

The Dynamics of Health Insurance Within Families: 2012–2021

By Eden Volkov, Ph.D., Employee Benefit Research Institute

AT A GLANCE

Over 70 percent of working adults are covered by a group health plan, making it the predominant source of health insurance coverage. However, there is still substantial variation in health coverage within and across families in the United States. The Patient Protection and Affordable Care Act (ACA) led to changes in the composition of health insurance coverage within families by increasing access to group, non-group, and Medicaid coverage. In this study, we document how health insurance coverage differs within and across families, show evidence regarding the impact of the “family glitch” on enrollment in Marketplace coverage, investigate family coverage trends, and document the profiles of female policyholders over time. These findings indicate that the ACA has increased access to Medicaid and group health insurance, but by reducing the affordability of Marketplace coverage for family members of group policyholders, the “family glitch” is a barrier to enrollment in non-group health plans. Our analyses show:

- Health plans differ within and across families. Health coverage of partners is highly correlated in two-parent and in two-adult childless families. Children’s coverage is more similar to their parents’ in two-parent families than in single-parent families.
- There is strong evidence that the ACA “family glitch” reduces the likelihood that partners are covered by non-group coverage, especially among families with children. Women whose partner has group coverage are 2–3 times more likely to be uninsured than have non-group coverage.
- Coinciding with the ACA’s 2014 Medicaid expansion and the 2016 employer mandate, differences in Medicaid and group coverage within families narrowed.
- Mothers are increasingly likely to be the provider of group coverage for the whole family and are replacing fathers as the providers of family coverage. On the other hand, group policy-holding rates have been steady for both childless men and women.
- Increased group policy-holding rates among mothers can be explained by increased labor force participation and an “upscaling” of jobs.
- Finally, women with group coverage are earning more over time, further reflecting entrance into higher paid occupations.

Eden Volkov is a Health Research Associate at the Employee Benefit Research Institute (EBRI). This *Issue Brief* was written with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF), or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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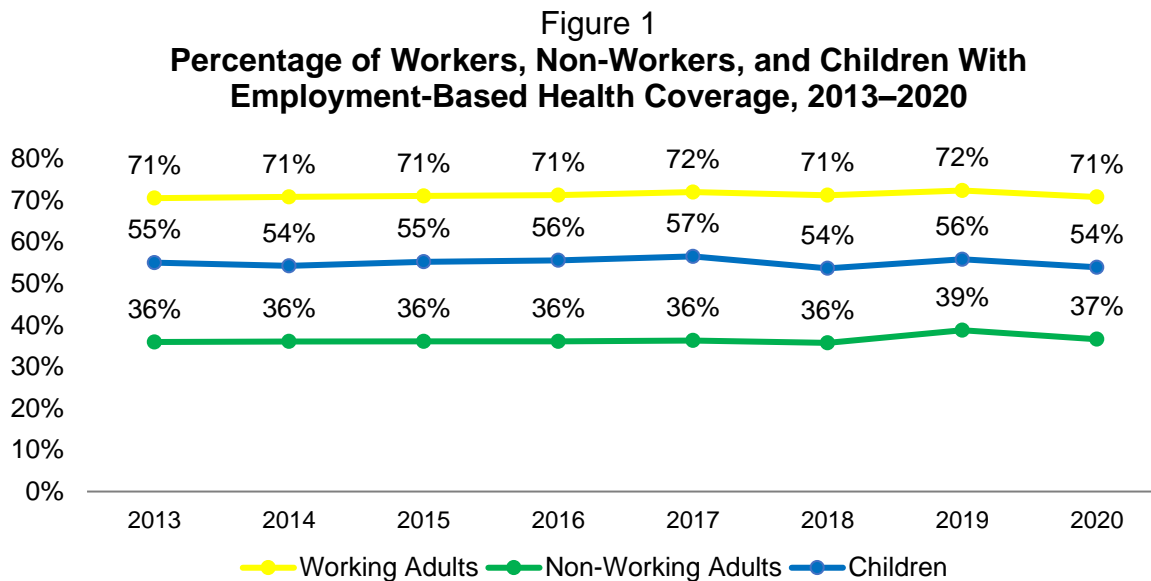
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Introduction

From 2012–2020, 70 percent of working-age adults had private health insurance.¹ Factors like employment, income, marital status, and age explain differences in health plans across individuals. For example, working adults are 27 percent more likely to have group coverage as compared with non-working adults (Figure 1). Not only is there variation across individuals in these factors, but there is also variation within families. Differences in spousal labor supply and occupations and varying income cutoffs for child vs. adult Medicaid eligibility are just some of the reasons why health plans may differ within families in any given year and over time.



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2014–2021 Supplements.

Furthermore, provisions of the 2010 Patient Protection and Affordable Care Act (ACA) like the Medicaid expansion and the employer shared responsibility mandate impacted the composition of health plans within families over time. By raising parents’ income eligibility cutoffs for Medicaid, differences in Medicaid coverage among families with children could narrow. In addition, by mandating insurance coverage for firms with 50 or more full-time-equivalent (FTE) employees, the 2014 employer shared responsibility mandate may reduce disparities in group coverage among parents and childless couples, as women are more likely to be working in industries that have had historically low group coverage rates.

While these provisions are expected to have increased group and Medicaid coverage, the “family glitch” potentially hindered enrollment in non-group coverage and thereby limited the ACA’s ability to reduce disparities in coverage within families. The “family glitch” exists because eligibility for a family’s premium subsidies on the Marketplace exchanges depends on whether group coverage is available and affordable for the employee only, even if it’s not actually affordable for the whole family. By basing eligibility for Marketplace subsidies on the affordability of coverage for employees only, this may preclude other family members from enrolling in non-group health insurance. On October 11, 2022, the Biden Administration published a final rule that aims to fix the “family glitch” by making family members

of an employee with access to group coverage eligible for premium subsidies on Marketplace plans if the family premium under the employer coverage exceeds 9.5 percent of the family's income in 2022. The rule change applies to individuals applying for 2023 Marketplace coverage.²

There is limited evidence regarding how and whether health insurance coverage differs within families. Early work shows that in 1996, 14 percent of families had insurance for some, but not all, family members because of differences in parents' employers and differences in Medicaid income eligibility cutoffs between children and parents (Hanson 2001). More recently, work by Percheski and Bzostek (2013) indicates that from 2009–2011, differences in health insurance coverage among siblings are limited on aggregate, but differences are more pronounced among blended families with step- and half-siblings.

This *Issue Brief* uses data from the 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC). The present study makes several contributions to the existing literature. First, this *Issue Brief* updates the prior analyses using more current data from 2013–2022. Second, this project addresses how recent policy developments have impacted variation in health insurance coverage within families. Third, this project uses a broader sample than the existing work by examining how health insurance varies within two-parent and single-parent families with children, as well as within childless couple families. Last, this work identifies recent trends in maternal employment that help explain changes in health insurance coverage within families beyond the ACA. This research is important because it documents how health insurance coverage differs within households that represent 80 percent of all U.S. households. It also highlights the role of recent public policies and other labor market trends in reducing disparities in coverage within families. Reducing the differences in health insurance coverage types within families may help mitigate challenges that arise from having various sources of health coverage within the same family, such as having to navigate differences in coverage, benefit programs, doctors, and networks, which may ultimately contribute to less health care use. Finally, this research helps inform policymakers who are considering reforms that would tackle uninsurance.

Background

The Patient Protection and Affordable Care Act (ACA) was enacted on March 23, 2010. Five main provisions impacting differences in health plans within families were the:

- Medicaid expansion, which set income eligibility for Medicaid coverage for all individuals to 138 percent of the federal poverty level (FPL).
- Employer shared responsibility mandate, which required that all employers with 50 or more full-time-equivalent (FTE) employees provide affordable health insurance to their workers.
- “Guaranteed Issue” provision, which stipulated that all individual and group health plans must guarantee issue policies to all applicants, regardless of health status or other factors.
- Individual mandate, which required most individuals to purchase health insurance coverage or pay a penalty.
- Creation of state-level insurance exchanges, where individuals could shop for non-group coverage on the private market.

Medicaid Expansion

Starting in 2014, over half of U.S. states chose to expand eligibility for the Medicaid program to all individuals with incomes up to 138 percent of the FPL.³ Research has consistently shown that this policy led to increases in Medicaid coverage in the expansion states (Mazurenko et al. 2018). This policy potentially reduced the Medicaid coverage gap between children and their parents. This is because prior to 2014, states could set their own income limits to determine Medicaid eligibility. These income cutoffs differed drastically for children and parents. For example, in 2011, Medicaid income eligibility for parents was as low as 17 percent of the FPL in Arkansas and as high as 215 percent of the FPL in

Minnesota (KFF 2011 report). By comparison, Medicaid income eligibility for children ages 0–18 was 200 percent of the FPL in Arkansas and 280 percent of the FPL in Minnesota in the same year.

Employer Shared Responsibility Mandate

Originally scheduled to take effect January 1, 2014, the Employer Mandate was eventually fully implemented in 2016 after a series of delays. As of January 1, 2016, employers with 50 or more FTE employees have to offer health insurance coverage to 95 percent of their full-time workers and their dependents. While over 90 percent of workers at firms with 100 or more employees already provided coverage prior to 2014, only 77 percent of firms with 25–99 workers did so. If more workers and their children get access to health insurance coverage benefits, a larger share of families should have group coverage.⁴

The Individual Mandate, Guaranteed Issue, and the Creation of “Marketplace” Exchanges

The ACA called for health insurance exchanges to be established in all states and the District of Columbia. Many sets did set up their own exchanges (18/50), but other states have federally run exchanges (23/50), and a third set of states have jointly federal- and state-run exchanges (9/50). The health insurance exchanges began operating in October 2013 to allow individuals to shop for health insurance plans providing coverage starting on January 1, 2014. The primary purpose of these exchanges was to address the challenges of cost, quality, and access to health care services in the U.S. health care system. Important to accomplishing these objectives was the implementation of the “guaranteed issue” provision, as well as the individual mandate.

By setting up “rules of engagement” for participating insurers and offering consumers a menu of health plan choices, the exchanges would shift the market from competition based on risk to competition based on price and quality (Fronstin and Ross 2009). Furthermore, the individual mandate would ensure that everyone was in the risk pool, with individuals required to purchase insurance or face significant financial consequences. This would balance out the effect of the “guaranteed issue” provision, which requires insurance companies to offer plans to individuals regardless of their health status, by forcing young and healthy consumers onto the exchanges to cross-subsidize those with pre-existing health conditions. This risk adjustment is necessary to curtail risk selection as an insurance business model and thereby bolster the ability of the exchanges to facilitate competition based on costs and quality (Fronstin and Ross 2009).

Another way the ACA sought to increase health insurance coverage rates was through cost sharing premium subsidies to individuals with incomes between 100 percent and 400 percent of the FPL who purchased insurance through the exchanges. The premium subsidy or tax credit works by limiting the amount an individual must contribute toward the premium for the “benchmark” plan, which is the second-lowest-cost silver plan available to the individual in their state Marketplace. This “required individual contribution” is set on a sliding income scale. In 2022, for individuals with incomes up to 150 percent of the FPL, the required contribution is zero, while at an income of 400 percent of the FPL or above, the required contribution is 8.5 percent of household income (Figure 2).

These amounts were set by the American Rescue Plan Act (ARPA) and are in effect on a temporary basis for the 2021 and 2022 plan years. Before ARPA, the required contribution percentages for the 2014–2020 plan years ranged from 2 percent of household income for people with incomes between 100 percent and 133 percent of the FPL to 9.5 percent of income for people with incomes from 300 percent to 400 percent of the FPL. An important difference is that prior to ARPA, people with incomes above 400 percent of the FPL were not eligible for premium tax credits (Table 1).

Figure 2
Premium Credits by Income Under American Rescue Plan Act

Household Income Range (expressed as % of federal poverty level)	Required % of Household Income at Start of Range	Required % of Household Income at Top of Range
Up to 150%	0	0
150% up to 200%	0	2
200% up to 250%	2	4
250% up to 300%	4	6
300% up to 400%	6	8.5
400% and Higher	8.5	8.5

Source: Center on Budget and Policy Priorities.

Figure 3
Premium Credits by Income Under 2010 Patient Protection and Affordable Care Act

Household Income Range (expressed as % of federal poverty level)	Required % of Household Income at Start of Range	Required % of Household Income at Top of Range
100% up to 133%	2	2
133% up to 150%	3	4
150% up to 200%	4	6.3
200% up to 250%	6.3	8.1
250% up to 300%	8.1	9.5
300% up to 400%	9.5	9.5

Source: Kaiser Family Foundation.

However, prior to the October 2022 “family glitch” fix, not all individuals who met the income cutoffs were eligible for the premium subsidies. One reason this situation arose is because eligibility for premium subsidies on the Marketplace exchanges was also contingent on whether a family member receives affordable health insurance through their employer. As such, any family member with income between 100 percent and 400 percent would be ineligible for premium subsidies if someone in their family received *employee-only coverage* with a premium that was at most 9.86 percent of their family income through their employer. This is what is referred to as the “family glitch.” A 2021 analysis done by the Kaiser Family Foundation found that 5.1 million people fall into the ACA’s “family glitch.” Most of them are children, and among adults, women are more likely to fall into the glitch than men.⁵ Most of those who fall in the family glitch have group coverage but could pay lower premiums if they had access to Marketplace subsidies. Others are uninsured or have Medicaid. For these individuals, non-group and group coverage are simply too expensive. Thus, the “family glitch” may be a factor that contributes to differences in health plans within families. By making family members of an employee with access to group coverage eligible for premium subsidies on Marketplace plans if the *family coverage* premium exceeds 9.5 percent of the family’s income in 2022, we might expect to see increases in Marketplace coverage in 2023.

Data and Study Sample

The present study uses data from the 2013–2022 CPS ASEC. The ASEC provides yearly data on families, household composition, and health insurance coverage, which makes it the ideal dataset for this *Issue Brief*. The analysis period covers years before and after the implementation of the Medicaid expansion and the employer shared responsibility mandate, allowing us to document how these policies impacted health plan coverage within families. The health plans documented are group, non-group (including Marketplace), Medicaid, and Medicare, as well as being uninsured.⁶

This *Issue Brief* shows how health insurance coverage patterns differ within four distinct sets of family types:

- Two-parent families with co-resident children ages 0–26.
- Single-mother families with co-resident children ages 0–26.
- Single-father families with co-resident children ages 0–26.
- Two-adult families without children.

The ages of all adults are restricted to 18–64.⁷ Each year of the survey, these four samples represent approximately 64 million, 18.2 million, 3.4 million, and 41.2 million families, respectively. Overall, this sample accounts for 80 percent of all families across all ages in the United States.

Methods

This *Issue Brief* presents summary statistics on how coverage with group, non-group (including Marketplace), Medicaid, and Medicare, as well as being uninsured, differs within families in 2019, as well as over time from 2012–2021. The cross-sectional results highlight important differences in health plan coverage within and across families in 2019. This analysis shows health insurance coverage in 2019 since it is the latest pre-pandemic year and allows for a more representative portrayal of health coverage within and across families in the United States.

The longitudinal results demonstrate how differences in sources of health coverage have changed over time and shed light on the role of the ACA. Longitudinal trends on group policy holding by gender and changes in the profiles of women with group coverage are documented. This analysis is supplemented by showing how changes in labor supply and employment industry explain these trends. Finally, we present evidence that the “family glitch” reduced enrollment in Marketplace coverage in 2019.⁸

Cross-Sectional Analyses of Health Plans Within and Across Families in 2019

Across family types, there was a strong correlation in coverage types among members of the same family unit, but this correlation was far from 1-to-1. Furthermore, health plans were most similar within two-adult families without children and least similar within single-parent families. Finally, similarities in coverage between all family members were greatest for group coverage and Medicaid. The next strongest correlations were in non-group coverage, being uninsured, and having Medicare, respectively. The results also indicate large differences in the primary source of coverage across the family types. In two-adult families with and without children, as well as in single-father families, the primary source of health insurance was group coverage. However, in single-mother families, the primary source of health insurance was Medicaid closely followed by group coverage. Seventy percent of male partners had group coverage in two-adult families with and without children, and other family members had a 90 percent or higher of chance of also having group coverage. Fifty-four percent of single fathers had group coverage, and 70 percent of children raised by single fathers with group coverage also had group coverage, indicating that 38 percent of children in single-father families had group coverage. For 40 percent of single mothers, Medicaid was the primary source of health insurance coverage, followed by group health insurance at 39 percent. While only 63 percent of children raised by single mothers with group coverage had group coverage themselves, 95 percent of children raised by single mothers with Medicaid were also covered by Medicaid. This indicates that Medicaid was the primary source of coverage for single-mother families.

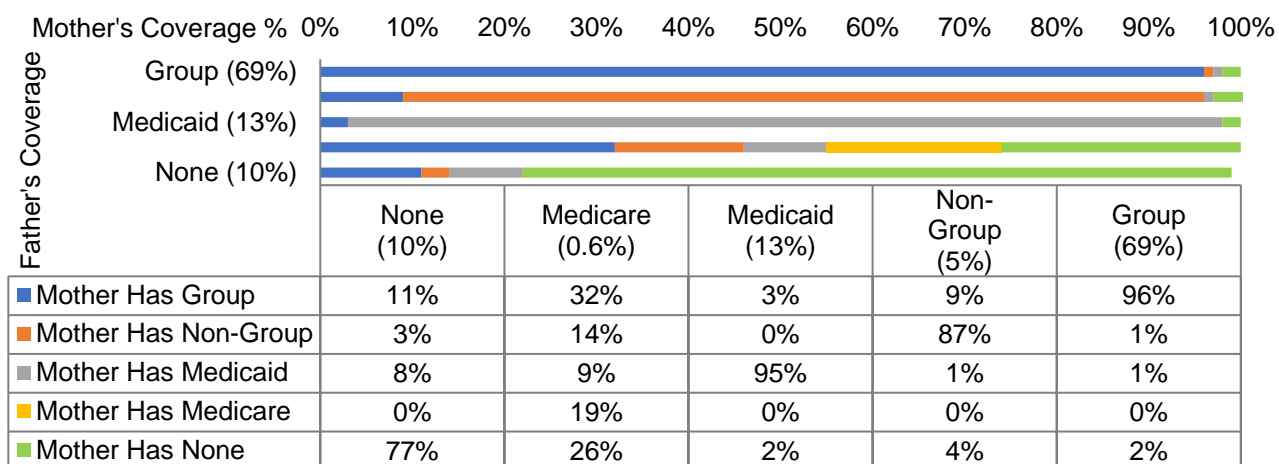
Two-Parent Families With Children⁹

Father’s coverage strongly influences coverage type for the family:

- If fathers had group coverage, in 96 percent of cases, the mother also had group coverage (Figure 4), and in 89 percent of cases, the children also had group coverage (Figure 5).
- In 99 percent of cases where the father and children had group coverage, the children were enrolled as dependents. In 61 percent of cases where the father and mother had group coverage, the mother was enrolled as a dependent.
- In 80 percent of cases where fathers had non-group coverage, so did the mother (Figure 4).
- When the father had a non-group health plan, children were more likely to not have this form of coverage. Only 48 percent of children had non-group coverage when their father had non-group coverage (Figure 5).
- In cases where the father had Medicaid, 95 percent of mothers have Medicaid (Figure 4).
- If fathers had Medicaid, in 94 percent of cases the children also had Medicaid (Figure 5).

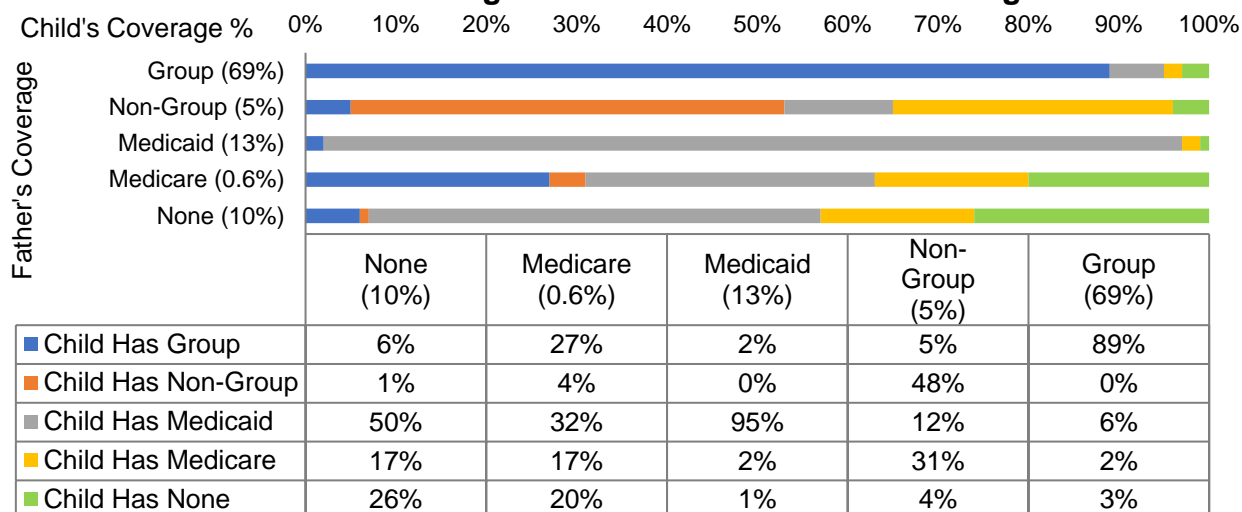
- Children were much less likely to be uninsured than their fathers. When the father was uninsured, in 77 percent of the cases, the mother was as well (Figure 4). However, only 26 percent of children were uninsured when their father was uninsured (Figure 5).
- Only 0.6 percent of fathers under age 65 were covered by Medicare, but among those who were, in 19 percent of cases the mother also had Medicare (Figure 4), while in 17 percent of cases the children did as well (Figure 5).¹⁰

Figure 4
Mother's Coverage Conditional on Father's Coverage



Note: Sample is two-parent families with co-resident children ages 0–26. Parents were ages 18–64. Excludes 3.2 percent of fathers who have military (CHAMP) coverage. EBRI analysis of 2020 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Figure 5
Child's Coverage Conditional on Father's Coverage

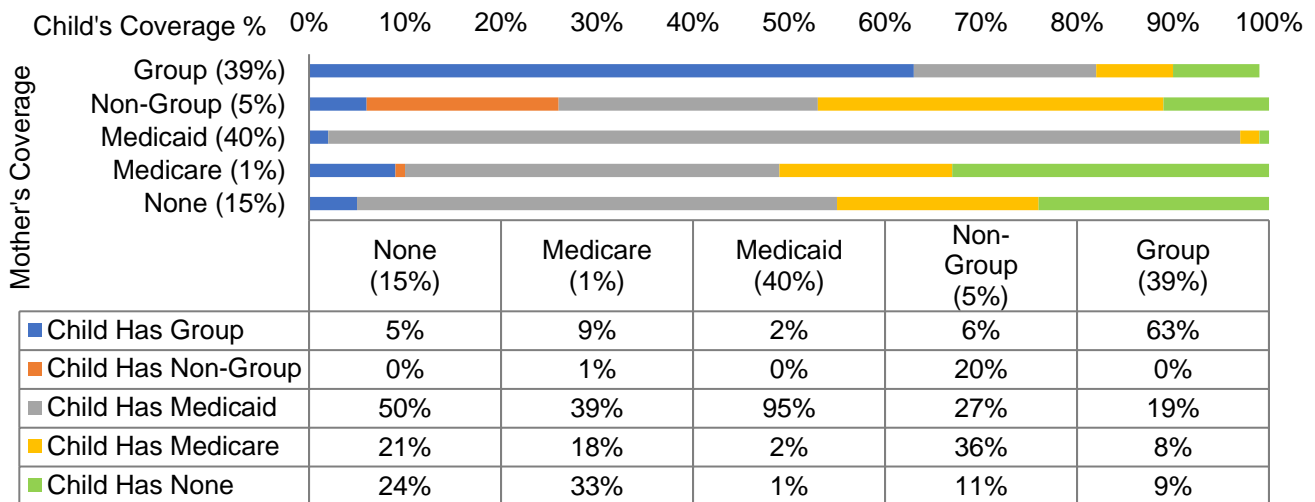


Note: Sample is two-parent families with co-resident children ages 0–26. Parents were ages 18–64. Excludes 3.2 percent of fathers who have military (CHAMP) coverage. EBRI analysis of 2020 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Single-Parent Families

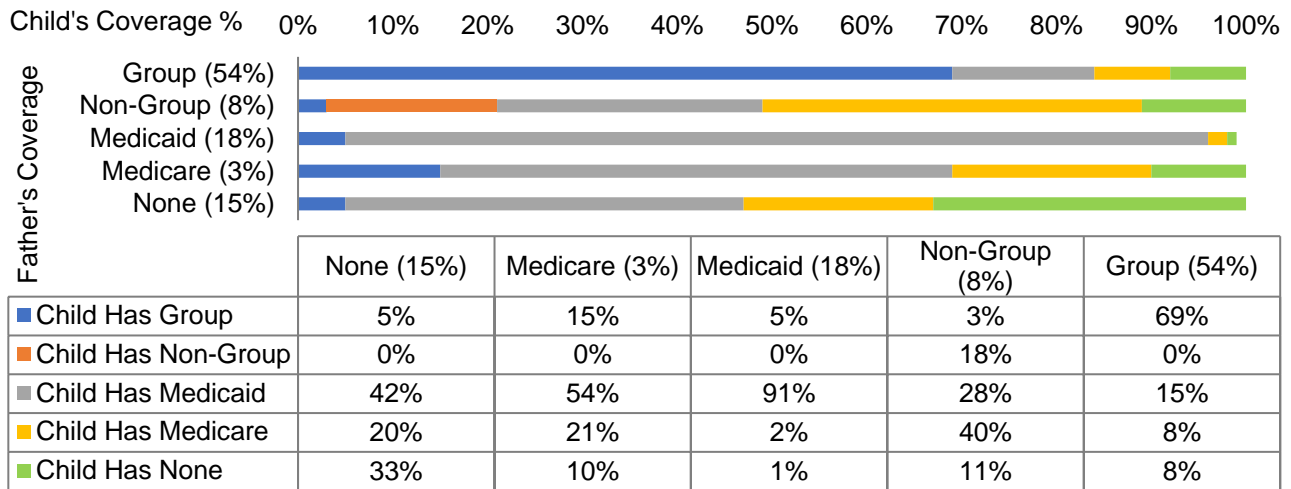
- Over half of single mothers were either uninsured (15 percent) or were covered by Medicaid (40 percent) (Figure 6), while a third of single fathers were either uninsured (15 percent) or were covered by Medicaid (18 percent) (Figure 7).
- Over 90 percent of children in single-parent families had Medicaid coverage if their parent had Medicaid coverage, but only 63–69 percent of children had group coverage if their parent had group coverage (Figures 6 and 7).
- In 96 percent of cases where the father and children had group coverage, the children were enrolled as dependents. In 96 percent of cases where the mother and children had group coverage, the children were enrolled as dependents.
- For other coverage types, there was little association between parental and child coverage.

Figure 6
Child's Coverage Conditional on Single Mother's Coverage



Note: Sample is single-mother families with co-resident children ages 0–26. Mothers were ages 18–64. EBRI analysis of 2020 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Figure 7
Child's Coverage Conditional on Single Father's Coverage



Note: Sample is single-father families with co-resident children ages 0–26. Fathers were ages 18–64. EBRI analysis of 2020 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Two-Adult Families Without Children¹¹

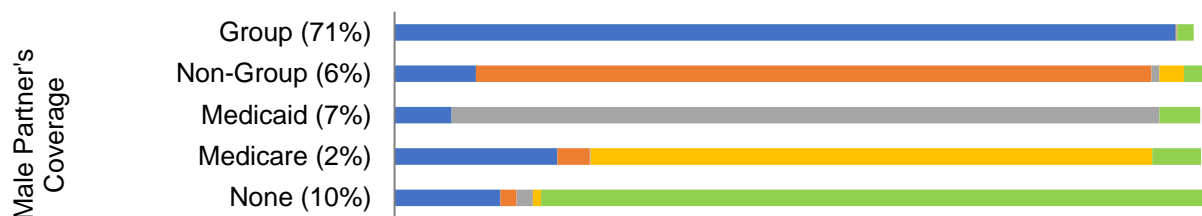
Health insurance coverage was very similar among members of two-adult families without children.

- The strongest correlation was in group coverage, followed by Medicaid coverage, non-group coverage, being uninsured, and Medicare coverage, respectively.
- If the male partner had group coverage, 96 percent of female partners also had group coverage, and 43 percent were enrolled as dependents (Figure 8).
- If the male partner had non-group coverage, 83 percent of female partners also had non-group coverage (Figure 8).
- If the male partner had Medicaid, 87 percent of female partners also had Medicaid (Figure 8).
- If the male partner had Medicare, 69 percent of female partners had Medicare (Figure 8).
- If the male partner was uninsured, 82 percent of female partners were also uninsured (Figure 8).

Figure 8

Female Partner's Coverage Conditional on Male Partner's Coverage

Female Partner's Coverage % 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



	None (10%)	Medicare (2%)	Medicaid (7%)	Non-Group (6%)	Group (71%)
■ Female Partner Has Group	13%	20%	7%	10%	96%
■ Female Partner Has Non-Group	2%	4%	0%	83%	0%
■ Female Partner Has Medicaid	2%	0%	87%	1%	0%
■ Female Partner Has Medicare	1%	69%	0%	3%	0%
■ Female Partner Has None	82%	6%	5%	3%	2%

Note: Sample is two-adult families without children. Adults were ages 18–64. Excludes 1.85 percent of individuals who have military (CHAMP) coverage. EBRI analysis of 2020 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

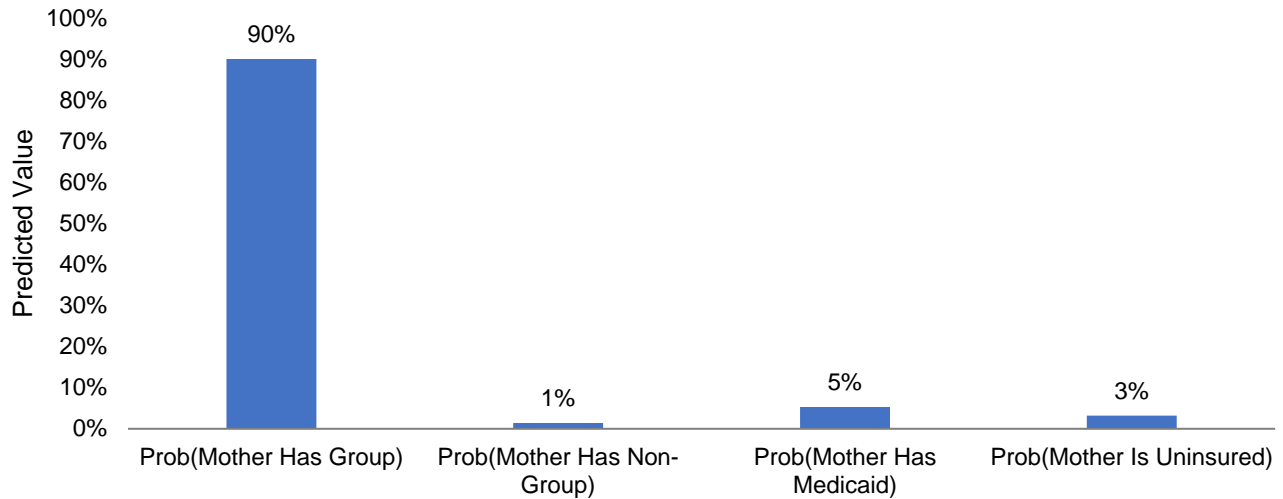
The “Family Glitch”

The preceding results show that independent of family type, if the father or male partner had group coverage, the other family members were more likely to have Medicaid or be uninsured, as opposed to having non-group coverage. One potential explanation for this observation is the “family glitch.” By basing eligibility for Marketplace subsidies on the affordability of coverage for employees only, the “family glitch” may preclude the purchase of non-group coverage for the spouse or dependents of the employee with group coverage. Instead of enrolling in Marketplace non-group coverage, the other family member could be enrolled in Medicaid or have no coverage instead.

To test for this hypothesis, we predict the likelihood that women with and without children had various forms of insurance in 2019, given their male partner had group coverage in 2019, controlling for important determinants of insurance coverage. The results indicate that after controlling for important determinants of a woman’s insurance coverage like employment, poverty status, employer size, and marital status, there is a higher likelihood that female partners are uninsured and have Medicaid, relative to having non-group coverage, if their male partners have group coverage.

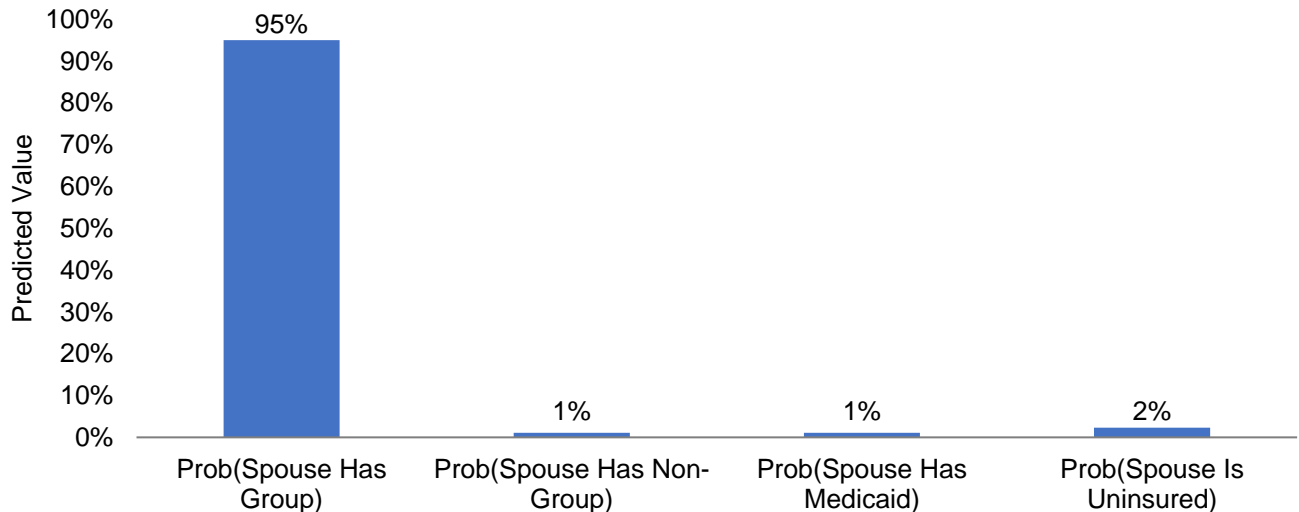
All else equal, the results in Figure 9 show that if the father had group coverage, only 1 percent of mothers had non-group coverage, while 5 percent had Medicaid, and 3 percent were uninsured. Thus, mothers were three times more likely to be uninsured, relative to having non-group coverage. The results in Figure 10 show that if their partner had group coverage, only 1 percent of childless women had non-group coverage, while 1 percent had Medicaid and 2 percent were uninsured. This indicates that childless women are two times more likely to be uninsured, relative to having non-group coverage. Given that having no coverage is less desirable than having non-group coverage, the evidence in this table provides strong evidence that the “family glitch” reduces enrollment in Marketplace exchanges among women whose partner has group coverage.

Figure 9
Evidence of the "Family Glitch" in Two-Parent Families



Note: Ordinary least squares (OLS) estimates from linear probability model. Sample is two-parent families where the father had group coverage in 2019 and co-resident children ages 0–26. Outcomes were also measured in 2019. Parents were ages 18–64. EBRI analysis of 2020 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Figure 10
Evidence of the "Family Glitch" in Two-Adult Families



Note: Ordinary least squares (OLS) estimates from linear probability model. Sample is two-adult families without children where the male partner had group coverage in 2019. Outcomes were also measured in 2019. Individuals are ages 18–64. EBRI analysis of 2020 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Longitudinal Analyses of Health Plans Within Families from 2012–2021

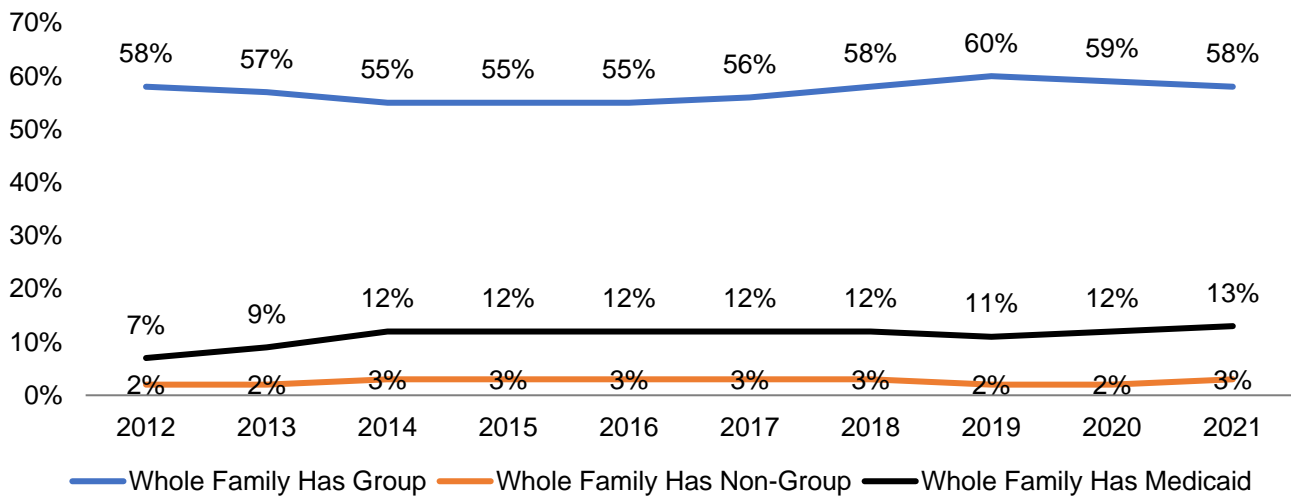
From 2012–2021, the composition of health plan coverage within two-parent families and two-adult families without children changed. These changes coincided with the implementation of the 2014 Medicaid expansion and the 2016 employer shared responsibility mandate as part of the ACA. After 2014, whole-family Medicaid coverage increased. After 2016, whole-family group coverage increased. These changes in coverage show that the ACA was successful at increasing Medicaid and group health coverage for all family types. However, whole-family non-group coverage

remained flat, showing that the ACA had no impact on non-group coverage. Following the increases in Medicaid and group coverage, uninsured rates fell among all family types. Finally, group coverage gains were driven by mothers.

Two-Parent Families With Children

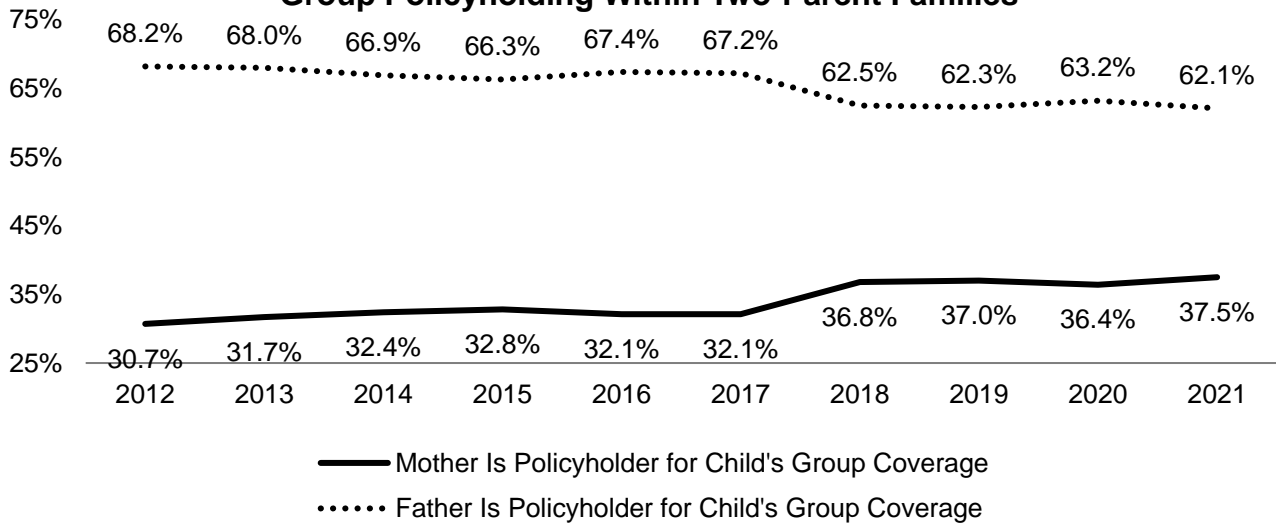
- Starting in 2014 and continuing through 2021, the share of families fully covered by Medicaid rose by approximately 3 percentage points (Figure 11), representing a 50 percent increase relative to 2012–2013 (pre-Medicaid expansion).
- From 2012–2021, the average share of families fully covered by group health insurance was flat at 58 percent. This share fell to 55 percent starting in 2015 (the year before the employer mandate was fully implemented) before rising to 60 percent in 2019. The share of families fully covered by group health insurance fell to 58 and 59 percent in 2020 and 2021, respectively (Figure 11).
- From 2012–2021, the share of families fully covered by non-group health insurance remained constant at 2–3 percent (Figure 11).
- Coinciding with the growing share of families fully covered by group health insurance, the share of mothers who were the group policyholders for their child’s group health insurance rose by 7 percentage points (to 22 percent), while the share of fathers who were the group policyholders fell by 6 percentage points (to 10 percent) (Figure 12).
- As group policy holding rose among mothers and fell among fathers, the number of group policyholders in a family remained constant, ranging from 0.86–0.88 policyholders per family. In families where the child had group coverage, the number of group policyholders was also constant and ranged from 1.18–1.22 (Figure 13).
- Given that the number of group policyholders per family remained constant but the share of families fully covered by group health insurance rose, this indicates that the policyholder is covering more family members.
- Following the gains in group and Medicaid coverage, the uninsured rate was reduced by half, from 4.5 percent in 2012 to 2.3 percent in 2021. Furthermore, the share of families with at least one uninsured family member fell from 23.5 percent in 2012 to 15.8 percent in 2021 (Figure 14).
- Seventy-three percent of all families had all members covered by group health insurance, non-group health insurance, or Medicaid, or had all members uninsured. The next most common coverage scenarios were both parents being uninsured and the children having Medicaid (6 percent), and both parents having group coverage and the children having Medicaid (5 percent). Other insurance compositions each represented 2 percent of families or fewer.

Figure 11
Health Coverage Changes Within Two-Parent Families



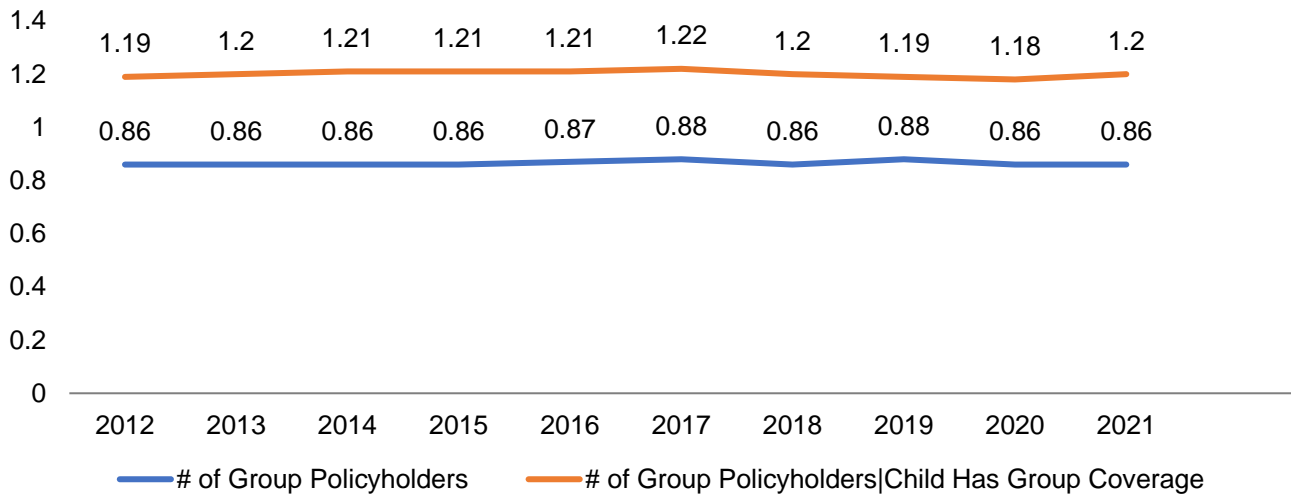
Note: Sample is two-parent families with co-resident children ages 0–26. Parents were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Figure 12
Group Policyholding Within Two-Parent Families



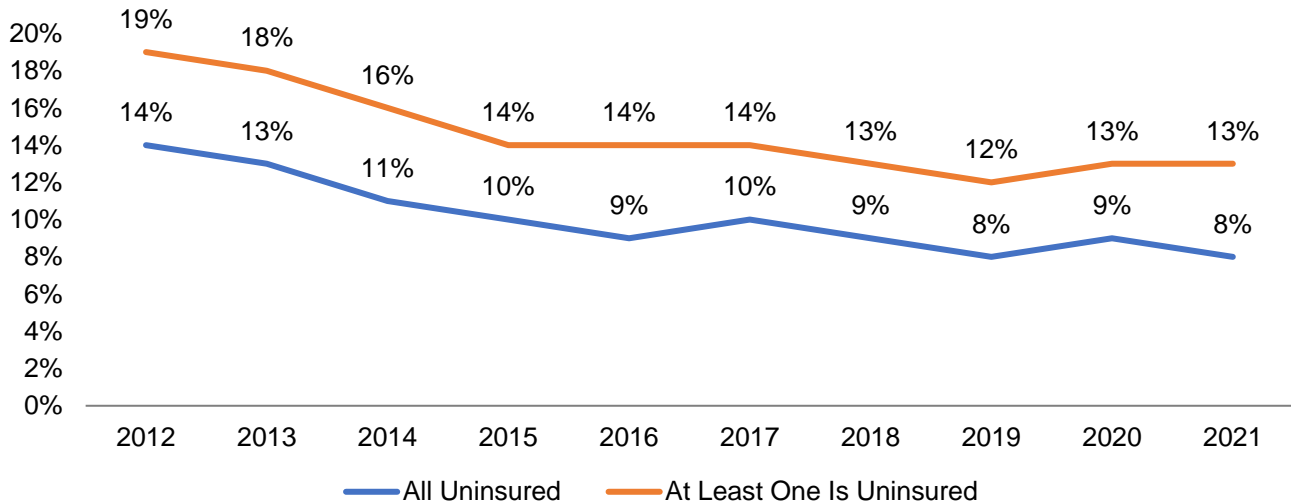
Note: Sample is two-parent families with co-resident children ages 0–26 who were covered by group health insurance. Parents were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Figure 13
Number of Group Policyholders in Two-Parent Families



Note: Sample is two-parent families with co-resident children ages 0–26. Parents were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Figure 14
Uninsured Rates Among Two-Adult Childless Families



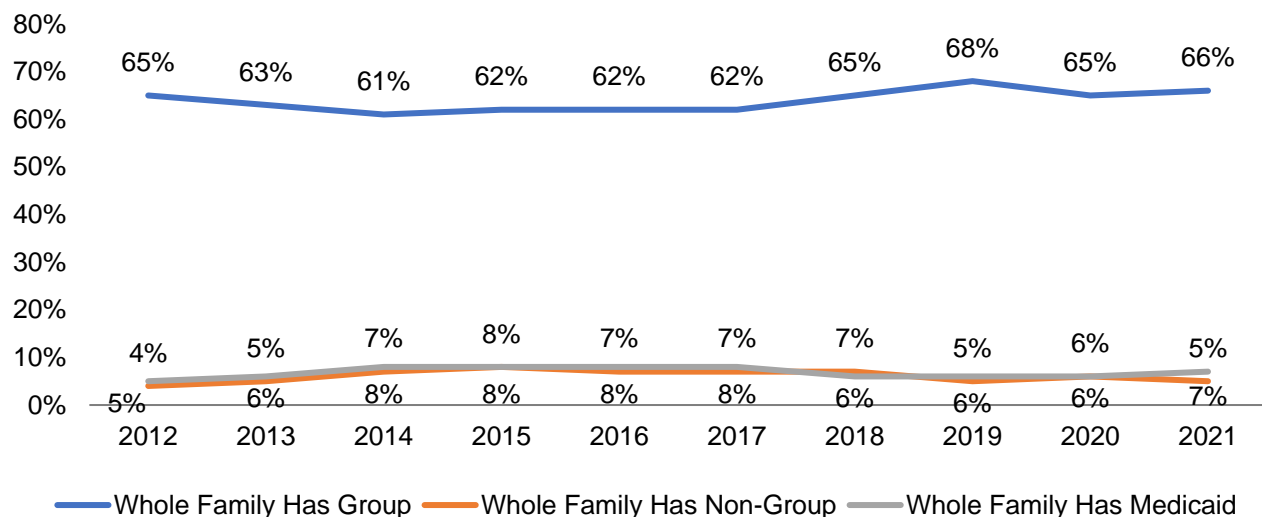
Note: Sample is two-parent families with co-resident children ages 0–26. Parents were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Two-Adult Families Without Children

- From 2014–2017 (post-Medicaid expansion), the share of families fully covered by Medicaid rose by 2 percentage points, from 6 percent to 8 percent (33 percent increase) relative to 2012–2013 (pre-Medicaid expansion). These gains did not persist (Figure 15).
- There were some gains in the shares of families with all family members covered by a non-group health plan from 2013–2018, but these gains reversed in 2019 (Figure 15).

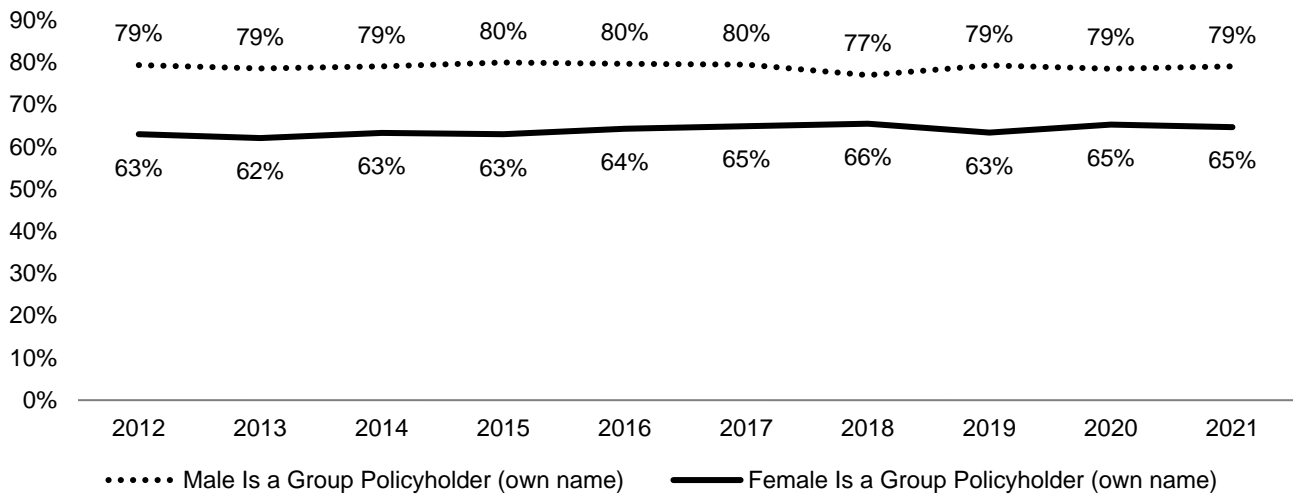
- Whole-family group coverage was on average 3 percentage points higher (at 5 percent) from 2018–2021, relative to 2012–2017. However, from 2012–2021, there was no change in group coverage. In 2012 and in 2021, 65 percent of childless families were fully covered by group health insurance.
- Unlike in the two-parent families, the share of male and female group policyholders remained relatively flat in childless families. Seventy-nine percent of males had group policies in their own name from 2012–2021, while 63–65 percent of females did (Figure 16).
- The number of group policyholders per family reached a peak of 1.07 in 2019, a 7 percent increase relative to 2017. Among families where the male had group coverage, the peak number of family members with group coverage was 1.29, and this was reached in 2020. By 2021, there was an average of 1.06 group policyholders per family. In families where the male had group coverage, there was an average of 1.27 group policyholders per family (Figure 17).
- Coverage gains in group, Medicaid, and non-group coverage resulted in a fall in the uninsured rate from 14 percent in 2012 to 8 percent in 2021 (Figure 18).
- Eighty-nine percent of all families had all members covered by group health insurance, non-group health insurance, or Medicaid, or had all members uninsured. The next most common coverage types were both partners having military health plans (4 percent), one partner being uninsured and the other having group coverage (2 percent), and one partner having group coverage and the other being uninsured (1.4 percent). Other insurance compositions each represent 1 percent of families or fewer.

Figure 15
Health Coverage Changes Within Two-Adult Childless Families



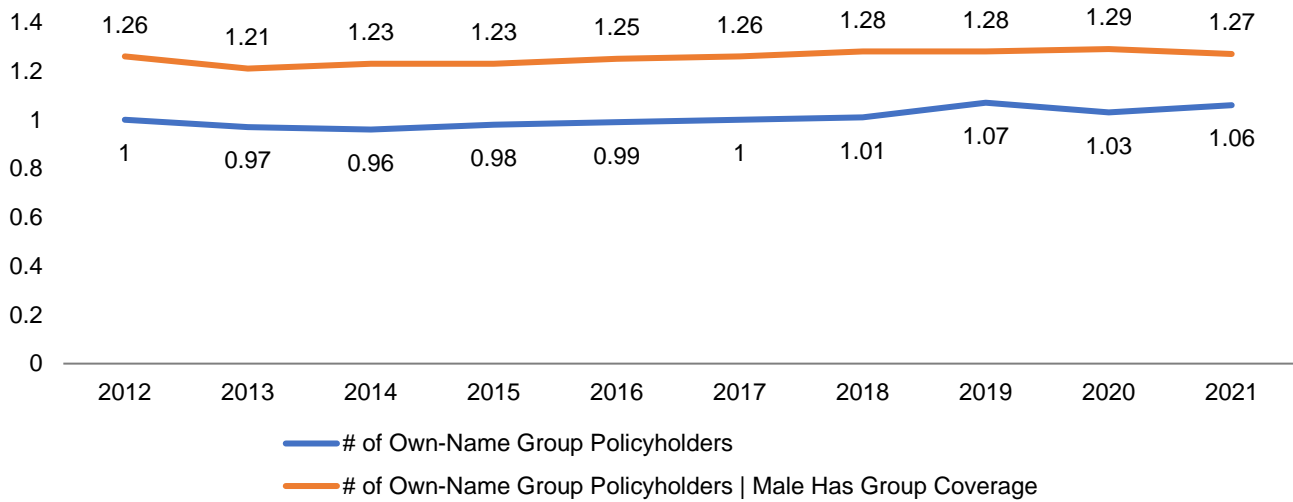
Note: Sample is two-adult families without children. Adults were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Figure 16
Group Policyholding Within Two-Adult Childless Families



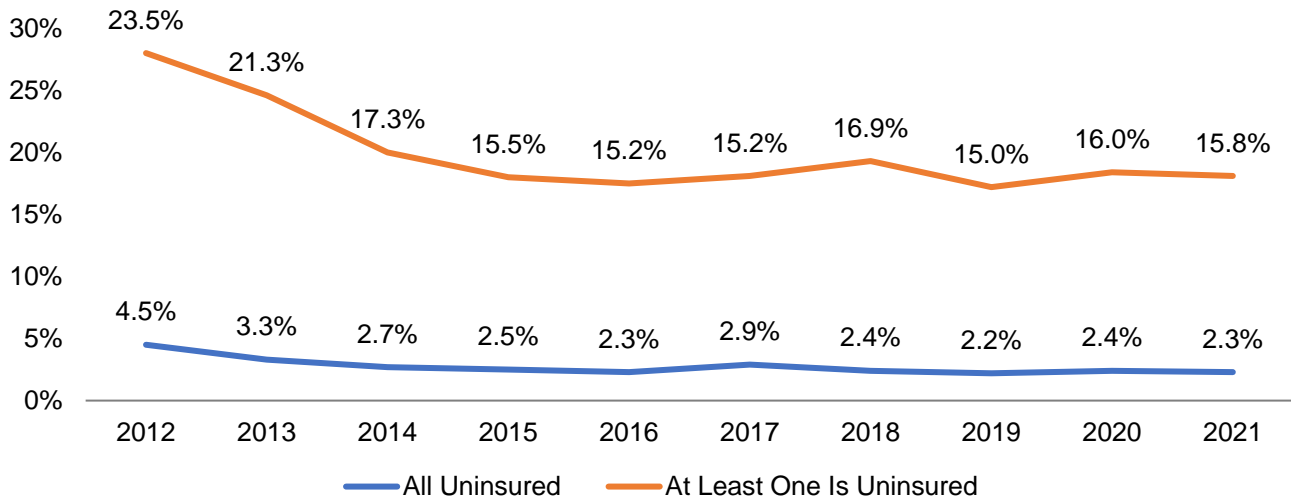
Note: Sample is two-adult families without children. Adults were ages 18–64 and had group coverage. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights. “Own name” indicates that the policy was held by the individual and they were not a dependent.

Figure 17
Number of Group Policyholders in Two-Parent Families



Note: Sample is two-adult families without children. Adults were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights. “Own name” indicates that the policy was held by the individual and they were not a dependent.

Figure 18
Uninsurance Rates Among Two-Parent Families



Note: Sample is two-adult families without children. Adults were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

How Have the Profiles of Childless Women and Mothers With Group Coverage Changed Over Time?

Women have had higher household and personal incomes over time, possibly reflecting entrance into higher-paid occupations. As their incomes rise, they have fewer children, and their children are also less likely to be covered by Medicaid. In particular:

- From 2012–2021, women with group coverage earned significantly more in the labor market. Mothers’ real earnings increased from \$42,058 in 2013 to \$55,051 in 2022, representing a 33 percent increase (Figure 19). The real earnings of childless women increased from \$48,360 in 2013 to \$57,050 in 2022, representing an 18 percent increase (Figure 20).
- These earnings gains cannot be explained by changes in labor force participation. Tables 3 and 4 show that the employment rates and the employment sectors of mothers and childless women, respectively, have been constant over time.
- Mothers with group coverage were, on average, 41 years old from 2012–2021 (Figure 19). Childless women with group coverage tended to be younger over time. From 2012–2015, these women were on average 47 years old, and by 2021, these women were 44 on average (Figure 20). This reflects the growing number of women who never have children (Chen 2021).
- Mothers with group coverage have had fewer children over time, declining from 2.9 in 2012 to 2.5 in 2021 (Figure 19). In addition, a smaller share of their children have Medicaid over time. In 2012, 0.3 of the 2.9 children had Medicaid (10 percent), but by 2021, only 0.18 of the 2.5 children had Medicaid (7.5 percent). This is consistent with their earnings increasing, making their children ineligible for Medicaid.

Figure 19
Profiles of Mothers With Group Coverage From 2012–2021

Household Income (\$)	143,450	147,493	152,955	153,202	159,447	160,703	167,430	182,273	178,487	171,462
Personal Income (\$)	42,058	43,371	45,241	46,801	48,873	49,942	51,879	57,855	55,744	55,051
Child's Age	11	11	11	11	11	11	11	11	11	11
Mother's Age	41	41	41	41	41	41	41	41	42	42
# of Children	2.9	2.9	2.6	2.5	2.5	2.5	2.5	2.5	2.5	2.5
# of Children With Medicaid	0.3	0.35	0.32	0.28	0.28	0.29	0.21	0.18	0.19	0.18
Married (%)	96	96	96	96	96	95	95	95	95	95
Non-Hispanic (%)	87	86	86	86	85	84	85	85	85	86
Hispanic (%)	13	14	14	14	15	16	15	15	15	14
Employed (%)	77	78	78	79	79	79	79	79	79	80
Works at Firm With 100+ Employees (%)	50	52	53	53	53	53	55	54	56	56
Private-Sector Employee (%)	54	55	56	56	57	56	56	56	55	56
Public-Sector Employee (%)	17	18	18	18	17	17	18	17	19	19
Self-Employed (%)	5	5	5	5	5	5	5	6	5	6

Note: Sample is mothers ages 18–64, in two-parent families with group coverage in the prior year and co-resident children ages 0–26. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights. Dollar amounts are in 2021 dollars.

Figure 20
Profiles of Childless Women With Group Coverage From 2012–2021

Year	2,012	2,013	2,014	2,015	2,016	2,017	2,018	2,019	2,020	2,021
Household Income (\$)	128,045	126,598	131,832	138,683	144,044	143,170	144,938	152,893	148,549	145,376
Personal Income (\$)	48360	48272	50433	53314	57032	56693	56009	58545	58109	57050
Age	47	47	47	47	46	46	45	45	45	44
Married (%)	86	85	84	84	85	83	82	81	80	81
Non-Hispanic (%)	93	92	92	92	91	91	90	90	90	90
Hispanic (%)	7	8	8	8	9	9	10	10	10	10
Employed (%)	55	7	58	59	59	60	58	58	60	60
Works at Firm with 100+ employees (%)	83	84	84	84	84	85	85	85	85	85
Private Sector Employee (%)	61	63	61	62	63	64	65	63	63	64
Public Sector Employee (%)	18	17	18	18	17	17	16	16	17	16
Self Employed (%)	4	4	5	4	4	4	5	6	5	5

Note: Sample is childless women ages 18–64, in two-adult families with group coverage in the prior year. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights. Dollar amounts are in 2021 dollars.

What Explains the Group Policy-Holding Patterns of Men and Women Over Time?

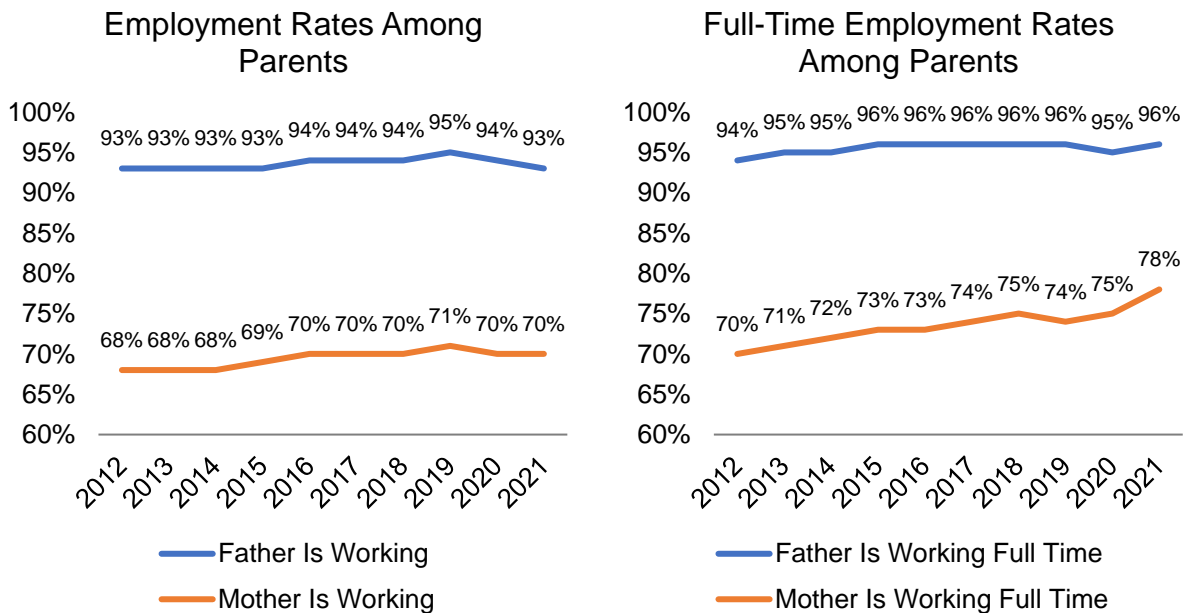
In this section, we discuss two potential explanations for the group policy-holding trends of men and women highlighted in the previous sections.

The first trend identified was that mothers are more likely to be group policyholders while fathers are less likely. Furthermore, while the number of group policyholders in a family remained constant, the share of two-parent families

with children who are fully covered by group health insurance rose. Thus, not only is the group policyholder providing coverage to more family members over time, but the group policyholder is also more likely to be the mother. The second trend identified was that there have been slight gains in group coverage over time among co-residing men and women without children. These gains in coverage translate to a higher number of group policyholders per family in this sample.

The first potential explanation for these trends is changes in labor force participation among men and women. Mothers are more likely to be working and to be working full-time. By working full time, they are eligible for group coverage. Figure 21 shows that 66 percent of mothers worked in 2012, while 72 percent did so in 2019.¹² In addition, among those who worked, 70 percent worked full time in 2012, and 78 percent did so in 2021. While labor force participation among mothers increased, it remained flat among fathers. Over 90 percent of fathers worked from 2012–2021, and among those who worked, 96 percent did so at the full-time level.

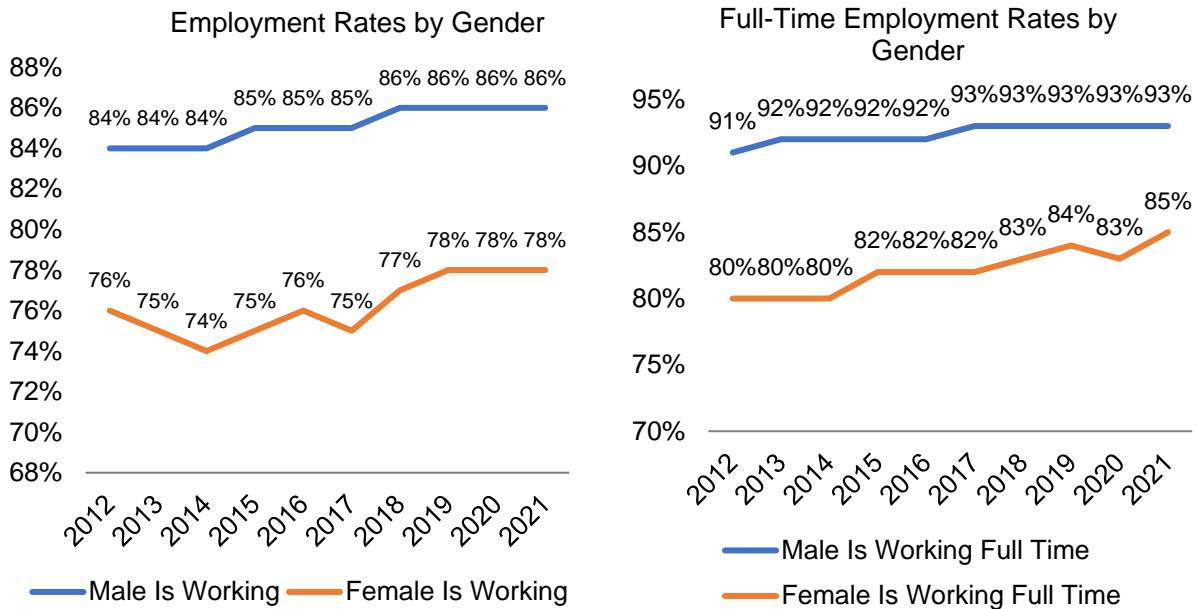
Figure 21
Changes in Employment Rates Among Parents Ages 18–64 From 2012–2021



Note: Sample is two-adult families with co-resident children ages 0–26. Parents were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

Figure 22 shows that co-residing men and women without children were both more likely to be working and to be working full time from 2012–2021. These trends were especially pronounced for women and can partially explain increased group policy holding over time. According to Figure 22, 76 percent of childless women worked in 2012, while 78 percent did so in 2021. Among those working, 80 percent worked full time in 2012, and 85 percent did so in 2021. Eighty-four percent of childless men worked in 2012, and this share rose to 86 percent in 2021. Ninety-one percent of working men worked at the full-time level in 2012, and 93 percent did so in 2021.

Figure 22
Changes in Employment Rates by Gender, Ages 18–64, From 2012–2021



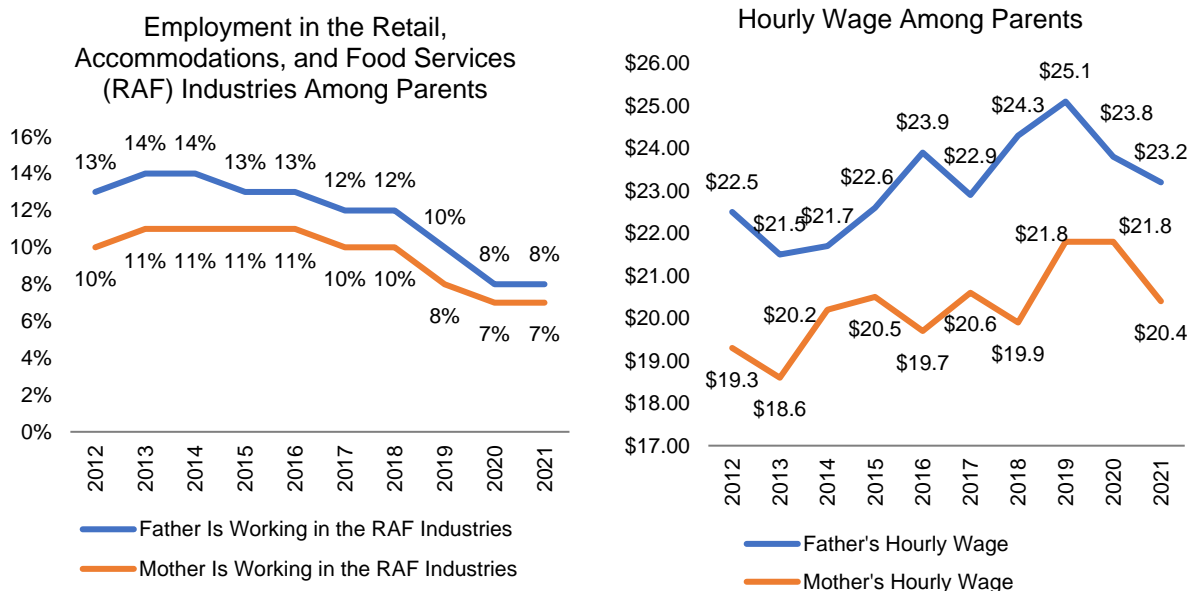
Note: Sample is two-adult families without children. Adults were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights.

The second potential explanation for these trends is changes in employment industries. There has been a rapid decline in employment in the retail, accommodations, and food services (RAF) industries among parents starting in 2017. This decline has coincided with increases in average real wages, suggesting that there is “upscaling” of jobs among parents. As parents’ employment shifts towards higher-paid sectors, they may become increasingly likely to have group coverage. These trends have been most pronounced for mothers, leading to a convergence in employment rates in these industries among mothers and fathers and a 6 percent rise in real wages among mothers. In 2012, 13 percent of mothers worked in the RAF industries, while 10 percent of fathers did so (Figure 23). By 2021, 8 percent of mothers worked in these industries, while 7 percent of fathers did so. Coinciding with this shift away from employment in the RAF industries, real hourly wages among mothers rose from \$19.3 in 2012 to \$20.4 in 2021 (Figure 23).

Childless women were also less likely to working in these industries, but this trend started as far back as 2012 and is not nearly as stark as the trend for mothers. While 17 percent of childless women were employed in the RAF industries in 2012, only 15 percent were in 2021. Coinciding with the modest declines in employment in the RAF industries among childless women, there was also a 4 percent rise in real hourly wage. In 2012, the real hourly wage among childless women was \$19.3, and in 2021 it rose to \$20.1 (Figure 24). In contrast, the real hourly wage remained constant among childless men, as has the share employed in the RAF industries. Thirteen percent of childless men were employed in these industries in 2012 and in 2021, and the real hourly wage was \$23 (Figure 24).

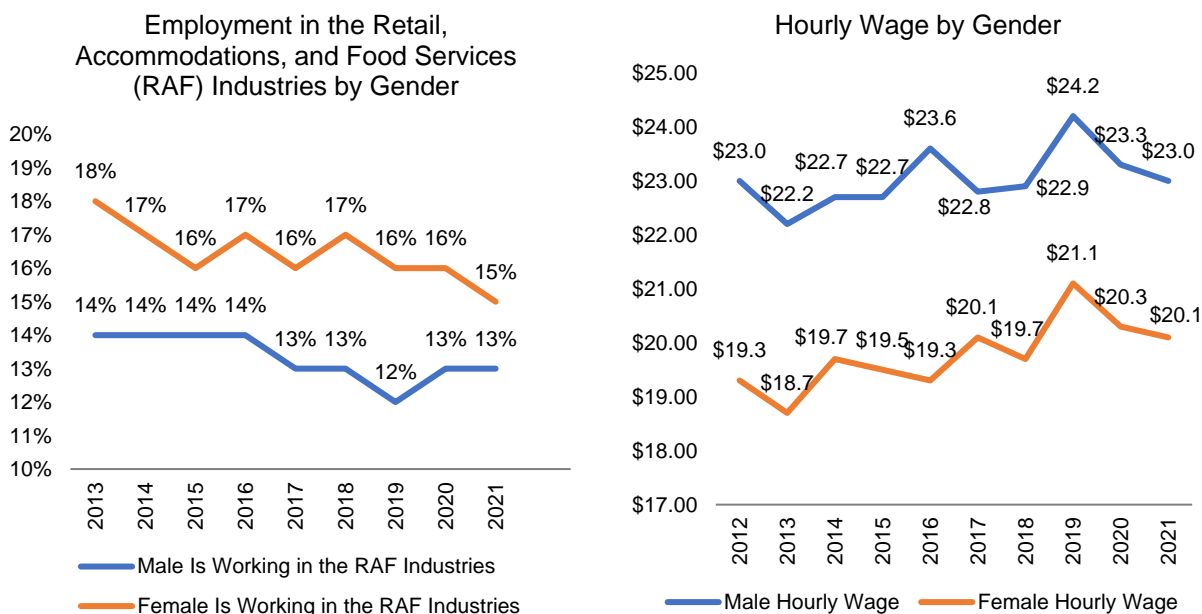
These industries have had historically low group coverage offer rates, so declines in employment in these industries and an “upscaling” of jobs particularly among mothers could lead to higher group coverage. Furthermore, convergence in employment in these industries could explain why mothers are replacing fathers as the group policyholders.

Figure 23
Changes in Wages and Retail, Accommodations, and Food Services (RAF) Industries Employment Among Parents, Ages 18–64, From 2012–2021



Note: Sample is two-parent families with co-resident children ages 0–26. Adults were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) data. Weighted using ASEC family weights. Dollar amounts are in 2021 dollars.

Figure 24
Changes in Wages and Retail, Accommodations, and Food Services (RAF) Industries Employment Among Childless Adults, Ages 18–64, from 2012–2021



Note: Sample is two-parent families with co-resident children ages 0–26. Sample in the right panel is two-adult families without children. Adults were ages 18–64. EBRI analysis of 2013–2022 Annual Socioeconomic Supplement of the Current Population Survey (CPS ASEC) survey. Weighted using ASEC family weights. Dollar amounts are in 2021 dollars.

Limitations of the Analysis

There are a few limitations with the measure of health coverage used in this analysis. First, this measure reflects ASEC responses regarding coverage in the prior calendar year. As such, these responses are subject to recall bias. An alternative measure could be based on the ASEC data referring to current coverage. However, this measure would be subject to time-period bias because the survey is fielded from February to April. This does not coincide with open enrollment on marketplace exchanges or when most people start new jobs and enroll in group coverage and might therefore bias insurance coverage downward.

Thus, even though the prior-year variable is subject to recall bias, it is preferable since it is a summary measure of a full year of coverage and not subject to point-in-time bias. In fact, work by Medalia et al. (2016) shows that the survey changes in 2013, which asked respondents about prior-year coverage, led to improved insurance coverage estimates. Another drawback of this health insurance measure used for this analysis is that it does not capture different sources of coverage within a year. For example, if a child has group coverage and Medicaid in the same year, they would be coded as having Medicaid and not group coverage in that year. This is the hierarchy used by the Kaiser Family Foundation (KFF) to classify coverage, so we use this convention as well.

Conclusion

This *Issue Brief* documents that health plans differ within and across families, in a single year and over time. Differences in health insurance coverage within families were impacted by the ACA and by changes in this labor market. Following the 2014 Medicaid expansion, the share of families with children fully covered by Medicaid increased 50 percent, and the share of families without children fully covered by Medicaid increased by 33 percent. The 2016 employer mandate also led to increases in group coverage, but these were much smaller than the Medicaid expansion. Starting in 2017, the share of families with children fully covered by group health insurance increased 4 percent, and the share of families without children fully covered by group health insurance increased 5 percent. The comparatively limited coverage gains after the employer mandate are consistent with prior work (Lennon 2021).

In addition, the ACA “family glitch” reduced the likelihood that partners were covered by non-group health insurance, especially among families with children. After controlling for important determinants of insurance coverage, we estimate that mothers whose partner had group coverage were three times more likely to be uninsured, relative to having non-group coverage. Furthermore, childless women whose partner had group coverage were two times more likely to be uninsured, relative to having non-group coverage. These findings suggest that the 2022 “family glitch fix” has the potential to increase enrollment in Marketplace health insurance and reduce uninsured rates among women whose partners have group coverage.

Mothers were more likely to be the provider of group coverage for the whole family and are replacing fathers as the providers of family coverage. On the other hand, group policy-holding rates were relatively flat for both childless men and women. These trends can be explained by rising labor force participation rates and a decline in employment in the RAF industries that reflects an “upscaling” of jobs among mothers. Finally, women with group coverage were earning more over time, further reflecting entrance into higher-paid occupations.

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Endnotes

¹ Authors calculations based on 2013–2022 CPS ASEC data.

² According to the White House, about 1 million Americans will gain coverage or see their insurance become more affordable under the rule change.

³ As result of the Supreme Court decision *National Federation of Independent Business v. Sebelius*, which declared the mandatory Medicaid eligibility expansion unconstitutional, states were given the option of expanding Medicaid eligibility to people with incomes up to 138 percent of the federal poverty level. By the end of 2014, 28 states and the District of Columbia had expanded access to their Medicaid programs.

⁴ The share of firms with fewer than 50 employees that offer health insurance has been steadily declining from a high of 47.2 percent in 2000 before stabilizing at about 30 percent starting in 2017. In contrast, from 1995–2014, 93–94 percent of firms with 50 or more employees offered health insurance, and this share rose to 96–97% after 2014 (Source: Medical Expenditure Panel Survey Insurance Component (MEPS-IC)).

⁵ See <https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage/>.

⁶ In a given survey, health plan coverage refers to coverage in the prior calendar year.

⁷ Co-resident children as old as 26 are included in the families with children sample given that starting in 2010, employers who offer dependent coverage must allow dependents up to age 26 to remain covered.

⁸ This is done using ordinary least squares (OLS) regression analysis.

⁹ The following results are conditional on father's coverage type, but the results are unchanged when father's and child's coverage are conditioned on mother's health insurance coverage, except in the case of Medicaid coverage.

¹⁰ Those receiving Medicare have a disability that qualifies them for Social Security Disability Insurance (SSDI).

¹¹ The following results are nearly identical if the male partner's coverage was conditioned on the female partner's coverage.

¹² Maternal employment rates fell during the COVID-19-induced recession.