.38	11.6	0.82	20.6	0.72
Marital Status										
Married	54.2	0.25	61.6	0.39	64.5	0.43	34.3	1.18	55.3	1.02
Widowed	2.0	0.07	2.6	0.1	1.9	0.10	4.8	0.58	7.2	0.51
Divorced	10.2	0.12	11.2	0.23	9.7	0.25	17.4	0.86	18.7	0.74
Separated	1.3	0.07	2.2	0.1	1.9	0.12	5.1	0.63	2.1	0.30
Never married	32.3	0.25	22.5	0.31	22.0	0.31	38.4	1.32	16.7	0.84
Employment Status										
Employed, full-time	51.8	0.20	64.9	0.33	73.6	0.35	24.6	0.95	16.6	0.71
Employed, part-time	14.7	0.16	7.5	0.16	7.4	0.2	9.5	0.66	7.3	0.53
Unemployed	7.1	0.13	3.4	0.12	3.2	0.13	7.1	0.69	2.9	0.3
Not in labor force	26.4	0.18	24.1	0.28	15.8	0.26	58.8	1.2	73.3	0.84

Table 1. Demographic characteristics of adults (age 19-64) who have nongroup insurance alone or in combination with another type of coverage: 2009

Universe: U.S. Civilian Noninstitutionalized Population Age 19-64

	Percentage with Nongroup Insurance				Percentage with Nongroup & Employer-based Insurance		Percentage with Nongroup & Medicaid[1]		Percentage with Nongroup & Other Private or Public Coverage[2]	
	Alone		In Combination							
	Estimate	MOE[3]	Estimate	MOE[3]	Estimate	MOE[3]	Estimate	MOE[3]	Estimate	MOE[3]
Poverty Status (% FPL)										
< 100	13.3	0.20	7.4	0.21	5.3	0.23	32.9	1.18	9.3	0.59
100-138	5.2	0.12	4.5	0.16	3.0	0.15	14.7	1.07	10.5	0.71
139-199	9.0	0.15	8.0	0.18	6.5	0.21	15.0	0.94	16.4	0.82
200-299	16.0	0.21	15.3	0.33	14.9	0.38	15.0	1.05	19.8	0.82
300-399	13.6	0.20	15.3	0.33	16.0	0.38	8.4	0.69	13.8	0.63
400 or higher	42.9	0.28	49.4	0.44	54.3	0.51	14.0	0.87	30.1	1.02
Survey mode										
Mail	64.9	0.63	49.5	0.64	47.7	0.66	50.0	1.65	63.9	1.02
CATI	8.3	0.15	18.5	0.31	18.9	0.36	15.8	0.79	16.9	0.64
CAPI	26.8	0.66	32.0	0.77	33.4	0.82	34.1	1.68	19.2	1.05
Write in status										
Does not have a write in	91.8	0.18	84.2	0.25	87.0	0.25	64.9	1.43	74.8	0.87
Has a write in	8.2	0.18	15.8	0.25	13.0	0.25	35.1	1.43	25.2	0.87
Household characteristics										
Presence of non-English speaker in household										
No	22.9	0.28	21.2	0.31	22.0	0.36	27.1	1.17	11.1	0.69
Yes	77.1	0.28	78.8	0.31	78.0	0.36	72.9	1.17	88.9	0.69
Receives food stamps										
No	96.9	0.10	93.5	0.21	96.0	0.21	63.2	1.33	92.0	0.54
Yes	3.1	0.10	6.5	0.21	4.0	0.21	36.8	1.33	8.0	0.54
Number of own children in household										
No children	69.5	0.28	66.3	0.38	63.3	0.43	69.0	1.4	89.0	0.59
1 - 2 children	24.9	0.26	27.5	0.36	30.0	0.41	23.7	1.27	9.6	0.54
3 or more children	5.6	0.15	6.2	0.21	6.7	0.25	7.4	0.72	1.4	0.28
Metropolitan status										
Not an urban area	6.7	0.13	6.9	0.18	6.7	0.18	6.7	0.56	9.1	0.54
Metropolitan central city	33.6	0.26	32.3	0.41	32.0	0.46	44.6	1.48	26.9	0.95
Metropolitan non-central city	50.1	0.28	49.9	0.43	50.7	0.48	37.8	1.28	50.5	1.00
Micropolitan area	9.6	0.15	10.9	0.21	10.6	0.23	10.8	0.79	13.5	0.59

[1] "Medicaid" refers to Medicaid and other means-tested public coverage. The item used to estimate enrollment in means-tested public coverage reads, "Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability.

[2] Other private and public coverage includes Medicare, TRICARE or other military health care, and VA Health Care.

3 Data are based on a sample and are subject to sampling variability. A margin of error is a measure of an estimate's variability. The larger the margin of error in relation to the size of the estimate, the less reliable the estimate. This number when added to and subtracted from the estimate forms the 90-percent confidence interval.

Source: U.S. Census Bureau, 2009 American Community Survey

Table 2. Nongroup insurance status among adults (age 19-64), by state: 2009

Universe: U.S. Civilian Noninstitutionalized Population Age 19-64

	Total Population		Population with Nongroup Alone				Population with Nongroup in Combination			
	Estimate	MOE[1]	Estimate	MOE[1]	Percent	MOE[1]	Estimate	MOE[1]	Percent	MOE[1]
Numbers in thousands										
Alabama	2,762	9	176	9	6.4	0.34	120	6	4.3	0.24
Alaska	417	4	16	3	3.8	0.61	12	2	2.9	0.56
Arizona	3,802	12	253	10	6.7	0.27	88	6	2.3	0.16
Arkansas	1,669	7	107	6	6.4	0.38	57	5	3.4	0.28
California	22,113	25	1,845	23	8.3	0.11	591	17	2.7	0.08
Colorado	3,087	10	295	10	9.6	0.32	81	5	2.6	0.18
Connecticut	2,096	7	133	7	6.3	0.32	69	4	3.3	0.21
Delaware	520	4	23	3	4.4	0.59	17	2	3.3	0.43
District of Columbia	378	3	28	3	7.5	0.71	27	4	7.1	1.19
Florida	10,690	22	786	19	7.4	0.18	287	11	2.7	0.10
Georgia	5,822	14	351	13	6.0	0.22	200	8	3.4	0.14
Hawaii	736	5	49	4	6.6	0.55	50	6	6.8	0.78
Idaho	888	5	91	5	10.3	0.56	29	3	3.3	0.34
Illinois	7,717	12	479	13	6.2	0.17	203	7	2.6	0.10
Indiana	3,791	10	211	9	5.6	0.23	114	6	3.0	0.17
Iowa	1,749	6	157	6	9.0	0.33	67	5	3.8	0.26
Kansas	1,647	5	126	6	7.7	0.38	53	4	3.2	0.22
Kentucky	2,574	7	148	7	5.7	0.27	83	5	3.2	0.18
Louisiana	2,644	9	173	9	6.5	0.33	101	6	3.8	0.23
Maine	802	3	48	4	5.9	0.47	25	2	3.1	0.31
Maryland	3,452	11	212	8	6.1	0.24	139	8	4.0	0.24
Massachusetts	4,013	11	258	9	6.4	0.22	146	7	3.6	0.18
Michigan	5,962	12	349	12	5.9	0.19	194	8	3.3	0.13
Minnesota	3,178	7	257	8	8.1	0.26	103	5	3.3	0.15
Mississippi	1,681	7	98	7	5.8	0.39	64	5	3.8	0.27
Missouri	3,529	8	227	7	6.4	0.20	107	5	3.0	0.13
Montana	578	4	57	4	9.9	0.74	22	3	3.8	0.56
Nebraska	1,044	5	99	5	9.5	0.45	36	3	3.5	0.28
Nevada	1,583	6	83	6	5.3	0.35	82	7	5.2	0.46
New Hampshire	812	4	48	4	5.9	0.49	18	2	2.3	0.29
New Jersey	5,238	11	273	9	5.2	0.18	173	9	3.3	0.17
New Mexico	1,159	7	72	5	6.2	0.42	36	4	3.1	0.33
New York	11,828	20	634	16	5.4	0.14	491	16	4.2	0.13
North Carolina	5,516	10	387	14	7.0	0.25	185	8	3.3	0.14
North Dakota	379	2	43	3	11.4	0.78	15	2	4.1	0.46
Ohio	6,849	12	362	12	5.3	0.17	199	8	2.9	0.11
Oklahoma	2,116	8	124	6	5.8	0.29	71	5	3.4	0.23
Oregon	2,318	7	186	8	8.0	0.33	71	5	3.1	0.20
Pennsylvania	7,417	13	477	11	6.4	0.15	281	11	3.8	0.15
Rhode Island	633	4	38	3	6.1	0.46	19	3	3.1	0.44
South Carolina	2,668	9	164	7	6.1	0.28	104	6	3.9	0.23
South Dakota	465	3	51	4	11.0	0.87	21	2	4.5	0.52
Tennessee	3,763	9	246	10	6.5	0.25	119	6	3.2	0.16
Texas	14,483	21	754	16	5.2	0.11	410	10	2.8	0.07
Utah	1,577	6	125	8	7.9	0.49	51	4	3.3	0.28
Vermont	383	2	25	2	6.6	0.60	9	1	2.4	0.38

Table 2. Nongroup insurance status among adults (age 19-64), by state: 2009

Universe: U.S. Civilian Noninstitutionalized Population Age 19-64

	Total Population		Population with Nongroup Alone				Population with Nongroup in Combination			
	Estimate	MOE[1]	Estimate	MOE[1]	Percent	MOE[1]	Estimate	MOE[1]	Percent	MOE[1]
Virginia	4,673	13	301	11	6.4	0.24	201	8	4.3	0.18
Washington	4,049	11	302	11	7.4	0.26	116	7	2.9	0.16
West Virginia	1,094	5	39	3	3.6	0.32	49	4	4.4	0.40
Wisconsin	3,405	8	199	7	5.8	0.21	92	5	2.7	0.14
Wyoming	328	3	27	3	8.4	0.90	12	2	3.6	0.65

[1] Data are based on a sample and are subject to sampling variability. A margin of error is a measure of an estimate's variability. The larger the margin of error in relation to the size of the estimate, the less reliable the estimate. This number when added to and subtracted from the estimate forms the 90-percent confidence interval.

Source: U.S. Census Bureau, 2009 American Community Survey

Table 3. Correlates of nongroup in combination relative to nongroup insurance alone among adults (age 19-64): 2009

Universe: U.S. Civilian Noninstitutionalized Population Age 19-64

	Nongroup & Employer-based Insurance				Nongroup & Medicaid[1]				Nongroup & Other Private or Public Coverage[2]			
	Average Marginal Effects (%)		95% Confidence Interval		Average Marginal Effects (%)		95% Confidence Interval		Average Marginal Effects (%)		95% Confidence Interval	
Individual Characteristics												
Male	-2.06	**	2.43	-1.69	0.03		-0.13	0.20	1.97	**	1.76	2.17
Age												
27-34 years	0.90		-0.05	1.84	1.13	**	0.74	1.52	2.02	**	1.10	2.94
35-44 years	1.23	*	0.20	2.26	1.31	**	0.88	1.74	4.41	**	3.70	5.11
45-54 years	1.03	*	0.09	1.97	1.36	**	0.95	1.77	5.53	**	4.80	6.25
55-64 years	1.63	**	0.59	2.66	1.40	**	0.95	1.85	7.08	**	6.38	7.79
Race and Hispanic Origin												
Black, not Hispanic or Latino	20.42	**	19.54	21.30	1.21	**	0.91	1.51	1.66	**	1.20	2.12
Some other race, not Hispanic or Latino	2.52	**	1.37	3.67	0.55	**	0.14	0.96	-0.86	**	-1.49	-0.22
Hispanic or Latino (any race)	9.17	**	8.21	10.13	0.52	**	0.16	0.88	0.45		-0.07	0.96
Citizen	6.30	**	5.12	7.48	0.60	**	0.17	1.03	4.32	**	3.33	5.32
With a disability	9.89	**	9.08	10.71	4.08	**	3.85	4.30	6.80	**	6.58	7.01
Educational Attainment												
High school graduate (includes equivalency)	-1.09		-2.21	0.03	-0.92	**	-1.20	-0.63	0.09		-0.29	0.47
Some college or associate's degree	-0.91		-1.89	0.06	-1.91	**	-2.15	-1.67	0.22		-0.15	0.60
Bachelor's degree or higher	-4.49	**	-5.54	-3.43	-3.33	**	-3.68	-2.98	-1.06	**	-1.46	-0.65
Marital Status												
Widowed	-2.94	**	-4.66	-1.23	1.05	**	0.65	1.46	1.40	**	0.98	1.81
Divorced	-4.35	**	-5.15	-3.55	1.52	**	1.24	1.80	0.89	**	0.63	1.15
Separated	0.84		-1.04	2.72	1.38	**	0.80	1.97	0.54		-0.35	1.43
Never married	-6.49	**	-7.31	-5.67	1.62	**	1.32	1.91	0.07		-0.28	0.43
Employment Status												
Employed, part-time	-15.65	**	-16.42	-14.88	0.88	**	0.64	1.12	2.17	**	1.77	2.57
Unemployed	-18.42	**	-19.56	-17.28	0.57	**	0.16	0.98	0.43		-0.13	0.99
Not in labor force	-14.25	**	-14.77	-13.73	2.27	**	2.06	2.48	5.75	**	5.46	6.03
Poverty Status (% FPL)												
100-138	0.83		-0.73	2.38	0.90	**	0.56	1.24	3.25	**	2.78	3.72
139-199	4.87	**	3.48	6.26	0.40	**	0.13	0.68	3.31	**	2.85	3.77

Table 3. Correlates of nongroup in combination relative to nongroup insurance alone among adults (age 19-64): 2009

Universe: U.S. Civilian Noninstitutionalized Population Age 19-64

	Nongroup & Employer-based Insurance				Nongroup & Medicaid[1]				Nongroup & Other Private or Public Coverage[2]			
	Average Marginal Effects (%)		95% Confidence Interval		Average Marginal Effects (%)		95% Confidence Interval		Average Marginal Effects (%)		95% Confidence Interval	
200-299	9.45	**	8.24	10.65	-0.34	*	-0.65	-0.04	2.74	**	2.32	3.17
300-399	14.01	**	12.87	15.14	-0.80	**	-1.13	-0.48	2.43	**	1.97	2.88
400 or higher	17.17	**	16.10	18.25	-1.61	**	-1.93	-1.29	2.28	**	1.81	2.75
Survey Mode												
CATI	18.31	**	17.70	18.93	1.21	**	0.97	1.45	1.61	**	1.35	1.87
CAPI	9.04	**	8.39	9.69	-0.11		-0.38	0.16	-0.81	**	-1.15	-0.47
Write in	12.55	**	11.78	13.32	2.79	**	2.55	3.03	4.19	**	3.89	4.49
Household Characteristics												
Presence of non-English speaker in household	2.14	**	1.26	3.02	-0.25		-0.55	0.04	1.16	**	0.72	1.60
Receives food stamps	3.44	**	2.00	4.88	3.35	**	3.06	3.64	0.90	**	0.41	1.39
Number of own children in household												
1 - 2 children	2.35	**	1.68	3.03	0.89	**	0.62	1.16	-1.21	**	-1.54	-0.88
3 or more children	3.40	**	2.25	4.56	0.89	**	0.46	1.31	-2.45	**	-3.43	-1.47
Metropolitan Status												
Metropolitan central city	1.20	*	0.15	2.24	0.29		-0.06	0.64	-0.13		-0.50	0.24
Metropolitan non-central city	1.44	**	0.49	2.39	-0.31		-0.62	0.01	-0.02		-0.35	0.30
Micropolitan area	3.22	**	2.08	4.37	0.31		-0.09	0.70	0.38	*	0.02	0.75

* p<0.05; ** p<0.01

1 "Medicaid" refers to Medicaid and other means-tested public coverage. The item used to estimate enrollment in means-tested public coverage reads, "Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability."

[2] Other private and public coverage includes Medicare, TRICARE or other military health care, and VA Health Care.

Source: U.S. Census Bureau, 2009 American Community Survey

Table 4. Write in responses among adults (age 19-64) who have nongroup insurance alone or in combination with another type of coverage: 2009

Universe: U.S. Civilian Noninstitutionalized Population Age 19-64

	Population with Nongroup & Employer-based Insurance				Population with Nongroup & Medicaid[1]				Population with Nongroup & Other Private or Public Coverage[2]			
	Count	MOE[3]	Percent	MOE[3]	Count	MOE[3]	Percent	MOE[3]	Count	MOE[3]	Percent	MOE[3]
Total Population	4,985,765	54,032			444,550	11,327			590,146	11,686		
With a write in	650,465	12,795	13.0	0.3	156,237	7,501	35.1	1.4	148,424	6,295	25.2	0.9
No write in	4,335,300	51,454	87.0	0.3	288,312	9,765	64.9	1.4	441,723	9,426	74.8	0.9
Write in is nongroup insurance	566,372	12,311	11.4	0.3	131,990	6,781	29.7	1.3	140,102	6,032	23.7	0.9
Write in is other type in combination[4]	24,353	2,777	0.5	0.1	15,712	2,537	3.5	0.6	1,922	768	0.3	0.13

[1] "Medicaid" refers to Medicaid and other means-tested public coverage. The item used to estimate enrollment in means-tested public coverage reads, "Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability."

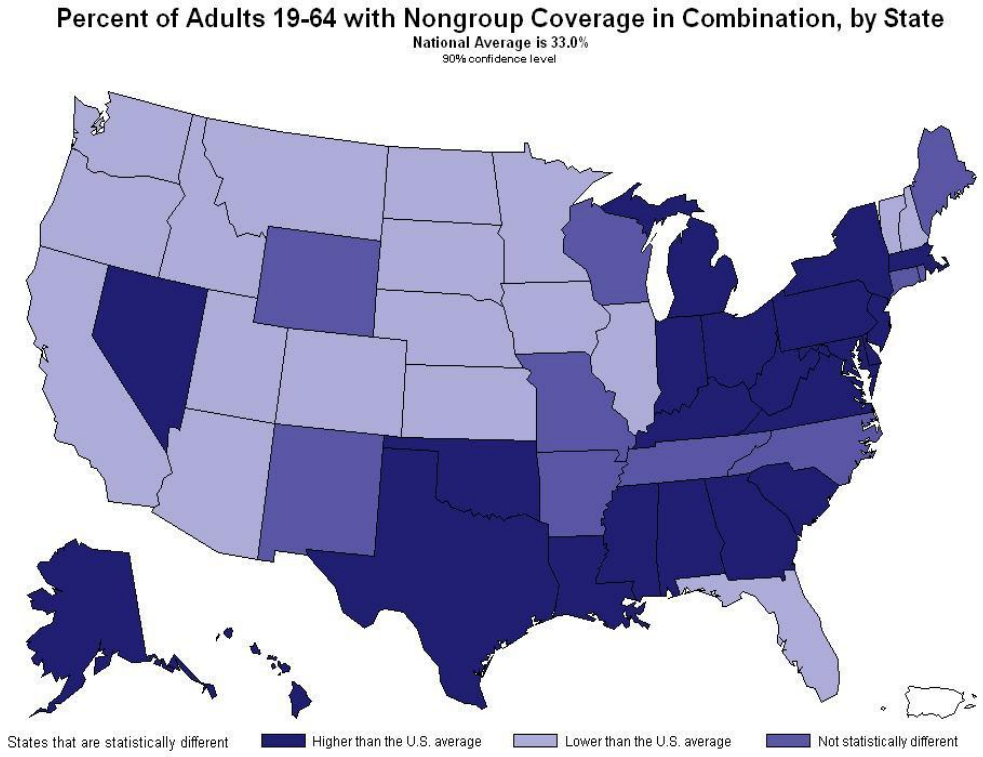
[2] Other private and public coverage includes Medicare, TRICARE or other military health care, and VA Health Care.

3 Data are based on a sample and are subject to sampling variability. A margin of error is a measure of an estimate's variability. The larger the margin of error in relation to the size of the estimate, the less reliable the estimate. This number when added to and subtracted from the estimate forms the 90-percent confidence interval.

[4] For the nongroup & employer-based insurance population, this estimate is for employer-based insurance. For the nongroup & Medicaid population, this estimate is for Medicaid or other means-tested public coverage. For the nongroup & other private or public coverage population, this estimate is for Medicare, TRICARE or other military health care, and VA Health Care.

Source: U.S. Census Bureau, 2009 American Community Survey

Figure 1.



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