**Effects of the Recent Medicaid Expansion on Cohabitation and Marriage: Comparing Estimates from the American Community Survey and the Current Population Survey***

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**Abstract**

The Affordable Care Act (ACA) was passed in 2010 and was designed, in part, to vastly increase health insurance coverage. In this study, I build on past research to examine whether the Medicaid expansion provision of the ACA affected rates of cohabitation and marriage among young adults, and I compare estimates across two nationally representative data sets: the American Community Survey (ACS) and the Current Population Survey (CPS). I use data from the 2008-2016 waves to estimate difference-in-difference models. Preliminary results indicate that the Medicaid expansion was associated with significant declines in both cohabitation and marriage, with effects for cohabitation being larger in the CPS than in the ACS, likely as a result of differences in the measurement of cohabitation, and effects generally being larger for women than men. Implications of these findings and discrepancies are discussed.

**Effects of the Recent Medicaid Expansion on Cohabitation and Marriage: Comparing Estimates from the American Community Survey and the Current Population Survey**

The Affordable Care Act (ACA) was passed in 2010 and was designed, in part, to vastly increase health insurance coverage. I focus on the Medicaid expansion provision that expanded Medicaid coverage to previously ineligible adults (Kaiser Family Foundation 2013a). Recent research indicates that another provision of the ACA (the dependent coverage provision) has had effects on marriage, childbearing and cohabitation among young adults (Abramowitz 2016, Heim et al. 2017, Ma 2015). In this study, I build on past research to examine whether the Medicaid expansion affected rates of cohabitation and marriage among young adults, and I compare estimates across two nationally representative data sets: the American Community Survey (ACS) and the Current Population Survey (CPS).

**Background**

*ACA Medicaid Expansion*

The Medicaid expansion was a response to the fact that most low-income adults were not eligible for Medicaid and thus also had very high levels of uninsurance (Kaiser Family Foundation 2013b). Coverage under Medicaid prior to the expansion was limited to specific low-income groups, such as the elderly, persons with disabilities, children, pregnant women, and in more recent years, some groups of parents (Kaiser Family Foundation 2013b). The goal of the expansion was to extend health insurance coverage to all poor individuals, including those who were previously ineligible and those whose income was up to 138% of the federal poverty line (Kaiser Family Foundation 2013a). This latter part of the provision increased the income cutoff for an individual to $15,417 for example (Kaiser Family Foundation 2013b). The intention was

for all states to adopt the expansion, but in 2012 the Supreme Court issued a decision allowing states to opt out of the expansion (Kaiser Family Foundation 2013b). As of November 2017, 18 states had not expanded Medicaid coverage, 25 states and Washington D.C. had expanded coverage as intended, and seven states had extended coverage but under a waiver program (Kaiser Family Foundation 2013b). The expansion went into effect in 2014, although some states did not expand Medicaid until later (Kaiser Family Foundation 2013b). The lack of a universal adoption allows for a natural experiment comparing family formation patterns in states that did not expand Medicaid and states that did expand Medicaid.

*Theory*

The underlying premise of this study is that improved access to health insurance has an effect on family formation behavior. The specific focus of this study is on cohabitation and marriage. To understand this premise requires understanding the mechanisms through which insurance might operate. Five potential mechanisms are identified, although all may not be fully relevant to marriage and cohabitation: 1) financial protection; 2) cash value; 3) behavioral incentives; 4) health outcomes; 5) behavior around eligibility notches. Insurance can provide financial protection from significant health expenses (e.g., Yu et al. 2008). It potentially has a cash value, allowing an insured person to spend money on something else, which is often referred to as an income effect (Buchmueller and Valletta 1999, Currie and Madrian 1999). There may be behavioral incentives with insurance, such as price incentives to engage or not engage in certain activities (Currie and Madrian 1999, Volpp et al. 2009). Health outcomes may be relevant, especially at the bottom of the income distribution (Finkelstein et al. 2012). Finally, there can be behavioral changes around eligibility notches (Gruber and Yelowitz 1999). For both marriage and cohabitation, the financial protection and cash value mechanisms likely dominate.

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From qualitative evidence about financial barriers to marriage among low-income cohabiting couples (Edin and Kefalas 2011, Smock, Manning, and Porter 2005), we might expect the financial protection and cash value mechanisms of the Medicaid expansion to increase rates of marriage. Health outcomes could also be relevant. For example, women with worse mental health and with lower engagement in exercise appear to be selected into marriage and cohabitation, and in terms of cohabitation specifically, both men and women with poor health behaviors, and men with higher levels of depression, appear to be particularly selected into cohabitation (Pollard and Harris 2013). If new access to health insurance changes these behaviors or mental health states, there may be an influence on cohabitation and marriage.

Prior to the enactment of the ACA there was evidence of individuals marrying for health insurance reasons, with financial protection (but also possibly cash value) being a driving factor (Montez et al. 2009). Thus, if the Medicaid expansion reduced the likelihood of marrying for health insurance specifically, marriage rates may have declined, and the type of individuals who would have married for health insurance may have chosen to substitute cohabitation instead, thus increasing cohabitation rates (Abramowitz 2016). Furthermore, newly eligible individuals may be concerned about losing this eligibility if they marry (because of the way eligibility is calculated) (Moffitt, Reville, and Winkler 1998), and they may also substitute cohabitation for marriage. For example, a recent study on the Earned Income Tax Credit (EITC), which has strict income cutoffs like Medicaid, indicated that single mothers who expect to lose EITC benefits when they marry are less likely to marry and more likely to cohabit than single mothers for whom marriage would either not change or would increase their EITC benefit (Michelmore 2018).

Additionally, if individuals are cohabiting with the intent to marry (this is one motivation for cohabitation but not the only reason (Lundberg and Pollak 2014)), and marriage becomes less likely after the Medicaid expansion was implemented, then individuals may opt out of cohabitation along with marriage, potentially lowering cohabitation rates (Abramowitz 2016). Furthermore, if insurance has a cash value, newly insured individuals may be less likely to cohabit primarily for the financial cost savings of combining households (Raley et al. 2007, Smock et al. 2008), which could also lead to reductions in cohabitation.

*Prior Research*

There is limited research related to how health insurance may impact cohabitation, but there is a larger literature about changes in marriage. In terms of the dependent coverage provision of the ACA, Abramowitz (2016) found the provision was associated with decreases in the likelihood of marriage and cohabitation for those affected by the provision using ACS data. Enactment and implementation were associated with declines in the probability of cohabitation for those ages 23-25 of between 0.62 and 1.42 percentage points, which corresponded to decreases in cohabitation rates of 4.3% to 9.8% compared to before provision enactment (Abramowitz 2016). Similarly, for marriage, enactment and implementation were associated with declines in the probability of marriage for those ages 23-25 of between 0.53 and 0.56 percentage points, which corresponded to decreases in marriage rates of 8.8% to 9.3% compared to before provision enactment (Abramowitz 2016).

Using tax data, Heim and colleagues (2017) found the dependent coverage provision was associated with a decline in marriage among 24-25 year olds, but they were unable to examine cohabitation. Gender differences have also been shown, such that women who qualify for health

insurance through their parents after the dependent coverage provision seem less likely to be married but not men (Depew 2013, but see Heim et al. 2017).

To date no studies appear to have examined the role of the ACA Medicaid expansion for marriage or cohabitation. However, research on prior Medicaid expansions and marriage has found mixed results. Yelowitz (1998) found a prior Medicaid expansion to be associated with an increase in the probability of marriage; one might expect similar increases in cohabitation if the expansion was working through reducing financial constraints to family formation. Yet, Decker (2000) found that earlier Medicaid expansions were associated with an increased probability of mothers being single, suggesting a reduction in the likelihood of marriage, which potentially implies a substitution of cohabitation (or singlehood) for marriage. Thus, the expected effect of the Medicaid expansion on marriage and cohabitation, if any, is unclear.

*Contributions*

I make two main contributions to the literature with this study. First, I use both the ACS and CPS to study marriage and cohabitation because cohabitation is measured differently in the two data sets, and both data sets have strengths and weaknesses. The ACS benefits from a very large sample size, but cohabitation measurement is limited to household heads and partners, whereas the CPS captures cohabitation more broadly within the household but has a much smaller sample size (though still quite large). The implications of these measurement differences will be one of the focuses of the analysis; Manning (2015) has noted that measuring household relationships in terms of relation to the household head provides a limited understanding of family relationships and reduces accurate measurements of non-traditional families. Second, because I have data through 2016, I am able to examine the short-run effects of the Medicaid

expansion for marriage and cohabitation, providing arguably the first estimates of the potential effects of the ACA Medicaid expansion on cohabitation and marriage.

**Methods**

*Sample*

Data come from the 2008-2016 rounds of the ACS and CPS. The samples include unmarried civilians ages 18-30 (cohabitation analysis) and also married civilians ages 18-30 (marriage analysis); active duty military members are not included in the sample because their health insurance is provided through the military. The sample size in the ACS for the cohabitation analysis is 2,298,058, and the sample size in the CPS for the cohabitation analysis is 148,908. The samples sizes for the marriage analyses are 3,233,422 in the ACS and 218,881 in the CPS.

*Dependent Variables*

The first dependent variable is an indicator of the respondent being in a cohabiting relationship compared to another (non-marital) relationship state. In the ACS this can only be ascertained for heads of household and their partners. In the CPS this can be ascertained for anyone in the household. I return to the potential implications of this difference in measurement in the Discussion. The second dependent variable is an indicator of the respondent being married compared to another relationship state.

*Independent Variables*

Two variables are used as independent variables: 1) a dummy variable equal to one to indicate being in an expansion state prior to the expansion (=0 otherwise) and 2) a dummy variable equal to one to indicate being in a Medicaid expansion state in a year after which

Medicaid was expanded in that state (=0 otherwise). The comparison is being in a non-expansion state and year.

*Controls*

The main models control for a linear measure of age, gender, race/ethnicity, school enrollment (ACS only), state-level unemployment rate, the interaction between the state-level unemployment rate and a categorical measure of age, state fixed effects, year fixed effects, and state by year fixed effects. Race/ethnicity has five categories: non-Hispanic white, non-Hispanic black, Hispanic, non-Hispanic Asian/Pacific Islander, and non-Hispanic other. School enrollment is an indicator variable representing enrolled vs. not enrolled; in the CPS it is not available for those older than 24 until 2013, so it is omitted from the main models using the CPS data. Age in categories compares ages 21-25 with ages 26-30. The model includes an additional interaction between Medicaid expansion and the unemployment rate.

*Analytic Strategy*

The general analytic strategy is to estimate difference-in-difference models of the effects of the Medicaid expansion provision on cohabitation and marriage with standard errors clustered at the state level. I estimate models for the sample as a whole and then separately for men and women. Equation 1 demonstrates the difference-in-difference equation for the analysis. The model is similar to that estimated by Abramowitz (2016) and Heim and colleagues (2017) for the dependent coverage provision of the ACA. $B_3$ is the main coefficient of interest, referring to being in an expansion state in a year after the expansion was implemented. $B_4$-$B_6$ represent state, year, and state by year fixed effects, respectively. $B_7$ represents coefficients on the control variables, and $B_8$ represents the coefficient for the state-level unemployment rate. Analyses are weighted to be representative of the population.

$y_{ist}=\beta_0+\beta_1Expansion_{ist}+\beta_2ExpandYear_{ist}+\beta_3(Expansion_{ist}*ExpandYear_{ist})+\beta_4State_s+\beta_5Year_t+$

$\beta_6(State_s*Year_t)+\beta_7X_i+\beta_8Z_{st}+\varepsilon_{ist}$ (1)

**Results**

*Trends in Cohabitation and Marriage*

The method of analysis requires that we assume the treatment and control groups have similar trends in cohabitation and marriage prior to the enactment of the provision. I provide descriptive patterns of the pre-treatment trends in Figures 1-4. Prior to the Medicaid expansion, in the ACS data the expansion and non-expansion states appear to have very similar patterns of cohabitation (Figure 1), and there is some indication that cohabitation may have declined slightly in non-expansion states in 2016, after implementation. The CPS data suggest that, after the expansion, the expansion states experienced slight increases in cohabitation while the non-expansion states experienced slight decreases (Figure 2). Prior to the Medicaid expansion in the ACS data the expansion and non-expansion states appear to be following similar decreasing trajectories of marriage (Figure 3), and it is not immediately apparent that this trend changed after the Medicaid expansion. On the other hand, the CPS data suggest that while both types of states had similar trends until about 2013, after the Medicaid expansion, the expansion states appeared to experience a leveling off and then a sharper decline in marriage, whereas the non-expansion states initially experienced a continued decline and then experienced a leveling off. Overall the pre-treatment trends appear fairly consistent across expansion and non-expansion states.

[Figures 1-4 about here]

*Descriptive Statistics*

Descriptive statistics are shown in Table 1. In Panel 1 descriptive statistics are shown by Medicaid expansion status for both data sets. In Panel 2 descriptive statistics are shown by cohabiting and marital status. The descriptive statistics for the control variables are generally similar across data sets, but there are some differences by cohabitation and marriage, and Medicaid expansion status. For example, cohabiters are more likely to be female, white, and older, whereas those not cohabiting are more likely to be black, Asian/Pacific Islander, and enrolled in school. Married individuals are also more likely to be female, white or Hispanic, and older, whereas the non-married are more likely to be black, enrolled in school, and unemployed. In terms of differences by Medicaid expansion status, those in expansion states are less likely to be black and more likely to be Asian/Pacific Islander or white. The dependent variable of cohabitation is observed at lower percentages in the ACS compared to the CPS, likely as a result of only being measured for heads and partners in the ACS. Nonetheless, the percentages reported in the ACS are consistent with other ACS estimates of cohabitation in the literature (e.g., Fry and Cohn 2011). Marriage rates are comparable across data sets, but results indicate that marriage rates are higher on average in non-expansion states than expansion states.

[Table 1 about here]

*Hypothesis Testing*

Results for Model 1, testing the effect of the Medicaid expansion on cohabitation, are shown in Table 2. Looking at the results for the full sample in the ACS, there is a large and significant negative effect (2 percentage points) of the Medicaid expansion, corresponding to a 35.1% decrease in cohabitation from baseline. Results of the gender-stratified models indicate the reduction is seen for both men and women (34.7% and 31.3% decreases, respectively).

Turning to the CPS results, there is again a large and statistically significant reduction (7.5 percentage points) in cohabitation associated with Medicaid expansion; the decrease is 49.0% from baseline. The gender-stratified models indicate both men and women experience large and significant reductions in cohabitation after the Medicaid expansion (41.2% and 58.2% decreases, respectively).

[Table 2 about here]

Results for Model 2, testing the effect of the Medicaid expansion on marriage, are shown in Table 3. Looking at the results for the full sample in the ACS, there is a large and significant negative effect (2.5 percentage points) of the Medicaid expansion, corresponding to a 12.5% decrease in marriage from baseline. Results of the gender-stratified models indicate the reduction is seen for both men and women (14.9% and 10.3% decreases, respectively). Turning to the CPS results, there is again a large and statistically significant reduction (5.8 percentage points) in marriage associated with Medicaid expansion; the decrease is 26.7% from baseline. The gender-stratified models indicate both men and women experience large and significant reductions in marriage after the Medicaid expansion (22.0% and 28.8% decreases, respectively).

[Table 3 about here]

**Discussion**

The goal of this study was to determine whether the ACA Medicaid expansion affected rates of marriage and cohabitation among young adults. For marriage there are large declines associated with the expansion in both the ACS and CPS and for both men and women, although results from the CPS suggest that women might be more affected than men, consistent with Depew's (2013) findings of gender differences in marriage in the wake of the dependent coverage provision's implementation. Overall these results are most consistent with Decker's (2000)

research on a prior Medicaid expansion, although his sample was limited to mothers. The results are also consistent with findings for young adults after the implementation of the dependent coverage provision (Abramowitz 2016, Heim et al. 2017). These findings may suggest less marriage for reasons of obtaining health insurance or may reflect concerns about loss of eligibility for new Medicaid insurance that could accompany marriage. However, both of those potential mechanisms suggest that a substitution of cohabitation could be plausible.

Nonetheless, the results of the cohabitation analysis do not suggest a substitution of cohabitation for marriage after the Medicaid expansion. Instead, the Medicaid expansion is also associated with significant reductions in cohabitation. This suggests that the cash value of health insurance might be allowing low-income individuals to choose to stay single, rather than cohabiting or marrying for financial reasons. The declines in cohabitation are consistent with declines seen for the dependent coverage provision in the ACS data (Abramowitz 2016).

Notably, there is a difference in the estimated declines in cohabitation across the two data sets. In the ACS, the estimates suggest declines of approximately 2 percentage points, and this is true for both men and women. These declines correspond to 30-35% lower cohabitation rates in the ACS. But, in the CPS, the estimates are much larger. In the sample overall the decline is approximately 7.5 percentage points, with a 10.3 percentage point decline estimated for women and a 5.4 percentage point decline estimated for men. These corresponded to 41-58% lower cohabitation rates in the CPS. These estimates also suggest that the Medicaid expansion had larger effects for women, consistent with the pattern of findings from Depew (2013) for marriage after the dependent coverage provision implementation. Although the patterns of declines are similar across data sets, the results make abundantly clear that the way in which cohabitation is measured matters for policy implications. Not only are baseline values of cohabitation nearly 2.5

times higher in the CPS than in the ACS, but the estimated declines are three or more times the magnitude as in the ACS, and they correspond to decreases in cohabitation rates that are more than 30% larger than the size of those estimated using the ACS.

Future analyses should examine heterogeneity in the effects of the expansion by race/ethnicity, parental status, and socioeconomic status, and should expand the age range of the sample to include middle-aged individuals. Future research would also benefit from an examination of effects on childbearing and divorce. I hope to address some of these issues as the project continues forward.

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Table 1. Descriptive Statistics

| | American Community Survey | | | | Current Population Survey | | | |
|---|---|---|---|---|---|---|---|---|
| *Panel 1.* | By Medicaid Expansion | | | | By Medicaid Expansion | | | |
| | Expanded | Not Expanded | | | Expanded | Not Expanded | | |
| Cohabiting | 5.7% | 5.5% | | | 15.2% | 15.6% | | |
| Married | 19.3% | 23.0% | | | 20.6% | 25.5% | | |
| Female | 47.1% | 47.1% | | | 47.1% | 47.5% | | |
| Race/ethnicity | | | | | | | | |
|   NH White | 56.5% | 54.3% | | | 57.1% | 53.9% | | |
|   NH Black | 12.7% | 21.1% | | | 12.5% | 21.1% | | |
|   Hispanic | 20.3% | 18.5% | | | 20.2% | 18.9% | | |
|   NH Asian/ Pac. Islander | 6.8% | 3.1% | | | 6.7% | 3.0% | | |
|   NH Other | 3.8% | 3.1% | | | 3.5% | 3.1% | | |
| Enrolled in school | 40.7% | 39.7% | | | 43.6% | 40.7% | | |
| *Panel 2.* | By Cohabitation | | By Marriage | | By Cohabitation | | By Marriage | |
| | Cohabiting | Not Cohabiting | Married | Not Married | Cohabiting | Not Cohabiting | Married | Not Married |
| Female | 55.2% | 46.6% | 57.3% | 47.1% | 54.5% | 45.9% | 59.1% | 47.2% |
| Race/ethnicity | | | | | | | | |
|   NH White | 63.3% | 55.2% | 61.9% | 55.7% | 65.1% | 54.3% | 61.8% | 56.0% |
|   NH Black | 10.7% | 16.1% | 6.8% | 15.8% | 10.1% | 16.6% | 6.4% | 15.6% |
|   Hispanic | 19.9% | 19.6% | 22.6% | 19.6% | 18.6% | 19.9% | 23.3% | 19.7% |
|   NH Asian/ Pac. Islander | 2.7% | 5.6% | 6.1% | 5.4% | 2.6% | 5.9% | 6.2% | 5.4% |
|   NH Other | 3.4% | 3.5% | 2.6% | 3.5% | 3.6% | 3.3% | 2.4% | 3.4% |
| Enrolled in school | 17.8% | 41.7% | 14.6% | 40.4% | 18.2% | 46.4% | 13.1% | 42.6% |
| Age | 25.42 (3.08) | 23.08 (3.63) | 26.66 (2.83) | 23.21 (3.64) | 25.10 (3.15) | 22.90 (3.56) | 26.69 (2.78) | 23.24 (3.59) |
| Unemployed | 8.7% | 10.2% | 5.5% | 10.1% | 8.6% | 8.9% | 5.1% | 8.9% |

Table 2. Estimates of the Medicaid Expansion on Cohabitation, American Community Survey and Current Population Survey

| | American Community Survey | | | Current Population Survey | | |
|---|---|---|---|---|---|---|
| | Full Sample | Women | Men | Full Sample | Women | Men |
| Expansion State, Pre-Expansion | 0.052 (0.001)*** | 0.042 (0.001)*** | 0.057 (0.001)*** | 0.095 (0.002)*** | 0.066 (0.002)**** | 0.131 (0.003)*** |
| Expansion State, Post-Expansion | -0.020 (0.0001)*** | -0.021 (0.0001)*** | -0.017 (0.0001)*** | -0.075 (0.001)*** | -0.103 (0.001)*** | -0.054 (0.002)*** |
| Observations | 2,298,058 | 1,069,997 | 1,228,061 | 148,908 | 73,221 | 75,687 |
| *Dependent Variable Means* | | | | | | |
| Treated, pre-expansion | 0.057 | 0.067 | 0.049 | 0.153 | 0.177 | 0.131 |
| Control, pre-expansion | 0.056 | 0.064 | 0.048 | 0.158 | 0.181 | 0.136 |
| Treated, post-expansion | 0.056 | 0.067 | 0.046 | 0.152 | 0.175 | 0.131 |
| Control, post-expansion | 0.055 | 0.065 | 0.046 | 0.154 | 0.177 | 0.133 |

Note: Models control for age, race/ethnicity, school enrollment (ACS), state-level unemployment rate, state-level unemployment rate X categorical age, state fixed effects, year fixed effects, state by year fixed effects, and Medicaid expansion status X state-level unemployment rate. Standard errors are clustered at the state level.
*p<.05; **p<.01; ***p<.001

Table 3. Estimates of the Medicaid Expansion on Marriage, American Community Survey and Current Population Survey

| | American Community Survey | | | Current Population Survey | | |
|---|---|---|---|---|---|---|
| | Full Sample | Women | Men | Full Sample | Women | Men |
| Expansion State, Pre-Expansion | -0.008 (0.003)** | -0.002 (0.003) | -0.016 (0.002)*** | -0.029 (0.003)*** | -0.018 (0.004)*** | -0.037 (0.003)*** |
| Expansion State, Post-Expansion | -0.025 (0.0003)*** | -0.024 (0.0003)*** | -0.025 (0.0004)*** | -0.058 (0.0003)*** | -0.074 (0.001)*** | -0.039 (0.001)*** |
| Observations | 3,233,422 | 1,608,875 | 1,624,547 | 218,881 | 114,671 | 104,210 |
| | | | | | | |
| *Dependent Variable Means* | | | | | | |
| Treated, pre-expansion | 0.200 | 0.234 | 0.168 | 0.217 | 0.257 | 0.177 |
| Control, pre-expansion | 0.239 | 0.275 | 0.204 | 0.270 | 0.315 | 0.224 |
| Treated, post-expansion | 0.178 | 0.209 | 0.147 | 0.191 | 0.231 | 0.153 |
| Control, post-expansion | 0.213 | 0.247 | 0.179 | 0.234 | 0.274 | 0.193 |

Note: Models control for age, race/ethnicity, school enrollment (ACS), state-level unemployment rate, state-level unemployment rate X categorical age, state fixed effects, year fixed effects, state by year fixed effects, and Medicaid expansion status X state-level unemployment rate. Standard errors are clustered at the state level.
*p<.05; **p<.01; ***p<.001

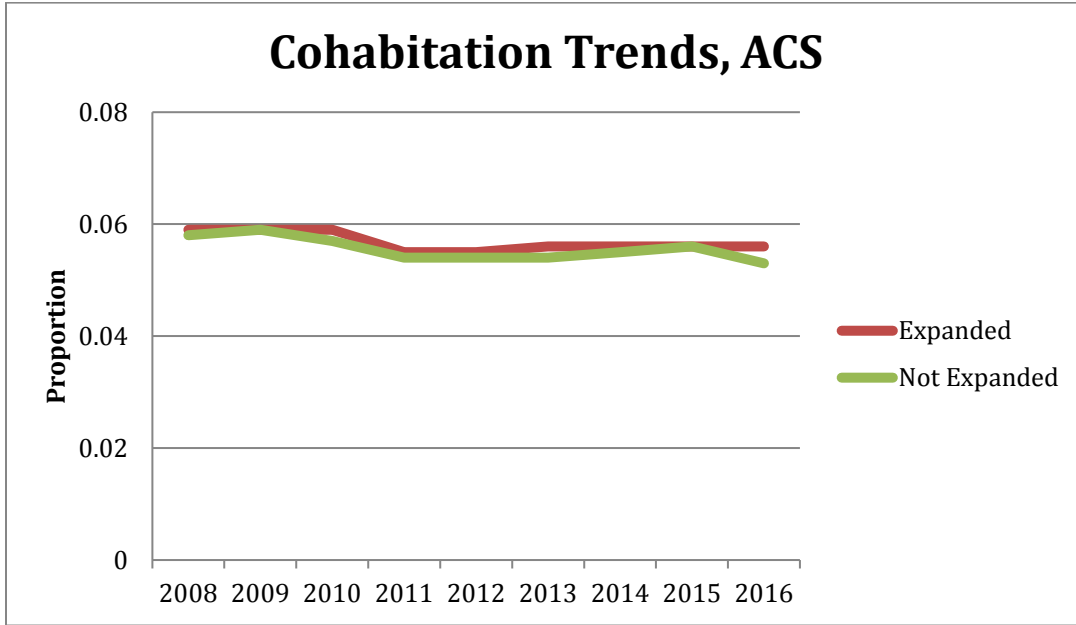Figure 1. Trends in Cohabitation in the American Community Survey



**Cohabitation Trends, ACS**

Figure 2. Trends in Cohabitation in the Current Population Survey



**Cohabitation Trends, CPS**
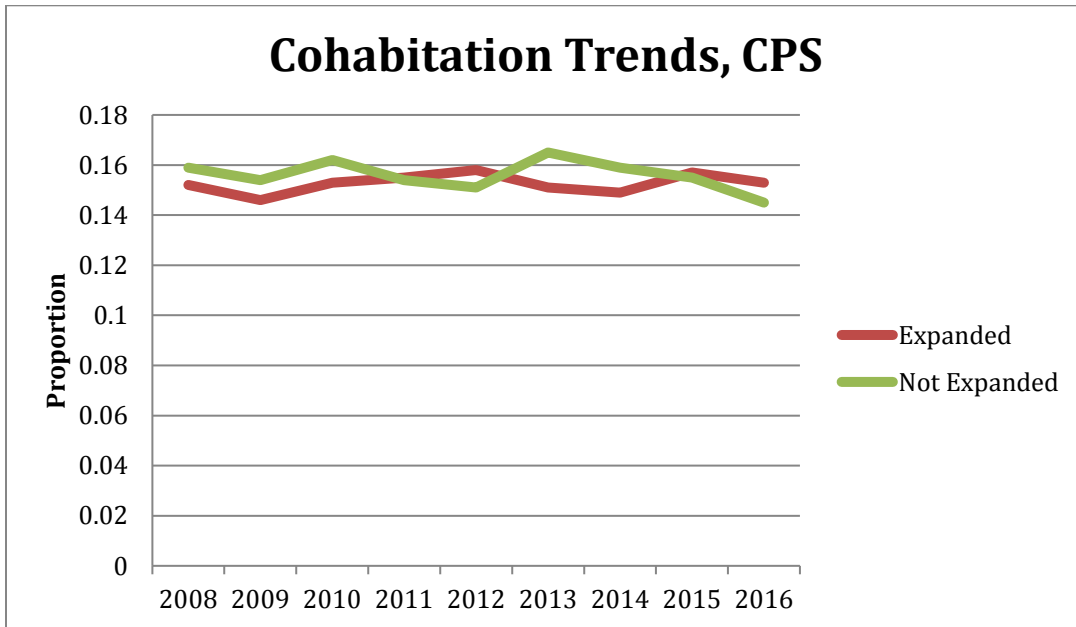
Figure 3. Trends in Marriage in the American Community Survey
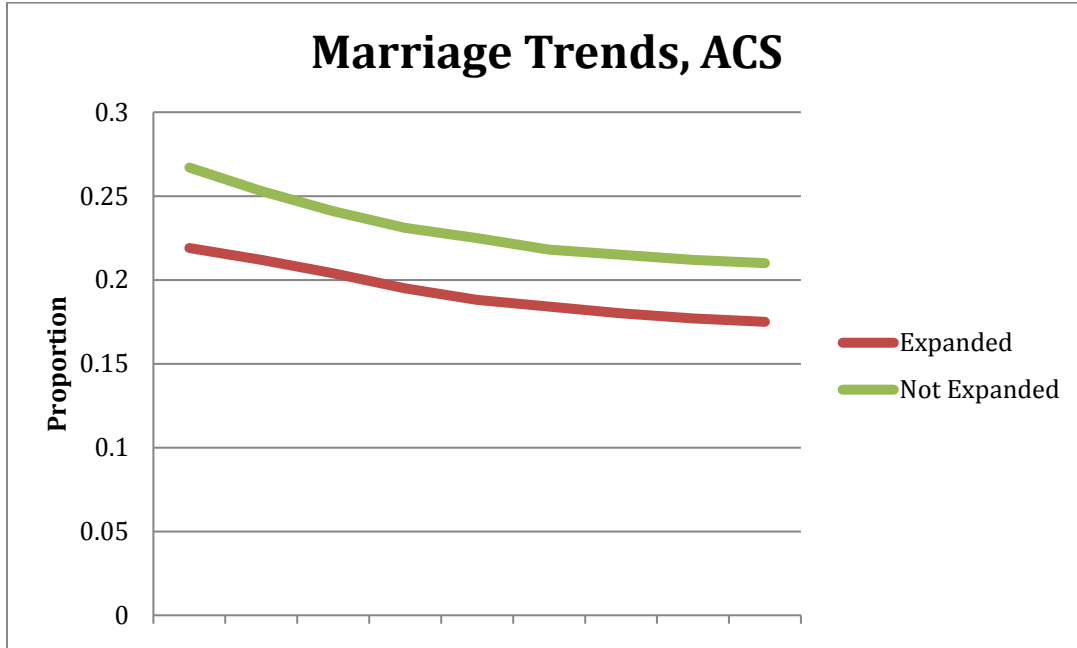


**Marriage Trends, ACS**

Figure 4. Trends in Marriage in the Current Population Survey



**Marriage Trends, CPS**