

Endnotes

1 Analysis of data from the U.S. Census Bureau's American Community Survey, looking at uninsured Idahoans ages 18 to 64 with incomes up to 138 percent of poverty. See the full methodology.

2 The Affordable Care Act was structured assuming all states would expand Medicaid eligibility to 138 percent of poverty. Tax credits are available to consumers with incomes between 100 and 400 percent of poverty to make health insurance premiums affordable. However, because the law anticipated that Medicaid would cover all lower-income consumers, there are no tax credits for consumers with incomes below 100 percent of poverty. The Supreme Court ruled that expanding Medicaid had to be optional for states. Therefore, in states that do not expand Medicaid, residents with incomes below 100 percent of poverty who are not eligible for the state's existing Medicaid program do not have any option for affordable health insurance.

3 Through 2016, the federal government will pay 100 percent of the cost of expanding Medicaid. Beginning in 2017, the federal share will gradually decline until it reaches 90 percent in 2020, where it will remain.

4 Idaho Commerce, *Governor Otter Announces Accelerate Idaho* (Boise, ID: Idaho.gov, May 2014), available online at <http://commerce.idaho.gov/press-releases/governor-otter-announces-accelerate-idaho-economic-development-initiative>.

5 Insurance coverage, including Medicaid, is strongly related to better health outcomes for adults and children. For a comprehensive review of the literature on the impact of insurance on health, see Jill Bernstein et al., *How Does Health Insurance Improve Health Outcomes?* (Princeton, NJ: Mathematica Policy Research, Inc., April 2010), available online at http://www.mathematica-mpr.com/publications/PDFs/health/reformhealthcare_IB1.pdf.

6 For a discussion of the link between workers' health and productivity, see Centers for Disease Control and Prevention, *Workplace Health Promotion, Worker Productivity*, available online at <http://www.cdc.gov/workplacehealthpromotion/businesscase/reasons/productivity.html>, page last updated on October 23, 2013. Also see R. Leoppke et al., "Health and Productivity as a Business Strategy," *Journal of Occupational and Environmental Medicine* 51, no. 4 (2009): 411-428, available online at http://www.acoem.org/uploadedFiles/Healthy_Workplaces_Now/HPM%20As%20a%20Business%20Strategy.pdf.

7 Idaho Community Action Network and Alliance for a Just Society, *Expanding Health Coverage with Federal Funds Will Create Economy-Boosting Jobs in Idaho* (Boise, ID: Idaho Community Action Network and Alliance for a Just Society, February 2014), available online at <http://idahocan.org/wp-content/uploads/2014/02/Report-Expanding-Health-Coverage-with-Federal-Funds-Will-Create-Economy-Boosting-Jobs-in-Idaho-FINAL1.pdf>.

Methodology

Data Source

To analyze the employment status and occupations held by individuals who could be helped by the Medicaid expansion, Families USA used the Public Use Microdata Sample (PUMS) database. This database is derived from the American Community Survey. The American Community Survey is an ongoing public survey conducted by the U.S. Census Bureau. It is designed to give communities the current information that they need to plan and invest. Both national and state data are available. Among the data collected is information on respondents' household income, age, health insurance status, work status, and occupation. Families USA used data for 2010-2012. Using a three-year sample provides a more accurate picture of the population than a one-year sample. (More information about the American Community Survey is available online at https://www.census.gov/acs/www/about_the_survey/american_community_survey/.)

How We Sorted and Interpreted the Data

To identify the population that could benefit from the Medicaid expansion in a given state, Families USA sorted the sample to capture responses of individuals with a household income below 138 percent of poverty who were between ages 18 and 64 and who were uninsured. Sorting based on these criteria excludes individuals who are currently covered by their state's Medicaid program, as well as those who already have insurance, either through an employer or other payer. It gave us a sample that represents the population that will benefit the most from a Medicaid expansion.

- » The sample was further grouped based on work status, either “In the Workforce” or “Not in the Workforce.” This classification was made based on responses to survey questions about work status. The American Community Survey asks respondents if they have worked within the last week, within the last year, and within the last five years.
- » **In the Workforce:** Respondents were classified as “In the Workforce” if they had worked within the past five years. For these individuals, the PUMS data set lists the current or previous occupation in which the individual worked.
 - › Respondents classified as “working” include those currently working full-time or part-time (individuals who worked in the last week) or within the last 12 months. That allowed us to capture seasonal workers, contractors, self-employed respondents, and others who work but whose work schedule may not be consistent throughout the year. Respondents were classified in the occupation they reported that they currently or last held.
 - › Respondents were classified as “not working/unemployed” if they had not worked during the past 12 months but had been unemployed for less than five years. Respondents in this category were further classified based on their status as students, spouses, having a disability, being a dependent aged 18 to 24, or other. Responses were classified in only one subcategory to avoid double-counting.

» **Not in the Workforce:** Respondents were classified as “Not in the Workforce” if they reported they had never worked or had not worked in more than five years (including those who have retired). Responses in this group were further classified as students, spouses, having a disability, or being a dependent age 18 to 24. Responses were classified in only one subcategory to avoid double-counting.

Occupation Codes Reported

The American Community Survey groups respondents into occupations using the occupation codes from the Standard Occupational Classification System Manual. Occupations profiled in our report are those with the largest number of respondents from the sample. The example jobs associated with each occupation are also drawn from the Standard Occupational Classification System Manual, which lists jobs under each occupation classification. For illustrative purposes, we selected those jobs within each occupation classification that were associated with lower mean annual salaries based on the state’s May 2012 Occupational Employment and Wage Estimates reported by the Bureau of Labor Statistics. The jobs listed are solely for the purpose of illustrating the types of jobs that fall into each occupation category.

Assumptions

The PUMS data set included a variable for household income measured against the poverty level. However, a small percent

of the observations (responses) did not include a value for this measure. For those observations that were for a single member of a household, we divided the reported personal income by \$11,170 (the federal poverty level for an individual in 2012) to derive income as a percent of poverty. We corrected for the higher federal poverty level for the state of Alaska (where the federal poverty level was \$13,970 in 2012). For the very small percent of observations without a poverty level measure who were members of a household greater than one, we could not capture household income in relation to the poverty level. They were not included in this analysis. In addition, a small number of observations did not have a reported personal income. These observations were also excluded. As a result, our analysis likely undercounts those who may benefit from the Medicaid expansion.

Our analysis does not take into consideration citizenship status or immigration history, in part because there are doubts about the accuracy of the PUMS data set in capturing this information. Because qualified legal immigrants have a five-year mandatory disqualification period (known as the “five-year bar”), and because undocumented immigrants are ineligible for non-emergency Medicaid, our estimates may include some individuals who would ultimately not benefit from Medicaid expansion.

Finally, our analysis uses a weighting factor to convert analysis from responses into population-level statistics. These population-level weights were provided by the PUMS data set. We did not make any additional adjustments to the data.