Debra Robinson’s profession comes with many nonfinancial benefits—nurturing young minds and hearts, seeing children succeed, being a positive influence. What it doesn’t provide is health insurance.

The Littleton, Colo., resident manages five child-care facilities operating at schools in Jefferson and Park counties.

Robinson, 57, didn’t blame anyone for her lack of health insurance, and she didn’t complain. She raised two children without steady health insurance coverage, but she had gone 13 years without a full physical or annual exams.

She knew most women, let alone men, wouldn’t risk living without a medical safety net. Years ago she thought long and hard about getting a job that provided health coverage, dental and vision care, a pension plan, and other benefits that would have made things comfortable and secure.

“That wasn’t my path,” she said.

Her job entails caring for kids who are dropped off at school at 6:30 in the mornings and wait to be picked up at 6:30 in the evenings. She does homework with them. She listens to their problems. She reminds them to cough into their arms, not people’s faces, to use Kleenex and to wash their hands. She teaches them not to tattle on each other and to work out their own problems. She’s big into personal responsibility.

This is what she loves—helping children. But some days she barely makes ends meet with her hourly wage of $11. She’s helping pay her daughter’s tuition at Colorado School of Mines—a public research university in Golden, Colo., devoted to engineering and applied science. After accounting for her living expenses, Robinson can’t afford private health insurance.

“My job is something I need to do for me,” she said. “That’s where I derive my biggest
As with many women her age, Robinson’s hair is graying, her skin wrinkling and arthritis is creeping into her joints. She has given up high heels for sensible shoes and wears glasses to read and do paperwork at work. Knowing diabetes is likely, she monitors her blood sugar and manages the symptoms through diet and exercise. No matter how many herbs she takes or holistic ways she tries to keep herself healthy, she realizes she may require more and more traditional medical services in the years to come.

Robinson was prepared to live with the choices she had made—and aware that many may have considered her views naïve and irresponsible.

At least now she isn’t just getting by. With the changes to healthcare coverage under the

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**Medicaid Expansion as of July 2015**

- States that have expanded Medicaid
- States that have not expanded Medicaid
- States that have not made the decision on Medicaid expansion
Affordable Care Act, and new Colorado laws, Robinson became eligible for Medicaid and now receives the healthcare that she once thought was out of her reach.

The Affordable Care Act

The Affordable Care Act (ACA) was signed into law in 2010 with the goal of achieving near-universal health insurance coverage. The ACA not only has effected health insurance decisions of U.S. firms and individuals, but also the labor market due to the tight link between employment and health insurance. Thirty-three states have implemented provisions of the ACA, such as the expansion of Medicaid; however, the goal of providing or obtaining some form of health coverage still applies to firms and individuals.

Didem Tüzemen, an economist with the Federal Reserve Bank of Kansas City, and Makoto Nakajima, an economist with the Federal Reserve Bank of Philadelphia, say economists have debated the ACA's effect on the labor market since it was signed into law.

For instance, one ACA provision mandates firms with 50 or more full-time employees offer health insurance to full-time employees or face penalties. The concern was that firms could respond by cutting hours or replacing full-time employees with part-time employees.

An economist whom Tüzemen and Nakajima cite in their research as someone who estimates that healthcare reform will have a greater impact on the labor market is Casey B. Mulligan.

In his research, “The Affordable Care Act and the New Economics of Part-Time Work,” Mulligan, a professor of economics at the University of Chicago, attributes a decline in labor demand and a reduction of 3 percent in total hours worked to the ACA.

The economists also denote the Congressional Budget Office's analysis, which also estimates a decline in total hours worked of 1.5 to 2 percent.

Tüzemen and Nakajima analyzed the macroeconomic and welfare implications of the ACA, focusing on the interaction between the health insurance market and the labor market. They estimated, based on the model they created, that the ACA achieves its goal of near-universal coverage. The effects are a welfare gain equivalent of 0.5 percent, and the uninsured rate drops from 22.6 to 5.6 percent, which is in line with the Congressional Budget Office's recent estimate of a drop of 7 percent among the nonelderly population.

The economists estimate the ACA will affect the allocation of part-time and full-time employment. Their model predicts the ACA will result in an additional 2.1 million part-time jobs, 1.3 percent of the labor force, at the expense of 1.6 million full-time jobs.

An important difference from Mulligan's study, however, is that Tüzemen and Nakajima find that the decline in hours worked in their model is primarily due to a decline in labor supply rather than labor demand.

“Workers do not need to cling to (full-time) jobs with health insurance when the ACA is introduced, and workers can work (part time) and still obtain subsidized health insurance through either the exchange or Medicaid.”

The employer mandate for firms, on the other hand, does not appear to affect the share of full time versus part time jobs offered by firms.

Overall, the effect of the ACA on total hours worked, however, is a modest 0.36 percent decline compared to Mulligan and the Congressional Budget Office's estimations.

Their analysis also suggested there is still a “coverage gap” among workers.

Individuals fall into the coverage gap when their income level is below 100 percent of the federal poverty level, but they do not qualify for Medicaid. One of the ACA's main goals was to expand the federal poverty level line, making many ineligible workers eligible for Medicaid.
The expansion, however, relied on states adopting the expansion of Medicaid coverage. “However, in many states that opted out of expansion of Medicaid, individuals in the coverage gap cannot receive health insurance subsidies even though their income is lower than 100 percent of the FPL,” the economists said.

Because in some of those states Medicaid eligibility was as low as 50 percent of the poverty line and issues such as gender and pregnancy affected eligibility.

“Our experiments suggest that, if the coverage gap is left open nationally, 2.0 million more workers (1.3 percent of the labor force) end up uninsured.”

The welfare gains of implementing the ACA become zero if Medicaid is not expanded and the coverage gap is left open.

“Although it is not straightforward to extrapolate our results to the actual situation in which only a subset of states decline expanding Medicaid, our experiments are suggestive about the serious consequences of leaving the coverage gap.”

They also compared their model’s outcomes to the data from the 2006 Massachusetts Health Care Reform, upon which the ACA is loosely based.

Massachusetts’ reform created a significant drop in the uninsured rate with only minimal effect on the overall labor market. The economists found their model’s predictions were consistent with Massachusetts’ data.

Yet, it’s still too early in the implementation of the ACA to know the long-term economic effects on the labor market.

Healthcare reform in Colorado

Joe Sammen, executive director for the Colorado Coalition for the Medically Underserved, says with changes in the law—the expansion of Medicaid and state enacted health insurance marketplaces and incentives—

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**Individuals who qualify for Medicaid***

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Yearly Income</th>
<th>Monthly Income</th>
<th>Hourly Income</th>
</tr>
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<tbody>
<tr>
<td>✩</td>
<td>$11,490</td>
<td>$957</td>
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<tr>
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<tr>
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<td>$23,550</td>
<td>$1,962</td>
<td>$11.34</td>
</tr>
</tbody>
</table>

Source: Congressional Budget Office

*Could vary according to a particular state’s laws
the labor force may see a resurgence of entrepreneurship.

Studies over the years have suggested many people don’t take the risk of starting their own businesses because they are unable to find affordable health insurance, Sammen said. This situation often is described as “job-lock” or “entrepreneurship lock.”

Sammen is familiar with the concept. His father worked two jobs. One was a full-time job with health insurance benefits. The other was the small business he created. He never quit his other job to expand his small business because he couldn’t obtain affordable health insurance as a small business owner.

Sammen refers to a 2011 study by the RAND Corp. that concluded the lack of affordable health insurance options for self-employed individuals is a key reason individuals decide to stay in an unsatisfying job instead of starting their own business.

The Urban Institute in Colorado estimates 27,000 more Coloradans will decide to become self-employed as a direct result of health reform in that state, and under the ACA, access to high-quality, subsidized health insurance coverage no longer will be exclusively tied to employment.

Colorado and New Mexico currently are the only states in the Tenth District to adopt the Medicaid expansion provision under the ACA.

Before healthcare reform, there were 750,000 Coloradans in 2013 unable to obtain healthcare services.

“That number has been cut in half since the new healthcare reforms,” Sammen said.

Since then, 50,000 young adults have obtained health insurance coverage and 1.2 million have gained preventive services. An estimated 500,000 Coloradans will be eligible for tax credits to defray the costs of health insurance through the state’s Connect for Health Colorado marketplace.

A majority of Coloradans, however, was unaffected by federal and state healthcare reform.

“Many people already had coverage and access to care didn’t change,” Sammen said.

Some persistent gaps, however, remain among the uninsured and underinsured and those with insurance, which mainly fall along socioeconomic and racial lines, Sammen said.

Whites in the state experienced a bigger drop in the number of underinsured or uninsured than Latinos. About 5 percent of whites are uninsured compared to 12 percent of Latinos. Region also affects healthcare coverage and access. For instance, Douglas County, south of Denver, only has a 2.4 percent uninsured gap, while the gap in some communities in northwest Colorado are as much as 12 percent.

“What we’ve learned is that the reforms are starting point; it takes a community working together, collaboration, to make these reforms meet their needs,” Sammen said.