# Improved Access to Care for Uninsured Adults Had They Participated in the Affordable Insurance Exchanges, 2002-08

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**Abstract:** The uninsured report worse access to care than the insured. As part of the efforts in the Affordable Care Act (ACA) to remedy this problem, starting in 2014, uninsured people with modified adjusted gross family incomes above 138% of the federal poverty guidelines will be encouraged to obtain private insurance through Affordable Insurance Exchanges. In the exchanges, cost sharing will be limited for lower income families, so benefit generosity will vary with income. The cost sharing subsidies for people with MAGIs at or below 250% of the federal poverty line may result in plans with cost sharing similar to that currently available through employment-related insurance. The less generous cost sharing for people with MAGIs above 250% of the federal poverty line may be similar to cost sharing currently found in individual or nongroup insurance, which typically has higher deductibles and copayments than employment-related insurance.

This analysis pooled seven MEPS panels to yield sufficient sample sizes of adults with the relevant insurance statuses and MAGIs above 138% of poverty. The measures of access included having: a usual source of care, any provider visits, unmet needs, problems seeing specialists, and problems getting care, tests, or treatment. MEPS access questions refer to access during the prior 12 months. Among lower-income adults ages 26 to 64, I compared those uninsured for 12 months (N=2,470), those uninsured for 1 to 11 months (N=1,469), and those with employment-related insurance for 12 months (N=4,261) prior to the fourth interview. Among higher-income adults ages 26 to 64, I compared those uninsured for 12 months (N=2,098), those uninsured for 1 to 11 months (N=2,109), and those with individual insurance for 12 months (N=689) prior to the fourth interview.

Probit regressions controlled for health status, attitudes, health behaviors, socioeconomic and geographic characteristics, and year fixed effects. For lower-income uninsured, the results are from models that control for all these factors, and the sample was limited to exclude those with the most choice in their insurance status. Specifically, I removed those offered insurance who did not take it, including the uninsured who were married to someone offered insurance. Among those with employment-related insurance, I removed dependents, because the family decided to pay the additional premium to cover spouses. Although the regressions were estimated on a reduced sample, the coefficients were used to estimate marginal effects on the original sample of all low-income uninsured. Among those with higher incomes, a comparison group of adults with exogenous individual insurance cannot be devised because a decision was made to purchase individual insurance. Sensitivity analyses suggest that the impact of unobserved factors would likely be very small.

The regression results were used to simulate the potential improvements in access to care for uninsured adults if they had instead had private insurance through the exchanges. If the uninsured had instead had private insurance similar to that available through the exchanges, then their access would have been much better. Lower-income adults would have experienced improvements in more aspects of access than higher-income adults.