Reports and Research

Table of Contents

November 17, 2016 Board Meeting

- *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch* – ***The Commonwealth Fund***
  October 1, 2016

- *Consumers Enrolling in Exchanges through Special Enrollment Periods Have Higher Costs, Lower Risk Scores, than Open Enrollment Consumers* – ***Avalere***
  October 5, 2016

- *Marketplace Grace Periods Working as Intended* – ***Center on Budget and Policy Priorities***
  October 14, 2016

- *Estimates of Eligibility for ACA Coverage among the Uninsured in 2016* – ***Kaiser Family Foundation***
  October 19, 2016

- *Why Do Millions of U.S. Adults Remain Uninsured?* – ***The Commonwealth Fund***
  October 21, 2016

- *2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces* – ***Kaiser Family Foundation***
  October 24, 2016

- *Community Health Centers Play a Critical Role in Caring for the Remaining Uninsured in the Affordable Care Act Era* – ***UCLA Center for Health Policy Research***
  October 26, 2016

- *The Uninsured: A Primer - Key Facts about Health Insurance and the Uninsured in the Wake of National Health Reform* – ***Kaiser Family Foundation***
  November 1, 2016

- *Access to Employer-Sponsored Health Coverage for Same-Sex Spouses* – ***Kaiser Family Foundation***
  November 2, 2016

California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

What Will Consumers Pay in Premiums for Covered California Silver Plans in 2017?

Amy Adams, California Health Care Foundation

Covered California's fourth annual open enrollment begins November 1. Explore how the 2017 premiums for the second-lowest cost silver plan vary across the 19 pricing regions, and the premium subsidies for which consumers are eligible based on their income.

October 2016

Covered California's fourth annual open enrollment begins November 1 and CHCF's ACA 411 data center provides the 2017 premiums for the second-lowest cost silver plan in each of Covered California's 19 pricing regions. While Covered California consumers can choose from a variety of plans with different costs and benefit structures, the second-lowest cost silver plan is particularly important because it serves as the benchmark by which federal premium subsidies are determined. Overall, 64% of Covered California consumers chose silver plans in 2016.

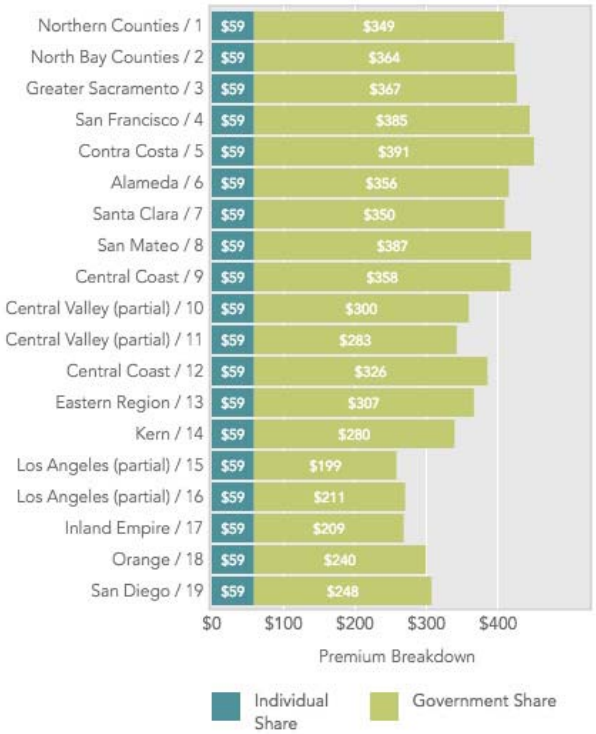
How to Use the Data

See what the 2017 total monthly premium is for the second-lowest cost silver plan in a region, how it compares to other regions, and the level of premium subsidies for which consumers are eligible based on their income. In the example below, the map on the left below shows the total monthly premium (before federal premium subsidies) by region. It ranges from a low of $258 in Los Angeles to a high of $450 in Contra Costa in 2017. (Premiums also vary based on age, although the Affordable Care Act limits the amount of variation. The premium figures used in ACA 411 are for a 40 year-old.)

(Click on the images to explore the data.)

California Covered Premiums and Subsidies, for All Regions, 2017, at 150% FPL,

for Second-Lowest Cost Silver Plan for a 40-Year-Old

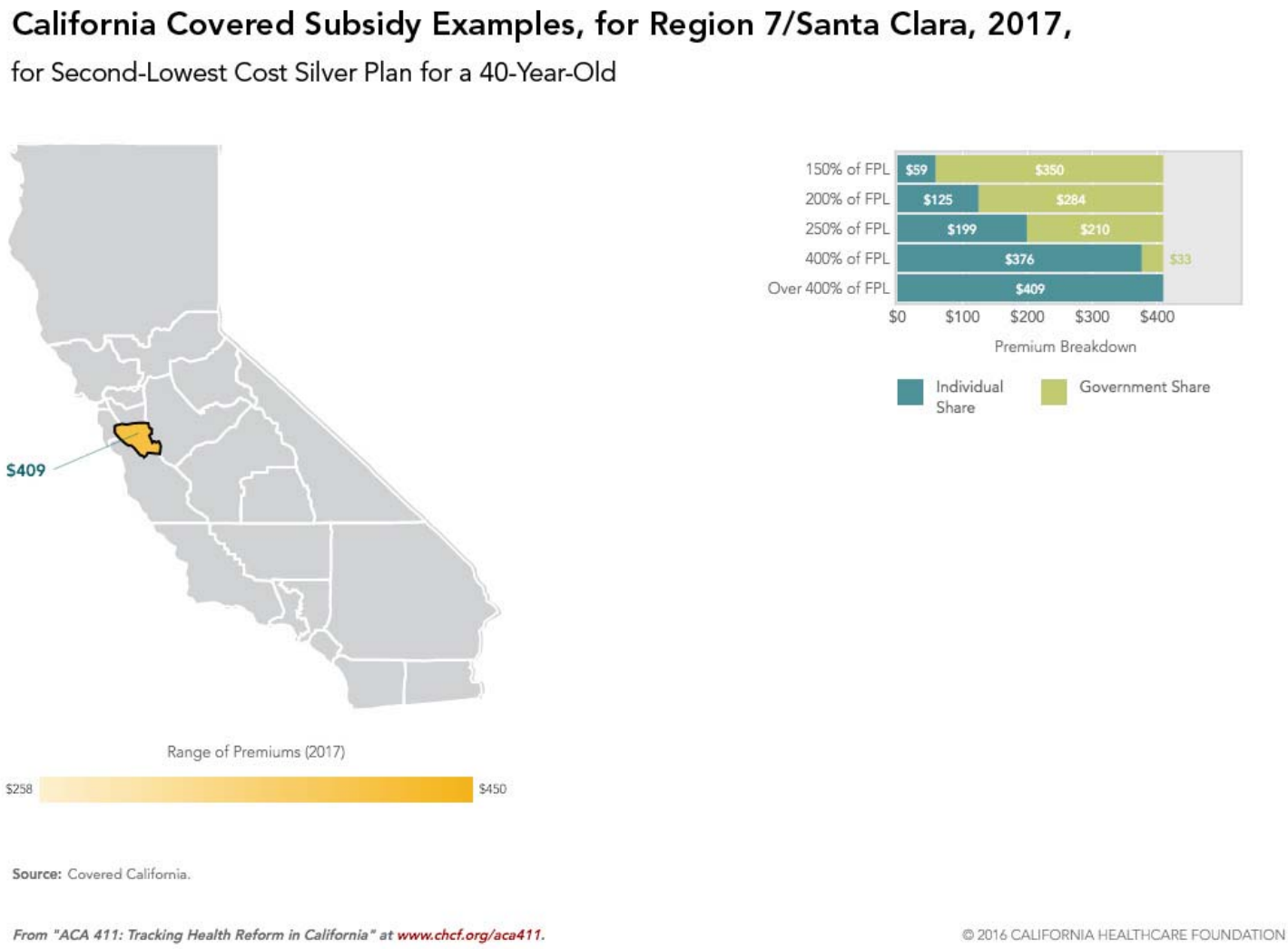


Source: Covered California.

From "ACA 411: Tracking Health Reform in California" at www.chcf.org/aca411.

However, most Covered California consumers pay less than the total monthly premium. Almost 90% earn less than 400% of the federal poverty level (FPL), making them eligible for federal premium subsidies. The amount they are required to contribute towards premiums is capped at a percentage of income ("individual share" in the chart above) with the premium subsidy ("government share") covering the rest. ACA 411 shows this by region and by income level. The example above is based on a consumer earning 150% FPL, or about $17,820, for a one-person household.

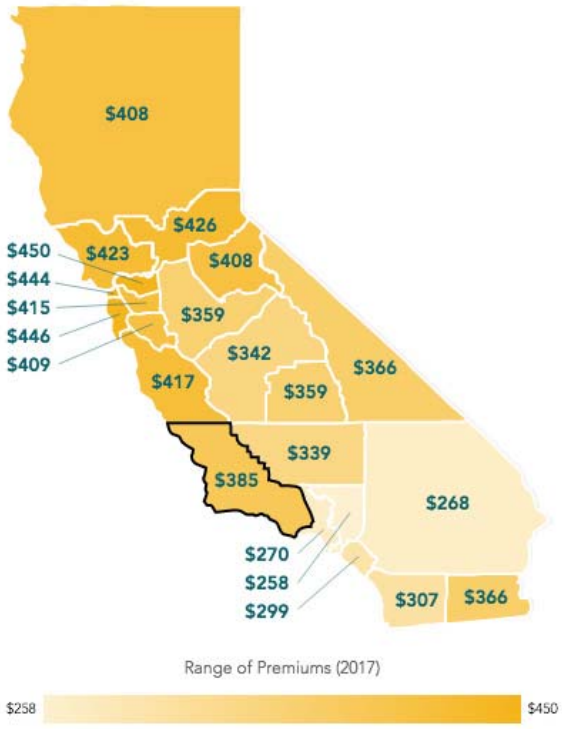
Or, dive into a specific region and explore the subsidy amounts available to consumers across various income levels. The example below is for Region 7, Santa Clara.

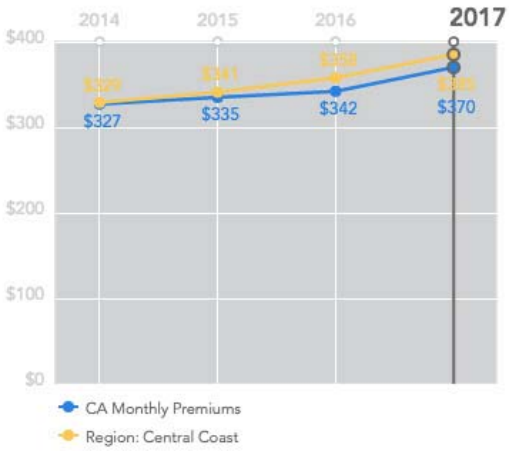


It's also possible to track how the total monthly premium for the second-lowest cost silver plan in a region has changed since 2014 and how it has compared to the Covered California average. Remember, these are the before-subsidy premium amounts, not the amount most consumers will pay. The example below is for Region 12, Central Coast.

California Covered Total Monthly Premium, 2014-2017, for Region 12/Central Coast versus Statewide Average,

for Second-Lowest Cost Silver Plan for a 40-Year-Old





Source: Covered California.

From "ACA 411: Tracking Health Reform in California" at www.chcf.org/aca411.

Putting the Data in Context

Tracking the premium costs for the second-lowest cost silver plans on Covered California offers some important insights into the costs that many consumers will face in this upcoming open enrollment and how those costs have changed over time. But it is important to remember that consumers can choose other plan options, including different metal tiers, which have very different premiums (and benefit levels).

There has already been intense scrutiny and discussion of the proposed 2017 Covered California premiums, which are set to rise, on average, 13.2%. Keep in mind the following:

- The 13.2% average premium increase masks the wide variation in premium costs and in the rate of increase by region.
- Premiums vary widely by insurer. Covered California's plan book shows how insurers compare.
- The 13.2% average increase is before premium subsidies are taken into account. As the ACA 411 examples above illustrate, federal premium subsidies can significantly lower what consumers have to actually pay toward premiums. The subsidies will play a crucial role in shielding most consumers from having to absorb the full brunt of premium increases in 2017. (Notice that the amount the individual pays is often rather flat, while the government share and the total premium rise, as in this example from Sacramento.)

ACA 411 will continue to track a variety of other Covered California metrics, including overall enrollment, deductible levels, plan selection, and the average value of premium subsidies, to show the evolving impact of the health insurance marketplace on California consumers.

NCHS Data Brief ■ No. 262 ■ October 2016

Health Care Access and Utilization Among Adults Aged 18–64, by Poverty Level: United States, 2013–2015

Michael E. Martinez, M.P.H., M.H.S.A. and Brian W. Ward, Ph.D.

Data from the National Health Interview Survey, 2013–2015

- From 2013 through 2015, the percentage of adults aged 18–64 who were uninsured at the time of interview decreased for poor (40.0% to 26.2%), near-poor (37.8% to 23.9%), and not-poor (11.7% to 7.7%) adults.
- The percentage of adults aged 18–64 who had a usual place to go for medical care increased for poor (66.9% to 73.6%) and near-poor (71.1% to 75.9%) adults.
- The percentage of adults aged 18–64 who had seen or talked to a health professional in the past 12 months increased for poor (73.2% to 75.8%) and near-poor (71.9% to 75.9%) adults.
- The percentage of adults aged 18–64 who did not obtain needed medical care due to cost at some time during the past 12 months decreased for poor (16.8% to 12.4%), near-poor (14.6% to 11.0%), and not-poor (4.9% to 3.8%) adults.

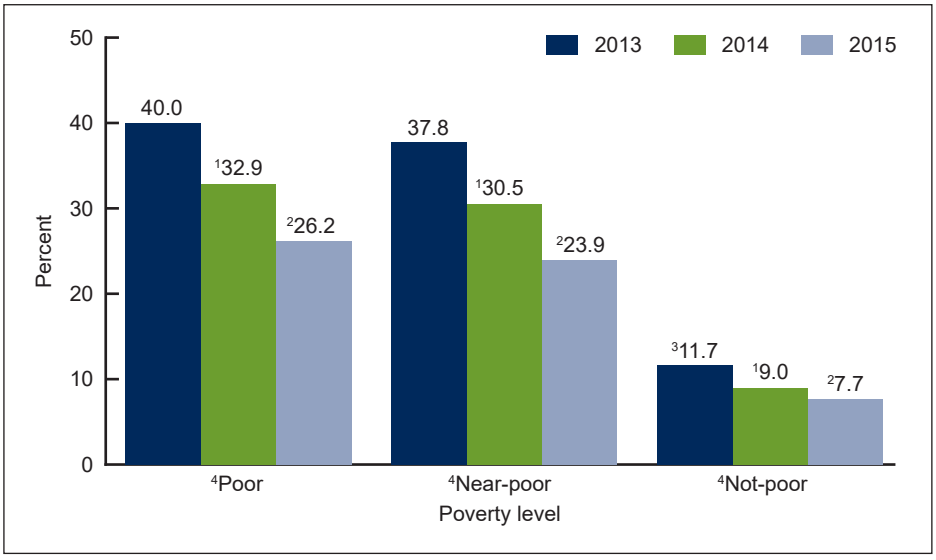
In 2014, U.S. adults could purchase a private health insurance plan through the Health Insurance Marketplace or state-based exchanges established as part of the Affordable Care Act (ACA). Additionally, under ACA some states opted to expand Medicaid coverage to low-income adults. Individuals living in or

their lower rates of health insurance coverage (1). Data from the 2013–2015 National Health Interview Survey (NHIS) are used to describe recent changes in health insurance coverage and selected measures of health care access and utilization for adults aged 18–64 by family poverty level.

Keywords: Affordable Care Act • medical care • health insurance • National Health Interview Survey

The percentage of uninsured adults decreased from 2013 through 2015 for all poverty level subgroups.

Figure 1. Adults aged 18–64 who were uninsured, by family poverty level: United States, 2013–2015



[1]Significantly different from the other two poverty status groups in 2014.
[2]Significantly different from the other two poverty status groups in 2015.
[3]Significantly different from the other two poverty status groups in 2013.
[4]Significant decreasing linear trend from 2013 through 2015.
NOTE: Access data table for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/db262_table.pdf#1.
SOURCE: NCHS, National Health Interview Survey, 2013–2015.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

- From 2013 through 2015, the percentage of adults aged 18–64 who were uninsured at the time of interview decreased for poor (from 40.0% to 26.2%), near-poor (from 37.8% to 23.9%), and not-poor (from 11.7% to 7.7%) adults (Figure 1).
- From 2013 through 2015, not-poor adults aged 18–64 were the least likely to be uninsured.

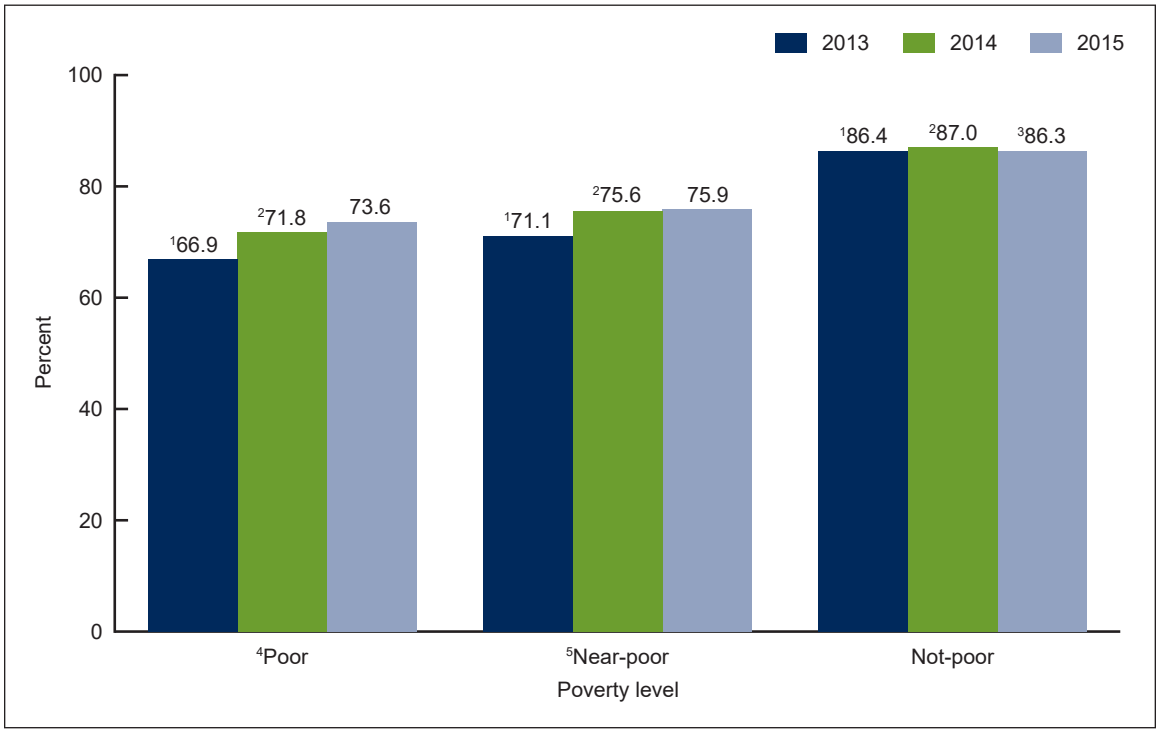
The percentage of poor and near-poor adults with a usual place to go for medical care increased from 2013 through 2015.

- From 2013 through 2015, the percentage of adults aged 18–64 who had a usual place to go for medical care increased from 66.9% to 73.6% for poor adults, and from 71.1% to 75.9% for near-poor adults (Figure 2).
- There was an increasing linear trend in the percentage of poor adults aged 18–64 who had a usual place to go for medical care from 2013 through 2015, but for near-poor adults, there

  2015.
- From 2013 through 2015, the percentage of not-poor adults aged 18–64 who had a usual

  .
- From 2013 through 2015, not-poor adults aged 18–64 were the most likely to have a usual place to go for medical care.

Figure 2. Adults aged 18–64 with a usual place to go for medical care, by family poverty level: United States, 2013–2015

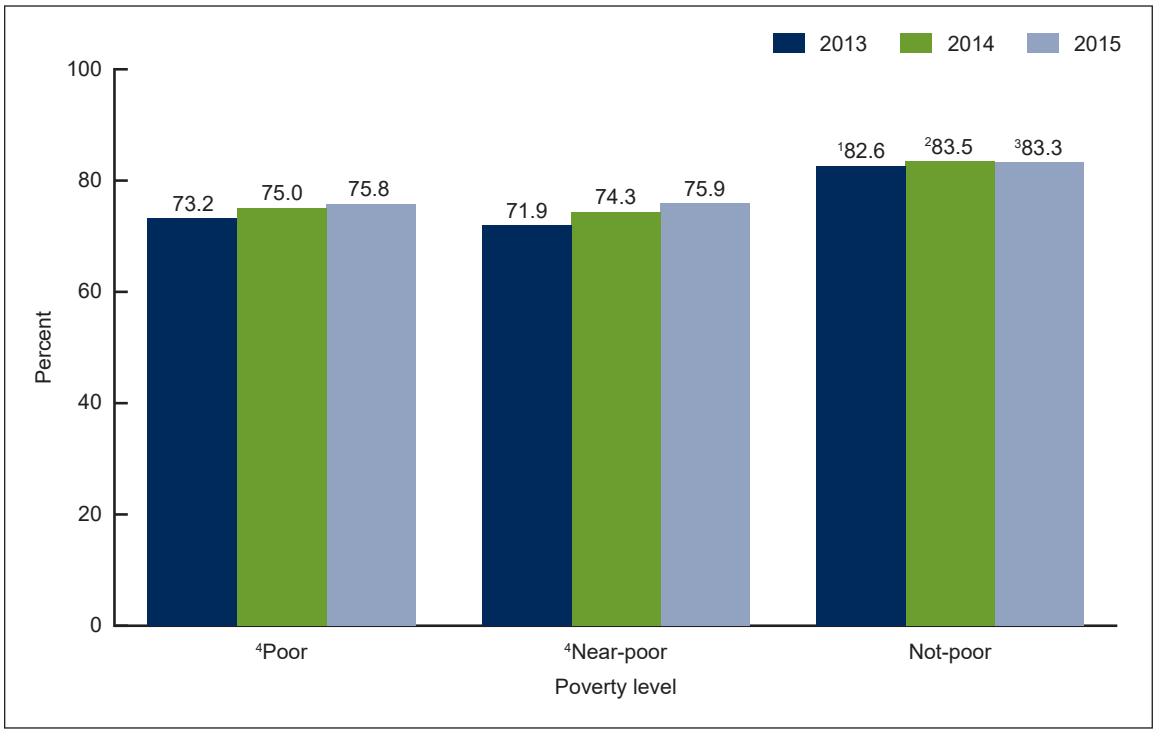


[1]Significantly different from the other two poverty status groups in 2013.
[2]Significantly different from the other two poverty status groups in 2014.
[3]Significantly different from the other two poverty status groups in 2015.
[4]Significant increasing linear trend from 2013 through 2015.
[5]Significant quadratic trend from 2013 through 2015; significant difference between 2013 and 2014.
NOTE: Access data table for Figure 2 at: http://www.cdc.gov/nchs/data/databriefs/db262_table.pdf#2.
SOURCE: NCHS, National Health Interview Survey, 2013–2015.

The percentage of poor and near-poor adults who had seen or talked to a health professional in the past 12 months increased from 2013 through 2015.

- From 2013 through 2015, the percentage of adults aged 18–64 who had seen or talked to a health professional in the past 12 months increased from 73.2% to 75.8% for poor adults, and from 71.9% to 75.9% for near-poor adults (Figure 3).
- From 2013 through 2015, the percentage of not-poor adults aged 18–64 who had seen or .
- From 2013 through 2015, not-poor adults aged 18–64 were the most likely to have seen or talked to a health professional in the past 12 months.

Figure 3. Adults aged 18–64 who had seen or talked to a health care professional in the past 12 months, by family poverty level: United States, 2013–2015

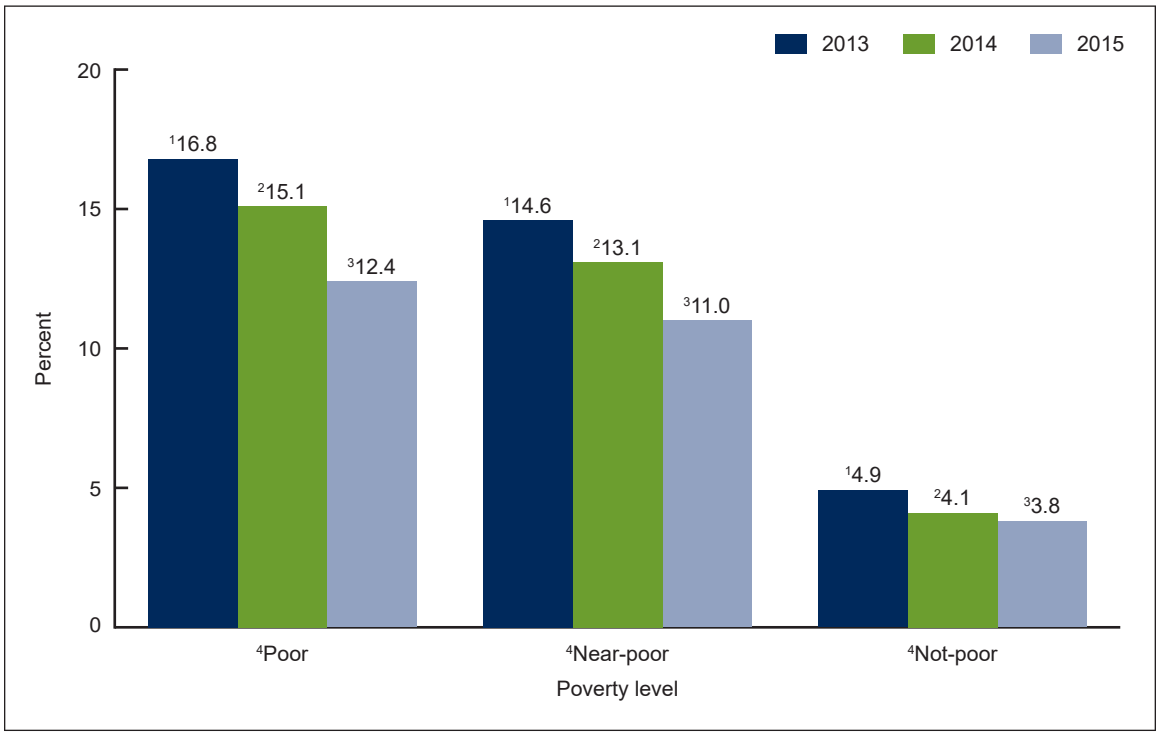


[1]Significantly different from the other two poverty status groups in 2013.
[2]Significantly different from the other two poverty status groups in 2014.
[3]Significantly different from the other two poverty status groups in 2015.
[4]Significant increasing linear trend from 2013 through 2015.
NOTE: Access data table for Figure 3 at: http://www.cdc.gov/nchs/data/databriefs/db262_table.pdf#3.
SOURCE: NCHS, National Health Interview Survey, 2013–2015.

The percentage of adults aged 18–64 who did not obtain needed medical care due to cost decreased from 2013 through 2015 for all poverty level subgroups.

- From 2013 through 2015, the percentage of adults aged 18–64 who did not obtain needed medical care due to cost at some time during the past 12 months decreased for poor (from 16.8% to 12.4%), near-poor (from 14.6% to 11.0%), and not-poor (from 4.9% to 3.8%) adults (Figure 4).
- From 2013 through 2015, poor adults aged 18–64 were the most likely to not obtain needed medical care due to cost at some time during the past 12 months.
- From 2013 through 2015, not-poor adults aged 18–64 were the least likely to not obtain needed medical care due to cost at some time during the past 12 months.

Figure 4. Adults aged 18–64 who did not obtain needed medical care due to cost at some time during the past 12 months, by family poverty level: United States, 2013–2015



[1]Significantly different from the other two poverty status groups in 2013.
[2]Significantly different from the other two poverty status groups in 2014.
[3]Significantly different from the other two poverty status groups in 2015.
[4]Significant decreasing linear trend from 2013 through 2015.
NOTE: Access data table for Figure 4 at: http://www.cdc.gov/nchs/data/databriefs/db262_table.pdf#4.
SOURCE: NCHS, National Health Interview Survey, 2013–2015.

Summary

through 2015 in the percent uninsured. Insurance can lead to improvements in health care access and utilization. Indeed, relative to 2013, poor and near-poor adults aged 18–64 in 2015 were

they were more likely to have seen or talked to a health professional. However, for not-poor

medical care and having seen or talked to a health professional within the past 12 months. All

those who did not obtain needed medical care due to cost at some time during the past 12 months.

Despite improvements in insurance coverage and health care access for poor and near-poor adults aged 18–64, they were still less likely than not-poor adults to have a usual place for medical care and to have seen or talked to a health care professional in the past 12 months.

Did not obtain needed medical care due to cost in the past 12 months: Based on the question, "During the past 12 months, was there any time when [person] needed medical care, but did not get it because [person] couldn't afford it?" Responses exclude dental care.

Federal poverty level: Determined by dividing the total family income by the U.S. Census Bureau' s size and age of the members in that family. This ratio is multiplied by 100, and family poverty level was determined based on where a family fell relative to certain thresholds. Adults were considered poor if their family poverty level fell below 100% of the threshold. Adults were considered near-poor if their family poverty level fell at or above 100% but less than 200%. And adults were considered not-poor if their family poverty level fell at or above 200%.

Seen or talked to a health professional in the past 12 months: Based on combined responses of "6 months or less" and "more than 6 months, but not more than 1 year ago" to the survey question, "About how long has it been since you last saw or talked to a doctor or other health care professional about your own health? Include doctors seen while a patient in a hospital."

Uninsured: Determined by not having any private health insurance, Medicare, Medicaid, CHIP (Children's Health Insurance Program), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A
she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. The analyses excluded persons with unknown health insurance status (about 1% of respondents each year).

Usual place to go for medical care: Based on the question, "Is there a place that you usually go to when you are sick or need advice about your health?" If there was at least one such place, then a follow-up question was asked: "What kind of place [is it/do you go to most often]—a clinic, doctor' gency room, or some other place?" Adults who indicated that the emergency room was their usual place for care were considered not to have a usual place for health care.

Data source and methods

Data from the 2013–2015 NHIS were used for this analysis. NHIS is a multipurpose health survey conducted continuously throughout the year by the National Center for Health Statistics (NCHS). Interviews are conducted in person in respondents' homes, but follow-ups to complete interviews may be conducted over the telephone. Questions about health insurance coverage and not obtaining needed medical care are from the survey's Family Core component, while questions about a usual place to go for medical care and having seen or talked to a health professional in the past 12 months are from the Sample Adult component. The Family Core component collects information on all family members, and the Sample Adult component collects additional

used to help create the poverty variables. For further information about NHIS, including the questionnaire, visit the NHIS website (available from: http://www.cdc.gov/nchs/nhis/index.htm).

All analyses used weights to produce national estimates. Data weighting procedures are described elsewhere (2). Point estimates and their estimated variances were calculated using SUDAAN software (3) and the Taylor series linearization method to account for the complex design of NHIS. T All estimates shown in this report meet the NCHS standard of reliability (relative standard error less than or equal to 30%). Logistic regression was used to assess trends.

About the authors

Michael E. Martinez and Brian W. Ward are with the National Center for Health Statistics, Division of Health Interview Statistics.

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CS270381

HEALTH INSURANCE MARKETPLACE ENROLLMENT PROJECTIONS FOR 2017

October 19, 2016

The Affordable Care Act (ACA) has led to 20 million Americans gaining health coverage, many for the first time ever.[1] In the first quarter of 2016, the uninsured rate reached a record low of 8.6 percent of Americans.[2] These gains are expected to grow as individuals continue to enroll in coverage through the Health Insurance Marketplaces ("Marketplaces") and more states participate in Medicaid expansion. This brief looks ahead to estimate how many individuals nationwide might select a Marketplace plan during the upcoming Open Enrollment period (November 1, 2016–January 31, 2017) and how many – on average throughout 2017 – might have Marketplace coverage.[3]

[1] Namrata Uberoi, Kenneth Finegold, and Emily Gee, "Health Insurance Coverage and the Affordable Care Act, 2010-2016," *ASPE Issue Brief,* Assistant Secretary for Planning and Evaluation, March 3, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf.

[2] Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2016," National Health Interview Survey Early Release Program, *Centers for Disease Control and Prevention*, September 2016, available at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf.

[3] This brief considers only individual market Qualified Health Plan (QHP) enrollment through the Marketplaces and not enrollment through the Small Business Health Options Program (SHOP).

Key Highlights

Plan Selections

- By the end of open enrollment for 2017, we expect 13.8 million people to have selected a plan, an increase of 1.1 million people or nearly 9 percent over the 12.7 million plan selections at the end of 2016 Open Enrollment.

- Of these 13.8 million people, we estimate that individuals may enroll from three primary groups:
  - 9.2 million individuals are estimated to be re-enrollees with 2016 Marketplace coverage,
  - 3.5 million are estimated to be uninsured individuals, and
  - 1.1 million are estimated to be individuals with 2016 off-Marketplace non-group coverage.

Average Monthly Effectuated Enrollment

- We estimate that 11.4 million individuals will effectuate their enrollment on an average monthly basis over the course of 2017. This does not include individuals enrolled in coverage through New York and Minnesota's Basic Health Programs, which currently enroll about 650,000 people.

Addressable Market

- More than 8 in 10 (84 percent) of the QHP-eligible uninsured have family incomes between 100/138% and 400% of the Federal Poverty Level (FPL).

- More than one-third (40 percent) of the QHP-eligible uninsured individuals are between the ages of 18 and 34.

- We estimate that between 2011 and 2016, the number of people buying insurance in the individual market has grown by approximately 65 percent from 11 million to 18 million. Of the estimated 18 million 2016 individual market consumers, we estimate two-thirds (66 percent) are potentially eligible for tax credits.

Estimates of Marketplace Enrollment

Plan Selections in the Fourth Open Enrollment

Our projection builds a national estimate from state-level information on previous enrollment periods and analysis of the broader insurance market. This method yielded an estimated 13.8 million plan selections at the end of the 2017 Open Enrollment, which represents a growth of 1.1 million people over projected plan selections at the end of 2016 Open Enrollment, or nearly 9 percent. This represents about the same growth in plan selections as last year. This figure is

based on assumptions about the effectuated enrollment at the end of 2016 (the starting point for the fourth Open Enrollment projections), rates of re-enrollment, and take-up by new enrollees.[4]

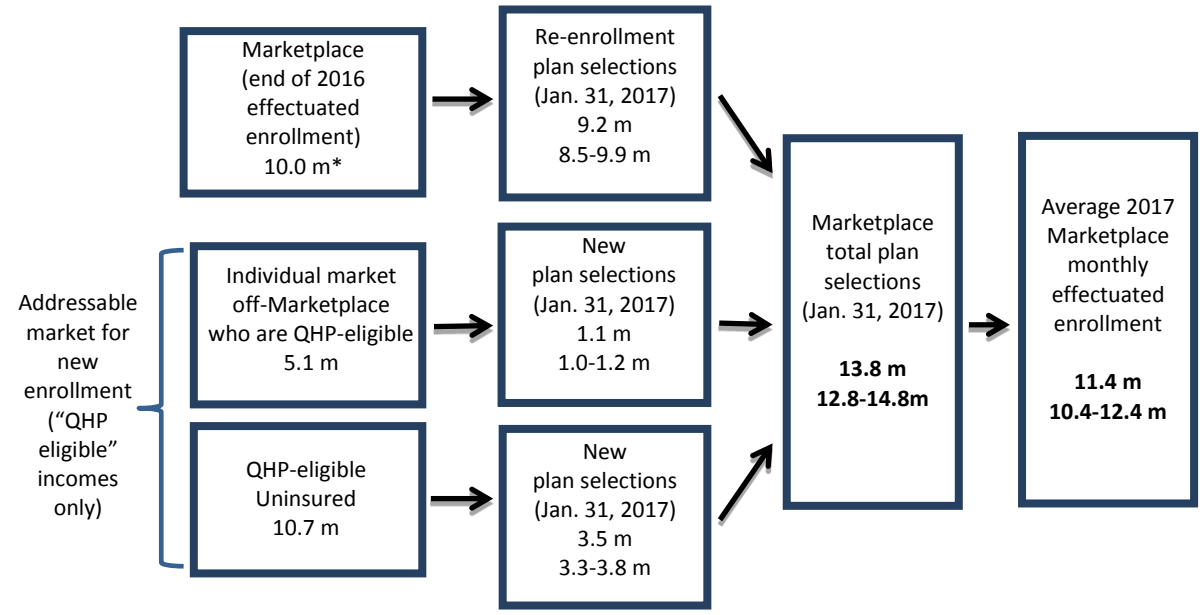
Projection of Marketplace Enrollment in 2017

In generating the estimate for 2017 enrollment, we analyzed the potential for re-enrollment and new enrollment in coverage through the Marketplaces. We modeled 2017 enrollment as coming via three primary channels (Figure 1):

- **Continued enrollment by 2016 Marketplace enrollees**: The number of Marketplace policyholders with plan year 2016 coverage and the rate at which they will re-enroll;
- **Shifts from off-Marketplace individual coverage into coverage through the Marketplaces**: The number of individuals who currently hold "off-Marketplace" individual policies and will have plan selections through the Marketplaces in the fourth Open Enrollment; and
- **Enrollment of the uninsured through the Marketplaces**: The number of QHP-eligible uninsured who will have plan selections through the Marketplaces in Open Enrollment.

Given the variety of factors that may affect enrollment, we provide ranges around our point estimates in the figure below. These ranges reflect the considerable degree of uncertainty in making such projections.

FIGURE 1



*Estimated

[4] See U.S. Department of Health and Human Services, "How Many Individuals Might Have Marketplace Coverage at the End of 2016?," *ASPE Issue Brief*, October 15, 2015, available at: https://aspe.hhs.gov/sites/default/files/pdf/118601/Target_brief_1014_FINAL.pdf.; U.S. Department of Health and Human Services, "How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period?," *ASPE Issue Brief*, November 10, 2014, available at: https://aspe.hhs.gov/sites/default/files/pdf/77161/ib_Targets.pdf.

For the first element, **continued enrollment by 2016 Marketplace enrollees**, we used data from the Centers for Medicare & Medicaid Services (CMS) on individuals currently enrolled in coverage through the Marketplaces and an analysis of re-enrollment rates from the third Open Enrollment period to project a range for the fourth Open Enrollment period. Based on currently available data, we estimate that 10.0 million individuals will be enrolled in coverage through Marketplaces at the end of 2016, consistent with our enrollment projections from October 2015.[5]

The latter two elements, **shifts from off-Marketplace individual coverage and enrollment of the uninsured into coverage through the Marketplaces**, are inflows from the "addressable market" for new enrollment. We define the "addressable market" as all nonelderly individuals who are uninsured or have coverage through the off-Marketplace individual market and have household incomes at or above the level for eligibility for Marketplace insurance affordability programs (generally greater than 100% or 138% of the Federal Poverty Level, depending on state Medicaid expansion status). To estimate the size and growth of the individual market over time, ASPE used Medical Loss Ratio data from 2011 - 2014 (see appendix A). To estimate the size of the uninsured portion of the addressable market, we used data from the American Community Survey (ACS) and the National Health Interview Survey (NHIS) with adjustments from the Gallup-Healthways Well-Being Index, a daily poll of American adults. Information from a variety of sources including the NHIS, ACS, Kaiser Family Foundation, and NAIC data was used to estimate the size of the off-Marketplace individual market (see appendix B).

We estimate that there are currently about 15.8 million people in the addressable market for new enrollment, consisting of 5.1 million people with off-Marketplace non-group coverage and 10.7 million who are uninsured. Based on the 2014 ACS and 2015 NHIS, we calculated the number of QHP-eligible uninsured individuals prior to the third Open Enrollment, adjusting that estimate to reflect the reduction in uninsured rates for nonelderly adults between 2015 and the second quarter of 2016 (April-June) according to the Gallup-Healthways Well-Being Index. This suggests that there are currently 10.7 million QHP-eligible uninsured. This estimate is based on updated data that indicates an estimated 11.5 million people were uninsured and QHP-eligible in 2015.[6]

Demographic Characteristics of the Addressable Market

Among QHP-eligible uninsured individuals (see appendix C for additional demographics):

- **Income:** More than 8 in 10 (84 percent) of the QHP-eligible uninsured have family incomes between 100/138% and 400% of the Federal Poverty Level (FPL) and may qualify for the advance payments of the premium tax credit (APTC). More than half (57

[5] U.S. Department of Health and Human Services, "10 million people expected to have Marketplace coverage at end of 2016," *Press Release,* October15, 2015, available at: http://www.hhs.gov/about/news/2015/10/15/10-million-people-expected-have-marketplace-coverage-end-2016.html.

[6] As new survey information has become available, we are able to make more accurate estimates about the remaining uninsured. Our revised estimate, which uses updated data that had not been available last year at this time and more sophisticated methodology, is that 11.5 million people were uninsured and QHP-eligible in 2015. Based on this information and more up-to-date polling from the Gallup-Healthways Well-Being Index we estimate that there are 10.7 million QHP eligible uninsured as of 2016.

percent) of the QHP-eligible uninsured individuals have family incomes between 100/138% and 250% FPL and may qualify for cost-sharing reductions (CSR) in addition to APTC. The remaining 16 percent have family incomes above 400% FPL.

- **Gender:** An estimated 56 percent of the QHP-eligible uninsured are men.

- **Age:** About 40 percent of the QHP-eligible uninsured individuals are between the ages of 18 and 34, 40 percent are between the ages of 35 and 54, 14 percent are between the ages of 55 and 64, and the remaining 7 percent are under the age of 18.

- **Race:** Over 40 percent of the QHP-eligible uninsured are people of color: 25 percent are Hispanic, 12 percent are African American, and 3 percent are Asian American.

- **Gender and Race:** Nearly one-third (31 percent) of the QHP-eligible uninsured are White males, 15 percent are Hispanic males, and 26 percent are White females.

Among the 5.1 million QHP-eligible individuals with off-Marketplace non-group coverage, ASPE previously estimated that about half (2.5 million) have family income between 100/138% and 400% of the FPL and may qualify for APTC. About 22 percent (1.1 million) have family incomes between 100/138% and 250% of the FPL and may qualify for cost-sharing reductions.[7]

2017 Plan Selections

The projection for new enrollment depends on the likelihood that potential consumers from the addressable market will enroll in Marketplace coverage, or the "take-up rate." To predict take-up in the addressable market, we stratified the QHP-eligible uninsured and individuals with off-Marketplace non-group coverage into three groups by household income:

- Individuals that may be eligible for a higher share of their premium covered by APTC with CSR (100/138-250% FPL),
- Individuals that may be eligible for a lower share of their premium covered by APTC without CSR (250-400% FPL), and
- Individuals with incomes too high to be eligible for financial assistance (greater than 400% FPL).

State-level Open Enrollment take-up rates are based on observed rates for each of these income groups in the third Open Enrollment, adjusted to account for increasing awareness of the Marketplaces and the individual shared responsibility penalty, improvements in outreach, and changes in premiums and plan offerings. We vary these rates to account for uncertainty, which generates an estimate for plan selections through the Marketplaces in 2017. Our analyses suggest that approximately 1.0 to 1.2 million individuals with non-group coverage outside the Marketplaces and 3.3 to 3.8 million eligible uninsured individuals will select plans through the Marketplaces.

[7] U.S. Department of Health and Human Services, "About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies," *ASPE Data Point*, October 4, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/208306/OffMarketplaceSubsidyeligible.pdf.

We combined these population estimates and take-up rates for re-enrollment and new enrollment to estimate total Marketplace plan selections at the end of Open Enrollment. By the end of the Open Enrollment period, we expect approximately 13.8 million individuals will have selected plans for 2017 coverage through the Marketplaces, with a range of potential outcomes from 12.8 million to 14.8 million. Our analyses suggest that re-enrollees will account for a majority of total Marketplace plan selections (about two thirds).

2017 Effectuated Enrollment

Rather than providing a single point-in-time estimate as we have done in previous years, this year's projection reports an average monthly projection. This shift is consistent with the shift CMS is making to its effectuated enrollment reports.[8] Average effectuated enrollment provides a more meaningful metric of Marketplace participation, since it captures all enrollments over the time period, rather than only enrollment at a particular point in time. The new reporting will also facilitate comparisons to projections made by the Congressional Budget Office (CBO), which reflect average enrollment throughout the year.

Based on the experience of the Marketplaces' first three years, we expect that plan selections at the end of Open Enrollment will exceed Marketplace effectuated enrollment as the year progresses. The number of individuals joining through Special Enrollment Periods (SEP) throughout the year does not fully offset those who leave for other forms of coverage or other reasons. The Marketplace was designed to provide insurance coverage for people who may be moving from one form of coverage to another over the course of a year, as well as those who purchase insurance for the entire year. During the first half of 2015, 50 percent of those who enrolled during an SEP did so because of a loss of other health insurance coverage, 19 percent were determined ineligible for Medicaid or CHIP, 15 percent enrolled in a tax season SEP, and 16 percent enrolled for other reasons.[9] California reports that 85 percent of those who leave the Marketplace remain insured by transitioning to another source of coverage.[10]

Compared to estimates of plan selections, estimates of effectuated enrollment are subject to additional uncertainty, since they depend on plan selections but also on assumptions about attrition rates for Open Enrollment consumers and enrollment rates for Special Enrollment Periods (SEPs). Recent policy changes impacting retention for consumers affected by data-matching issues and enrollment rates for SEPs introduce additional uncertainty.[11] Given that uncertainty, we estimate a range of 10.4 to 12.4 million average monthly effectuated

[8] U.S. Department of Health and Human Services, "March 31, 2016 Effectuated Enrollment Snapshot," *Centers for Medicare & Medicaid Services*, June 30, 2016, available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html.

[9] U.S. Department of Health and Human Services, "2015 Special Enrollment Period Report – February 23 – June 30, 2015," *Centers for Medicare & Medicaid Services*, August 13, 2015, available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-13.html.

[10] Covered California, "Covered California Finishes Open Enrollment Strong with More Than 425,000 New Consumers and An Increase In Young Enrollees," February 4, 2016, available at: http://news.coveredca.com/2016/02/covered-california-finishes-open.html.

[11] U.S. Department of Health and Human Services, "Frequently Asked Questions Regarding Verification of Special Enrollment Periods," *Centers for Medicare & Medicaid Services*, September 6, 2016, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf.

Marketplace enrollments over the course of 2017, with a point estimate of 11.4 million. This figure is based on projected plan selections and assumptions regarding attrition of those who initially select a plan but do not maintain coverage for the entire year.

These figures do not include the approximately 650,000 individuals who enroll in coverage through New York and Minnesota's Basic Health Programs (BHP), which allow continuous enrollment throughout the year rather than having set Open Enrollment Periods.[12]

Last year, we estimated that 10.0 million people would be enrolled through the Marketplaces at the end of 2016. Had we instead issued a point projection for average monthly effectuated enrollment at that time, the estimate would have been 10.5 million.

Uncertainty

There is a high degree of uncertainty about any projection, especially in the early years of a program. The Marketplaces have been in place for only three years, and so there is still only limited data upon which to base our projections. There are numerous factors that affect consumers' insurance enrollment, including attitudes of consumers and employers, the effect of payments of the individual responsibility fee, the size of premiums and premium tax credits, the ease of the enrollment process, communication and outreach efforts, Marketplace policy changes, issuer entry and exit, and whether and how insurance products change over time. As Marketplace coverage becomes more widespread and the size of the uninsured population eligible for enrollment shrinks, the remaining uninsured may be harder to reach, slowing enrollment growth. On the other hand, as awareness increases about the availability of financial assistance and the individual responsibility fee, and as transitional and grandfathered plans phase out, take-up rates may increase. Beyond these factors, there are macroeconomic forces such as changes in population and economic conditions which are difficult to predict but likely to affect enrollment. Thus, actual enrollment could vary significantly from projected levels.

[12] Under the Affordable Care Act, states have the option of using the Basic Health Program to provide affordable health coverage for low-income residents who would generally otherwise be eligible to purchase coverage through the Health Insurance Marketplace. The most recently available BHP enrollment data indicates that 565,000 individuals are enrolled in New York and nearly 100,000 are enrolled in Minnesota. For more information about the Basic Health Program, see https://www.medicaid.gov/basic-health-program/basic-health-program.html.

Why are ASPE's projections different from those by the Congressional Budget Office?

In its most recent estimates, published in March 2016, the Congressional Budget Office (CBO) estimated that 15 million people on average would be enrolled in the Marketplace during 2017. A key explanation for the discrepancy between ASPE and CBO is that CBO's projections assume that, by 2017, 4 million fewer people would have employer-based plans as a result of the ACA.[13] The evidence to date suggests that no such shifting has occurred.[14]

Earlier CBO forecasts projected much higher Marketplace enrollment for 2017. For example, in May 2013, in its last projections before implementation of the ACA Marketplaces, CBO forecast Marketplace enrollment of 22 million in 2016, and 24 million in 2017. As with the more recent projections, the main difference between the CBO and the ASPE forecasts is the projections for where people will get their coverage, rather than how many people will have coverage. In its earlier projections, CBO assumed that 6 million people would have shifted from employer plans to the Marketplace by 2016 and that 4 million people would have shifted from off-Marketplace coverage to the Marketplace, a shift that also does not seem to have occurred to date. CBO also assumed that the Marketplace would reach steady state participation levels around 2017. In contrast, based on experiences from other federal programs, ASPE assumes that it may take more time for participation in the Marketplace to reach steady-state levels.[17]

The Bottom Line

Our approach results in estimates of 13.8 million plan selections at the end of the fourth Open Enrollment and estimated average monthly effectuated enrollment over the course of calendar year 2017 of 11.4 million. These estimates incorporate the considerable degree of uncertainty that comes in making such projections and actual enrollment may differ from these projections.

Marketplace enrollment is one essential component of achieving the ACA's goal of reducing the number of uninsured individuals in the United States. The uninsured rate reached a historic low

[13] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026," March 2016, available at: https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline_OneCol.pdf.

[14] U.S. Census Bureau, "Health Insurance Coverage Status and Type of Coverage by State-- Persons Under 65: 2008 to 2015," September 13, 2016, available at: http://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/acs/hic06_acs.xls.

[15] Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026," March 2016, available at: https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline_OneCol.pdf.

[16] Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2016," National Health Interview Survey Early Release Program, *Centers for Disease Control and Prevention*, September 2016, available at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf.

[17] U.S. Department of Health and Human Services, "How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period?," *ASPE Issue Brief*, November 10, 2014, available at: https://aspe.hhs.gov/sites/default/files/pdf/77161/ib_Targets.pdf.

of 8.6 percent in the first quarter of 2016.[18] As detailed in a recent ASPE analysis, uninsured rates have dropped for Americans at every income level, of every age, race, and ethnicity, and all across the country.[19] The breadth of these coverage gains shows how the different coverage provisions of the ACA, targeting different groups, have worked in concert to reduce the uninsured rate. With continued support for Marketplace retention, new Marketplace enrollment, Medicaid expansion, and a strong system of employer-sponsored insurance, we will continue to make progress in providing every American with access to high-quality, affordable insurance.

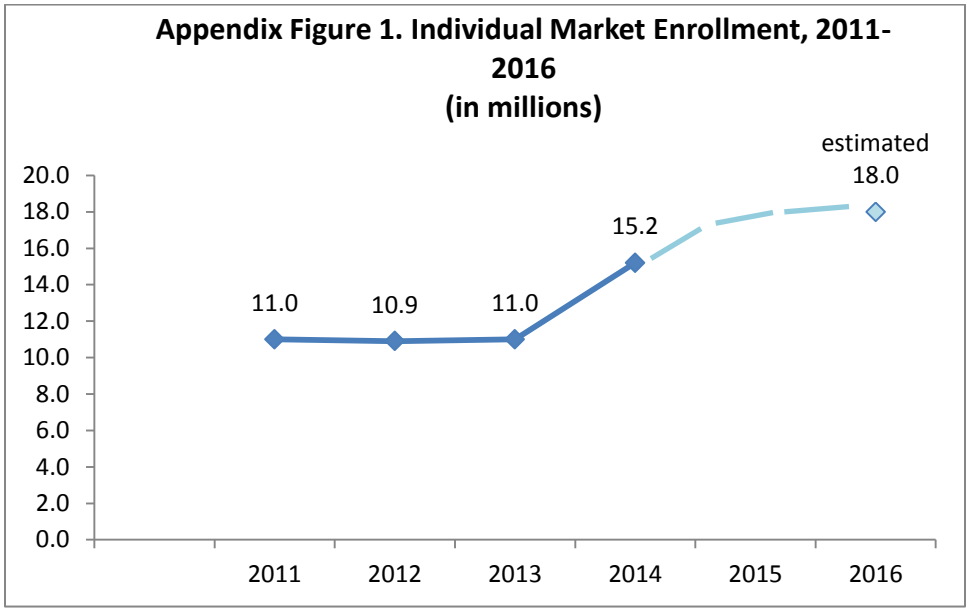
[18] Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2016," National Health Interview Survey Early Release Program, *Centers for Disease Control and Prevention*, September 2016, available at: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf.

[19] Kelsey Avery, Kenneth Finegold, and Amelia Whitman, "Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage," *ASPE Issue Brief,* September 29, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/207946/ACAHistoricIncreaseCoverage.pdf.

APPENDIX A: Estimates of Individual Market Growth, 2011-2016

ASPE analysis suggests that, through 2016, the number of people buying insurance in the individual market has grown by approximately 65 percent since 2011, from 11 million to 18 million. A substantial portion of the individual market's enrollment growth coincided with the implementation of Marketplaces, when the individual market increased by over 4 million life-years (or approximately 38 percent) from 11.0 million in 2013 to 15.2 million in 2014. MLR data for 2015 is not yet available. The 18 million individual market enrollees includes an estimated 6.9 million individuals who currently purchase health insurance in the off-Marketplace individual market (including those who may not be eligible for Marketplace coverage) combined with the 11.1 million Marketplace enrollees with effectuated coverage as of March 2016.[20]

Using Medical Loss Ratio (MLR) data, ASPE estimated the size of the individual market over time.[21] Since 2011 (the first year MLR data was collected) the individual health insurance market has grown from approximately 11 million life-years in 2011 to 15.2 million life-years in 2014 (see appendix figure 1).



SOURCE: ASPE Estimates from MLR data 2011-2014, ASPE estimates for 2016.

Calculations of the size of the individual market from 2011 – 2014 were made using data from the Medical Loss Ratio (MLR) Data 2011-2014 (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html). The MLR data are collected as part of required disclosure by health insurers on what percentage of their premiums

[20] U.S. Department of Health and Human Services, "About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies," *ASPE Data Point,* October 4, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/208306/OffMarketplaceSubsidyeligible.pdf.

[21] In 2011, as part of the ACA, issuers began reporting Medical Loss Ratio (MLR) data to CMS. This information includes enrollment data that can be used to calculate the share of life-years for enrollees in the individual market.

are spent on health care expense versus administrative costs. As part of the submissions, insurers must report their number of life-years. This allows for the calculation of total life-years by market (individual, small group, large group) and by state. The individual market size was calculated by summing the number of lives, using the NUMBER_OF_COVERED_LIVES variable from Part1 of the MLR data and the CMM_INDIVIDUAL_Q1 (Individual Market - As of 03/31) reporting period. The totals were calculated across all 50 states and the District of Columbia for each year 2011-2014.

APPENDIX B: Technical Notes on Survey Data

Our estimates of the number of individuals who are uninsured or enrolled in off-Marketplace coverage, and their income levels, are based on analysis of National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files for January-December 2015. The NHIS interview on health insurance coverage includes the collection of health insurance plan names. Plan names are used to validate health insurance coverage types. NHIS also obtains the information on age, income, and state of residence that is needed to assess eligibility for Marketplace coverage and subsidies. We classified an individual as having off-Marketplace coverage if that person had private coverage and did not have either Marketplace or employer-sponsored coverage. We multiplied the total number of individuals with off-Marketplace coverage by 55 percent to account for change from 2015 to 2016 and to improve consistency with other sources of data on the individual market.[22]

The 2015 NHIS Preliminary Quarterly Microdata capture family income rather than income for the Health Insurance Unit (HIU), which comes closer to the tax concepts used to determine eligibility for Medicaid, CHIP, and the Marketplaces. Family income and HIU income will be the same for many families, but for others the two concepts will produce different results. The income of a young adult living at home, for example, would be counted in family income along with that of parents who might earn more, but the child's and parents' income would be broken out separately in HIU income. To obtain HIU income, we used Iterative Proportional Fitting (IPF) to reweight 2014 data from the American Community Survey Public Use Microdata Sample (ACS PUMS) on individuals reporting non-group coverage (on- or off-Marketplace) to targets by state, income group, age group, gender, race, and ethnicity from our analysis of the 2015 NHIS Preliminary Quarterly Microdata.[23]

The NHIS quarterly data do not provide information on citizenship or immigration status. Such information is needed to determine Marketplace eligibility because immigrants who are not lawfully present are not eligible for Marketplace coverage. The 2014 ACS PUMS data include information on place of birth and citizenship but do not distinguish persons who are not lawfully present from legally resident noncitizens. To exclude estimated persons who are not lawfully present from our estimates of the uninsured, we adjusted the IPF weights for noncitizens based on the estimated probability that that individual is not lawfully present. Our estimates of immigrants who are not lawfully present are based on ASPE analysis of data from the 2014 ACS, using an adjustment methodology based on imputations of immigrant legal status in

[22] Estimates of the total number of people with off-Marketplace coverage range from about 5 to 9 million. We chose an adjustment factor of 55% to account for the combined effects of reporting error in the NHIS and changes in coverage between 2015 and 2016 while producing a total within this range. See U.S. Department of Health and Human Services, "About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies," *ASPE Data Point*, October 4, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/208306/OffMarketplaceSubsidyeligible.pdf.

[23] For background on IPF, see W.E. Deming, and F.F. Stephan, "On a Least Squares Adjustment of a Sampled Frequency Table When the Expected Marginal Totals are Known," *Annals of Mathematical Statistics* 11 (4): 427–444 (1940); Y.M. Bishop, R.J. Light, F. Mosteller, S.E. Fienberg, and P.W. Holland, *Discrete Multivariate Analysis: Theory and Practice* (New York: Spring, 2007); and S. Kolenikov, "Calibrating survey data using iterative proportional fitting (raking)," *The Stata Journal*, 14(1): 22–59 (2014).

ASPE's TRIM3 microsimulation model. The TRIM3 imputation methods, originally developed by Jeffrey Passel and Rebecca Clark in the 1990s, assign noncitizens in data from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) to one of four possible legal statuses: legal permanent resident ("LPR," or "green card" holder); refugee or asylee; nonimmigrant (temporary legal resident, generally in the U.S. with a student visa or work visa); or immigrants who are not lawfully present.

Estimates of the "QHP-Eligible Uninsured" exclude adults with incomes at or below 200% FPL in Minnesota and New York, who are eligible for Basic Health Program coverage; adults with incomes at or below 215% FPL in the District of Columbia, who are potentially eligible for Medicaid; adults with incomes at or below 138% FPL in all other Medicaid expansion states; adults with incomes below 100% FPL in states that have not expanded Medicaid (the "Medicaid gap"); children with incomes at or below 250% FPL in all states, who may be eligible for Medicaid or CHIP. These estimates also exclude individuals estimated to be immigrants not lawfully present.

APPENDIX C: QHP Eligible Uninsured: Demographic Characteristics

ASPE prepared these tables based on our analysis of data from the National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files, American Community Survey Public Use Microdata Sample (ACS PUMS), and Current Population Survey Annual Social and Economic Supplement (CPS ASEC).

Appendix Table 1: Percent of QHP-Eligible Uninsured by Age and Income

	100/138-250% FPL	250-400% FPL	>400% FPL	Total
Ages 0-17	0.0%	4.5%	2.6%	7.1%
Ages 18-25	10.8%	3.2%	1.3%	15.2%
Ages 26-34	15.9%	5.9%	2.7%	24.5%
Ages 35-54	22.8%	10.1%	6.7%	39.6%
Ages 55-64	7.6%	3.3%	2.7%	13.6%
Total	57.1%	27.0%	15.9%	100.0%

Sources: ASPE analysis of data from the National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files, American Community Survey Public Use Microdata Sample (ACS PUMS), and Current Population Survey Annual Social and Economic Supplement (CPS ASEC).

Appendix Table 2: Number of QHP-Eligible Uninsured by Age and Income

	100/138-250% FPL	250-400% FPL	>400% FPL	Total
Ages 0-17	0	481,204	275,160	756,364
Ages 18-25	1,151,425	341,564	136,937	1,629,926
Ages 26-34	1,702,895	631,304	283,595	2,617,793
Ages 35-54	2,434,195	1,077,877	717,040	4,229,112
Ages 55-64	813,620	354,012	288,016	1,455,648
Total	6,102,135	2,885,961	1,700,748	10,688,843

Sources: ASPE analysis of data from the National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files, American Community Survey Public Use Microdata Sample (ACS PUMS), and Current Population Survey Annual Social and Economic Supplement (CPS ASEC).

Appendix Table 3: Percent of QHP-Eligible Uninsured by Race/Ethnicity and Gender

	Male	Female	Total
Non-Hispanic White	31.2%	25.6%	56.8%
Non-Hispanic Black	6.3%	5.8%	12.0%
Non-Hispanic Asian	1.7%	1.5%	3.2%
Hispanic	14.8%	10.4%	25.1%
Non-Hispanic Other Races & Multiple Races	1.5%	1.3%	2.8%
Total	55.5%	44.5%	100.0%

Sources: ASPE analysis of data from the National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files, American Community Survey Public Use Microdata Sample (ACS PUMS), and Current Population Survey Annual Social and Economic Supplement (CPS ASEC).

Appendix Table 4: Number of QHP-Eligible Uninsured by Race/Ethnicity and Gender

	Male	Female	Total
Non-Hispanic White	3,337,238	2,735,535	6,072,773
Non-Hispanic Black	669,229	616,647	1,285,877
Non-Hispanic Asian	182,248	165,051	347,299
Hispanic	1,579,004	1,107,080	2,686,083
Non-Hispanic Other Races & Multiple Races	161,767	135,044	296,811
Total	5,929,486	4,759,358	10,688,843

Sources: ASPE analysis of data from the National Health Interview Survey (NHIS) Preliminary Quarterly Microdata Files, American Community Survey Public Use Microdata Sample (ACS PUMS), and Current Population Survey Annual Social and Economic Supplement (CPS ASEC).

APPENDIX D: Spells Without Health Insurance Coverage

Over the last several years, as health insurance coverage has increased, we are seeing those without health insurance having shorter spells without coverage. For example, the proportion of QHP-eligible uninsured going without insurance coverage for one year or less has increased by 13 percent: up from 25.6 percent in 2010 to 29.0 percent in 2015. As the ranks of the uninsured start to shift toward those with shorter spells without health insurance and the long-term uninsured move into coverage, over time we may see shorter spells of being uninsured between other forms of coverage.[24] A portion of these individuals who experience a break in health insurance coverage participate in the Marketplace through SEPs. During the first half of 2015, 50 percent of those who enrolled during an SEP did so because of a loss of other health insurance coverage, 19 percent were determined ineligible for Medicaid or CHIP, 15 percent enrolled in a tax season SEP, and 16 percent enrolled for other reasons.[25] As these individuals join the Marketplace, they increase the number of effectuated enrollments, partially offsetting any decrease in enrollments due to individuals leaving the Marketplace for other coverage or another reason. California reports that 85 percent of those who leave the Marketplace remain insured by transitioning to another source of coverage.[26]

Estimates of the percentage of nonelderly QHP-eligible uninsured by the length of time since they were last covered from 2010 to 2015 below are based on ASPE analysis of the full annual NHIS public use files for those years, including imputed income files, matched to restricted identifiers including state of residence. For purposes of assessing QHP eligibility, states were assigned Medicaid expansion status based on their decisions as of December 31, 2015. These estimates are not adjusted for immigration status.

Appendix Table 5: Percentage of Nonelderly QHP-Eligible Uninsured by Time Since Last Covered, 2010-2015

	2010	2011	2012	2013	2014	2015
1 year or less	25.6%	24.1%	23.4%	22.8%	24.2%	29.0%
More than 1 year	74.4%	75.9%	76.6%	77.2%	75.8%	71.0%

Source: ASPE Analysis of National Health Interview Survey (NHIS) public use and restricted microdata.
Notes:

ASPE appreciates the assistance of the Centers for Disease Control and Prevention National Center for Health Statistics Research Data Center in facilitating our access to and analysis of the restricted 2015 NHIS Preliminary Quarterly Microdata Files and restricted variables in the final 2010-2015 files. The findings and conclusions in this brief are those of the authors and do not

[24] Andy Allison, Matt Carey, Erica Coe, and Nina Jacobi, "Transitions in coverage type are the norm for most consumers over time," *McKinsey & Company*, July 2016, available at: http://healthcare.mckinsey.com/transitions-coverage-type-are-norm-most-consumers-over-time.
[25] Centers for Medicare & Medicaid Services, "2015 Special Enrollment Period Report – February 23 – June 30, 2015," August 13, 2015, available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-13.html.
[26] Covered California, "Covered California Finishes Open Enrollment Strong with More Than 425,000 New Consumers and An Increase In Young Enrollees," February 4, 2016, available at: http://news.coveredca.com/2016/02/covered-california-finishes-open.html.

necessarily represent the views of the Research Data Center, the National Center for Health Statistics, or the Centers for Disease Control and Prevention.

ASPE
RESEARCH BRIEF

HEALTH PLAN CHOICE AND PREMIUMS IN THE 2017 HEALTH INSURANCE MARKETPLACE

October 24, 2016

The Affordable Care Act (ACA) strengthened protections for consumers who purchase coverage in the individual health insurance market. Before the Affordable Care Act, individuals could be denied health insurance coverage based on pre-existing conditions, it was difficult for consumers to make apples-to-apples comparisons among plans and premiums, and people without employer-sponsored health insurance or who were ineligible for public programs (such as Medicare, Medicaid, and the Children's Health Insurance Program) generally received no financial help paying for coverage. Today, the Health Insurance Marketplace gives eligible consumers options when purchasing a health plan, provides consumers with tools to compare options, and offers financial assistance in the form of advance premium tax credits that reduce the cost of health insurance to the majority of enrollees.

When the 2017 Open Enrollment Period begins on November 1, 2016, millions of Americans will once again be able to shop for high-quality, affordable health care coverage through the Marketplace.[1] The Marketplace is welcoming new consumers and encouraging those who have previously enrolled to come back, update their information, and select the plan that best meets their needs and budget. All plans in the Marketplace cover essential health benefits and recommended preventive care. Consumers can see detailed information about each health insurance plan offered in their area, in addition to estimated yearly out-of-pocket expenses, before they apply. HealthCare.gov has tools to help consumers evaluate plans based on factors important to them, such as premiums, deductibles, out-of-pocket costs, provider network, prescription drug formulary, customer service, and more.[2] Consumers may be eligible for

[1]The Health Insurance Marketplace includes the Marketplaces established in each of the states (and the District of Columbia) and run by the state or the federal government. This report focuses primarily on individual market Marketplaces using the HealthCare.gov eligibility and enrollment system, and select State-Based Marketplaces. This analysis excludes stand-alone dental and SHOP plans.

[2] This brief does not analyze consumers' final expenses, after considering other health plan features, such as deductibles and copayments. Consumers may examine all elements of health insurance plans in order to estimate expected total out-of-pocket costs.

financial assistance to help pay for the cost of premiums. In fact, 84 percent of consumers receive financial assistance (see Table 5 in Appendix A for state data).[3]

This brief presents analysis of Qualified Health Plan (QHP) data in the individual market Marketplace for states that use the HealthCare.gov Marketplace platform and State-Based Marketplaces where data is available.[4] It examines plan affordability in 2017 after taking into account premium tax credits and also examines the plan choices that new and returning consumers will have for 2017. This brief shows that the Affordable Care Act is continuing to promote affordability and choice in the Marketplace for plan year 2017.[5]

[3] This represents the percentage of individuals who have effectuated Marketplace coverage and qualified for an advance premium tax credit (APTC), with or without a cost-sharing reduction. See: U.S. Department of Health and Human Services, "First Half of 2016 Effectuated Enrollment Snapshot," CMS, October 19, 2016, available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html.

[4] These 39 states are: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. However, some tables are limited to the 38 states that were included in the 2016 Marketplace landscape files (excluding Kentucky). Kentucky is new to the HealthCare.gov platform for 2017. Meanwhile, tables include data for states not using the HealthCare.gov platform where available. More information is in the methodology and limitations section of the Appendix.

[5] The 2017 plan landscape file used in this brief is a snapshot of issuer participation and plans as of October 14, 2016 and does not reflect changes in issuer and plan offerings after that date. Similar to last year's analysis (available at https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace), we compare data from the 2017 landscape file to data from the most recent available version of the 2016 landscape file (dated July 29, 2016 and available at https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/). The 2016 file incorporates some changes in plan offerings that have taken place since the 2016 Open Enrollment Period.

Key Findings

The Affordable Care Act continues to promote access to affordable health insurance plans through the Marketplace, where consumers can choose the health insurance product that best meets their needs and budget.

Affordability

- **Marketplace consumers will have affordable options.** More than 7 in 10 (72 percent) current Marketplace enrollees can find a plan for $75 or less in premiums per month, after applicable tax credits in 2017. Nearly 8 in 10 (77 percent) current Marketplace enrollees can find a plan for $100 or less in premiums per month, after applicable tax credits in 2017.

- **Premium tax credits protect consumers from rate increases.** Marketplace tax credits adjust to match changes in each consumer's benchmark silver plan premium. A 27-year-old with an income of $25,000 a year will on average get a monthly tax credit of $160, a 62 percent increase compared to their tax credit in 2016. As a result, this consumer will pay $142 per month to purchase the benchmark plan in 2017, almost exactly the same as in 2016, when the consumer would have paid $143.

- **Additional consumers are eligible for tax credits.** As Marketplace tax credits adjust to match increases in benchmark premiums, some consumers in areas that had low benchmark premiums in 2016 may be newly eligible for tax credits in 2017. Of the nearly 1.3 million HealthCare.gov consumers who did not receive tax credits in 2016, 22 percent have benchmark premiums and incomes in the range that may make them eligible for tax credits in 2017. In addition, an estimated 2.5 million consumers currently paying full price for individual market coverage off-Marketplace have incomes indicating they could be eligible for tax credits.

Choice

- **Switching plans can save consumers significant amounts on their premiums.** If all consumers switched from their current plan to the lowest premium plan in the same metal level, the average 2017 Marketplace premium after tax credits would be $28 per month less than the average 2016 Marketplace premium after tax credits – a 20 percent reduction.

- **Consumers will be able to choose among plans with different combinations of premiums, out-of-pocket costs, networks, and other features.** All consumers will have a choice of plans and on average consumers will have 30 plans to choose from, including 14 silver plans and 10 bronze plans (the most popular metal levels selected by 9 out of 10 Marketplace enrollees). In addition, nearly 8 out of 10 (79 percent) consumers returning to the Marketplace will be able to choose from 2 or more issuers for 2017 coverage. Among people with health insurance coverage through an employer, plan choice is often considerably narrower. According to a 2015 survey 30 percent of employees who were offered health insurance were offered only one plan from one issuer.

Overview

Section I of this brief provides an overview of advance premium tax credits (APTC) and premiums in HealthCare.gov states and State Based Marketplaces where data are available for 2017 and illustrates how consumers may benefit from returning to the Marketplace to shop for a plan that meets their needs and budget.

Section II of this brief describes the choices of issuers and plans that consumers will have in the 2017 coverage year in states using the HealthCare.gov platform and in State Based Marketplaces where data are available.

SECTION I: MARKETPLACE HEALTH PLAN PREMIUMS IN 2016 AND 2017

In this section, we examine the affordability of 2017 Marketplace coverage, taking into account benchmark premium changes, tax credits, and shopping.

We find that, notwithstanding higher benchmark premium increases than in previous years, the majority of consumers will continue to have access to affordable coverage because they are protected by the combination of financial assistance and the ability to shop. Specifically, as shown in Table 1, 77 percent of returning Marketplace consumers will be able to find a plan for $100 per month or less and 72 percent will be able to find a plan for $75 or less per month, similar to these metrics for previous years. (Percentages of those who could obtain coverage for a premium of $100 or less, $75 or less, and $50 or less by state are shown in Table 8 in Appendix A.)

TABLE 1. Percent of Current Marketplace Enrollees Who Could Obtain Coverage for $100 or Less after Applicable Advance Premium Tax Credits in 2017, Regardless of Metal Level Chosen, in HealthCare.gov States

Monthly Premium After Advance Premium Tax Credits	Any Plan Types	Bronze	Silver	Gold	Platinum
$100 or less	77%	76%	63%	13%	0%
$75 or Less	72%	71%	55%	5%	0%
$50 or Less	65%	64%	44%	1%	0%

Source: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 38 states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis.
Note: Columns may not sum due to rounding. This analysis holds *all* enrollee characteristics unchanged and calculates 2017 premiums and tax credits based on the same age, family composition, and household income as in 2016. This analysis includes only enrollees who could be linked to complete plan and premium data for both 2016 and 2017, and excludes tobacco users. This analysis includes both enrollees who will be automatically crosswalked into a 2017 plan with the same issuer and other returning consumers. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section at the end of this brief for more details.

Benchmark Premium Increases

In the second year of the Marketplace, average premiums for the second-lowest cost silver plan increased only 2 percent, and in the third year they increased 7 percent. This year, Marketplace

premiums are increasing more than they have the past two years. Through 2016, Marketplace rates remained below initial projections from the independent Congressional Budget Office, and below the cost of comparable coverage in the employer market. This year, with two years of cost data available, issuers are adjusting their premiums to bring them in line with costs. In addition, some of the ACA's programs designed to support the new market in its early years are ending this year, putting transitory upward pressure on premium growth.

Under the ACA, people can no longer be denied coverage because they have a pre-existing condition, a crucial reform for up to 129 million Americans with conditions like asthma, diabetes, or heart disease. But because excluding people with pre-existing conditions was previously allowed in the individual market, there were no data available on how much it would cost to extend coverage to everyone, and many issuers' initial premiums were below actual costs.

Notably, Marketplace rates through 2016 remained 12 to 20 percent below initial projections from the independent Congressional Budget Office.[6,7] In addition, Urban Institute researchers recently found that 2016 Marketplace premiums were well below premiums for comparable employer coverage.[8] Even with this year's increases, Marketplace premiums in 2017 will still be roughly in line with the projections by the Congressional Budget Office. (See Appendix C for a detailed discussion.)

Table 6, in Appendix A, shows the estimated increase in the average second-lowest cost silver plan by state. (The second-lowest cost silver plan is significant because it provides the benchmark by which tax credits are calculated.) Across states using the HealthCare.gov platform, the median increase in the second-lowest cost silver plan premium is 16 percent, while the average increase is 25 percent.[9,10] See Table 2 (See Table 13 in Appendix A for information by select cities and counties).

[6] Levitt, L., Cox, C., & Claxton, G, "How ACA Marketplace Premiums Measure Up to Expectations," Kaiser Family Foundation, August 1, 2016, available at: http://kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations/.

[7] Adler, L. & Ginsburg, P. B., "Obamacare Premiums Are Lower Than You Think," The Brookings Institution, July 21, 2016, available at: http://healthaffairs.org/blog/2016/07/21/obamacare-premiums-are-lower-than-you-think/.

[8] Blumberg, L., Holahan, F., & Wengle, E, "Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance," Urban Institute, September 2016, available at http://www.urban.org/sites/default/files/2000931-are-nongroup-marketplace-premiums-really-high-not-in-comparison-with-employer-insurance.pdf.

[9] There are 39 states using the HealthCare.gov platform for the 2017 plan year. Kentucky is new to the HealthCare.gov platform for 2017 and is not included in the HealthCare.gov states average or median.

[10] This brief closely follows the actual methodology used to determine the benchmark for advanced premium tax credits (APTC) and enrollees' APTC amount. For the purposes of calculating the APTC, a second-lowest cost silver plan for a specific taxpayer is identified based on what is available to the taxpayer at the time of enrollment, in the taxpayer's geographical area. In this brief for analytic purposes, at times we use the term "benchmark plan" to refer to the second-lowest cost silver plan in a county, which may not be the benchmark plan for all individual consumers. This brief identifies the second-lowest cost silver benchmark plan based on the portion of the premium that covers essential health benefits (EHB), which may be less than the full premium price charged by issuers. For more details on how benchmark premiums are calculated, see the "Methodology and Limitations" section at the end of this brief.

The gap between the average and the median rate increase in HealthCare.gov states reflects that most consumers are experiencing below average increases. Moderate rate increases or rate decreases in states like Arkansas, Indiana, Nevada, New Hampshire, New Jersey, North Dakota, Michigan, and Ohio suggest that Marketplaces in states around the country are maturing and approaching stable price points. Meanwhile, several of the states experiencing larger increases had 2016 premiums that were well below the national average and especially far below the cost of comparable employer plans in that state (for example, Arizona, Hawaii, Illinois, Kansas, and Pennsylvania).[11]

While complete data on Marketplace premiums in the 12 states not using the HealthCare.gov platform are not available, data on benchmark premiums are available for four states (California, Connecticut, Massachusetts, and Minnesota) and the District of Columbia, constituting about 60 percent of State-Based Marketplace enrollment. If these states are included, we estimate that the increase in the average second-lowest cost silver plan would be 22 percent. In particular, benchmark premiums in California, which accounts for about half of State-Based Marketplace enrollment, are increasing by an average of 7 percent.

TABLE 2. Change in Benchmark Premiums from 2016 to 2017, HealthCare.gov States and Select State-Based Marketplaces for Which Data are Available Before Shopping and Tax Credits

	Percent
Average Increase in 2017 Benchmark Premium for HealthCare.gov States	25%
Median Increase in 2017 Benchmark Premium for HealthCare.gov States	16%
Average Increase in 2017 Benchmark Premium for HealthCare.gov States and State-Based Marketplaces for Which Data are Available	22%
Average Premium Change for Returning Consumers IF All Consumers Shopped and Selected Lowest-Cost Plan in Metal Level	-20%

Source: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 38 states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis.
Note: State-Based Marketplaces for which data are available include California, Connecticut, District of Columbia, Massachusetts, and Minnesota. We calculated a weighted average increase in the second-lowest cost silver plan including these State-Based Marketplaces using plan selections in each state from February 1, 2016 (as reported in "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," *ASPE Issue Brief*, ASPE, March 11, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.). Plan and premium information were provided by each state, with the exception of Minnesota; data for Minnesota were provided by the state and calculations were done by ASPE.

Financial Assistance

Most Marketplace enrollees will receive financial assistance to help with the cost of their monthly premiums. Not only do 84 percent of Marketplace enrollees who selected a plan during

[11] Blumberg, L., Holahan, F., & Wengle, E, "Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance," Urban Institute, September 2016, available at: http://www.urban.org/sites/default/files/2000931-are-nongroup-marketplace-premiums-really-high-not-in-comparison-with-employer-insurance.pdf.

the third Open Enrollment period receive tax credits to help pay for coverage[12], but we also estimate that 84 percent of the uninsured who are eligible for coverage through the Marketplaces have incomes between 100 percent and 400 percent of the Federal Poverty Level (FPL) and may be eligible to receive tax credits for plan year 2017.[13] In addition, ASPE recently estimated that as many as 2.5 million people currently purchasing off-Marketplace individual market coverage could be eligible for financial assistance if they purchase 2017 coverage through the Marketplaces.[14] In total, about 78 percent of all consumers who are uninsured, who purchase Marketplace coverage, or who purchase individual market coverage outside the Marketplace have incomes making them potentially eligible for advance premium tax credits.[15]

Consumers who receive premium tax credits are protected by the ACA's cap on the amount they pay for the benchmark plan, the second-lowest cost silver plan in their area. For those eligible for premium tax credits, the law sets a maximum amount of family income ("applicable percentage") that can be paid toward Marketplace coverage. This means that no matter the cost of the benchmark plan in an individual's area, a tax credit eligible consumer's premium is capped. Because the dollar amount of the premium tax credit depends on the benchmark plan's premium, the tax credit amount a consumer is eligible for adjusts with the premium of the benchmark plan. If premiums for all plans in an area rise similarly, the difference between the maximum required monthly premium and the benchmark premium would increase, resulting in a higher tax credit that would offset the dollar increase in premiums.

The applicable percentage varies only by household income as a percentage of the Federal Poverty Level (FPL) and does not depend on household members' ages, the number of people within the household covered through the Marketplace, or Marketplace premiums. (For examples of 2017 incomes and maximum applicable percentages for a single adult who is eligible for tax credits, see Table 16 in Appendix B.) The applicable percentage is converted into a maximum dollar amount the household is required to pay annually, and the tax credit is applied to make up the difference, if any, between the maximum dollar amount and the benchmark premiums for the family members who are seeking Marketplace coverage.[16,17]

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[12]This represents the percentage of individuals who have effectuated Marketplace coverage and qualified for an advance premium tax credit (APTC), with or without a cost-sharing reduction and includes SEP enrollment. See: U.S. Department of Health and Human Services, "First Half of 2016 Effectuated Enrollment Snapshot," CMS, October 19, 2016, available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html.

[13] U.S. Department of Health and Human Services, "Marketplace Enrollment Projections for 2017," *ASPE Issue Brief,* ASPE, October 19, 2016, available at: https://aspe.hhs.gov/pdf-report/marketplace-enrollment-projections-2017.

[14] U.S. Department of Health and Human Services, "About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies," *ASPE Issue Brief*, ASPE, October 4, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/208306/OffMarketplaceSubsidyeligible.pdf.

[15] Ibid.

[16] If the premium of the second-lowest cost silver plan falls below the maximum amount the household pays for benchmark coverage, then the household does not receive a tax credit and pays the full premium for the benchmark plan.

[17] The maximum percent of income paid toward the second-lowest cost silver plan is adjusted annually by a measure of the difference between premium growth and income growth.

The textbox on page 9 provides an illustrative example for a single 27-year-old woman in Dallas, TX earning $25,000 per year. Based on her income, her maximum monthly payment for the benchmark plan is $143 in 2016. In the first example, the monthly premium for the benchmark plan is $216; thus, the woman is eligible for a tax credit of $73 per month, which she may apply to her choice of a qualified health plan. In the second example, premiums are adjusted to reflect 2017 plan options, making the monthly premium for the benchmark plan $232. Because the applicable percentage of income that the consumer is required to contribute to the cost of the benchmark premium remains approximately the same, her contribution to the benchmark plan remains roughly the same as well at $142, and her tax credit increases to $90 per month to cover the remaining premium cost. Thus, the consumer has a higher dollar amount of tax credit to apply to a plan of her choice and, therefore, could pay less out-of-pocket for all plans with premiums below the benchmark premium cost. This example illustrates that the tax credit ensures that enrollees can obtain coverage at an affordable price.

Premium Tax Credits: Examples

Example 1: Single 27-year-old in Dallas, TX with an income of $25,000 for 2016

Calculate her tax credit for 2016 coverage:

- Income as percentage of FPL: 212%
- Maximum monthly payment for second-lowest silver benchmark plan: $143
- Monthly total premium of second-lowest silver benchmark plan: $216
- Advance premium tax credit per month: $216 – $143= $73

Suppose she's trying to decide among two silver plans and a bronze. She can apply her tax credit to any of them.

- Before tax credit, the monthly premiums are
  - Bronze: $180
  - Lowest silver: $214
  - Second-lowest silver: $216
- After applying her tax credit, the monthly premiums are
  - Bronze: $180 – $73 = $107
  - Lowest silver after tax credit: $214 – $73 = $141
  - Second-lowest silver after tax credit: $216 – $73 = $143

Example 2: Premiums for a 27-year-old making $25,000 in Dallas, TX for 2017

Calculate her tax credit for 2017 coverage:

- Income as percentage of FPL: 210%
- Maximum monthly payment for second-lowest silver benchmark plan: $142
- Monthly total premium of second-lowest silver benchmark plan: $232
- Advance premium tax credit per month: $232 – $142 = $90

Even if premiums rose from 2016 to 2017, the tax credit protects consumers from higher prices.

- Before tax credit, the monthly premiums are
  - Bronze: $195
  - Lowest silver: $227
  - Second-lowest silver: $232
- After applying her tax credit, the monthly premiums are
  - Bronze: $195 – $90 = $105
  - Lowest silver after tax credit: $227 – $90 = $137
  - Second-lowest silver after tax credit: $232 – $90 = $142

Shopping

The Marketplace enables consumers to comparison shop for a plan that meets their needs and budget. In 2015, 47 percent of individuals who selected a plan in the Marketplace selected the lowest cost (31 percent) or second-lowest cost plan (17 percent) in their metal tier, and in 2016,

45 percent of individuals who selected a plan in the Marketplace selected the lowest cost (30 percent) or second-lowest cost plan (15 percent) in their metal tier.[18] Previous ASPE analysis illustrates that Marketplace consumers are active shoppers with a demonstrated willingness to switch plans to get a better deal. In 2016, nearly 70 percent of HealthCare.gov consumers that came back to the Marketplace actively selected a plan, and nearly 43 percent of consumers who reenrolled in a Marketplace plan in 2016 switched to a new plan.[19]

The Marketplace continues to be dynamic, and plans that were the second-lowest cost silver plan or lowest-cost silver plan in 2016 may not be the second-lowest cost or lowest-cost plan in 2017, so it will be important for returning consumers to review other options in 2017. The actual payment made by consumers for their insurance depends on the plan they choose when enrolling in coverage through the Marketplace and the level of tax credit they qualify for.

In 2017, more than 7 in 10 (76 percent) current Marketplace enrollees can find a lower premium plan in the same metal level by returning to the Marketplace to shop for coverage rather than reenrolling in their current plan, as illustrated in Table 3 (next page). For example, the average lowest-cost premium for a silver plan available to current silver-level enrollees is $433 per month for 2017 before applicable tax credits. Consumers who bought a silver plan in 2016 would save an average of $58 a month by switching to the lowest premium plan in 2017. This results in total premium savings of $691 a year for these consumers.[20] If all silver plan holders with potential savings switch to the lowest-cost silver plan available to them for 2017, the total savings for the year would be $3.2 billion. Across all metal levels, the total premium savings would be $4.3 billion if all consumers with potential savings switch to the lowest-cost plan within their 2016 metal level (state-level analyses are in Table 7 in Appendix A).

[18] May not sum due to rounding. Percentages do not include tobacco users.
[19] U.S. Department of Health and Human Services, "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," *ASPE Issue Brief*, ASPE, March 11, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.
[20] Average premium savings by switching to the lowest-cost plan within metal level are calculated only for consumers who would not be automatically crosswalked into the lowest-cost plan within their metal level and thus have the ability to save by switching. Savings for individual enrollees may differ from this amount based on their choice of plan, eligibility for premium tax credits, and other characteristics.

TABLE 3. Potential Savings from Shopping Based on Premium if Current Marketplace Enrollees Switch to 2017 Lowest-Cost Premium Plan within Metal Level, HealthCare.gov States

Current Marketplace Enrollees	All Plan Types	Bronze	Silver	Gold	Platinum
Average Lowest-Cost 2017 Monthly Premium within Metal Level before Applicable Tax Credit	N/A	$366	$433	$538	$674
% of Enrollees Who Could Save on Premium Costs by Switching to the Lowest-Cost Plan in Metal Level	76%	74%	77%	67%	73%
Average 2017 Monthly Premium Savings from Switching to Lowest-Cost Plan within Metal Level, Across All Enrollees	$57	$50	$58	$71	$81
ANNUAL Average Savings in Premium Costs per Enrollee Across All Enrollees	$682	$603	$691	$852	$967
MONTHLY Aggregate Amount of Savings in Premium Costs Across All Enrollees	$360 M	$67 M	$270 M	$21 M	$3 M
ANNUAL Aggregate Amount of Savings in Premiums Costs Across All Enrollees	$4.3 B	$800 M	$3.2 B	$254 M	$32 M

Source: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 38 states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis.
Note: Amounts presented here do not take into account potential premium tax credits. The lowest-cost premium refers to the plan with the lowest premium within the county within each metal tier. In some cases, plans were tied for lowest premium. This analysis includes only enrollees linked to complete plan and premium data for both 2016 and 2017, and excludes tobacco users, who may face additional surcharges. This analysis only includes enrollees who will be automatically crosswalked into a 2017 plan with the same issuer. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. We assume that *all* enrollee characteristics are unchanged and calculate premiums based on the same age, family composition, and household income as in 2016. Metal-level analysis is based on the metal consumers would be automatically crosswalked into for 2017, based on their metal choice in 2016. The lowest cost plan does not take into account other cost-sharing features, but refers only to the cost of the premium charged for that plan. See the "Methods and Limitations" section at the end of this brief for more details.

Health Insurance Plan Affordability for 2017 Taking Into Account Advance Premium Tax Credits and Shopping

Table 1, on page 4, shows the percentage of current Marketplace enrollees in 38 states who could get coverage for as little as $75 or less across all available plans. Table 4 (next page) shows the share who could get coverage for $75 or less taking into account any applicable tax credits *while staying in their current metal level,* thereby maintaining comparable responsibility for out of pocket costs.[21] For example, nearly 6 in 10 (58 percent) of all customers returning to the Marketplace can get coverage for a premium of $75 or less if they selected a lower-premium

[21] The health plan category or "metal level" determines how consumers and plans can expect to share the costs of care. For example, with a silver level plan the health plan pays about 70 percent of the total costs of care for essential health benefits, on average, and the consumer pays 30 percent of these costs. This takes into account the plan's deductibles, copayments, coinsurance, and out-of-pocket maximums.

plan in their same metal level in 2017. Of those who selected a silver plan in 2016, 64 percent could get silver plan coverage for a premium of $75 or less in 2017 if they choose a lower-cost plan. (Percentages of those who could obtain coverage for a premium of $100 or less, $75 or less, and $50 or less by state regardless of metal level are shown in Table 8 in Appendix A.)

TABLE 4. Percent of Current Marketplace Enrollees Who Could Obtain Coverage *within Their Current Metal Level* for $100 or Less after Advance Premium Tax Credits in 2017, 38 States

Monthly Premium After Advance Premium Tax Credits	All Plan Types	Bronze	Silver	Gold	Platinum
$100 or less	66%	61%	73%	4%	0%
$75 or Less	58%	54%	64%	1%	0%
$50 or Less	48%	45%	52%	0%	0%

Source: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 38 states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis.
Note: Columns may not sum due to rounding. This analysis holds *all* enrollee characteristics unchanged and calculates 2017 premiums and tax credits based on the same age, family composition, and household income as in 2016. This analysis includes only enrollees linked to complete plan and premium data for both 2016 and 2017, and excludes tobacco users. This analysis includes both enrollees who will be automatically cross walked into a 2017 plan with the same issuer and other returning consumers. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. Metal-level analysis is based on the metal level consumers would be automatically cross walked into for 2017, based on their metal choice in 2016. See the "Methods and Limitations" section at the end of this brief for more details.

In addition, if every returning consumer nationwide selected the lowest-cost plan available within their current metal level, average premiums would decrease by $28 per month, or 20 percent, compared to average premiums in 2016 (taking tax credits into account). (Estimates by state are shown in Table 9 in Appendix A.) In fact, many consumers do not choose the lowest cost plan available, because they are willing to pay more for a wider network or other plan features, but this calculation confirms that affordable options for 2017 coverage are available to consumers who shop around to find a better deal.

SECTION II: CONSUMER CHOICE FROM 2016 TO 2017

With an average of 30 Marketplace plans to choose from in 2017, both new and returning consumers have options when shopping for coverage.

Issuers

There are 167 issuers participating in the Marketplace in HealthCare.gov states in 2017 (see Tables 10, 14 in Appendix A). Based on analysis at the county level, the average Marketplace consumer can choose from 3 issuers in their county for 2017 coverage.[22] Seventy-nine percent (or about four in five) of consumers will have a choice of two or more issuers, and 56 percent will have a choice of three or more (see Table 15 in Appendix B).

[22] Note that some previous ASPE issue briefs on plan choice and availability presented analyses at the rating area level. Because plans available in some parts of a rating area are not always available in all parts of a rating area, conducting the analysis at the county level better captures the set of options consumers will see when they shop and more closely matches consumers' shopping experience.

The number of issuers offering health plans in the Marketplace has decreased from 2016 to 2017, as shown in Table 10 in Appendix A. Across the HealthCare.gov states, 15 new issuers will begin offering Marketplace plans for the 2017 coverage year, while 83 issuers that offered plans in 2016 will no longer offer plans through the Marketplace in 2017.[23] Reduced participation in large part reflects multi-state withdrawals by a few large insurers; in particular, withdrawals by United Health and Aetna account for 26 and 17 issuer exits, respectively. A number of other firms are entering the Marketplace or expanding their participation into new states (or new service areas within states), but they are doing so more gradually.

Table 10 in Appendix A provides the number of issuers by state for the years 2016 and 2017. (Not all issuers operate in all counties within a state, however, and thus the number of issuers available to a particular consumer may be less than the number of issuers that operate anywhere in the state.)

Plans

Issuers can sell multiple plans across the various metal levels. In 2017, consumers can choose from 30 plans in their county on average, as shown in Tables 11, 12 in Appendix A, and all consumers will have a choice of plans. That means all consumers will be able to choose among different combinations of premiums, out-of-pocket costs, and networks of hospitals and physicians. Among people with health insurance coverage through an employer, plan choice can be considerably narrower. According to a 2015 survey 30 percent of employees who were offered health insurance were offered only one plan by one issuer.[24] Limited plan choice through employers is not new. One leading survey estimated in 2005 that 37 percent of workers enrolled in employer-provided health insurance coverage had only one issuer offering one plan and another 20 percent of workers had only two plan options.[25]

As shown in Table 15 in Appendix B, there continues to be particularly robust choice among silver and bronze plans, which were the choice of 68 percent and 23 percent of consumers who selected a plan during the third Open Enrollment period respectively, with the least choice among platinum plans and catastrophic plans, which were the choice of only 2 percent and 1 percent of consumers respectively.[26] Table 15 shows additional details on the number of plans an average consumer can choose from.

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[23] The total number of issuers is calculated based on identifying an issuer by its unique five-digit Health Insurance Oversight System (HIOS) ID. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS issuer ID is specific to the state in which it operates, such that a company offering QHPs through the Marketplace in two states would be counted twice—once for each state. Issuer totals for 2017 and 2016 include 38 states and do not include Kentucky, which is beginning to use the HealthCare.gov platform for the 2017 coverage year.

[24] Agency for Healthcare Research and Quality, "MEPS Insurance Component Chartbook 2015," August 2016, available at https://meps.ahrq.gov/mepsweb/data_files/publications/cb20/cb20.pdf.

[25] Kaiser Family Foundation, "Employer Health Benefits, 2005 Annual Survey," 2005, available at: https://kaiserfamilyfoundation.files.wordpress.com/2012/09/2005ehbs.pdf.

[26] U.S. Department of Health and Human Services, "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," *ASPE Issue Brief*, ASPE, March 11, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.

Conclusion

As the Health Insurance Marketplace matures, new and returning customers to the Marketplace will continue to be able to choose affordable, quality health insurance in 2017. Premium tax credits will also continue to play an important role in ensuring that consumers have access to affordable options. Many consumers who purchased plans in 2015 through the Marketplace realized substantial savings by switching plans for the 2016 plan year, and consumers can realize substantial savings again this year if they shop around to find the plan that best meets their needs and their budget. They can do so by going to HealthCare.gov, which provides information for consumers looking to compare plans on premiums and other important plan features.

Methodology and Limitations

Data

The plan and premium data reported here are from the Marketplace QHP landscape individual market health plan files, which are publicly available at HealthCare.gov.[27] Data were not available for all states. This analysis focuses on the 39 states which were included in the 2017 Marketplace landscape file, including: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. However, some metrics are limited to the 38 states (39 states minus Kentucky) in the 2016 landscape file.

For most State-Based Marketplaces (SBMs) operating their own enrollment platforms, comprehensive plan and premium data were not available. SBMs included in the analysis in this brief are California, Connecticut, District of Columbia, Massachusetts, Minnesota, and New York. Plan and premium information was provided by each state, with the exception of Minnesota; data for Minnesota were provided by the state and calculations were done by ASPE. SBMs not included in the analysis in this brief are Colorado, Idaho, Maryland, Rhode Island, Vermont, and Washington. Some SBMs submit plan data to the Centers for Medicare & Medicaid Services (CMS) for display using the HealthCare.gov eligibility and enrollment platform. Idaho relied on the HealthCare.gov platform only in 2014 and is not included in this brief. New Mexico, Oregon, Nevada, and Hawaii have utilized the HealthCare.gov platform to support their eligibility and enrollment functions in past years and will continue to do so in 2017. Kentucky is new to the HealthCare.gov platform for 2017.

Plan information is based on the plan landscape files for the states using the HealthCare.gov platform as of July 2016 for the 2016 coverage year, and as of October 14, 2016, for the 2017 coverage year. The ASPE Issue Brief published last year, titled "Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace," used an older version of the landscape file for the 2016 coverage year.[28] Numbers relating to the 2016 coverage year have been updated for this brief using the July 2016 landscape file and plan selections as of February 1, 2016; as a result, some 2016 coverage year estimates in this brief may differ from previously published estimates. The 2017 plan landscape file used in this brief is a snapshot of issuer participation and plans as of October 14, 2016 and does not reflect changes in issuer and plan offerings after that date.

Enrollment information is based on active QHP selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of February 1, 2016 for the 2016 and 2017 coverage years. In this brief, we use the term "enrollees" to refer to individuals with active

[27] The Marketplace plan landscape files can be downloaded at: https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/.

[28] Brief available at https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace.

Marketplace individual market health plan selections; it does not refer to "effectuated enrollees"—individuals who selected plans and paid the premium.

Weighted averages have been calculated at the county level for all counties in the HealthCare.gov states and weighted by 2016 plan selections in 38 states as of February 1, 2016, unless otherwise specified. The median for HealthCare.gov states reported in Table 6 is also weighted by 2016 plan selections. Weighted averages that include SBM states were calculated at the county level for all counties in HealthCare.gov states and weighted at the state level, using plan selections as of February 1, 2016 (as reported in "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," *ASPE Issue Brief*, ASPE, March 11, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.), for SBM states, with the exception of Minnesota (data for Minnesota were provided by the state and calculations were done by ASPE).

Additionally, we exclude tobacco users from our calculations of premiums because their premium rates may be higher than standard, non-tobacco rates. We also exclude enrollees in Virginia plans covering treatment of morbid obesity. Our calculations of the savings from switching plans (Tables 3, 7, 9) and premium tax credits (Tables 1, 4 and 8) are based only on enrollees whom we were able to link to complete premium and plan data for both 2016 and 2017. Our calculations for Tables 3, 7 and 9 only include enrollees who will be automatically crosswalked into a 2017 plan with the same issuer. Our calculations for Tables 1, 4 and 8 include nearly all returning enrollees. Excluding tobacco users, non-tobacco users who were missing required data, non-tobacco users who could not be linked to 2017 plans, and non-tobacco users who selected catastrophic plans reduced the number of plan selections in the 38 HealthCare.gov states as of February 2016 from 9.6 million to 9.0 million used for this analysis.

Issuers and Plans

We calculate the total number of issuers by unique five-digit Health Insurance Oversight System (HIOS) issuer IDs. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS ID is specific to the state in which it operates, such that a company offering QHPs through the Marketplace in two states would be counted twice—once for each state.

Some previous ASPE issue briefs on plan choice and availability presented analyses at the rating area level. Because plans available in some part of a rating area are not always available in all parts of a rating area, in this brief we have conducted the analysis at the county level. Conducting the analysis at the county level better captures the set of options consumers will see when they shop and thus more closely matches consumers' shopping experience.

The analysis in this brief does not include stand-alone dental plans, child-only plans, or small-group Marketplace (SHOP) plans.

Premiums

In this issue brief, we examine the plans and premiums available at the county level. Because some plans may not serve all counties within a rating area, county-level analysis provides a better approximation of plan availability. Analyses in some previous ASPE briefs on

Marketplace premiums was typically at the rating area level; therefore, numbers in this brief should not be compared against those in previous briefs using rating area analysis.

Our analysis of premiums in Tables 1, 3, 4, 7, 8 and 9 considers only current enrollees, based on the batch auto-reenrollment crosswalk developed by CMS or the state. Our calculations for Tables 3, 7 and 9 only include enrollees who will be automatically crosswalked into a 2017 plan with the same issuer. Our calculations for Tables 1, 4 and 8 include nearly all returning enrollees. Consumers can be automatically crosswalked into other coverage within the same issuer or to another issuer if their plan is not available for the next year.

In our dataset, we observe some households that are not receiving tax credits in 2016 but do appear eligible on the basis of household income.[29] New to this analysis for 2017, we impute the maximum amount that these households would need to pay toward benchmark coverage by applying the 2016 IRS applicable percentages and calculating the amount, if any, of tax credit the household would be eligible for in 2017. We impute tax credits for these consumers because some consumers who do not receive tax credits in 2016 due to benchmark premiums that were below the maximum required monthly premium payment may see their 2017 premium increase enough to qualify for tax credits.

Identifying Benchmark Plans

Plans in the Health Insurance Marketplace are required to offer a comprehensive package of items and services, known as essential health benefits (EHB). Marketplace plans can also offer benefits beyond these minimum benefits.

Each Marketplace plan reports what percentage of its premium is related to EHB. Most plans have an EHB percentage of 100 percent. However, plans that cover benefits beyond EHB have EHB percentages smaller than 100 percent, reflecting the fact that a portion of the premium pays for these additional benefits. The amount of premium that covers EHB is used to rank silver plans available to a consumer and determine which plan is the second-lowest cost silver plan—also called the benchmark plan—for the purposes of calculating advance premium tax credits.

In this issue brief, the EHB amount enters into our analysis in two ways. We ranked silver plans by the EHB amount of premium in order to determine what we define for analytic purposes as each county's "benchmark" plan.[30] We then compared the full premium amount of each year's respective benchmark to calculate the increase in the second-lowest cost silver plan. Secondly, EHB amounts affect the calculation of premiums after applicable advance premium tax credits. Premium tax credits can be applied only to the portion of the plan's premium that covers EHB.

[29] There are various reasons a consumer may not appear to be receiving APTC but have a household income that would suggest they may be eligible (i.e., from 100/138 percent to 400 percent of the Federal Poverty Level). For example, the benchmark plan available to the consumer may be priced below the maximum monthly premium payment, the household may receive an offer of affordable employer-sponsored coverage, or the plan selection or income data in our analytic file are not up-to-date.

[30] For the purposes of calculating the advance premium tax credit, a second-lowest cost silver level plan for a specific taxpayer is identified based on what is available to the taxpayer at the time of enrollment, in the taxpayer's geographical area. In this brief for analytic purposes, at times we use the term "benchmark plan" to refer to the second-lowest cost silver plan in a county, which may not be the benchmark plan for all individual consumers.

For example, suppose a consumer has a $200 premium tax credit. If he selects a plan that costs $200 before tax credit and has an EHB percent of 95%, the tax credit will cover $190 of the plan premium and he will be responsible for covering the remaining $10.

The 2016 and 2017 QHP landscape files include a variable called "EHB percent of total premium," which represents the proportion the plan's premium cost that covers EHB. For plan years 2014 and 2015, the EHB percentage of premium variable is not available on the landscape file but is available on the Health Insurance Marketplace public use files.[31]

In this analysis, we rank silver plans according to the percentage of premium that is related to EHB; however, premiums reported in this brief are for the full premium amount, not just the premium amount that covers EHB.

[31] The Health Insurance Marketplace public use files are available at: https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html.

APPENDIX A: TABLES BY STATE AND COUNTY

TABLE 5. Percent of 2016 HealthCare.gov Enrollees Receiving Financial Assistance, by State

State	Percent of Plan Selections with APTC	Percent of Plan Selections with CSRs	Median Income as Percent of FPL	Percent of Plan Selections with Household Income <100% FPL	Percent of Plan Selections with Household Income 100-250% FPL	Percent of Plan Selections with Household Income 250-400% FPL	Percent of Plan Selections with Household Income >400% FPL
HealthCare.gov States	**85%**	**59%**	**165%**	**3%**	**78%**	**17%**	**2%**
AK	86%	42%	202%	3%	68%	27%	3%
AL	89%	73%	144%	4%	83%	12%	1%
AR	87%	55%	189%	2%	75%	21%	2%
AZ	74%	51%	189%	2%	75%	19%	3%
DE	82%	43%	212%	2%	63%	30%	4%
FL	91%	71%	137%	2%	86%	10%	1%
GA	86%	65%	141%	4%	82%	13%	2%
HI	81%	61%	164%	29%	53%	16%	2%
IA	85%	51%	196%	2%	71%	24%	2%
IL	75%	45%	194%	3%	69%	23%	4%
IN	81%	45%	196%	2%	68%	27%	3%
KS	82%	57%	168%	4%	75%	18%	2%
LA	89%	61%	148%	3%	80%	15%	2%
ME	87%	56%	188%	2%	71%	24%	3%
MI	83%	51%	195%	2%	72%	24%	3%
MO	87%	57%	157%	3%	79%	16%	2%
MS	90%	74%	129%	4%	89%	7%	1%
MT	83%	45%	196%	2%	67%	27%	3%
NC	89%	64%	157%	3%	79%	16%	2%
ND	85%	45%	209%	1%	66%	29%	3%
NE	88%	51%	185%	3%	73%	22%	2%
NH	66%	35%	211%	2%	62%	30%	6%
NJ	80%	50%	199%	4%	66%	26%	5%
NM	68%	44%	200%	2%	68%	25%	4%
NV	87%	58%	188%	3%	75%	20%	2%
OH	80%	44%	203%	2%	70%	25%	3%
OK	84%	60%	164%	4%	77%	17%	2%
OR	71%	39%	216%	2%	62%	31%	5%
PA	76%	51%	190%	2%	71%	23%	4%
SC	89%	71%	153%	2%	82%	15%	2%
SD	88%	60%	187%	3%	73%	23%	2%
TN	85%	58%	159%	4%	77%	17%	2%
TX	84%	57%	153%	4%	81%	13%	2%
UT	86%	63%	177%	2%	80%	16%	2%
VA	82%	56%	169%	4%	75%	18%	3%
WI	84%	54%	187%	1%	70%	25%	3%
WV	85%	51%	199%	1%	69%	27%	3%
WY	90%	54%	198%	2%	68%	27%	2%

Source: U.S. Department of Health and Human Services, "Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," ASPE Issue Brief, ASPE, March 11, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/188026/MarketPlaceAddendumFinal2016.pdf.
Note: Columns may not sum due to rounding.

TABLE 6

Average Monthly Premiums for Second-Lowest Cost Silver Plans for a 27-Year-Old (Before Tax Credits), 2016–2017 in HealthCare.gov States & State-Based Marketplaces for Which Data are Available

State	Average Second-Lowest Cost Silver Premium for a 27-Year-Old		
	2016	2017	% Change, 2016–2017
HealthCare.gov States			
Average	*$242*	*$302*	*25%*
Median Change	*N/A*	*N/A*	*16%*
HealthCare.gov States and State-Based Marketplaces for Which Data are Available			
Average	*$243*	*$296*	*22%*
HealthCare.gov States			
AK	$590	$760	29%
AL	$244	$384	58%
AR	$244	$248	2%
AZ	$196	$422	116%
DE	$292	$347	19%
FL	$238	$270	14%
GA	$237	$273	15%
HI	$213	$288	35%
IA	$246	$308	25%
IL	$208	$298	43%
IN	$235	$229	-3%
KS	$217	$308	42%
KY	N/A	$259	N/A
LA	$290	$340	17%
ME	$275	$317	15%
MI	$213	$228	7%
MO	$257	$305	18%
MS	$230	$273	19%
MT	$264	$381	44%
NC	$319	$446	40%
ND	$270	$288	7%
NE	$272	$411	51%
NH	$215	$219	2%
NJ	$272	$286	5%
NM	$174	$224	29%
NV	$234	$249	6%
OH	$222	$226	2%
OK	$251	$424	69%
OR	$225	$287	27%
PA	$213	$327	53%
SC	$247	$319	29%
SD	$270	$374	39%
TN	$236	$385	63%
TX	$221	$261	18%
UT	$245	$294	20%
VA	$239	$264	10%
WI	$262	$304	16%
WV	$294	$386	32%
WY	$380	$413	9%
State-Based Marketplaces			

CA #	$255	$272	7%
CT	$291	$340	17%
DC	$181	$222	22%
MA	$227	$219	-3%
MN	$214	$340	59%

Source: For states using the HealthCare.gov platform in 2016 and 2017, plan and premium information is from the plan landscape files. For State-Based Marketplaces using their own Marketplace platforms, plan and premium information was provided by the state. Plan and premium information from Minnesota was provided by the state and calculations were done by ASPE.

Note: The numbers in this table represent premiums before the application of advance premium tax credits. State and HealthCare.gov average premiums are weighted by the number of Marketplace plan selections in each county, except for Kentucky, in which all counties were weighted equally. Weighted averages that include SBM states were calculated at the county level for all counties in HealthCare.gov states and weighted at the state level, using plan selections as of February 1, 2016 (as reported in "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," *ASPE Issue Brief*, ASPE, March 11, 2016, available at: https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.), for SBM states, with the exception of Minnesota (data for Minnesota were provided by the state and calculations were done by ASPE). The 2016 and 2017 averages use 2016 plan selections in 38 states. Kentucky, as well as State-Based Marketplaces using their own Marketplace platforms, are not included in the HealthCare.gov states average. This analysis identifies the second-lowest cost silver plan in each county based on the portion of the premium that covers essential health benefits (EHB); however, premiums reported in this table are for the full premium amount, not just the premium amount that covers EHB. See the "Methodology and Limitations" section for details.

California averages are by rating region rather than county.

TABLE 7

Potential Savings from Shopping Based on Premium if Current Marketplace Enrollees Switch to 2017 Lowest-Cost Premium Plan within Metal Level in HealthCare.gov States

State	Average Lowest-Cost 2017 Monthly Premium Within Metal Level	Average 2017 Monthly Premium Savings if Consumers Switch to Lowest-Cost Plan within Metal Level*	Annual Average Potential Savings in Premium Costs per Enrollee*	% of Enrollees Who Could Save on Premium Costs by Switching to the Lowest-Cost Plan within Metal Level*
HealthCare.gov States	**N/A**	**$57**	**$682**	**76%**
AK	$1,004	$7	$85	61%
AL	$552	$20	$245	54%
AR	$379	$60	$725	99%
AZ	$620	$15	$175	30%
DE	$534	$63	$753	99%
FL	$407	$54	$653	80%
GA	$362	$76	$910	93%
HI	$444	$44	$531	76%
IA	$435	$18	$219	30%
IL	$431	$111	$1,332	95%
IN	$351	$119	$1,433	97%
KS	$439	$15	$183	83%
LA	$480	$83	$999	73%
ME	$498	$24	$290	89%
MI	$343	$88	$1,055	95%
MO	$438	$43	$518	79%
MS	$416	$53	$636	77%
MT	$515	$81	$968	76%
NC	$650	$24	$288	56%
ND	$378	$25	$300	74%
NE	$540	$14	$173	48%
NH	$348	$68	$821	87%
NJ	$463	$46	$557	78%
NM	$344	$26	$310	46%
NV	$371	$25	$300	93%
OH	$330	$91	$1,097	94%
OK	$586	$34	$407	68%
OR	$420	$52	$628	91%
PA	$478	$29	$353	42%
SC	$507	$10	$121	100%
SD	$513	$30	$357	73%
TN	$575	$25	$305	37%
TX	$362	$74	$889	70%
UT	$330	$25	$302	54%
VA	$374	$42	$501	80%
WI	$476	$51	$608	82%
WV	$652	$61	$728	60%
WY	$594	$12	$144	50%

Source: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 38 states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis.

Note: Amounts presented here do not take into account potential premium tax credits. The lowest-cost premium refers to the plan with the lowest premium within the county within each metal tier. In some cases, plans were tied for lowest premium. This

analysis includes only enrollees linked to complete plan and premium data for both 2016 and 2017, and excludes tobacco users, who may face additional surcharges. This analysis only includes enrollees who will be automatically crosswalked into a 2017 plan with the same issuer. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. We assume that *all* enrollee characteristics are unchanged and calculate premiums based on the same age, family composition, and household income as in 2016. Metal-level analysis is based on the metal consumers would be automatically crosswalked into for 2017, based on their metal choice in 2016. The lowest cost plan does not take into account other cost-sharing features, but refers only to the cost of the premium charged for that plan. See the "Methods and Limitations" section at the end of this brief for more details.

TABLE 8

Percent of Current Marketplace Consumers Who Could Obtain Coverage for $100 or Less after Applicable Tax Credits in 2017, Regardless of 2016 Metal Level, HealthCare.gov States

State	Monthly Premium After Advance Premium Tax Credits		
	$100 or less	$75 or less	$50 or less
HealthCare.gov States Total	**77%**	**72%**	**65%**
AK	82%	79%	76%
AL	90%	89%	87%
AR	62%	52%	38%
AZ	78%	74%	70%
DE	63%	55%	45%
FL	84%	80%	74%
GA	81%	76%	70%
HI	76%	71%	67%
IA	71%	65%	56%
IL	60%	53%	43%
IN	56%	48%	36%
KS	74%	69%	62%
LA	84%	81%	76%
ME	68%	60%	50%
MI	73%	65%	55%
MO	78%	73%	67%
MS	85%	81%	75%
MT	80%	77%	72%
NC	85%	82%	77%
ND	77%	71%	62%
NE	82%	77%	70%
NH	49%	42%	34%
NJ	61%	54%	46%
NM	65%	56%	48%
NV	76%	70%	61%
OH	60%	51%	38%
OK	86%	84%	82%
OR	62%	56%	49%
PA	75%	71%	66%
SC	74%	68%	59%
SD	83%	79%	71%
TN	83%	81%	77%
TX	78%	73%	66%
UT	82%	76%	66%
VA	73%	67%	60%
WI	69%	63%	56%
WV	69%	63%	55%
WY	74%	68%	60%

Source: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 38 states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis.

Note: Columns may not sum due to rounding. This analysis holds all enrollee characteristics unchanged and calculates 2017 premiums and tax credits based on the same age, family composition, and household income as in 2016. This analysis includes only enrollees who could be linked to complete plan and premium data for both 2016 and 2017, and excludes tobacco users. This analysis includes both enrollees who will be automatically crosswalked into a 2017 plan with the same issuer and other returning consumers. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section for more details.

TABLE 9

Potential Savings Compared to 2016 Premium if Current Marketplace Enrollees Switch to Lowest Premium Plan within Metal Level in 2017, HealthCare.gov States

State	Average Net Premium 2016	Average Net Premium 2017 if Selecting the Lowest Cost Plan within Metal Tier	Difference in 2016 Net Premium and 2017 Net Premium of Lowest Cost Plan in Metal Tier	% Difference
HealthCare.gov States	**$137**	**$109**	**-$28**	**-20%**
AK	$218	$172	-$46	-21%
AL	$122	$78	-$44	-36%
AR	$149	$138	-$10	-7%
AZ	$155	$173	$18	11%
DE	$195	$184	-$11	-6%
FL	$107	$74	-$32	-30%
GA	$122	$80	-$43	-35%
HI	$148	$138	-$10	-7%
IA	$143	$126	-$18	-12%
IL	$189	$158	-$32	-17%
IN	$190	$135	-$54	-29%
KS	$136	$124	-$12	-9%
LA	$112	$90	-$23	-20%
ME	$137	$150	$14	10%
MI	$169	$119	-$50	-30%
MO	$121	$105	-$15	-13%
MS	$110	$76	-$34	-31%
MT	$154	$112	-$43	-28%
NC	$126	$102	-$25	-19%
ND	$163	$129	-$34	-21%
NE	$129	$99	-$30	-23%
NH	$215	$178	-$37	-17%
NJ	$210	$178	-$33	-15%
NM	$169	$135	-$34	-20%
NV	$129	$112	-$17	-13%
OH	$192	$130	-$63	-33%
OK	$110	$113	$3	2%
OR	$189	$169	-$21	-11%
PA	$186	$167	-$19	-10%
SC	$121	$115	-$6	-5%
SD	$128	$102	-$25	-20%
TN	$132	$95	-$37	-28%
TX	$118	$89	-$29	-24%
UT	$105	$115	$10	9%
VA	$129	$110	-$19	-15%
WI	$164	$138	-$26	-16%
WV	$190	$164	-$25	-13%
WY	$149	$134	-$15	-10%

Source: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 38 states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis.

Note: This analysis considers enrollees who do and do not receive tax credits. The lowest premium plan refers to the plan with the lowest premium in the county within each metal tier and is based on all plans available in 2016. In some cases, plans were tied for lowest premium. This analysis includes only enrollees linked to complete plan and premium data for both 2016 and 2017, and excludes tobacco users, who may face additional surcharges. This analysis includes both enrollees who will be automatically cross walked into a 2017 plan and other returning consumers. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. We assume that *all* enrollee characteristics are unchanged and calculate premiums based on the same age, family composition, and household income as in 2016. Metal-level analysis is based on the metal level consumers would be automatically cross walked into for 2017, based on their metal choice in 2016. The lowest premium plan does not take into account other cost-sharing features, but refers only to the cost of the premium charged for that plan. See the "Methods and Limitations" section at the end of this brief for more details.

TABLE 10

Number of Marketplace Issuers by State, 2016–2017 in HealthCare.gov States & State-Based Marketplaces for Which Data are Available

State	Number of Issuers in State		Net Change in Number of Issuers in State, 2016–2017*	Number of New Issuers to the State in 2017*	Number of Issuers Exiting the State in 2017*
	2016	2017			
HealthCare.gov States Total	**232**	**167**	**-68**	**15**	**83**
Total for HealthCare.gov States and State-Based Marketplaces for Which Data are Available	**298**	**228**	**-73**	**16**	**89**
HealthCare.gov States					
AK	2	1	-1	0	1
AL	3	1	-2	0	2
AR	5	4	-1	0	1
AZ	8	2	-6	0	6
DE	3	3	0	0	0
FL	10	7	-3	1	4
GA	9	5	-4	0	4
HI	2	2	0	0	0
IA	4	5	1	2	1
IL	9	5	-4	1	5
IN	8	4	-4	0	4
KS	4	3	-1	1	2
KY*	N/A	3	N/A	N/A	N/A
LA	5	4	-1	0	1
ME	2	3	1	1	0
MI	14	10	-4	0	4
MO	7	4	-3	0	3
MS	3	2	-1	0	1
MT	3	3	0	0	0
NC	3	2	-1	1	2
ND	3	3	0	0	0
NE	4	2	-2	1	3
NH	4	4	0	0	0
NJ	6	3	-3	0	3
NM	4	4	0	1	1
NV	4	4	0	0	0
OH	16	11	-5	0	5
OK	2	1	-1	0	1
OR	9	6	-3	0	3
PA	13	8	-5	1	6
SC	4	1	-3	0	3
SD	2	2	0	0	0
TN	4	3	-1	0	1
TX	19	10	-9	0	9
UT	4	3	-1	0	1
VA	11	11	0	2	2
WI	16	15	-1	3	4
WV	2	2	0	0	0
WY	1	1	0	0	0

State-Based Marketplaces					
CA #	12	11	-1	0	1
CT	4	2	-2	0	2
DC	2	2	0	0	0
MA	11	10	-1	0	1
MN	5	4	-1	0	1
NY - Basic Health Plan ±	14	15	1	1	0
NY - Marketplace ±	18	17	-1	0	1

Source: For states using the HealthCare.gov platform in 2016 and 2017, plan and premium information is from the plan landscape files. For State-Based Marketplaces using their own Marketplace platforms, plan and premium information was provided by the state. Plan and premium information from Minnesota was provided by the state and calculations were done by ASPE.

Note: An issuer is counted as "new" in 2017 if it did not offer an individual market health plan in a given state's Marketplace in 2016 based on its HIOS issuer ID number, and "exiting" if it was active in a given state's Marketplace in 2016 but not in 2017. State-Based Marketplaces using their own Marketplace platforms are not included in the HealthCare.gov states totals.

*Kentucky is not included in the net change in the number of issuers from 2016 to 2017, the sum of new issuers in 2017, and the sum of issuers exiting in 2017.

± New York has begun enrolling eligible Marketplace enrollees in its Basic Health Program (BHP), known as the "Essential Plan" in New York, including individuals with incomes less than or equal to 200% of FPL, who would have otherwise been eligible for QHP or state-funded Medicaid enrollment. BHP includes QHP enrollees who were re-determined eligible for the Essential Plan on or after 11/1/2015, and the majority of the lawfully residing non-citizens below 138 percent of FPL who were previously eligible for state-funded Medicaid who were re-determined eligible for BHP since 4/1/2015.

California averages are by rating region rather than county.

TABLE 11

Average Number of Marketplace Qualified Health Plans per County, 2016–2017 in HealthCare.gov States & State-Based Marketplaces for Which Data are Available

State	Average Number of QHPs		Change in Average Number of QHPs, 2016-2017*	Average Number of QHPs per Issuer		Change in Average Number of QHPs per Issuer, 2016-2017*
	2016	2017		2016	2017	
HealthCare.gov States Average (38 States)	**47**	**30**	**-17**	**10**	**10**	**1**
HealthCare.gov States						
AK	15	5	-10	8	5	-3
AL	13	6	-7	6	6	0
AR	40	24	-16	8	6	-2
AZ	65	4	-61	9	4	-5
DE	28	19	-9	9	6	-3
FL	52	55	3	10	14	5
GA	48	32	-16	8	12	4
HI	20	22	2	10	11	1
IA	26	15	-11	9	6	-3
IL	55	29	-25	9	12	3
IN	61	44	-17	11	12	1
KS	26	13	-13	10	6	-3
KY	N/A	11	N/A	N/A	7	N/A
LA	34	19	-15	8	6	-2
ME	30	25	-5	10	8	-2
MI	88	62	-25	10	10	0
MO	37	17	-20	10	10	0
MS	23	18	-5	9	13	4
MT	30	21	-9	10	7	-3
NC	24	10	-14	10	9	-1
ND	21	19	-2	7	6	-1
NE	31	13	-18	8	6	-1
NH	39	32	-7	8	8	0
NJ	38	19	-20	8	6	-2
NM	20	20	0	7	5	-2
NV	49	26	-24	13	8	-5
OH	81	45	-36	9	11	3
OK	22	13	-9	11	13	2
OR	73	28	-45	9	7	-2
PA	31	12	-18	7	5	-1
SC	70	25	-45	19	25	6
SD	19	17	-2	10	9	-1
TN	57	7	-50	19	4	-14
TX	50	26	-24	9	10	2
UT	70	22	-48	18	8	-10
VA	35	34	-1	9	9	0
WI	60	44	-16	11	12	0
WV	18	13	-5	15	7	-7
WY	28	28	0	28	28	0
State-Based Marketplaces						
CA #	27	30	3	5	6	1
CT	37	17	-20	9	9	0

DC	24	18	6	12	9	-3
MA	70	53	17	7	6	1
MN	47	18	-29	10	6	-5
NY - Basic Health Plan ±	5	6	1	2	2	0
NY - Marketplace ±	75	65	-10	4	4	0

Source: For states using the HealthCare.gov platform in 2016 and 2017, plan and premium information is from the plan landscape files. For State-Based Marketplaces using their own Marketplace platforms, plan and premium information was provided by the state. Plan and premium information from Minnesota was provided by the state and calculations were done by ASPE.

Note: Numbers may not sum due to rounding. With the exception of Connecticut and New York's Health Insurance Marketplace, counts do not include catastrophic plans. Issuers that only offer a catastrophic plan in a county (applicable to 33 counties in New Mexico in 2016 and 1 county in Arizona in 2017) are excluded when calculating the average number of QHPs per issuer. Average number of plans from 2016-2017 represent the number of Marketplace QHPs per county, weighted by plan selections in the county. State and HealthCare.gov average premiums are weighted by the number of Marketplace plan selections in each county, except for Kentucky, in which all counties were weighted equally. The 2016 and 2017 averages use PY2016 plan selections in 38 states. Kentucky, as well as State-Based Marketplaces using their own Marketplace platforms, are not included in the HealthCare.gov states average.

*Numbers may not sum due to rounding.

California averages are by rating region rather than county.

± New York has begun enrolling eligible Marketplace enrollees in its Basic Health Program (BHP), known as the "Essential Plan" in New York, including individuals with incomes less than or equal to 200% of FPL, who would have otherwise been eligible for QHP or state-funded Medicaid enrollment. BHP includes QHP enrollees who were re-determined eligible for the Essential Plan on or after 11/1/2015, and the majority of the lawfully residing non-citizens below 138 percent of FPL who were previously eligible for state-funded Medicaid who were re-determined eligible for BHP since 4/1/2015.

TABLE 12

2017 Average Monthly Marketplace Premiums, Issuers, Available QHPs in HealthCare.gov States & State-Based Marketplaces For Which Data are Available

2017										
			27-Year-Old with a Household Income of $25,000				Family of Four with a Household Income of $60,000			
			Average				Average			
State	**Total Number of Issuers in State**	**Average Number of QHPs per County**	Second-Lowest Silver Before Advance Premium Tax Credit	Second-Lowest Silver After Advance Premium Tax Credit	Advance Premium Tax Credit Amount	Percent Increase in Advance Premium Tax Credit Amount over 2016	Second-Lowest Silver Before Advance Premium Tax Credit	Second-Lowest Silver After Advance Premium Tax Credit	Advance Premium Tax Credit Amount	Percent Increase in Advance Premium Tax Credit Amount over 2016
HealthCare.gov States Average (39 States)	**6**	**30**	**$302**	**$142**	**$160**	**62%**	**$1,090**	**$405**	**$686**	**47%**
HealthCare.gov States										
AK*	1	5	$760	$103	$657	35%	$2,750	$316	$2,434	34%
AL	1	6	$384	$142	$242	140%	$1,392	$405	$987	106%
AR	4	24	$248	$142	$106	5%	$897	$405	$492	3%
AZ	2	4	$422	$142	$280	428%	$1,529	$405	$1,124	270%
DE	3	19	$347	$142	$205	38%	$1,257	$405	$852	31%
FL	7	55	$270	$142	$128	35%	$979	$405	$574	26%
GA	5	32	$273	$142	$131	39%	$987	$405	$582	28%
HI*	2	22	$288	$117	$171	80%	$1,042	$348	$694	63%
IA**	5	15	$308	$142	$166	61%	$1,116	$405	$711	46%
IL	5	29	$298	$142	$156	140%	$1,078	$405	$673	94%
IN	4	44	$229	$142	$87	-5%	$829	$405	$424	-5%
KS	3	13	$308	$142	$166	124%	$1,114	$405	$709	87%
KY	3	11	$259	$142	$117	N/A	$939	$405	$534	N/A
LA	4	19	$340	$142	$198	35%	$1,230	$405	$825	28%
ME	3	25	$317	$142	$175	33%	$1,146	$405	$741	25%
MI	10	62	$228	$142	$86	23%	$827	$405	$422	15%
MO**	4	17	$305	$142	$163	43%	$1,103	$405	$698	33%
MS	2	18	$273	$142	$131	51%	$989	$405	$584	37%
MT**	3	21	$381	$142	$239	98%	$1,378	$405	$973	77%
NC	2	10	$446	$142	$304	73%	$1,613	$405	$1,208	61%
ND	3	19	$288	$142	$146	15%	$1,044	$405	$639	11%

2017										
			27-Year-Old with a Household Income of $25,000				Family of Four with a Household Income of $60,000			
			Average				Average			
State	**Total Number of Issuers in State**	**Average Number of QHPs per County**	Second-Lowest Silver Before Advance Premium Tax Credit	Second-Lowest Silver After Advance Premium Tax Credit	Advance Premium Tax Credit Amount	Percent Increase in Advance Premium Tax Credit Amount over 2016	Second-Lowest Silver Before Advance Premium Tax Credit	Second-Lowest Silver After Advance Premium Tax Credit	Advance Premium Tax Credit Amount	Percent Increase in Advance Premium Tax Credit Amount over 2016
NE	2	13	$411	$142	$269	109%	$1,487	$405	$1,082	87%
NH	4	32	$219	$142	$77	7%	$792	$405	$387	3%
NJ**	3	19	$286	$142	$144	12%	$1,036	$405	$631	9%
NM	4	20	$224	$142	$82	165%	$813	$405	$408	82%
NV	4	26	$249	$142	$107	18%	$903	$405	$498	12%
OH	11	45	$226	$142	$84	6%	$819	$405	$414	4%
OK	1	13	$424	$142	$282	161%	$1,536	$405	$1,131	124%
OR	6	28	$287	$142	$145	77%	$1,040	$405	$635	55%
PA	8	12	$327	$142	$185	164%	$1,185	$405	$780	113%
SC	1	25	$319	$142	$177	70%	$1,154	$405	$749	53%
SD	2	17	$374	$142	$232	83%	$1,355	$405	$950	66%
TN	3	7	$385	$142	$243	161%	$1,393	$405	$988	121%
TX	10	26	$261	$142	$119	53%	$945	$405	$540	37%
UT	3	22	$294	$142	$152	49%	$950	$405	$545	42%
VA	11	34	$264	$142	$122	27%	$957	$405	$552	19%
WI**	15	44	$304	$142	$162	36%	$1,099	$405	$694	28%
WV**	2	13	$386	$142	$244	62%	$1,399	$405	$994	51%
WY	1	28	$413	$142	$271	14%	$1,495	$405	$1,090	12%
State-Based Marketplaces										
CA **#	11	30	$272	$142	$130	16%	$985	$405	$580	12%
CT **	2	17	$340	$142	$198	34%	$1,231	$405	$826	27%
DC**	2	18	$222	$142	$80	111%	$980	$405	$575	46%
MA**	10	53	$219	$142	$77	-8%	$765	$405	$360	-7%
MN**	4	18	$340	$142	$198	179%	$1396	$405	$991	109%

Source: Plan information is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for 39 states using the HealthCare.gov platform in 2017. For State-Based Marketplaces using their own Marketplace platforms, plan and premium information was provided by the state. Plan and premium information from Minnesota was provided by the state and calculations were done by ASPE.

Note: Averages for premiums and number of QHPs per county are weighted by the county's number of Marketplace 2016 plan selections except for California, which reports by rating region rather than county. In this example, the family of four is one 40-year-old adult, one 38-year-old adult, and two children under the age of 21. For households eligible for premium tax credits, after-tax-credit benchmark premiums are capped at a given percentage of household income. After-tax benchmark premiums will differ slightly between

2016 and 2017 for identical family compositions and income amounts because of changes in the applicable percentages and the Federal Poverty Guidelines. The 2016 guidelines are used to calculate benchmark premiums for coverage in 2017. Because poverty guideline thresholds generally increase each year, a given dollar amount of income may equate to a smaller percentage of the Federal Poverty Level (FPL) in one year than it did in the previous year. For example, a four-person family with an income of $60,000 was at 247 percent of the FPL by 2016 and 2015 guidelines, but at 252 percent of the FPL by 2014 guidelines. As a result, the percentage of income the family could pay for the benchmark plan in one year could be smaller in the next year.

* Alaska and Hawaii's federal poverty guidelines are higher than those for the continental United States; consequently, the after tax credit premium is lower for a given amount of income.

** In all 39 states, our calculations of premiums after tax credits assume that all members of the family of four making $60,000 would be eligible for premium tax credits. However, in states with higher Medicaid/CHIP thresholds the children would be eligible for Medicaid/CHIP and not eligible for premium tax credits.

*** For purposes of this analysis, counties in Kentucky were weighted equally because corresponding plan selection information by county was not available. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in the HealthCare.gov state averages. State-Based Marketplaces using their own Marketplace platforms are not included in the HealthCare.gov states averages.

California averages are by rating region rather than county.

TABLE 13

Second-Lowest Cost Silver Plan Monthly Premiums, 27-Year-Old (Before Tax Credits), 2016–2017 in Selected Counties in HealthCare.gov States & State-Based Marketplaces for Which Data are Available

State	County	City in County	Second-Lowest Cost Silver Monthly Premium for a 27-year-old		
			2016	2017	% Change
HealthCare.gov States					
AK	Anchorage	Anchorage	$590	$741	26%
AK	Juneau	Juneau	$590	$760	29%
AL	Jefferson	Birmingham	$236	$404	71%
AR	Pulaski	Little Rock	$254	$257	1%
AZ	Maricopa	Phoenix	$170	$416	145%
AZ	Pima	Tucson	$178	$286	61%
DE	New Castle	Wilmington	$292	$347	19%
FL	Broward	Ft. Lauderdale	$239	$249	4%
FL	Duval	Jacksonville	$220	$254	16%
FL	Hillsborough	Tampa	$206	$258	25%
FL	Miami-Dade	Miami	$216	$251	16%
FL	Orange	Orlando	$256	$298	16%
FL	Palm Beach	West Palm Beach	$235	$244	4%
GA	Fulton	Atlanta	$210	$224	6%
HI	Honolulu	Honolulu	$213	$288	35%
IA	Linn	Cedar Rapids	$233	$247	6%
IL	Cook	Chicago	$160	$255	60%
IN	Marion	Indianapolis	$266	$235	-12%
KS	Sedgwick	Wichita	$203	$296	46%
KS	Wyandotte	Kansas City	$240	$324	35%
KY	Fayette	Lexington	N/A	$205	N/A
KY	Jefferson	Louisville	N/A	$188	N/A
LA	Orleans	New Orleans	$272	$306	13%
ME	Cumberland	Portland	$236	$280	19%
MI	Wayne	Detroit	$185	$194	5%
MO	St. Louis	St. Louis	$235	$254	8%
MS	Jackson	Jackson	$228	$297	30%
MT	Gallatin	Bozeman	$267	$399	49%
NC	Guilford	Greensboro	$292	$440	51%
NC	Mecklenburg	Charlotte	$335	$469	40%
NC	Wake	Raleigh-Durham	$294	$401	37%
ND	Cass	Fargo	$249	$271	9%
NE	Douglas	Omaha	$256	$302	18%
NH	Hillsborough	Manchester	$214	$219	2%
NJ	Essex	Newark	$271	$289	7%
NM	Bernalillo	Albuquerque	$153	$212	39%
NV	Clark	Las Vegas	$214	$231	8%
OH	Cuyahoga	Cleveland	$189	$196	4%
OH	Franklin	Columbus	$240	$247	3%
OH	Hamilton	Cincinnati	$197	$195	-1%
OH	Montgomery	Dayton	$217	$209	-3%
OK	Oklahoma	Oklahoma City	$242	$404	67%
OK	Tulsa	Tulsa	$247	$423	71%
OR	Multnomah	Portland	$215	$256	19%

State	County	City in County	Second-Lowest Cost Silver Monthly Premium for a 27-year-old		
			2016	2017	% Change
PA	Allegheny	Pittsburgh	$156	$193	24%
PA	Philadelphia	Philadelphia	$226	$343	51%
SC	Richland	Columbia	$258	$331	29%
SD	Lincoln	Sioux Falls	$253	$367	45%
SD	Minnehaha	Sioux Falls	$253	$367	45%
TN	Davidson	Nashville	$230	$344	49%
TN	Shelby	Memphis	$229	$341	49%
TX	Bexar	San Antonio	$186	$227	22%
TX	Comal	San Antonio	$194	$232	20%
TX	Medina	San Antonio	$201	$399	99%
TX	Dallas	Dallas	$216	$232	7%
TX	El Paso	El Paso	$197	$218	11%
TX	Harris	Houston	$210	$236	13%
TX	Hidalgo	McAllen	$159	$180	13%
TX	Travis	Austin	$222	$252	13%
UT	Salt Lake	Salt Lake City	$229	$275	20%
VA	Henrico	Richmond	$227	$243	7%
WI	Milwaukee	Milwaukee	$267	$311	16%
WV	Cabell	Huntington	$260	$343	32%
WV	Wayne	Huntington	$260	$343	32%
WY	Laramie	Cheyenne	$350	$380	9%
State-Based Marketplaces					
CA	Los Angeles	Los Angeles - 1*	$201	$212	6%
CA	Los Angeles	Los Angeles - 2*	$209	$222	6%
CA	San Diego	San Diego	$243	$252	4%
CA	San Francisco	Francisco	$318	$364	15%
CT	Fairfield	Stamford	$321	$372	16%
DC	Washington	Washington	$181	$222	22%
MA	Suffolk	Boston	$231	$216	-6%
MN	Hennepin	Minneapolis	$184	$286	55%
MN	Ramsey	St. Paul	$184	$286	55%

Source: For states using the HealthCare.gov platform in 2016 and 2017, plan and premium information is from the plan landscape files. For State-Based Marketplaces using their own Marketplace platforms, plan and premium information was provided by the state. Plan and premium information from Minnesota was provided by the state and calculations were done by ASPE.
Note: The premiums in this table represent premiums before the application of tax credits. The number of QHPs in the county does not include catastrophic plans. This brief identifies the second-lowest cost silver plan based on the portion of the premium that covers essential health benefits (EHB); however, premiums reported in this table are for the full premium amount, not just the premium amount that covers EHB.. See the "Methodology and Limitations" section for details.
*Los Angeles County is divided into two regions for premium determinations.

TABLE 14

Number of Marketplace Issuers in County, 2016–2017 for Selected Cities in HealthCare.gov States & State-Based Marketplaces for Which Data are Available

State	County	City in County	Number of Issuers		Net Change in Number of Issuers, 2016-2017
			2016	2017	
HealthCare.gov States					
AK	Anchorage	Anchorage	2	1	-1
AK	Juneau	Juneau	2	1	-1
AL	Jefferson	Birmingham	3	1	-2
AR	Pulaski	Little Rock	5	4	-1
AZ	Maricopa	Phoenix	8	1	-7
AZ	Pima	Tucson	5	2	-3
DE	New Castle	Wilmington	3	3	0
FL	Broward	Ft. Lauderdale	7	5	-2
FL	Duval	Jacksonville	5	4	-1
FL	Hillsborough	Tampa	5	5	0
FL	Miami-Dade	Miami	7	5	-2
FL	Orange	Orlando	4	2	-2
FL	Palm Beach	West Palm Beach	7	5	-2
GA	Fulton	Atlanta	8	4	-4
HI	Honolulu	Honolulu	2	2	0
IA	Linn	Cedar Rapids	3	3	0
IL	Cook	Chicago	7	3	-4
IN	Marion	Indianapolis	6	4	-2
KS	Sedgwick	Wichita	3	2	-1
KS	Wyandotte	Kansas City	2	2	0
KY	Lexington	Fayette	N/A	3	N/A
KY	Louisville	Jefferson	N/A	3	N/A
LA	Orleans	New Orleans	5	4	-1
ME	Cumberland	Portland	2	3	1
MI	Wayne	Detroit	12	9	-3
MO	St. Louis	St. Louis	4	2	-2
MS	Jackson	Jackson	2	1	-1
MT	Gallatin	Bozeman	3	3	0
NC	Guilford	Greensboro	3	1	-2
NC	Mecklenburg	Charlotte	3	1	-2
NC	Wake	Raleigh-Durham	3	2	-1
ND	Cass	Fargo	3	3	0
NE	Douglas	Omaha	4	2	-2
NH	Hillsborough	Manchester	4	4	0
NJ	Essex	Newark	6	3	-3
NM	Bernalillo	Albuquerque	4	4	0
NV	Clark	Las Vegas	4	3	-1
OH	Cuyahoga	Cleveland	11	5	-6
OH	Franklin	Columbus	8	4	-4
OH	Hamilton	Cincinnati	10	6	-4
OH	Montgomery	Dayton	10	6	-4
OK	Oklahoma	Oklahoma City	2	1	-1
OK	Tulsa	Tulsa	2	1	-1
OR	Multnomah	Portland	7	5	-2
PA	Allegheny	Pittsburgh	5	3	-2
PA	Philadelphia	Philadelphia	4	2	-2

State	County	City in County	Number of Issuers		Net Change in Number of Issuers, 2016-2017
			2016	2017	
SC	Richland	Columbia	4	1	-3
SD	Lincoln	Sioux Falls	2	2	0
SD	Minnehaha	Sioux Falls	2	2	0
TN	Davidson	Nashville	4	2	-2
TN	Shelby	Memphis	4	2	-2
TX	Bexar	San Antonio	8	4	-4
TX	Comal	San Antonio	6	3	-3
TX	Medina	San Antonio	3	1	-2
TX	Dallas	Dallas	8	3	-5
TX	El Paso	El Paso	5	3	-2
TX	Harris	Houston	7	3	-4
TX	Hidalgo	McAllen	7	4	-3
TX	Travis	Austin	8	3	-5
UT	Salt Lake	Salt Lake City	4	3	-1
VA	Henrico	Richmond	4	4	0
WI	Milwaukee	Milwaukee	6	4	-2
WV	Cabell	Huntington	2	2	0
WV	Wayne	Huntington	2	2	0
WY	Laramie	Cheyenne	1	1	0
State-Based Marketplaces					
CA	Los Angeles - 1*	Los Angeles	6	6	0
CA	Los Angeles - 2*	Los Angeles	7	7	0
CA	San Diego	San Diego	6	6	0
CA	Francisco	San Francisco	5	6	1
CT	Fairfield	Stamford	4	2	-2
DC	Washington	Washington	2	2	0
MA	Suffolk	Boston	10	9	-1
MN	Minneapolis	Hennepin	5	4	-1
MN	St. Paul	Ramsey	5	4	-1
NY - Basic Health Plan ±	Albany	Albany	5	4	-1
NY - Marketplace ± #	Albany	Albany	7	6	-1
NY - Basic Health Plan ±	Erie	Buffalo	5	7	2
NY - Marketplace ± #	Erie	Buffalo	4	4	0
NY - Basic Health Plan ±	New York	New York City	8	8	0
NY - Marketplace ± #	New York	New York City	10	9	-1
NY - Basic Health Plan ±	Monroe	Rochester	5	5	0
NY - Marketplace ± #	Monroe	Rochester	3	3	0
NY - Basic Health Plan ±	Onondaga	Syracuse	3	3	0
NY - Marketplace ± #	Onondaga	Syracuse	3	3	0

Source: For states using the HealthCare.gov platform in 2016 and 2017, plan and premium information is from the plan landscape files. For State-Based Marketplaces using their own Marketplace platforms, plan and premium information was provided by the state. Plan and premium information from Minnesota was provided by the state and calculations were done by ASPE.
Note: Qualified health plan issuers are counted based on unique HIOS issuer ID number.
* Los Angeles County is divided into two regions for premium determinations.
± New York has begun enrolling eligible Marketplace enrollees in its Basic Health Program (BHP), known as the "Essential Plan" in New York, including individuals with incomes less than or equal to 200% of FPL, who would have otherwise been eligible for QHP or state-funded Medicaid enrollment. BHP includes QHP enrollees who were re-determined eligible for the Essential Plan on or after 11/1/2015, and the majority of the lawfully residing non-citizens below 138 percent of FPL who were previously eligible for state-funded Medicaid who were re-determined eligible for BHP since 4/1/2015.
Data does not include stand-alone dental plans, child-only plans, or small-group Marketplace (SHOP) plans

APPENDIX B: ADDITIONAL TABLES

TABLE 15

Summary of Marketplace Health Plans and Issuers for HealthCare.gov States, 2016 – 2017

	2016 Average Weighted by 2016 Plan Selections	**2017 Average** Weighted by 2016 Plan Selections
Number of HealthCare.gov States Included in Calculations	*38*	*38*
Issuers in State	10	6
Issuers in County	5	3
Percent of consumers with choice of 3 or more issuers	88%	56%
Percent of consumers with choice of 2 or more issuers	98%	79%
Qualified Health Plans in County *(excluding catastrophic)*	47	30
Plans in County	50	32
Catastrophic Plans	3	1
Bronze Plans	15	10
Silver Plans	19	14
Gold Plans	11	5
Platinum Plans	2	1

Source: Information on plans and issuers is from the plan landscape files and active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform in 2016 and 2017. Kentucky is new to the HealthCare.gov platform in 2017 and is not included in this analysis.
Note: All averages in this table are weighted based on plan selections in the county. The 2016 and 2017 averages use 2016 plan selections in 38 states.The number of issuers per state is calculated by finding the total number of issuers offering QHPs anywhere in each state, then taking an average over all states weighted by plan selections in the state. Numbers may not sum due to rounding.

TABLE 16
Examples of Maximum Monthly Health Insurance Premiums for the Second-Lowest Cost Silver Plan for Marketplace Coverage for a Single Adult in 2017

Single Adult Income	Percent of the Federal Poverty Level	Maximum Percent of Income Paid toward Second-Lowest Cost Silver Plan	Maximum Monthly Premium Payment for Second-Lowest Cost Silver Plan
$11,880	100%	2.04%	$20
$17,820	150%	4.08%	$61
$23,760	200%	6.43%	$127
$29,700	250%	8.21%	$203
$35,640	300%	9.69%	$288
$41,580	350%	9.69%	$336
$47,520	401%	No Limit	No Limit

Source: Applicable percentages for 2017 coverage are available at: https://www.irs.gov/pub/irs-drop/rp-16-24.pdf. The 2016 Federal Poverty Guidelines, used for premium tax credits for 2017 coverage, are at: https://aspe.hhs.gov/poverty-guidelines.
Notes: Income examples are based on the 2016 federal poverty guidelines for the continental United States. Alaska and Hawaii have higher federal poverty guidelines, which are not shown in this table. In states expanding Medicaid, individuals and families at between 100 and 138 percent of the FPL who are eligible for Medicaid coverage are not eligible for premium tax credits. For more information on premium tax credits, see the Internal Revenue Service final rule on "Health Insurance Premium Tax Credit," (Federal Register, May 23, 2012, vol., 77, no. 100, p. 30392; available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf).

APPENDIX C: COMPARING 2017 MARKETPLACE PREMIUMS TO CBO PROJECTIONS

In November 2009, the Congressional Budget Office (CBO) projected that the national average premium for the second-lowest-cost Marketplace silver plan would be $5,200 for single coverage in 2016 under the version of the ACA debated by the Senate.[32] This is the only projection of the benchmark premiums under the law that CBO issued in advance of the law's passage.[33,34] CBO did not report its corresponding projection for 2017, so ASPE approximated CBO's premium projection for 2017 by trending the 2016 projection forward to 2017 using information reported in later CBO publications.

Specifically, CBO reported in March 2012 that its average underlying annual rate of growth in private insurance premiums for the period 2012 to 2022 was 5.7 percent; CBO further indicated that the average growth rate for this period was approximately 0.8 percentage points below the growth rate used in its March 2011 projections, implying that the average growth rate in those earlier projections had been around 6.5 percent.[35] CBO had previously indicated that the assumptions used in its March 2011 projections were similar to those used in its original estimates of the ACA.[36]

On that basis, ASPE used a trend rate of 6.5 percent to trend CBO's projection for 2016 forward to 2017 and estimated that CBO's November 2009 estimate of the national average premium for the second-lowest cost Marketplace silver plan in 2017 was around $5,538. For comparison, ASPE estimates that the weighted average premium for single coverage under the second-lowest cost silver plan will be $5,586 in the HealthCare.gov states in 2017, assuming that the age and geographic distribution of 2017 plan selections matches distribution of 2016 plan selections.[37] As discussed elsewhere in this brief, complete data are not available for State-Based Marketplaces using their own enrollment platforms. Available data on 2016 premiums and premium growth from 2016 to 207 indicate, however, that a nationwide average for 2017 would be very similar to this average for the HealthCare.gov states. Thus, nationwide 2017 Marketplace premiums appear to be very close to CBO's November 2009 projections.

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[32] Congressional Budget Office. November 2009. *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act.* http://cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf.

[33] The version of the ACA considered by the Senate differed somewhat from the final version of the law. CBO subsequently stated that premium projections under the final version of the ACA would have been "quite similar" to those included in this November 2009 letter. See Congressional Budget Office. March 2011. *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010.* http://www.cbo.gov/sites/default/files/03-30-healthcarelegislation.pdf.

[34] Another recent analysis has used this November 2009 projection to assess how CBO's initial projections of Marketplace premiums have compared to actual Marketplace premiums. See Larry Levitt, Cynthia Cox, and Gary Claxton August 2016 *How ACA Marketplace Premiums Measure Up to Expectations*. http://kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations.

[35] Congressional Budget Office. March 2012. *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*. https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/03-13-Coverage%20Estimates.pdf.

[36] Douglas Elmendorf. March 2011. *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010.* http://www.cbo.gov/sites/default/files/03-30-healthcarelegislation.pdf.

[37] Using the 5.7 percent growth rate implies a CBO estimate of the national average premium for the second-lowest cost Marketplace silver plan of around $5,496 in 2017 which is also slightly higher than the ASPE estimate of $5,586 for weighted average premium for single coverage under the second-lowest-cost silver plan.

NATIONAL CENTER FOR HEALTH STATISTICS
National Health Interview Survey Early Release Program

Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2016

by Emily P. Zammitti, M.P.H., Robin A. Cohen, Ph.D., and Michael E. Martinez, M.P.H., M.H.S.A.,
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What's New?

- This report provides health insurance estimates from selected states using 2016 National Health Interview Survey data.

Highlights

- In the first 6 months of 2016, 28.4 million (8.9%) persons of all ages were uninsured at the time of interview—20.2 million fewer persons than in 2010, but only 0.2 million fewer persons than in 2015 (a nonsignificant difference).
- In the first 6 months of 2016, among adults aged 18–64, 12.4% were uninsured at the time of interview, 20.0% had public coverage, and 69.2% had private health insurance coverage.
- In the first 6 months of 2016, among children aged 0–17 years, 5.0% were uninsured, 42.7% had public coverage, and 53.9% had private coverage.
- Among adults aged 18–64, the percentage with private coverage through the Health Insurance Marketplace or state-based exchanges has not changed significantly—from 4.8% (9.3 million) in the second quarter of 2015 to 4.8% (9.4 million) in the second quarter of 2016.
- The percentage of persons under age 65 with private insurance enrolled in a high-deductible health plan (HDHP) increased, from 25.3% in 2010 and 36.7% in 2015 to 38.8% in the first 6 months of 2016.

Introduction

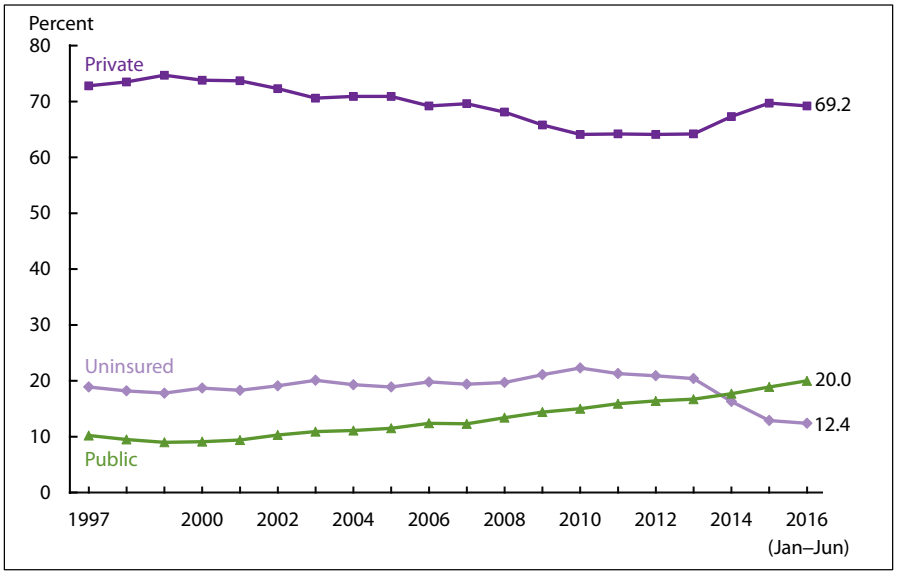
This report from the National Center for Health Statistics (NCHS) presents selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–June 2016 National Health Interview Survey (NHIS), along with comparable estimates from previous calendar years. Estimates for 2016 are based on data for 48,549 persons.

Three estimates of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured at least part of the year prior to interview (which includes persons uninsured for more than a year), and (c) uninsured for more than a year at the time of interview. Estimates of public and private coverage, coverage through exchanges, and enrollment in high-deductible health plans (HDHPs) and consumer-directed health plans (CDHPs) are also presented. Detailed appendix tables at the end of this report show estimates by selected demographics. Definitions are provided in the Technical Notes at the end of this report.

This report is updated quarterly and is part of the NHIS Early Release (ER) Program, which releases updated selected estimates that are available from the NHIS website at http://www.cdc.gov/nchs/nhis.htm.

Estimates for each calendar quarter, by selected demographics, are also available as a separate set of tables through the ER Program. For more information about NHIS and the ER Program, see the Technical Notes and Additional Early Release Program Products sections at the end of this report.

Figure 1. Percentage of adults aged 18–64 who were uninsured or had private or public coverage at the time of interview: United States, 1997–June 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 1997–2016, Family Core component.

Results

From January through June 2016, the percentage of persons of all ages who were uninsured at the time of interview was 8.9% (28.4 million). The decrease of 0.2 percentage points from the 2015 uninsured rate of 9.1% (28.6 million) was not statistically significant. About 20.2 million fewer persons lacked health insurance coverage in the first 6 months of 2016 compared with 2010 (48.6 million or 16.0%).

Long-term trends

In the first 6 months of 2016, among adults aged 18–64, 12.4% were uninsured at the time of interview, 20.0% had public coverage, and 69.2% had private health insurance coverage (Figure 1). From 1997 through 2013, the percentage of adults aged 18–64 who were uninsured at the time of interview generally increased. More recently, the percentage of uninsured adults aged 18–64 decreased, from 20.4% in 2013 to 12.4% in the first 6 months of 2016. During this 3-year period, corresponding increases were seen in both public and private coverage among adults aged 18–64.

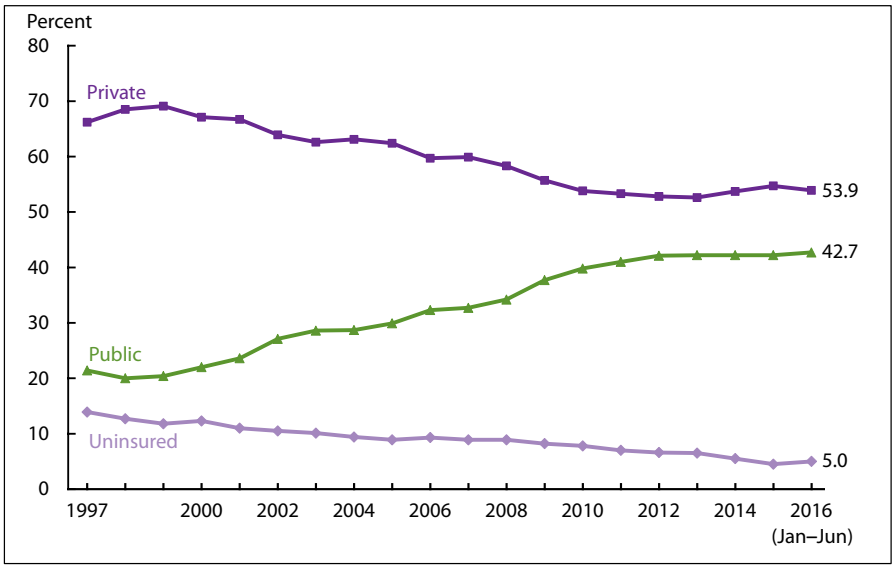
In the first 6 months of 2016, among children aged 0–17 years, 5.0% were uninsured, 42.7% had public coverage, and 53.9% had private coverage (Figure 2). The percentage of children who were uninsured generally decreased, from 13.9% in 1997 to 5.0% in the first 6 months of 2016. From 1997 through 2012, the percentage of children with private coverage generally decreased, and the percentage of children with public coverage generally increased. However, more recently, the percentage of children with public or private coverage has leveled off. From 2011 through the first 6 months of 2016, public coverage for children has ranged between 41.0% and 42.7%. The observed increase in private coverage for children, from 53.3% in 2011 to 53.9% in the first 6 months of 2016, was not significant.

Short-term trends by age

In the first 6 months of 2016, adults aged 25–34 were almost twice as likely as adults aged 45–64 to lack health insurance coverage (16.5% compared with 8.8%) (Figure 3). Adults aged 18–24 and 35–44 had similar rates of uninsurance, 14.1% and 14.3%, respectively.

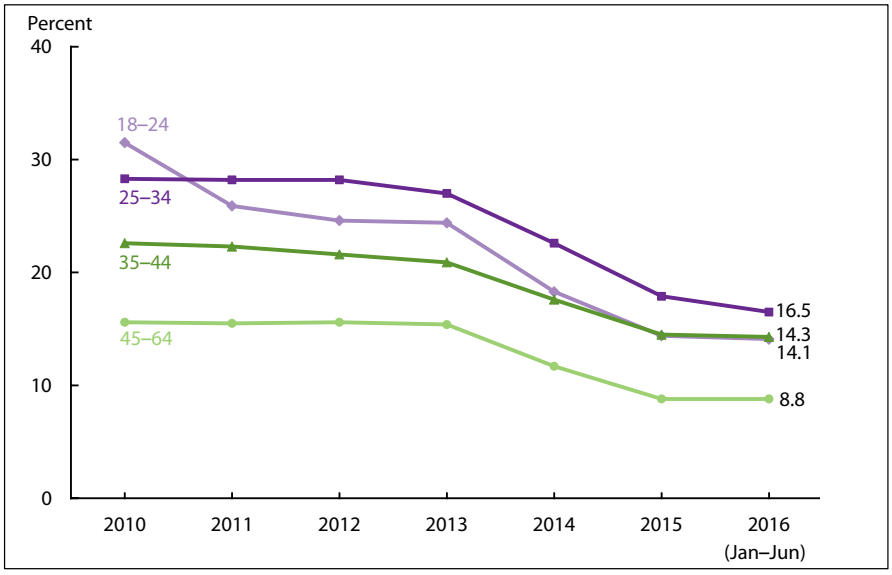
For all age groups shown in Figure 3, with the exception of adults aged 18–24, the rates of uninsurance at the time of interview remained relatively stable from 2010 through 2013. Among adults aged 18–24, the percentage of those uninsured decreased, from 31.5% in 2010 to 25.9% in 2011, and then remained stable through 2013. For all age groups, the percentage who were uninsured decreased significantly from 2013 through the first 6 months of 2016. The magnitude of the decreases ranged from –6.6 percentage points for adults aged 35–44 and 45–64 to –10.5 percentage points for adults aged 25–34. For all age groups shown in Figure 3, the rates of uninsurance at the time of interview did not change significantly between 2015 and the first 6 months of 2016.

Figure 2. Percentage of children aged 0–17 years who were uninsured at the time of interview or had private or public coverage: United States, 1997–June 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 1997–2016, Family Core component.

Figure 3. Percentage of adults aged 18–64 who were uninsured at the time of interview, by age group: United States, 2010–June 2016



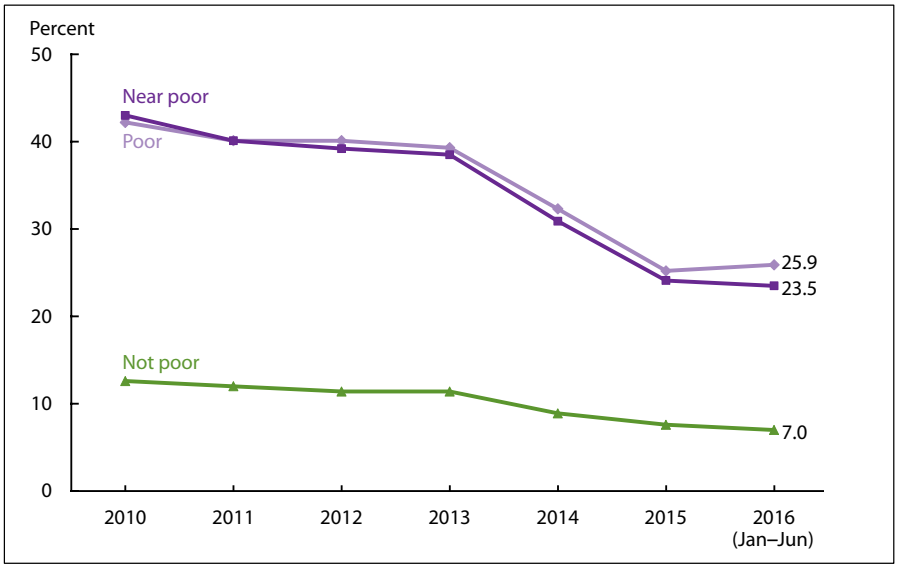
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Short-term trends by poverty status

In the first 6 months of 2016, among adults aged 18–64, 25.9% of those who were poor, 23.5% of those who were near poor, and 7.0% of those who were not poor lacked health insurance coverage at the time of interview (Figure 4). A decrease was noted in the percentage of uninsured adults from 2010 through the first 6 months of 2016 among all three poverty groups; however, the greatest decreases in the uninsured rate since 2013 were among adults who were poor or near poor. More recently, among adults who were poor, near poor, and not poor, there was no significant change in the percentage of those who were uninsured between 2015 and the first 6 months of 2016.

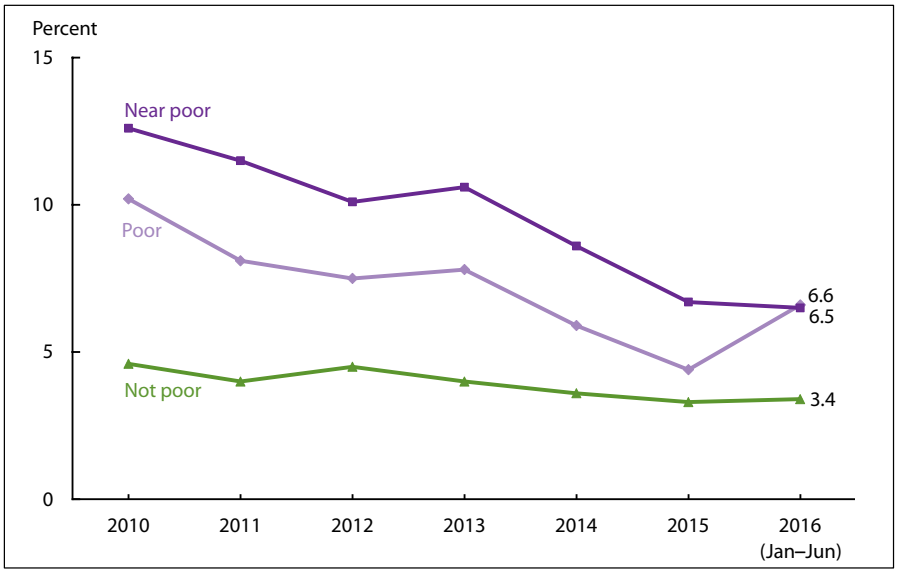
In the first 6 months of 2016, among children aged 0–17 years, 6.6% of those who were poor, 6.5% of those who were near poor, and 3.4% of those who were not poor lacked health insurance coverage at the time of interview (Figure 5). A general decrease in the percentage of uninsured children was observed among the poor, near poor, and not poor from 2010 through 2015. The observed change in the percentage of children who were uninsured between 2015 and the first 6 months of 2016 among near poor and not poor children was not significant. However, the increase in the percentage of children who were uninsured between 2015 (4.4%) and the first 6 months of 2016 (6.6%) among poor children was significant.

Figure 4. Percentage of adults aged 18–64 who were uninsured at the time of interview, by poverty status: United States, 2010–June 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Figure 5. Percentage of children aged 0–17 years who were uninsured at the time of interview, by poverty status: United States, 2010–June 2016

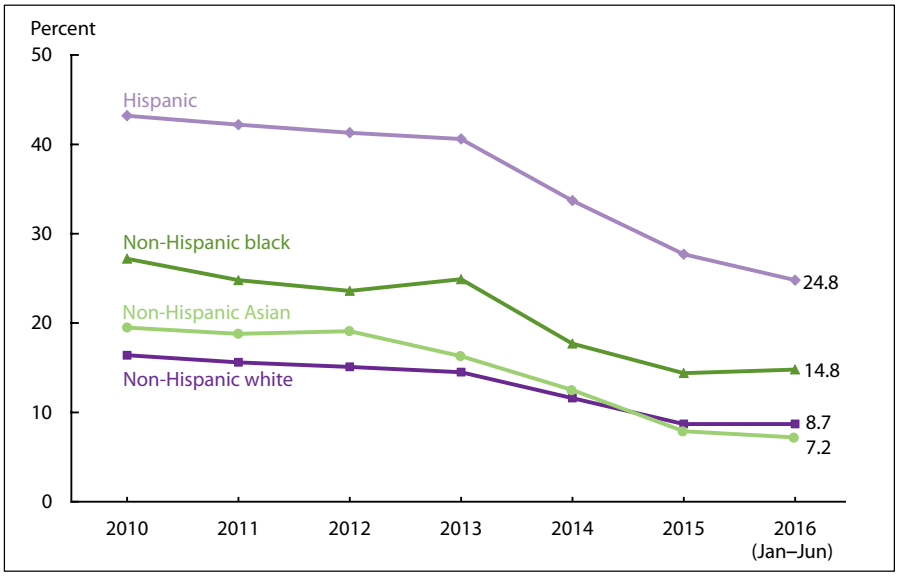


NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Short-term trends by race and ethnicity

In the first 6 months of 2016, 24.8% of Hispanic, 14.8% of non-Hispanic black, 8.7% of non-Hispanic white, and 7.2% of non-Hispanic Asian adults aged 18–64 lacked health insurance coverage at the time of interview (Figure 6). Significant decreases in the percentage of uninsured adults were observed between 2013 and the first 6 months of 2016 for Hispanic, non-Hispanic black, non-Hispanic white, and non-Hispanic Asian adults. Hispanic adults had the greatest percentage point decrease in the uninsured rate between 2013 (40.6%) and the first 6 months of 2016 (24.8%). For all race and ethnicity groups shown in Figure 6, the rates of uninsurance at the time of interview did not significantly change from 2015 through the first 6 months of 2016.

Figure 6. Percentage of adults aged 18–64 who were uninsured at the time of interview, by race and ethnicity: United States, 2010–June 2016



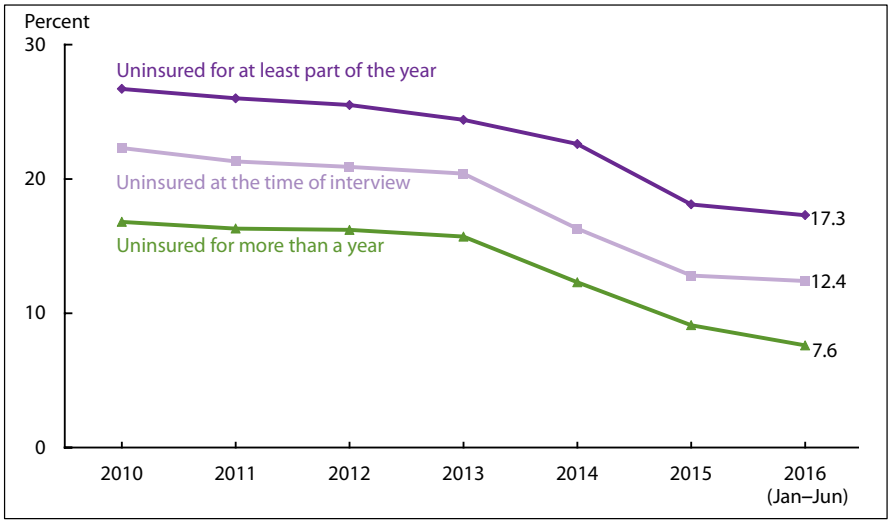
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Periods of noncoverage

Among adults aged 18–64, the percentage of those who were uninsured at the time of interview decreased, from 22.3% (42.5 million) in 2010 to 12.4% (24.4 million) in the first 6 months of 2016 (Figure 7). The percentage of adults who were uninsured for at least part of the past year decreased, from 26.7% (51.0 million) in 2010 to 17.3% (34.0 million) in the first 6 months of 2016. The percentage of adults who were uninsured for more than a year decreased, from 16.8% (32.0 million) in 2010 to 7.6% (15.0 million) in the first 6 months of 2016.

More recently, the observed changes in the percentage of adults aged 18–64 who were uninsured at least part of the year or at the time of interview between 2015 and the first 6 months of 2016 were not significant. However, the decrease in the percentage of adults who were uninsured for more than a year between 2015 (9.1%) and the first 6 months of 2016 (7.6%) was significant.

Figure 7. Percentage of adults aged 18–64 without health insurance, by three measures of uninsurance: United States, 2010–June 2016



NOTES: In 2016, answer categories for those who are currently uninsured concerning the length of non-coverage were modified. Therefore, 2016 estimates of "uninsured for at least part of the past year" and "uninsured for more than a year" may not be completely comparable to previous years. For more information on this change, see Technical Notes. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

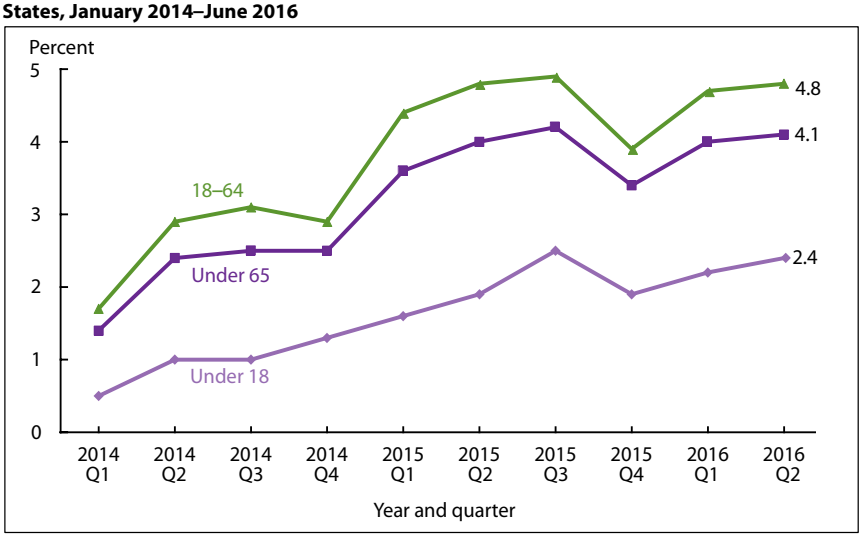
Private exchange coverage

Among persons under age 65, 65.0% (175.7 million) were covered by private health insurance plans at the time of interview in the first 6 months of 2016. This includes 4.1% (11.0 million) covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges. The observed increase in the percentage of persons under 65 who were enrolled in exchange plans, from 4.0% (10.7 million) in the second quarter of 2015 to 4.1% (11.1 million) in the second quarter of 2016, was not significant (Figure 8).

Among adults aged 18–64, 69.2% (136.1 million) were covered by private health insurance plans at the time of interview in the first 6 months of 2016. This includes 4.7% (9.3 million) covered by private health insurance plans obtained through the Health Insurance Marketplace or state-based exchanges. The percentage of adults aged 18–64 covered by exchange plans did not significantly change from the second quarter of 2015 (4.8% or 9.3 million) to the second quarter of 2016 (4.8% or 9.4 million). However, more recently, this percentage increased significantly, from 3.9% (7.8 million) in the fourth quarter of 2015 to 4.8% (9.4 million) in the second quarter of 2016 (Figure 8). The percentage of persons aged 18–64 who were enrolled in exchange plans did not significantly change from the first quarter of 2016 (4.7% or 9.2 million) to the second quarter of 2016 (4.8% or 9.4 million) (Figure 8).

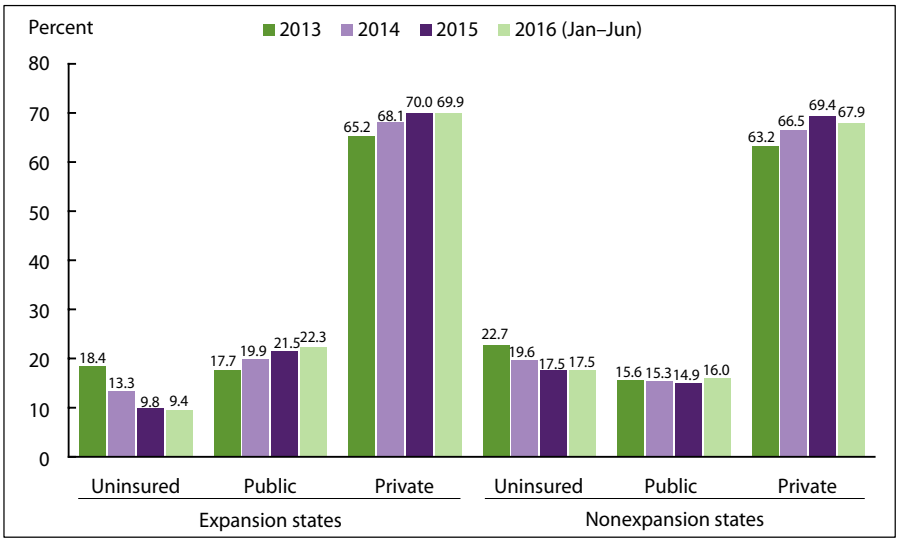
Among children aged 0–17 years, 53.9% (39.7 million) were covered by private health insurance at the time of interview in the first 6 months of 2016. This includes 2.3% (1.7 million) covered by plans obtained through the Health Insurance Marketplace or state-based exchanges. The 12-month increase in the percentage of children enrolled in exchange plans, from 1.9% (1.4 million) in the second quarter of 2015 to 2.4% (1.8 million) in the second quarter of 2016, was not significant (Figure 8).

Figure 8. Percentage of persons under age 65 with private health insurance obtained through the Health Insurance Marketplace or state-based exchanges, by age group and quarter: United States, January 2014–June 2016



NOTES: Includes persons who have purchased a private health insurance plan through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act of 2010 (P.L. 111–148, P.L. 111–152). 2014 is the first year that all states had exchange-based coverage. All persons who have exchange-based coverage are considered to have private health insurance. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2014–2016, Family Core component.

Figure 9. Percentage of adults aged 18–64 who were uninsured or had private or public coverage at the time of interview, by year and state Medicaid expansion status: United States, 2013–June 2016



NOTES: For 2013 and 2014, there were 26 Medicaid expansion states. For 2015, there were 29 Medicaid expansion states. For 2016, there were 32 Medicaid expansion states. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2013–2016, Family Core component.

Health insurance coverage by state Medicaid expansion status

Under provisions of the Affordable Care Act (ACA) of 2010, states have the option to expand Medicaid coverage to those with low income. From January through June 2016, adults aged 18–64 residing in Medicaid expansion states were less likely to be uninsured than those residing in nonexpansion states (Figure 9). In Medicaid expansion states, the percentage of uninsured adults decreased, from 18.4% in 2013 to 9.4% in the first 6 months of 2016. In nonexpansion states, the percentage of uninsured adults decreased, from 22.7% in 2013 to 17.5% in the first 6 months of 2016. In both Medicaid expansion states and nonexpansion states, the percentage of adults aged 18–64 who were uninsured or had private or public coverage did not change significantly between 2015 and the first 6 months of 2016.

Health insurance coverage by state Health Insurance Marketplace type

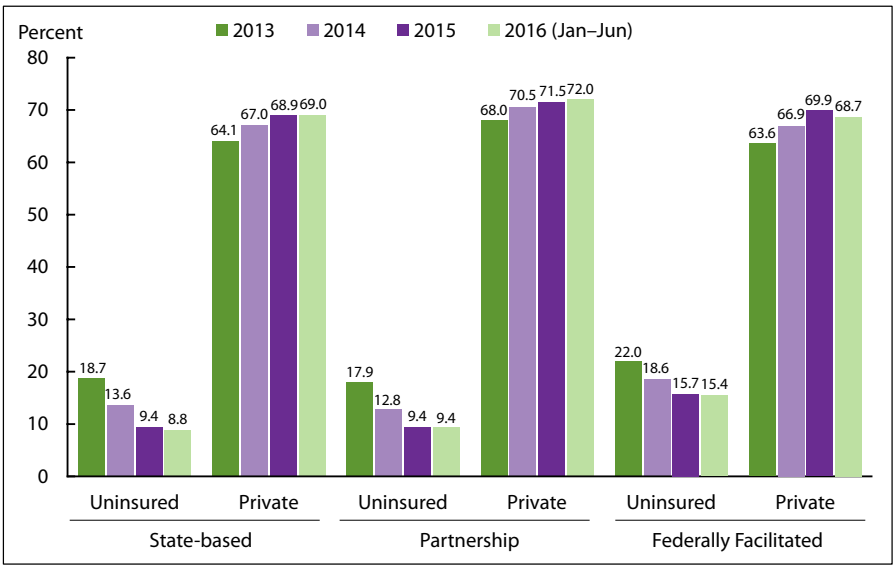
Under provisions of ACA, states have the option to set up and operate their own Health Insurance Marketplace, rely on a Federally Facilitated Marketplace operated solely by the federal government, or have a hybrid partnership Marketplace that is operated by the federal government but within which the state runs certain functions and makes key decisions. From January through June 2016, adults aged 18–64 in states with a Federally Facilitated Marketplace were more likely to be uninsured than those in states with a state-based Marketplace or states with a partnership Marketplace (Figure 10).

Among adults aged 18–64, decreases were seen in the uninsured rates between 2013 and the first 6 months of 2016 in states with a state-based Marketplace, a partnership Marketplace, and a Federally Facilitated Marketplace. For all three state Health Insurance Marketplace types displayed in Figure 10, the rates of uninsurance and private coverage at the time of interview among adults aged 18–64 did not significantly change from 2015 through the first 6 months of 2016.

Estimates of enrollment in HDHPs and CDHPs

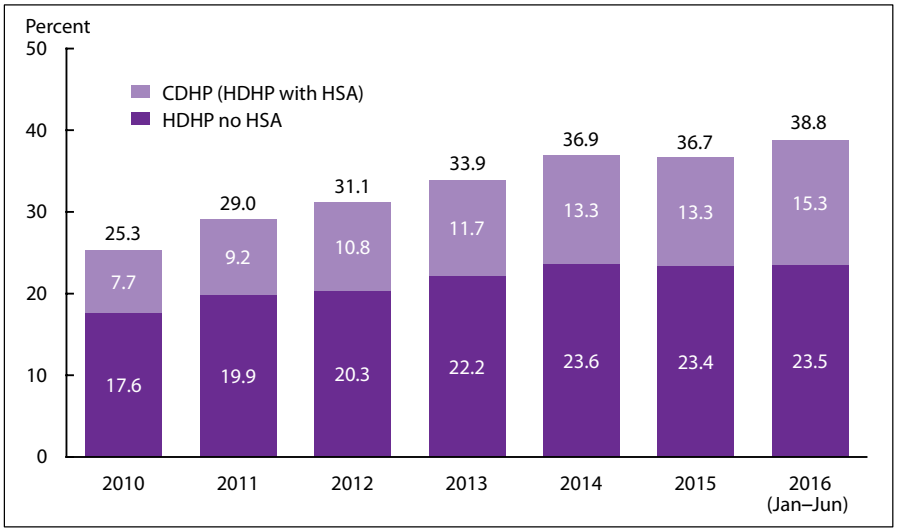
In the first 6 months of 2016, 38.8% of persons under age 65 with private health insurance were enrolled in an HDHP, including 15.3% who were enrolled in a CDHP (an HDHP with a health savings account [HSA]) and 23.5% who were enrolled in an HDHP without an HSA (Figure 11) (see Technical Notes for definitions of HDHP, CDHP, and HSA). Among those with private insurance, enrollment in HDHPs has generally increased since 2010. The percentage who were enrolled in an HDHP increased over 13 percentage points, from 25.3% in 2010 to 38.8% in the first 6 months of 2016. More recently, the percentage who were enrolled in an HDHP increased, from 36.7% in 2015 to 38.8% in the first 6 months of 2016. The percentage who were enrolled in a CDHP almost doubled, from 7.7% in 2010 to 15.3% in the first 6 months of 2016. More recently, the percentage who were enrolled in a CDHP increased, from 13.3% in 2015 to 15.3% in the first 6 months of 2016.

Figure 10. Percentage of adults aged 18–64 who were uninsured or who had private coverage at the time of interview, by year and state Health Insurance Marketplace type: United States, 2013–June 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2013–2016, Family Core component.

Figure 11. Percentage of persons under age 65 enrolled in a high-deductible health plan without a health savings account, or in a consumer-directed health plan, among those with private health insurance coverage: United States, 2010–June 2016

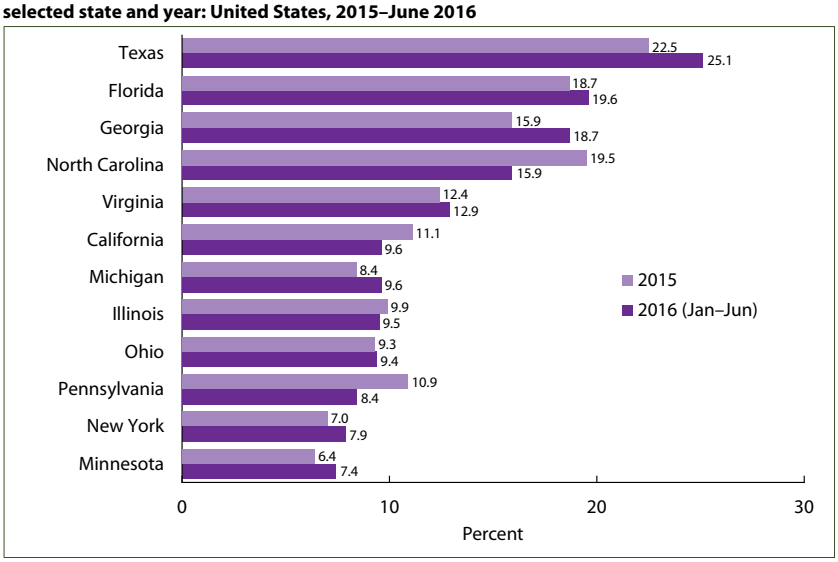


NOTES: CDHP is consumer-directed health plan, which is a high-deductible health plan (HDHP) with a health savings account (HSA). HDHP no HSA is a high-deductible health plan without an HSA. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Health insurance coverage in selected states

State-specific health insurance estimates for persons aged 18–64 are presented for 12 states (Figure 12). Of these 12 states, none had significantly different percentages of persons aged 18–64 who were uninsured in the first 6 months of 2016, compared with 2015.

Figure 12. Percentage of adults aged 18–64 who were uninsured at the time of interview, by selected state and year: United States, 2015–June 2016



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2015–2016, Family Core component.

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Technical Notes

The National Center for Health Statistics (NCHS) is releasing selected estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–June 2016 National Health Interview Survey (NHIS), along with comparable estimates from previous calendar years.

To reflect different policy-relevant perspectives, three measures of lack of health insurance coverage are provided: (a) uninsured at the time of interview, (b) uninsured for at least part of the year prior to interview (which also includes persons uninsured for more than a year), and (c) uninsured for more than a year at the time of interview. The three time frames are defined as:

- *Uninsured at the time of interview* provides an estimate of persons who at the given time may have experienced barriers to obtaining needed health care.
- *Uninsured for at least part of the past year* provides an annual caseload of persons who may experience barriers to obtaining needed health care. This measure includes persons who have insurance at the time of interview but who had a period of noncoverage in the year prior to interview, as well as those who are currently uninsured and who may have been uninsured for a long period of time.
- *Uninsured for more than a year* provides an estimate of those with a persistent lack of coverage who may be at high risk of not obtaining preventive services or care for illness and injury.

These three measures are not mutually exclusive, and a given individual may be counted in more than one of the measures. Estimates of enrollment in public and private coverage are also provided.

Persons who were uninsured at the time of interview were asked the following question (HILAST): *Not including Single Service Plans, about how long has it been since [you/Alias] last had health care coverage?* In 2016, the answer categories for the HILAST questions were modified to align NHIS responses to those of other national federal surveys. Therefore, 2016 estimates of "uninsured for at least part of the past year" and "uninsured for more than a year" may not be completely comparable to previous years. Prior to 2016, the answer categories for the HILAST question were: 6 months or less; More than 6 months, but not more than 1 year ago; More than 1 year, but not more than 3 years ago; More than 3 years; and Never. Beginning in 2016, the answer categories for the HILAST question are: 6 months or less; More than 6 months, but less than 1 year; 1 year; More than 1 year, but less than 3 years; 3 years or more; and Never.

This report also includes estimates for three types of consumer-directed private health care. Consumer-directed health care may enable individuals to have more control over when and how they access care, what types of care they use, and how much they spend on health care services. National attention to consumer-directed health care increased following enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108–173), which established tax-advantaged health savings accounts (HSAs) (1). In 2007, three questions were added to the health insurance section of NHIS to monitor enrollment in consumer-directed health care among persons with private health insurance. Estimates are provided for enrollment in high-deductible health plans (HDHPs), plans with high deductibles coupled with HSAs (i.e., consumer-directed health plans or CDHPs), and being in a family with a flexible spending account (FSA) for medical expenses not otherwise covered. For a more complete description of consumer-directed health care, see the "Definitions of selected terms" below.

The 2016 health insurance estimates are being released prior to final data editing and final weighting to provide access to the most recent information from NHIS. Differences between estimates calculated using preliminary data files and final data files are typically less than 0.1 percentage point. However, preliminary estimates of persons without health insurance coverage are generally 0.1–0.3 percentage points lower than the final estimates due to the editing procedures used for the final data files.

Estimates for 2016 are stratified by age group, sex, race and ethnicity, poverty status, marital status, employment status, region, and educational attainment.

Data source

NHIS is a multistage probability sample survey of the civilian noninstitutionalized population of the United States and is the source of data for this report. The survey is conducted continuously throughout the year by NCHS through an agreement with the U.S. Census Bureau.

NHIS is a comprehensive health survey that can be used to relate health insurance coverage to health outcomes and health care utilization. It has a low item nonresponse rate (about 1%) for the health insurance questions. Because NHIS is conducted throughout the year—yielding a nationally representative sample each month—data can be analyzed monthly or quarterly to monitor health insurance coverage trends.

A new sample design was implemented with the 2016 NHIS. Sample areas were reselected to take into account changes in the distribution of the U.S. population since 2006, when the previous sample design was first implemented; commercial address lists were used as the main source of addresses, rather than field listing; and the oversampling procedures for black, Hispanic, and Asian persons that were a feature of the previous sample design were not implemented in 2016. Some of the differences between estimates for 2016 and estimates for earlier years may be attributable to the new sample design. Visit the NCHS website at http://www.cdc.gov/nchs/nhis.htm for more information on the design, content, and use of NHIS.

The data for this report are derived from the Family Core component of the 1997–2016 NHIS, which collects information on all family members in each household. Data analyses for the January–June 2016 NHIS were based on 48,549 persons in the Family Core.

Data on health insurance status were edited using a system of logic

checks. Information from follow-up questions, such as plan name(s), were used to reassign insurance status and type of coverage to avoid misclassification. The analyses excluded persons with unknown health insurance status (about 1% of respondents each year).

Data points for all figures can be found in the detailed appendix tables at the end of this report, appendix tables from previous reports, and quarterly tables available separately through the ER program.

Estimation procedures

NCHS creates survey weights for each calendar quarter of the NHIS sample. The NHIS data weighting procedure is described in more detail at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_165.pdf. Estimates were calculated using NHIS survey weights, which are calibrated to census totals for sex, age, and race and ethnicity of the U.S. civilian noninstitutionalized population. Weights for 2010 and 2011 were derived from 2000 census-based population estimates. Beginning with 2012 NHIS data, weights were derived from 2010 census-based population estimates.

Point estimates and estimates of their variances were calculated using SUDAAN software (RTI International, Research Triangle Park, N.C.) to account for the complex sample design of NHIS, taking into account stratum and primary sampling unit (PSU) identifiers. The Taylor series linearization method was chosen for variance estimation.

Trends in coverage were generally assessed using Joinpoint regression (2), which characterizes trends as joined linear segments. A Joinpoint is the year where two segments with different slopes meet. Joinpoint software uses statistical criteria to determine the fewest number of segments necessary to characterize a trend and the year(s) when segments begin and end. Trends from 2010 to 2016 were also evaluated using logistic regression analysis.

State-specific health insurance estimates are presented for 12 states for persons of all ages, persons under age 65, and adults aged 18–64. State-specific estimates are presented for 8 states for children aged 0–17 years. Estimates are not presented for all 50 states and the District of Columbia due to considerations of sample size and precision. States with fewer than 1,000 interviews for persons of all ages are excluded. In addition, estimates for children in states that did not have at least 300 children with completed interviews are not presented.

Unless otherwise noted, all estimates shown meet the NCHS standard of having less than or equal to 30% relative standard error (RSE). Unless otherwise noted, differences between percentages or rates were evaluated using two-sided significance tests at the 0.05 level. All differences discussed are significant unless otherwise noted. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant.

Definitions of selected terms

Private health insurance coverage—Includes persons who had any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care.

Public health plan coverage—Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

Uninsured—A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

Directly purchased coverage—Private insurance that was originally obtained through direct purchase or other means not related to employment.

Employment-based coverage—Private insurance that was originally obtained through a present or former employer, union, or professional association.

Exchange-based coverage—A private health insurance plan purchased through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act (ACA) of 2010 (P.L. 111–148, P.L. 111–152). In response to ACA, several questions were added to NHIS to capture health care plans obtained through exchange-based coverage.

In general, if a family member is reported to have coverage through the exchange, that report is considered accurate unless there is other information (e.g., plan name or information about premiums) that clearly contradicts that report. Similarly, if a family member is not reported to have coverage through the exchange, that report is considered accurate unless other information clearly contradicts that report. For a more complete discussion of the procedures used in classifying exchange-based coverage, see http://www.cdc.gov/nchs/nhis/insurance.htm.

Based on these classification procedures, an average of 4.1% (standard error [SE] 0.18) of persons under age 65, 4.7% (SE 0.19) of adults aged 18–64, 2.3% (SE 0.24) of children under age 18, and 3.0% (SE 0.30) of adults aged 19–25 had exchange-based private health insurance coverage in the first 6 months of 2016. This equates to 11.0 million persons under age 65 and 9.3 million adults aged 18–64, 1.7 million children, and 0.9 million adults aged 19–25. If these procedures had not been used and reports of coverage through the exchanges (or lack thereof) had been taken at face value, the estimates would have been higher. For example, an average of 5.1% (13.7 million) of persons under age 65 would have been reported to have obtained their coverage through exchanges in the first 6 months of 2016.

High-deductible health plan (HDHP)—For persons with private health insurance, a question was asked regarding the annual deductible of each private health insurance plan. HDHP was defined in 2015 and 2016 as a private health plan with an annual deductible of at least $1,300 for self-only coverage or $2,600 for family coverage. The deductible is adjusted annually for inflation. For 2013 and 2014, the annual deductible was $1,250 for self-only coverage and $2,500 for family coverage. For 2010 through 2012, the annual deductible was $1,200 for self-only coverage and $2,400 for family coverage.

Consumer-directed health plan (CDHP)—An HDHP with a special account to pay for medical expenses. Unspent funds are carried over to subsequent years. For plans considered to be HDHPs, a follow-up question was asked regarding these special accounts. A person is considered to have a CDHP if there is a "yes" response to the following question: *With this plan, is there a special account or fund that can be used to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and are different from Flexible Spending Accounts.*

Health savings account (HSA)—A tax-advantaged account or fund that can be used to pay medical expenses. It must be coupled with an HDHP. The funds contributed to the account are not subject to federal income tax at the time of deposit. Unlike FSAs, HSA funds roll over and accumulate year to year if not spent. HSAs are owned by the individual. Funds may be used to pay qualified medical expenses at any time without federal tax liability. HSAs may also be referred to as Health Reimbursement Accounts (HRAs), Personal Care Accounts, Personal Medical funds, or Choice funds, and the term "HSA" in this report includes accounts that use these alternative names.

Flexible spending account (FSA) for medical expenses—A person is considered to be in a family with an FSA if there is a "yes" response to the following question*: [Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pretax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care. With this type of account, any money remaining in the account at the end of the year, following a short grace period, is lost to the employee.*

The measures of HDHP enrollment, CDHP enrollment, and being in a family with an FSA for medical expenses are not mutually exclusive; a person may be counted in more than one measure.

Medicaid expansion status—Under provisions of ACA, states have the option to expand Medicaid eligibility to cover adults who have income up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of October 31, 2013, 26 states and the District of Columbia were moving forward with Medicaid expansion. As of January 1, 2016, 32 states and the District of Columbia were moving forward with Medicaid expansion.

Health Insurance Marketplace—A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on cost, benefits, and other important features; choose a plan; and enroll in coverage. The marketplace also provides information on programs that help people with low-to-moderate income and resources pay for coverage. There are three types of Health Insurance Marketplaces: (a) a state-based Marketplace set up and operated solely by the state; (b) a hybrid partnership Marketplace in which the state runs certain functions, makes key decisions, and may tailor the marketplace to local needs and market conditions, but which is operated by the federal government; and (c) the Federally Facilitated Marketplace operated solely by the federal government.

Education—The categories of education are based on the years of school completed or highest degree obtained for persons aged 18 and over.

Employment—Employment status is assessed at the time of interview and is obtained for persons aged 18 and over. In this release, it is presented only for persons aged 18–64.

Hispanic or Latino origin and race—Hispanic or Latino origin and race are two separate and distinct categories. Persons of Hispanic or Latino origin may be of any race or combination of races. Hispanic or Latino origin includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or Spanish origin. Race is based on the family respondent's description of his or her own racial background, as well as the racial background of other family members. More than one race may be reported for a person. For conciseness, the text, tables, and figures in this report use shorter versions of the 1997 Office of Management and Budget terms for race and Hispanic or Latino origin. For example, the category "Not Hispanic or Latino, black or African American, single race" is referred to as "non-Hispanic black, single race" in the text, tables, and figures. Estimates for non-Hispanic persons of races other than white only, black only, and Asian only, or of multiple races, are combined into the "Other races and multiple races" category.

Poverty status—Poverty categories are based on the ratio of the family's income in the previous calendar year to the appropriate poverty threshold (given the family's size and number of children) as defined by the U.S. Census Bureau for that year (3–11). Persons categorized as "Poor" have a ratio less than 1.0 (i.e., their family income is below the poverty threshold); "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not poor" persons have incomes that are 200% of the poverty threshold or greater. The remaining group of respondents is coded as "Unknown" with respect to poverty status. The percentage of respondents with unknown poverty status (19.1% in 1997, 28.9% in 2005, 12.2% in 2010, 11.5% in 2011, 11.4% in 2012, 10.2% in 2013, 8.8% in 2014, 8.8% in 2015, and 7.9% in the first two quarters of 2016) is disaggregated by age and insurance status in Tables IV, V, and VI.

For more information on unknown income and unknown poverty status, see the NHIS Survey Description documents

for 1997–2015 (available from: http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm).

NCHS imputes income for approximately 30% of NHIS records. The imputed income files are released a few months after the annual release of NHIS microdata and are not available for the ER updates. Therefore, ER health insurance estimates stratified by poverty status are based on reported income only and may differ from similar estimates produced later (e.g., in *Health, United States* [12]) that are based on both reported and imputed income.

Region—In the geographic classification of the U.S. population, states are grouped into the following four regions used by the U.S. Census Bureau:

Region	*States included*
Northeast	Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, and Pennsylvania
Midwest	Ohio, Illinois, Indiana, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Kansas, and Nebraska
South	Delaware, Maryland, District of Columbia, West Virginia, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, Oklahoma, Arkansas, and Texas
West	Washington, Oregon, California, Nevada, New Mexico, Arizona, Idaho, Utah, Colorado, Montana, Wyoming, Alaska, and Hawaii

Expanded regions—Based on a subdivision of the four regions into nine divisions. For this report, the nine Census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic division. This approach was used previously by Holahan et al. (13).

Additional Early Release Program Products

Two additional periodical reports are published through the NHIS ER Program. *Early Release of Selected Estimates Based on Data From the National Health Interview Survey* (14) is published quarterly and provides estimates of 15 selected measures of health, including insurance coverage. Other measures of health include estimates of having a usual place to go for medical care, obtaining needed medical care, influenza vaccination, pneumococcal vaccination, obesity, leisure-time physical activity, current smoking, alcohol consumption, HIV testing, general health status, personal care needs, serious psychological distress, diagnosed diabetes, and asthma episodes and current asthma.

Wireless Substitution: Early Release of Estimates From the National Health Interview Survey (15) is published semiannually and provides selected estimates of telephone coverage in the United States.

Other ER reports and tabulations on special topics are released on an as-needed basis; see http://www.cdc.gov/nchs/nhis/releases.htm.

In addition to these reports, preliminary microdata files containing selected NHIS variables are produced as part of the ER Program. For each data collection year (January through December), these variables are made available four times approximately 5–6 months following the completion of data collection. NHIS data users can analyze these files through the NCHS Research Data Centers (http://www.cdc.gov/rdc/) without having to wait for the final annual NHIS microdata files to be released.

New measures and products may be added as work continues and in response to changing data needs. Feedback on these releases is welcome (nhislist@cdc.gov).

Announcements about ERs, other new data releases, and publications, as well as corrections related to NHIS, will be sent to members of the HISUSERS electronic mailing list. To join, visit the CDC website at: http://www.cdc.gov/nchs/products/ nchs_listservs.htm and click on the "National Health Interview Survey (NHIS) researchers" button, and follow the directions on the page.

Suggested Citation

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Table I. Percentages (and standard errors) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than a year, by age group and selected years: United States, 1997–June 2016

Age group and year	Uninsured[1] at the time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than a year[2]
All ages			
1997	15.4 (0.21)	19.5 (0.24)	10.4 (0.18)
2005	14.2 (0.21)	17.6 (0.23)	10.0 (0.18)
2010	16.0 (0.27)	19.8 (0.29)	11.7 (0.22)
2011	15.1 (0.25)	19.2 (0.29)	11.2 (0.21)
2012	14.7 (0.23)	18.6 (0.27)	11.1 (0.22)
2013	14.4 (0.26)	17.8 (0.27)	10.7 (0.23)
2014	11.5 (0.23)	16.5 (0.25)	8.4 (0.19)
2015	9.1 (0.19)	13.2 (0.23)	6.2 (0.15)
2016 (Jan–Jun)	8.9 (0.29)	12.6 (0.33)	5.2 (0.24)
Under 65 years			
1997	17.4 (0.24)	21.9 (0.28)	11.8 (0.21)
2005	16.0 (0.24)	19.9 (0.26)	11.3 (0.21)
2010	18.2 (0.30)	22.5 (0.33)	13.3 (0.24)
2011	17.3 (0.29)	21.8 (0.33)	12.7 (0.25)
2012	16.9 (0.27)	21.3 (0.31)	12.7 (0.24)
2013	16.6 (0.30)	20.4 (0.32)	12.4 (0.27)
2014	13.3 (0.26)	19.0 (0.29)	9.7 (0.22)
2015	10.5 (0.22)	15.3 (0.27)	7.2 (0.17)
2016 (Jan–Jun)	10.4 (0.34)	14.6 (0.37)	6.1 (0.27)
0–17 years			
1997	13.9 (0.36)	18.1 (0.41)	8.4 (0.29)
2005	8.9 (0.29)	12.6 (0.33)	5.3 (0.24)
2010	7.8 (0.32)	11.6 (0.37)	4.5 (0.23)
2011	7.0 (0.27)	10.9 (0.36)	3.7 (0.19)
2012	6.6 (0.27)	10.4 (0.35)	3.7 (0.19)
2013	6.5 (0.26)	10.0 (0.33)	3.6 (0.20)
2014	5.5 (0.27)	9.4 (0.40)	3.0 (0.19)
2015	4.5 (0.24)	7.7 (0.32)	2.3 (0.16)
2016 (Jan–Jun)	5.0 (0.41)	7.7 (0.47)	2.0 (0.26)
18–64 years			
1997	18.9 (0.23)	23.6 (0.26)	13.3 (0.21)
2005	18.9 (0.26)	22.8 (0.28)	13.8 (0.23)
2010	22.3 (0.35)	26.7 (0.37)	16.8 (0.30)
2011	21.3 (0.34)	26.0 (0.37)	16.3 (0.31)
2012	20.9 (0.31)	25.5 (0.34)	16.2 (0.29)
2013	20.4 (0.37)	24.4 (0.38)	15.7 (0.34)
2014	16.3 (0.31)	22.6 (0.34)	12.3 (0.27)
2015	12.8 (0.27)	18.1 (0.33)	9.1 (0.22)
2016 (Jan–Jun)	12.4 (0.39)	17.3 (0.43)	7.6 (0.34)
19–25 years			
1997	31.4 (0.63)	39.2 (0.67)	20.8 (0.51)
2005	31.2 (0.65)	37.9 (0.68)	21.6 (0.54)
2010	33.9 (0.73)	41.7 (0.78)	24.1 (0.61)
2011	27.9 (0.71)	36.1 (0.77)	20.1 (0.61)
2012	26.4 (0.72)	33.0 (0.72)	19.6 (0.62)
2013	26.5 (0.71)	31.3 (0.79)	19.8 (0.61)
2014	20.0 (0.65)	26.9 (0.73)	14.2 (0.56)
2015	15.8 (0.58)	22.2 (0.68)	10.2 (0.43)
2016 (Jan–Jun)	15.4 (0.88)	21.3 (0.92)	8.0 (0.77)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]In references to "part of the past year" and "more than a year," a year is defined as the 12 months prior to interview. In 2016, answer categories for those who are currently uninsured concerning the length of non-coverage were modified. Therefore, 2016 estimates of "uninsured for at least part of the past year" and "uninsured for more than a year" may not be completely comparable to previous years. For more information on this change, see Technical Notes.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table II. Numbers (in millions) of persons who lacked health insurance coverage at the time of interview, for at least part of the past year, and for more than a year, by age group and selected years: United States, 1997–June 2016

Age group and year	Uninsured[1] at the time of interview	Uninsured[1] for at least part of the past year[2]	Uninsured[1] for more than a year[2]
All ages			
1997	41.0	51.9	27.7
2005	41.2	51.3	29.2
2010	48.6	60.3	35.7
2011	46.3	58.7	34.2
2012	45.5	57.5	34.1
2013	44.8	55.4	33.4
2014	36.0	51.6	26.3
2015	28.6	41.7	19.6
2016 (Jan–Jun)	28.4	40.1	16.6
Under 65 years			
1997	40.7	51.4	27.6
2005	41.0	50.9	29.0
2010	48.2	59.6	35.4
2011	45.9	58.0	33.9
2012	45.2	56.8	33.9
2013	44.3	54.7	33.1
2014	35.7	50.8	26.1
2015	28.4	41.1	19.4
2016 (Jan–Jun)	28.1	39.6	16.4
0–17 years			
1997	9.9	12.9	6.0
2005	6.5	9.3	3.9
2010	5.8	8.7	3.4
2011	5.2	8.1	2.7
2012	4.9	7.7	2.7
2013	4.8	7.3	2.6
2014	4.0	6.9	2.2
2015	3.3	5.7	1.7
2016 (Jan–Jun)	3.7	5.7	1.5
18–64 years			
1997	30.8	38.5	21.7
2005	34.5	41.7	25.2
2010	42.5	51.0	32.0
2011	40.7	49.9	31.2
2012	40.3	49.2	31.2
2013	39.6	47.4	30.5
2014	31.7	44.0	23.9
2015	25.1	35.5	17.8
2016 (Jan–Jun)	24.4	34.0	15.0
19–25 years			
1997	7.7	9.7	5.1
2005	8.8	10.7	6.1
2010	10.0	12.3	7.1
2011	8.4	10.8	6.0
2012	7.9	9.9	5.9
2013	8.0	9.5	6.0
2014	6.0	8.1	4.3
2015	4.8	6.7	3.1
2016 (Jan–Jun)	4.6	6.4	2.4

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]In references to "part of the past year" and "more than a year," a year is defined as the 12 months prior to interview. In 2016, answer categories for those who are currently uninsured concerning the length of non-coverage were modified. Therefore, 2016 estimates of "uninsured for at least part of the past year" and "uninsured for more than a year" may not be completely comparable to previous years. For more information on this change, see Technical Notes.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table III. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected years: United States, 1997–June 2016

Age group and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
All ages			
1997	15.4 (0.21)	23.3 (0.27)	70.7 (0.32)
2005	14.2 (0.21)	26.4 (0.30)	67.3 (0.37)
2010	16.0 (0.27)	31.4 (0.39)	60.2 (0.48)
2011	15.1 (0.25)	32.4 (0.37)	60.1 (0.48)
2012	14.7 (0.23)	33.4 (0.35)	59.6 (0.43)
2013	14.4 (0.26)	33.8 (0.36)	59.5 (0.49)
2014	11.5 (0.23)	34.6 (0.37)	61.8 (0.45)
2015	9.1 (0.19)	35.6 (0.42)	63.2 (0.46)
2016 (Jan–Jun)	8.9 (0.29)	36.7 (0.49)	62.6 (0.60)
Under 65 years			
1997	17.4 (0.24)	13.6 (0.25)	70.8 (0.35)
2005	16.0 (0.24)	16.8 (0.29)	68.4 (0.39)
2010	18.2 (0.30)	22.0 (0.38)	61.2 (0.50)
2011	17.3 (0.29)	23.0 (0.37)	61.2 (0.51)
2012	16.9 (0.27)	23.5 (0.37)	61.0 (0.47)
2013	16.6 (0.30)	23.8 (0.35)	61.0 (0.52)
2014	13.3 (0.26)	24.5 (0.36)	63.6 (0.46)
2015	10.5 (0.22)	25.3 (0.43)	65.6 (0.50)
2016 (Jan–Jun)	10.4 (0.34)	26.2 (0.54)	65.0 (0.66)
0–17 years			
1997	13.9 (0.36)	21.4 (0.48)	66.2 (0.57)
2005	8.9 (0.29)	29.9 (0.56)	62.4 (0.60)
2010	7.8 (0.32)	39.8 (0.73)	53.8 (0.75)
2011	7.0 (0.27)	41.0 (0.74)	53.3 (0.76)
2012	6.6 (0.27)	42.1 (0.72)	52.8 (0.73)
2013	6.5 (0.26)	42.2 (0.70)	52.6 (0.76)
2014	5.5 (0.27)	42.2 (0.65)	53.7 (0.68)
2015	4.5 (0.24)	42.2 (0.79)	54.7 (0.78)
2016 (Jan–Jun)	5.0 (0.41)	42.7 (0.99)	53.9 (1.08)
18–64 years			
1997	18.9 (0.23)	10.2 (0.20)	72.8 (0.30)
2005	18.9 (0.26)	11.5 (0.22)	70.9 (0.36)
2010	22.3 (0.35)	15.0 (0.30)	64.1 (0.46)
2011	21.3 (0.34)	15.9 (0.29)	64.2 (0.45)
2012	20.9 (0.31)	16.4 (0.29)	64.1 (0.42)
2013	20.4 (0.37)	16.7 (0.30)	64.2 (0.47)
2014	16.3 (0.31)	17.7 (0.32)	67.3 (0.43)
2015	12.8 (0.27)	18.9 (0.36)	69.7 (0.43)
2016 (Jan–Jun)	12.4 (0.39)	20.0 (0.46)	69.2 (0.56)
19–25 years			
1997	31.4 (0.63)	11.2 (0.46)	58.4 (0.71)
2005	31.2 (0.65)	12.9 (0.51)	56.5 (0.79)
2010	33.9 (0.73)	15.7 (0.55)	51.0 (0.84)
2011	27.9 (0.71)	16.8 (0.60)	56.2 (0.85)
2012	26.4 (0.72)	17.5 (0.59)	57.2 (0.85)
2013	26.5 (0.71)	16.1 (0.54)	58.1 (0.84)
2014	20.0 (0.65)	19.1 (0.64)	61.9 (0.88)
2015	15.8 (0.58)	19.5 (0.68)	65.7 (0.81)
2016 (Jan–Jun)	15.4 (0.88)	22.4 (1.09)	63.5 (1.18)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table IV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–June 2016

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	32.7 (0.80)	46.1 (1.01)	22.9 (0.93)
2005	28.4 (0.78)	50.6 (0.98)	22.1 (0.89)
2010	29.5 (0.83)	56.0 (0.98)	15.5 (0.70)
2011	28.2 (0.66)	56.2 (0.82)	16.6 (0.77)
2012	28.3 (0.65)	57.1 (0.83)	16.1 (0.83)
2013	27.3 (0.68)	59.0 (0.81)	14.7 (0.72)
2014	22.3 (0.66)	62.1 (0.80)	16.6 (0.69)
2015	17.2 (0.63)	65.6 (0.87)	18.5 (0.78)
2016 (Jan–Jun)	18.7 (0.90)	66.8 (1.14)	16.1 (0.87)
Near poor (≥ 100% and < 200% FPL)			
1997	30.4 (0.70)	18.2 (0.56)	53.5 (0.80)
2005	28.6 (0.63)	30.0 (0.72)	43.2 (0.89)
2010	32.3 (0.69)	36.2 (0.63)	33.2 (0.77)
2011	30.4 (0.58)	37.7 (0.73)	33.5 (0.75)
2012	29.5 (0.56)	37.1 (0.66)	35.2 (0.75)
2013	29.3 (0.70)	39.1 (0.77)	33.4 (0.79)
2014	23.5 (0.60)	41.1 (0.74)	37.3 (0.81)
2015	18.2 (0.51)	45.1 (0.77)	39.1 (0.77)
2016 (Jan–Jun)	17.7 (0.76)	49.0 (1.03)	35.7 (1.17)
Not poor (≥ 200% FPL)			
1997	8.9 (0.22)	5.3 (0.19)	87.6 (0.27)
2005	9.1 (0.22)	7.4 (0.22)	84.7 (0.30)
2010	10.7 (0.24)	9.7 (0.28)	81.0 (0.36)
2011	10.1 (0.25)	9.9 (0.26)	81.4 (0.36)
2012	9.8 (0.23)	10.3 (0.33)	81.3 (0.39)
2013	9.6 (0.24)	10.5 (0.29)	81.2 (0.39)
2014	7.6 (0.20)	9.9 (0.28)	83.7 (0.36)
2015	6.6 (0.19)	10.6 (0.31)	84.1 (0.38)
2016 (Jan–Jun)	6.2 (0.30)	10.8 (0.32)	84.4 (0.45)
Unknown			
1997	21.6 (0.59)	13.2 (0.49)	66.7 (0.71)
2005	18.5 (0.48)	16.4 (0.48)	66.2 (0.68)
2010	22.7 (0.95)	21.0 (0.69)	57.3 (1.08)
2011	21.0 (0.64)	26.2 (0.95)	53.9 (1.09)
2012	20.4 (0.73)	28.8 (0.89)	52.1 (1.00)
2013	20.5 (0.76)	24.2 (0.94)	56.8 (1.24)
2014	15.0 (0.80)	22.2 (0.91)	64.1 (1.24)
2015	11.9 (0.80)	24.4 (1.16)	64.9 (1.20)
2016 (Jan–Jun)	13.6 (1.27)	28.2 (1.33)	60.1 (1.50)

[1]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table V. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–June 2016

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	40.2 (0.88)	34.3 (0.93)	26.8 (1.09)
2005	38.5 (0.95)	35.6 (0.98)	26.8 (1.03)
2010	42.2 (0.99)	38.8 (0.97)	19.6 (0.89)
2011	40.1 (0.92)	39.6 (0.93)	21.2 (1.02)
2012	40.1 (0.90)	40.8 (0.94)	20.2 (1.09)
2013	39.3 (1.00)	42.4 (0.95)	19.0 (0.97)
2014	32.3 (0.93)	46.6 (0.95)	21.9 (0.92)
2015	25.2 (0.90)	51.7 (1.08)	24.3 (1.04)
2016 (Jan–Jun)	25.9 (1.27)	53.7 (1.55)	21.6 (1.19)
Near poor (≥ 100% and < 200% FPL)			
1997	34.9 (0.71)	14.6 (0.51)	52.6 (0.76)
2005	36.6 (0.73)	20.0 (0.61)	45.0 (0.85)
2010	43.0 (0.74)	23.7 (0.55)	34.7 (0.74)
2011	40.1 (0.72)	25.9 (0.69)	35.4 (0.75)
2012	39.2 (0.68)	25.2 (0.57)	37.2 (0.74)
2013	38.5 (0.84)	26.6 (0.78)	36.4 (0.78)
2014	30.9 (0.72)	29.6 (0.76)	41.2 (0.81)
2015	24.1 (0.62)	34.2 (0.80)	43.8 (0.79)
2016 (Jan–Jun)	23.5 (1.03)	37.7 (1.18)	41.1 (1.24)
Not poor (≥ 200% FPL)			
1997	9.9 (0.22)	5.0 (0.18)	87.1 (0.26)
2005	10.7 (0.24)	6.2 (0.20)	84.4 (0.29)
2010	12.6 (0.27)	8.1 (0.27)	80.8 (0.36)
2011	12.0 (0.28)	8.3 (0.23)	81.1 (0.35)
2012	11.4 (0.26)	8.7 (0.29)	81.3 (0.38)
2013	11.4 (0.27)	8.9 (0.26)	81.2 (0.37)
2014	8.9 (0.23)	8.5 (0.26)	83.9 (0.35)
2015	7.6 (0.22)	9.1 (0.27)	84.7 (0.33)
2016 (Jan–Jun)	7.0 (0.31)	9.5 (0.28)	84.9 (0.39)
Unknown			
1997	22.9 (0.58)	10.1 (0.41)	68.6 (0.65)
2005	21.2 (0.52)	11.3 (0.36)	68.7 (0.61)
2010	27.1 (1.10)	15.6 (0.63)	58.4 (1.11)
2011	25.6 (0.77)	17.6 (0.73)	58.1 (0.96)
2012	25.7 (0.88)	18.9 (0.76)	56.9 (0.92)
2013	24.3 (0.87)	17.6 (0.77)	59.5 (1.11)
2014	17.2 (0.88)	17.2 (0.81)	67.0 (1.20)
2015	13.8 (0.82)	19.6 (0.94)	67.7 (1.09)
2016 (Jan–Jun)	15.2 (1.07)	22.8 (1.37)	64.3 (1.35)

[1]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table VI. Percentages (and standard errors) of children aged 0–17 years who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by poverty status and selected years: United States, 1997–June 2016

Poverty status[1] and year	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
Poor (< 100% FPL)			
1997	22.4 (0.99)	62.1 (1.31)	17.5 (1.09)
2005	13.0 (0.92)	73.3 (1.32)	15.0 (1.10)
2010	10.2 (0.96)	82.0 (1.22)	9.2 (0.70)
2011	8.1 (0.62)	84.4 (0.87)	8.9 (0.72)
2012	7.5 (0.58)	85.9 (0.80)	8.8 (0.78)
2013	7.8 (0.62)	86.1 (0.88)	7.7 (0.69)
2014	5.9 (0.52)	87.3 (0.72)	8.0 (0.62)
2015	4.4 (0.47)	87.9 (0.86)	9.1 (0.81)
2016 (Jan–Jun)	6.6 (0.95)	88.5 (1.21)	6.9 (0.85)
Near poor (≥ 100% and < 200% FPL)			
1997	22.8 (0.96)	24.3 (0.93)	55.0 (1.15)
2005	14.7 (0.79)	47.3 (1.21)	40.0 (1.31)
2010	12.6 (0.73)	59.2 (1.16)	30.5 (1.18)
2011	11.5 (0.69)	60.8 (1.17)	29.9 (1.07)
2012	10.1 (0.70)	61.0 (1.30)	31.1 (1.18)
2013	10.6 (0.72)	64.4 (1.16)	27.3 (1.17)
2014	8.6 (0.65)	64.3 (1.23)	29.4 (1.19)
2015	6.7 (0.59)	66.4 (1.17)	29.8 (1.14)
2016 (Jan–Jun)	6.5 (0.63)	71.0 (1.42)	25.3 (1.66)
Not poor (≥ 200% FPL)			
1997	6.1 (0.33)	6.3 (0.32)	88.9 (0.43)
2005	4.6 (0.30)	10.7 (0.47)	85.6 (0.52)
2010	4.6 (0.29)	14.9 (0.57)	81.4 (0.61)
2011	4.0 (0.27)	15.0 (0.55)	82.1 (0.58)
2012	4.5 (0.31)	15.2 (0.62)	81.3 (0.64)
2013	4.0 (0.28)	15.6 (0.62)	81.2 (0.65)
2014	3.6 (0.28)	14.4 (0.56)	83.1 (0.58)
2015	3.3 (0.26)	15.5 (0.69)	82.1 (0.74)
2016 (Jan–Jun)	3.4 (0.40)	15.1 (0.76)	82.7 (0.90)
Unknown			
1997	18.3 (0.90)	21.4 (0.97)	61.7 (1.18)
2005	11.0 (0.66)	30.8 (1.05)	59.3 (1.16)
2010	8.8 (0.89)	38.1 (1.71)	53.7 (1.74)
2011	10.4 (0.76)	45.9 (1.70)	44.5 (1.66)
2012	8.2 (0.77)	51.8 (1.50)	41.2 (1.49)
2013	9.2 (1.00)	43.7 (2.16)	48.6 (2.20)
2014	8.0 (1.41)	37.9 (2.01)	54.8 (2.05)
2015	6.3 (1.36)	37.9 (2.33)	56.6 (2.24)
2016 (Jan–Jun)	*9.1 (2.77)	44.1 (2.50)	48.0 (3.32)

*Estimate has a relative standard error greater than 30% and less than or equal to 50% and should be used with caution, because it does not meet standards of reliability or precision.

[1]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those with incomes below the poverty threshold; "Near poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "Not poor" persons have incomes of 200% of the poverty threshold or greater. For more information on the "Unknown" poverty status category, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 1997, 2005, and 2010–2016, Family Core component.

Table VII. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and sex: United States, January–June 2016

Age group and sex	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Age group (years)			
All ages	8.9 (0.29)	36.7 (0.49)	62.6 (0.60)
Under age 65	10.4 (0.34)	26.2 (0.54)	65.0 (0.66)
0–17	5.0 (0.41)	42.7 (0.99)	53.9 (1.08)
18–64	12.4 (0.39)	20.0 (0.46)	69.2 (0.56)
18–24	14.1 (0.78)	23.8 (1.04)	63.3 (1.11)
25–34	16.5 (0.62)	19.7 (0.77)	64.8 (0.87)
35–44	14.3 (0.67)	16.1 (0.72)	70.6 (0.98)
45–64	8.8 (0.37)	20.7 (0.53)	72.8 (0.61)
65 and over	0.6 (0.15)	95.9 (0.30)	49.5 (1.07)
19–25	15.4 (0.88)	22.4 (1.09)	63.5 (1.18)
Sex			
Male:			
All ages	10.2 (0.35)	34.3 (0.46)	63.3 (0.53)
Under age 65	11.7 (0.39)	24.5 (0.50)	65.4 (0.62)
0–17	4.8 (0.43)	42.7 (1.01)	54.1 (1.14)
18–64	14.4 (0.50)	17.3 (0.47)	69.8 (0.57)
18–24	16.3 (1.17)	18.3 (1.17)	66.6 (1.48)
25–34	20.3 (0.76)	15.4 (0.81)	65.4 (0.93)
35–44	16.6 (0.94)	12.8 (0.76)	71.3 (1.12)
45–64	9.7 (0.51)	20.0 (0.68)	72.7 (0.70)
65 and over	0.6 (0.15)	95.5 (0.42)	50.1 (1.13)
19–25	17.9 (1.21)	16.4 (1.16)	67.1 (1.49)
Female:			
All ages	7.7 (0.29)	39.1 (0.61)	62.0 (0.73)
Under age 65	9.1 (0.34)	28.0 (0.66)	64.6 (0.78)
0–17	5.2 (0.51)	42.7 (1.25)	53.7 (1.25)
18–64	10.5 (0.37)	22.6 (0.57)	68.5 (0.69)
18–24	11.8 (1.00)	29.4 (1.38)	60.0 (1.73)
25–34	12.8 (0.77)	23.8 (1.03)	64.2 (1.15)
35–44	12.1 (0.77)	19.1 (0.91)	70.0 (1.22)
45–64	8.1 (0.37)	21.3 (0.59)	72.9 (0.69)
65 and over	0.6 (0.18)	96.2 (0.29)	49.0 (1.20)
19–25	12.9 (1.08)	28.4 (1.45)	60.0 (1.81)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.

Table VIII. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race and ethnicity and year: United States, 2010–June 2016

Race and ethnicity and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Hispanic or Latino			
2010	31.9 (0.72)	32.0 (0.78)	36.6 (0.81)
2011	31.1 (0.68)	33.6 (0.74)	36.1 (0.82)
2012	30.4 (0.71)	34.0 (0.71)	36.4 (0.74)
2013	30.3 (0.66)	33.4 (0.62)	37.0 (0.76)
2014	25.2 (0.59)	34.6 (0.78)	41.2 (0.89)
2015	20.8 (0.56)	36.2 (0.84)	43.8 (0.81)
2016 (Jan–Jun)	19.0 (0.93)	37.9 (1.56)	44.2 (1.44)
Non-Hispanic white, single race			
2010	13.7 (0.30)	16.4 (0.42)	71.4 (0.57)
2011	13.0 (0.32)	17.1 (0.39)	71.4 (0.55)
2012	12.7 (0.28)	17.3 (0.39)	71.5 (0.51)
2013	12.1 (0.29)	17.9 (0.38)	71.6 (0.53)
2014	9.8 (0.25)	18.1 (0.41)	73.6 (0.50)
2015	7.4 (0.21)	18.9 (0.48)	75.4 (0.54)
2016 (Jan–Jun)	7.5 (0.31)	19.7 (0.50)	74.7 (0.63)
Non-Hispanic black, single race			
2010	20.8 (0.63)	36.3 (0.79)	44.6 (0.84)
2011	19.0 (0.51)	36.9 (0.83)	45.6 (0.85)
2012	17.9 (0.50)	38.2 (0.77)	45.4 (0.79)
2013	18.9 (0.51)	37.5 (0.92)	44.9 (1.01)
2014	13.5 (0.49)	40.3 (0.76)	47.7 (0.86)
2015	11.2 (0.48)	39.2 (1.01)	51.3 (1.02)
2016 (Jan–Jun)	11.6 (0.66)	39.4 (1.78)	50.4 (1.58)
Non-Hispanic Asian, single race			
2010	16.8 (0.76)	14.9 (0.98)	69.1 (1.17)
2011	16.0 (0.89)	17.6 (1.14)	67.0 (1.40)
2012	16.4 (0.93)	16.6 (0.85)	67.5 (1.24)
2013	13.8 (0.81)	17.5 (1.00)	69.4 (1.27)
2014	10.6 (0.61)	16.7 (0.86)	73.4 (1.01)
2015	6.7 (0.51)	18.0 (1.34)	75.9 (1.44)
2016 (Jan–Jun)	6.3 (0.88)	19.9 (1.48)	74.2 (1.70)
Non-Hispanic other races and multiple races			
2010	22.4 (4.83)	30.3 (2.14)	48.7 (3.83)
2011	19.1 (1.78)	32.5 (1.60)	50.6 (1.89)
2012	16.4 (1.33)	35.8 (1.77)	50.8 (2.16)
2013	16.0 (1.17)	35.9 (1.75)	50.1 (1.97)
2014	12.8 (1.30)	36.2 (1.69)	52.7 (2.01)
2015	11.1 (1.00)	37.0 (1.86)	53.7 (1.99)
2016 (Jan–Jun)	13.6 (1.36)	34.3 (2.43)	54.2 (2.62)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table IX. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by race and ethnicity and year: United States, 2010–June 2016

Race and ethnicity and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Hispanic or Latino			
2010	43.2 (0.91)	16.3 (0.64)	41.1 (0.85)
2011	42.2 (0.89)	18.1 (0.63)	40.3 (0.82)
2012	41.3 (0.89)	19.0 (0.64)	40.4 (0.73)
2013	40.6 (0.88)	18.0 (0.62)	42.1 (0.70)
2014	33.7 (0.76)	20.6 (0.73)	46.4 (0.86)
2015	27.7 (0.72)	23.0 (0.84)	50.0 (0.85)
2016 (Jan–Jun)	24.8 (1.21)	25.3 (1.76)	51.0 (1.58)
Non-Hispanic white, single race			
2010	16.4 (0.35)	12.8 (0.34)	72.2 (0.52)
2011	15.6 (0.35)	13.4 (0.31)	72.5 (0.48)
2012	15.1 (0.31)	13.7 (0.33)	72.7 (0.46)
2013	14.5 (0.34)	14.4 (0.32)	72.7 (0.49)
2014	11.6 (0.29)	14.6 (0.36)	75.3 (0.47)
2015	8.7 (0.25)	15.7 (0.42)	77.3 (0.47)
2016 (Jan–Jun)	8.7 (0.34)	16.7 (0.43)	76.4 (0.58)
Non-Hispanic black, single race			
2010	27.2 (0.75)	25.3 (0.70)	49.3 (0.81)
2011	24.8 (0.65)	26.2 (0.75)	50.5 (0.79)
2012	23.6 (0.61)	27.0 (0.68)	50.8 (0.75)
2013	24.9 (0.62)	26.6 (0.80)	50.0 (0.91)
2014	17.7 (0.60)	30.5 (0.73)	53.4 (0.84)
2015	14.4 (0.57)	29.7 (0.84)	57.8 (0.90)
2016 (Jan–Jun)	14.8 (0.84)	29.5 (1.44)	57.2 (1.35)
Non-Hispanic Asian, single race			
2010	19.5 (0.92)	11.2 (0.72)	70.2 (1.05)
2011	18.8 (0.96)	13.6 (0.87)	68.0 (1.27)
2012	19.1 (0.92)	13.2 (0.83)	68.2 (1.15)
2013	16.3 (0.88)	14.1 (0.91)	70.4 (1.28)
2014	12.5 (0.65)	13.7 (0.84)	74.5 (1.01)
2015	7.9 (0.58)	15.5 (1.16)	77.2 (1.27)
2016 (Jan–Jun)	7.2 (0.95)	16.8 (1.34)	76.5 (1.48)
Non-Hispanic other races and multiple races			
2010	32.8 (5.76)	20.6 (1.94)	48.5 (4.77)
2011	27.1 (2.01)	23.6 (1.53)	52.1 (2.17)
2012	24.9 (1.78)	26.1 (1.62)	52.0 (2.24)
2013	23.8 (1.66)	26.8 (1.84)	51.6 (2.26)
2014	19.5 (1.65)	25.2 (1.51)	56.9 (2.06)
2015	16.1 (1.42)	29.0 (1.76)	56.9 (1.88)
2016 (Jan–Jun)	17.7 (1.63)	26.4 (2.06)	58.0 (2.57)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table X. Percentages (and standard errors) of adults aged 18–64 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by selected demographic characteristics: United States, January–June 2016

Selected characteristic	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Race and ethnicity			
Hispanic or Latino	24.8 (1.21)	25.3 (1.76)	51.0 (1.58)
Non-Hispanic:			
White, single race	8.7 (0.34)	16.7 (0.43)	76.4 (0.58)
Black, single race	14.8 (0.84)	29.5 (1.44)	57.2 (1.35)
Asian, single race	7.2 (0.95)	16.8 (1.34)	76.5 (1.48)
Other races and multiple races	17.7 (1.63)	26.4 (2.06)	58.0 (2.57)
Region			
Northeast	8.2 (0.90)	21.8 (1.06)	71.8 (1.72)
Midwest	9.8 (0.65)	18.7 (0.67)	73.4 (1.19)
South	17.6 (0.66)	17.9 (0.71)	66.0 (0.80)
West	10.3 (0.53)	23.1 (1.00)	68.1 (1.19)
Education			
Less than high school	28.8 (1.23)	36.4 (1.32)	36.4 (1.25)
High school diploma or GED[4]	16.1 (0.57)	26.0 (0.61)	59.7 (0.82)
More than high school	7.5 (0.32)	14.1 (0.41)	79.9 (0.48)
Employment status			
Employed	11.3 (0.41)	11.3 (0.36)	78.3 (0.50)
Unemployed	31.7 (1.76)	38.6 (1.92)	30.3 (1.72)
Not in workforce	11.7 (0.54)	44.9 (0.87)	47.4 (0.88)
Poverty status[5]			
< 100% FPL	25.9 (1.27)	53.7 (1.55)	21.6 (1.19)
≥ 100% and ≤ 138% FPL	25.1 (1.76)	43.4 (1.91)	33.5 (1.90)
> 138% and ≤ 250% FPL	19.8 (0.83)	27.8 (0.94)	54.6 (1.00)
> 250% and ≤ 400% FPL	10.2 (0.64)	13.3 (0.61)	78.3 (0.81)
> 400% FPL	3.6 (0.26)	5.7 (0.26)	91.9 (0.32)
Unknown	13.5 (0.94)	19.4 (1.20)	69.1 (1.17)
Marital status			
Married	9.2 (0.42)	14.0 (0.45)	78.6 (0.53)
Widowed	14.2 (2.18)	37.7 (2.51)	50.9 (2.73)
Divorced or separated	13.7 (0.79)	30.2 (1.08)	58.1 (1.18)
Living with partner	20.0 (0.94)	26.0 (1.19)	55.0 (1.28)
Never married	15.6 (0.65)	25.4 (0.78)	60.2 (0.94)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]GED is General Educational Development high school equivalency diploma.

[5]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. The percentage of respondents with "Unknown" poverty status for this five-level categorization is 8.7%. This value is greater than the corresponding value for the three-level poverty categorization because of greater uncertainty when assigning individuals to more detailed poverty groups. For more information on poverty status, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.

Table XI. Percentages (and standard errors) of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, in a high-deductible health plan without a health savings account, and in a consumer-directed health plan, and who were in a family with a flexible spending account for medical expenses, by year: United States, 2010–June 2016

Year	Enrolled in high-deductible health plan (HDHP)[1]	Enrolled in HDHP without health savings account (HSA)[2]	Enrolled in consumer-directed health plan (CDHP)[3]	In family with flexible spending account (FSA) for medical expenses
2010	25.3 (0.54)	17.6 (0.46)	7.7 (0.33)	20.4 (0.50)
2011	29.0 (0.54)	19.9 (0.41)	9.2 (0.35)	21.4 (0.53)
2012	31.1 (0.57)	20.3 (0.42)	10.8 (0.34)	21.6 (0.45)
2013	33.9 (0.68)	22.2 (0.48)	11.7 (0.43)	21.6 (0.48)
2014	36.9 (0.77)	23.6 (0.52)	13.3 (0.47)	21.2 (0.49)
2015	36.7 (0.68)	23.4 (0.50)	13.3 (0.42)	21.7 (0.51)
2016 (Jan–Jun)	38.8 (0.80)	23.5 (0.62)	15.3 (0.54)	21.7 (0.59)

[1]HDHP was defined in 2016 as a health plan with an annual deductible of at least $1,300 for self-only coverage and $2,600 for family coverage. The deductible is adjusted annually for inflation. Deductibles for previous years are included in the Technical Notes.

[2]HSA is a tax-advantaged account or fund that can be used to pay for medical expenses. It must be coupled with an HDHP.

[3]CDHP is an HDHP coupled with an HSA.

NOTES: The measures of HDHP enrollment, CDHP enrollment, and being in a family with an FSA for medical expenses are not mutually exclusive. Therefore, a person may be counted in more than one measure. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table XII. Percentages (and standard errors) of persons under age 65 with private health insurance coverage who were enrolled in a high-deductible health plan, by year and source of coverage: United States, 2010–June 2016

Year	Employment based[1]	Directly purchased[2]
2010	23.3 (0.54)	48.0 (1.48)
2011	26.9 (0.53)	52.4 (1.49)
2012	29.2 (0.60)	54.7 (1.61)
2013	32.0 (0.67)	56.4 (1.50)
2014	36.2 (0.73)	54.1 (1.43)
2015	36.6 (0.72)	50.9 (1.50)
2016 (Jan–Jun)	38.7 (0.83)	52.4 (1.82)

[1]Private insurance that was originally obtained through a present or former employer or union, or through a professional association.

[2]Private insurance that was originally obtained through direct purchase or other means not related to employment.

NOTES: For persons under age 65, approximately 8% of private health plans were directly purchased from 2010 through 2013. In 2014 through June 2016, approximately 10% of private plans were directly purchased. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table XIII. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Medicaid expansion status, and year: United States, 2010–June 2016

Age group, state Medicaid expansion status, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Under 65 years			
Medicaid expansion states[4]:			
2010	16.4 (0.42)	21.8 (0.54)	63.1 (0.70)
2011	15.3 (0.35)	23.1 (0.56)	62.9 (0.72)
2012	15.0 (0.34)	23.1 (0.50)	63.3 (0.63)
2013	14.9 (0.40)	24.1 (0.48)	62.3 (0.68)
2014	10.9 (0.29)	25.6 (0.49)	64.9 (0.59)
2015	8.2 (0.23)	26.7 (0.57)	66.4 (0.64)
2016 (Jan–Jun)	8.1 (0.35)	27.4 (0.64)	66.3 (0.87)
Non-Medicaid expansion states[5]:			
2010	20.3 (0.48)	22.1 (0.51)	59.0 (0.76)
2011	19.6 (0.50)	22.7 (0.50)	59.1 (0.78)
2012	19.2 (0.45)	24.0 (0.55)	58.3 (0.75)
2013	18.4 (0.48)	23.4 (0.51)	59.6 (0.80)
2014	16.0 (0.44)	23.2 (0.52)	62.1 (0.76)
2015	14.0 (0.41)	23.2 (0.58)	64.4 (0.78)
2016 (Jan–Jun)	14.2 (0.55)	24.3 (0.89)	62.8 (0.96)
0–17 years			
Medicaid expansion states[4]:			
2010	6.7 (0.46)	38.2 (1.05)	56.5 (1.06)
2011	5.9 (0.33)	40.2 (1.11)	55.4 (1.09)
2012	5.3 (0.32)	40.4 (1.00)	55.9 (1.07)
2013	5.6 (0.33)	41.3 (0.86)	54.5 (0.95)
2014	4.3 (0.33)	41.0 (0.84)	56.2 (0.88)
2015	3.8 (0.28)	41.1 (0.99)	56.7 (1.00)
2016 (Jan–Jun)	4.3 (0.53)	41.3 (1.20)	56.3 (1.39)
Non-Medicaid expansion states[5]:			
2010	9.0 (0.47)	41.7 (0.99)	50.7 (1.08)
2011	8.3 (0.46)	42.0 (1.02)	50.9 (1.11)
2012	8.0 (0.46)	43.9 (1.11)	49.4 (1.07)
2013	7.5 (0.40)	43.1 (1.12)	50.5 (1.23)
2014	6.7 (0.43)	43.5 (1.06)	51.0 (1.11)
2015	5.5 (0.42)	43.7 (1.27)	52.0 (1.26)
2016 (Jan–Jun)	6.2 (0.58)	44.8 (1.72)	50.2 (1.70)
18–64 years			
Medicaid expansion states[4]:			
2010	20.1 (0.47)	15.5 (0.40)	65.6 (0.62)
2011	18.9 (0.41)	16.6 (0.41)	65.8 (0.61)
2012	18.5 (0.39)	16.7 (0.38)	66.0 (0.53)
2013	18.4 (0.49)	17.7 (0.44)	65.2 (0.65)
2014	13.3 (0.34)	19.9 (0.46)	68.1 (0.56)
2015	9.8 (0.28)	21.5 (0.49)	70.0 (0.56)
2016 (Jan–Jun)	9.4 (0.37)	22.3 (0.51)	69.9 (0.74)
Non-Medicaid expansion states[5]:			
2010	24.8 (0.58)	14.4 (0.45)	62.2 (0.70)
2011	24.1 (0.60)	15.1 (0.42)	62.3 (0.71)
2012	23.7 (0.54)	16.1 (0.44)	61.8 (0.69)
2013	22.7 (0.59)	15.6 (0.41)	63.2 (0.69)
2014	19.6 (0.54)	15.3 (0.41)	66.5 (0.69)
2015	17.5 (0.52)	14.9 (0.44)	69.4 (0.67)
2016 (Jan–Jun)	17.5 (0.71)	16.0 (0.70)	67.9 (0.80)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]For 2010 through 2014, states moving forward with Medicaid expansion included: AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV (as of October 31, 2013). Beginning with 2015, three additional states were included as expansion states: IN, NH, and PA. Beginning with 2016, three additional states were included as expansion states: AK, LA, and MT.

[5]For 2010 through 2014, states not moving forward with Medicaid expansion included: AL, AK, FL, GA, ID, IN, KS, LA, ME, MS, MO, MT, NE, NH, NC, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013). Beginning with 2015, three states have been removed from this grouping: IN, NH, and PA. Beginning with 2016, three additional states have been removed from this grouping: AK, LA, and MT.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table XIV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group, state Health Insurance Marketplace type, and year: United States, 2010–June 2016

Age group, state Health Insurance Marketplace type, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
Under 65 years			
State-based Marketplace states[4]:			
2010	16.3 (0.46)	21.6 (0.66)	63.2 (0.80)
2011	15.9 (0.46)	23.6 (0.70)	61.8 (0.88)
2012	15.2 (0.43)	24.2 (0.66)	61.8 (0.83)
2013	15.2 (0.48)	25.0 (0.56)	61.0 (0.83)
2014	11.1 (0.38)	26.4 (0.63)	63.7 (0.78)
2015	7.7 (0.30)	28.1 (0.80)	65.4 (0.92)
2016 (Jan–Jun)	7.5 (0.40)	28.3 (0.84)	65.6 (1.00)
Partnership Marketplace states[5]:			
2010	14.7 (0.87)	22.5 (1.15)	64.8 (1.73)
2011	14.3 (0.71)	22.7 (1.28)	64.5 (1.72)
2012	14.1 (0.70)	20.8 (1.12)	66.7 (1.53)
2013	14.2 (0.83)	21.8 (1.07)	65.6 (1.42)
2014	10.2 (0.57)	24.4 (1.06)	67.2 (1.28)
2015	8.0 (0.59)	26.1 (1.20)	67.7 (1.42)
2016 (Jan–Jun)	7.5 (0.67)	25.7 (1.35)	69.1 (2.06)
Federally Facilitated Marketplace states[6]:			
2010	20.1 (0.48)	22.1 (0.50)	59.1 (0.70)
2011	18.8 (0.45)	22.6 (0.47)	60.0 (0.71)
2012	18.6 (0.41)	23.6 (0.50)	59.3 (0.67)
2013	17.9 (0.44)	23.3 (0.49)	60.2 (0.74)
2014	15.3 (0.40)	23.3 (0.50)	62.8 (0.69)
2015	12.8 (0.33)	23.4 (0.54)	65.3 (0.66)
2016 (Jan–Jun)	12.8 (0.48)	25.0 (0.78)	63.8 (0.96)
0–17 years			
State-based Marketplace states[4]:			
2010	6.7 (0.50)	38.0 (1.32)	56.4 (1.31)
2011	6.4 (0.47)	40.9 (1.43)	54.2 (1.39)
2012	5.4 (0.43)	42.2 (1.37)	53.9 (1.46)
2013	5.7 (0.37)	42.8 (1.05)	52.6 (1.18)
2014	4.2 (0.40)	42.0 (1.11)	54.9 (1.13)
2015	3.1 (0.34)	42.4 (1.32)	55.8 (1.41)
2016 (Jan–Jun)	3.8 (0.71)	42.0 (1.44)	55.4 (1.76)
Partnership Marketplace states[5]:			
2010	4.1 (0.78)	40.7 (2.21)	57.9 (2.31)
2011	4.2 (0.53)	39.6 (2.44)	58.0 (2.39)
2012	3.6 (0.69)	38.5 (2.20)	59.9 (2.26)
2013	4.2 (0.53)	38.4 (1.95)	59.2 (2.08)
2014	3.2 (0.51)	40.8 (1.88)	58.4 (1.99)
2015	4.3 (0.73)	40.3 (2.53)	57.5 (2.34)
2016 (Jan–Jun)	2.2 (0.58)	39.6 (3.65)	60.7 (3.83)
Federally Facilitated Marketplace states[6]:			
2010	9.2 (0.48)	40.7 (0.91)	51.3 (0.97)
2011	8.0 (0.40)	41.4 (0.93)	51.8 (1.01)
2012	7.9 (0.41)	42.7 (1.00)	50.8 (0.98)
2013	7.5 (0.39)	42.6 (1.02)	51.3 (1.11)
2014	6.6 (0.41)	42.6 (0.94)	52.0 (1.00)
2015	5.3 (0.35)	42.4 (1.06)	53.6 (1.04)
2016 (Jan–Jun)	6.2 (0.53)	43.5 (1.45)	51.9 (1.48)

See footnotes at end of table.

Table XIV. Percentages (and standard errors) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age, state Health Insurance Marketplace type, and year: United States, 2010–June 2016—*Continued*

Age group, state Health Insurance Marketplace type, and year	Uninsured[1] at the time of interview	Public health plan coverage[2]	Private health insurance coverage[3]
18–64 years			
State-based Marketplace states[4]:			
2010	19.9 (0.52)	15.3 (0.48)	65.9 (0.68)
2011	19.5 (0.53)	17.1 (0.52)	64.7 (0.75)
2012	18.8 (0.50)	17.7 (0.49)	64.7 (0.69)
2013	18.7 (0.60)	18.4 (0.52)	64.1 (0.80)
2014	13.6 (0.45)	20.6 (0.57)	67.0 (0.75)
2015	9.4 (0.37)	22.9 (0.69)	68.9 (0.81)
2016 (Jan–Jun)	8.8 (0.40)	23.6 (0.70)	69.0 (0.82)
Partnership Marketplace states[5]:			
2010	18.9 (1.12)	15.3 (0.90)	67.6 (1.59)
2011	18.4 (0.92)	15.9 (0.87)	67.1 (1.52)
2012	18.1 (0.85)	13.9 (0.79)	69.3 (1.36)
2013	17.9 (0.98)	15.7 (0.91)	68.0 (1.29)
2014	12.8 (0.68)	18.2 (0.98)	70.5 (1.22)
2015	9.4 (0.74)	20.8 (0.95)	71.5 (1.26)
2016 (Jan–Jun)	9.4 (0.86)	20.9 (0.82)	72.0 (1.67)
Federally Facilitated Marketplace states[6]:			
2010	24.5 (0.56)	14.7 (0.43)	62.2 (0.66)
2011	23.0 (0.54)	15.1 (0.39)	63.3 (0.64)
2012	22.8 (0.48)	16.1 (0.41)	62.7 (0.61)
2013	22.0 (0.54)	15.9 (0.41)	63.6 (0.64)
2014	18.6 (0.49)	15.8 (0.41)	66.9 (0.63)
2015	15.7 (0.42)	16.0 (0.43)	69.9 (0.57)
2016 (Jan–Jun)	15.4 (0.61)	17.4 (0.62)	68.7 (0.82)

[1]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[4]State-based Marketplace states: CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, VT, and WA (as of October 31, 2013).

[5]Partnership Marketplace states: AR, DE, IL, IA, MI, NH, and WV (as of October 31, 2013).

[6]Federally Facilitated Marketplace states: AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, and WY (as of October 31, 2013).

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2010–2016, Family Core component.

Table XV. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and expanded region: United States, January–June 2016

Age group and expanded region[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
All ages			
All regions	8.9 (0.29)	36.7 (0.49)	62.6 (0.60)
New England	4.4 (0.44)	39.8 (1.72)	65.6 (1.27)
Middle Atlantic	6.1 (0.73)	37.4 (1.19)	66.1 (1.80)
East North Central	6.5 (0.39)	36.3 (0.72)	67.9 (1.32)
West North Central	7.6 (1.14)	32.3 (1.60)	69.7 (2.01)
South Atlantic	11.5 (0.53)	37.2 (1.79)	58.9 (1.37)
East South Central	8.4 (0.91)	42.9 (1.51)	58.5 (2.53)
West South Central	16.9 (0.93)	34.0 (1.20)	55.3 (0.84)
Mountain	9.3 (1.00)	35.4 (1.61)	61.7 (1.83)
Pacific	7.3 (0.59)	37.6 (1.37)	61.5 (1.65)
Under 65 years			
All regions	10.4 (0.34)	26.2 (0.54)	65.0 (0.66)
New England	5.2 (0.52)	28.4 (2.43)	68.7 (1.84)
Middle Atlantic	7.2 (0.87)	26.0 (1.36)	68.5 (2.16)
East North Central	7.7 (0.47)	25.0 (0.83)	69.4 (1.42)
West North Central	9.0 (1.32)	19.9 (1.63)	72.8 (2.37)
South Atlantic	13.7 (0.60)	25.4 (1.72)	62.1 (1.48)
East South Central	9.9 (1.13)	32.6 (2.34)	59.7 (2.62)
West South Central	19.2 (0.97)	25.0 (1.04)	57.0 (0.80)
Mountain	10.5 (1.18)	26.9 (1.60)	64.2 (1.93)
Pacific	8.3 (0.72)	28.8 (1.61)	64.3 (1.95)
0–17 years			
All regions	5.0 (0.41)	42.7 (0.99)	53.9 (1.08)
New England	*1.2 (0.59)	42.4 (3.16)	59.4 (2.75)
Middle Atlantic	4.5 (0.96)	38.6 (2.54)	59.1 (2.83)
East North Central	2.8 (0.48)	36.7 (2.19)	62.7 (2.53)
West North Central	5.2 (1.38)	34.8 (3.87)	62.2 (4.21)
South Atlantic	5.0 (0.81)	47.7 (3.41)	48.1 (3.15)
East South Central	*3.0 (1.19)	52.2 (4.33)	45.8 (3.97)
West South Central	8.9 (1.23)	49.6 (1.68)	43.1 (1.11)
Mountain	6.5 (1.95)	39.3 (2.23)	55.7 (2.44)
Pacific	5.1 (1.39)	43.2 (2.68)	52.8 (3.34)
18–64 years			
All regions	12.4 (0.39)	20.0 (0.46)	69.2 (0.56)
New England	6.5 (0.77)	23.7 (2.50)	71.8 (1.99)
Middle Atlantic	8.2 (1.02)	21.6 (0.99)	71.9 (1.93)
East North Central	9.5 (0.64)	20.7 (0.82)	71.8 (1.43)
West North Central	10.5 (1.51)	14.0 (1.11)	77.0 (1.88)
South Atlantic	16.9 (0.90)	17.1 (1.30)	67.3 (1.13)
East South Central	12.4 (1.29)	25.2 (1.80)	64.8 (2.28)
West South Central	23.7 (1.19)	14.2 (0.73)	63.2 (0.76)
Mountain	12.2 (1.00)	21.6 (1.56)	67.8 (1.72)
Pacific	9.4 (0.60)	23.8 (1.26)	68.2 (1.54)

*Estimate has a relative standard error greater than 30% and less than or equal to 50% and should be used with caution, because it does not meet standards of reliability or precision.

[1]The New England region includes CT, ME, MA, NH, RI, and VT. The Middle Atlantic region includes: DE, DC, MD, NJ, NY, and PA. The East North Central region includes: IL, IN, MI, OH, and WI. The West North Central region includes: IA, KS, MN, MO, NE, ND, and SD. The South Atlantic region includes: FL, GA, NC, SC, VA, and WV. The East South Central region includes: AL, KY, MS, and TN. The West South Central region includes: AR, LA, OK, and TX. The Mountain region includes: AZ, CO, ID, MT, NV, NM, UT, and WY. The Pacific region includes: AK, CA, HI, OR, and WA.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–June 2016

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
All ages			
All states[5]	8.9 (0.29)	36.7 (0.49)	62.6 (0.60)
California	7.4 (0.63)	38.4 (2.06)	59.3 (2.39)
Florida	13.1 (0.70)	40.6 (2.36)	54.3 (2.11)
Georgia	12.9 (1.96)	29.0 (3.42)	63.2 (3.97)
Illinois	6.5 (1.17)	33.5 (2.21)	71.6 (2.89)
Michigan	6.9 (1.25)	38.4 (3.40)	66.5 (3.87)
Minnesota	5.7 (0.73)	26.9 (1.47)	76.7 (1.18)
New York	5.5 (0.67)	37.3 (0.83)	64.6 (1.13)
North Carolina	11.4 (0.92)	34.9 (2.55)	60.2 (2.49)
Ohio	6.7 (1.16)	39.5 (1.89)	62.5 (2.79)
Pennsylvania	6.9 (1.77)	37.3 (2.25)	66.6 (3.64)
Texas	18.2 (1.20)	31.8 (0.81)	56.0 (1.25)
Virginia	8.4 (1.39)	38.3 (2.70)	62.0 (2.38)
Under 65 years			
All states[5]	10.4 (0.34)	26.2 (0.54)	65.0 (0.66)
California	8.4 (0.77)	30.1 (2.27)	62.5 (2.81)
Florida	16.2 (0.97)	26.4 (2.38)	58.4 (1.99)
Georgia	14.7 (2.29)	18.8 (2.88)	67.4 (4.50)
Illinois	7.6 (1.46)	22.3 (1.68)	72.5 (3.30)
Michigan	8.1 (1.46)	26.9 (3.17)	67.9 (4.17)
Minnesota	6.6 (0.86)	15.6 (1.89)	79.2 (1.82)
New York	6.6 (0.83)	26.0 (0.92)	68.6 (0.90)
North Carolina	12.9 (1.00)	25.6 (2.81)	62.9 (3.20)
Ohio	7.8 (1.39)	28.5 (2.24)	64.7 (2.93)
Pennsylvania	7.9 (2.05)	26.1 (2.76)	68.6 (4.04)
Texas	20.3 (1.26)	23.2 (0.69)	57.5 (1.20)
Virginia	9.9 (1.59)	27.4 (2.77)	63.3 (2.10)
0–17 years			
All states[5]	5.0 (0.41)	42.7 (0.99)	53.9 (1.08)
California	*5.1 (1.61)	44.9 (3.40)	50.8 (4.46)
Florida	7.2 (0.77)	49.4 (3.65)	44.4 (3.31)
Georgia	*5.3 (2.14)	40.9 (6.07)	54.7 (6.72)
New York	*2.4 (1.16)	35.2 (1.84)	63.0 (1.79)
North Carolina	5.0 (1.36)	48.3 (6.05)	47.0 (4.71)
Ohio	*3.4 (1.34)	39.6 (5.47)	57.6 (5.80)
Pennsylvania	*6.7 (2.67)	42.1 (3.62)	55.0 (4.61)
Texas	9.6 (1.53)	46.8 (1.54)	44.9 (1.38)

See footnotes at end of table.

Table XVI. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and selected states: United States, January–June 2016 —*Continued*

Age group and selected states[1]	Uninsured[2] at the time of interview	Public health plan coverage[3]	Private health insurance coverage[4]
18–64 years			
All states[5]	12.4 (0.39)	20.0 (0.46)	69.2 (0.56)
California	9.6 (0.63)	24.9 (1.86)	66.7 (2.29)
Florida	19.6 (1.21)	17.9 (1.84)	63.5 (1.61)
Georgia	18.7 (2.48)	9.2 (2.12)	72.9 (4.00)
Illinois	9.5 (1.74)	17.4 (1.18)	75.3 (2.64)
Michigan	9.6 (1.76)	24.3 (2.28)	68.8 (3.61)
Minnesota	7.4 (0.76)	12.7 (1.24)	81.1 (1.25)
New York	7.9 (1.14)	23.2 (1.00)	70.3 (0.93)
North Carolina	15.9 (1.69)	17.0 (2.02)	69.0 (2.92)
Ohio	9.4 (1.73)	24.5 (1.33)	67.4 (2.31)
Pennsylvania	8.4 (1.95)	19.2 (2.15)	74.4 (3.56)
Texas	25.1 (1.45)	12.8 (0.43)	63.1 (1.30)
Virginia	12.9 (2.15)	20.4 (2.71)	67.6 (1.68)

*Estimate has a relative standard error greater than 30% and less than or equal to 50% and should be used with caution, because it does not meet standards of reliability or precision.

[1]Estimates are presented for fewer than 50 states and the District of Columbia due to considerations of sample size and precision.

[2]A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[3]Includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

[4]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, or purchased through local or community programs. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[5]Includes all 50 states and the District of Columbia.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016, Family Core component.

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DATAWATCH

Employer-Sponsored Insurance Offers: Largely Stable In 2014 Following ACA Implementation

Affordable Care Act provisions implemented in 2014 could have influenced employers' decisions to offer health insurance. Using data for 2014 from the Medical Expenditure Panel Survey–Insurance Component, we found little change in employer-sponsored health insurance offerings: More than 95 percent of employers either continued offering coverage or continued not offering it between 2013 and 2014. Fewer than 3.5 percent of employers dropped coverage, and 1.1 percent added coverage.

In 2014 the Affordable Care Act (ACA) created new ways for people to obtain health insurance through federal and state-based Marketplaces and through expanding Medicaid eligibility in states that decided to participate in the expansion. Yet the ACA preserved—albeit with new regulations and penalties—the institution of employer-sponsored insurance. In the years leading up to 2014, concerns had been expressed that the ACA's new coverage options, regulations, and penalties might prompt companies to stop offering health insurance to their employees.[1]

In this study we used nationally representative data to examine the extent to which employers[2] dropped or added health insurance between 2013 and 2014. We found that 46.38 percent of private-sector employers offered coverage in both years, and 49.08 percent did not offer it in either year (Exhibit 1). Only 3.45 percent of employers dropped coverage and 1.10 percent added it between the two years.

The ACA may reduce employers' incentives for offering insurance in a number of ways, including the creation of new sources of insurance for workers, such as subsidized Marketplaces and expanded Medicaid coverage.[3,4] In contrast, the employer shared-responsibility requirement, which requires firms with fifty or more full-time-equivalent (FTE) workers to offer coverage or pay a penalty, is meant to increase offers of coverage. Despite the delay in implementation of this provision,[5] employers may have made decisions in anticipation of it. The individual mandate, which requires most individuals to have coverage or pay a penalty, also makes employer-sponsored insurance especially attractive to workers who are unlikely to qualify for Marketplace subsidies or Medicaid.

One early analysis found that ACA coverage provisions had little to no effect on either the offering or the uptake of employer-sponsored

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EXHIBIT 1

Changes in offers of employer-sponsored insurance from 2013 to 2014

SOURCE Authors' analysis of data for 2014 from the Medical Expenditure Panel Survey–Insurance Component. NOTE The sample of approximately 26,400 employers was restricted to private-sector establishments.

insurance.[6] Other work found minimal short-term effects of the ACA on jobs or part-time work.[7–9]

In this article we examine the provision of employer-sponsored insurance among US private-sector establishments. Using data from the 2014 Medical Expenditure Panel Survey–Insurance Component (MEPS-IC), we took advantage of two questions that asked establishments about their provision of employer-sponsored insurance during both the current and the previous years. Thus, we captured transitions in insurance provision that could not be identified with the use of repeated cross-sectional data. Additionally, we explored how such transitions were associated with establishment and workforce characteristics, labor-market conditions, and state-level policy changes in response to the ACA.

Study Data And Methods

To examine changes in insurance offers among employers between 2013 and 2014, we used responses to the following two MEPS-IC survey questions: "Did your organization make available or contribute to the cost of any health insurance plans for its active employees at this location in 2014?" and "In 2013, did your organization offer health insurance as a benefit to its active employees at this location?" We categorized establishments as those that offered insurance in both years, those that did not offer it in either year, those that offered insurance in 2013 but did not in 2014, and those that did not offer it in 2013 but did in 2014.

From the MEPS-IC data, we identified establishment and workforce characteristics related to workers' demand for health insurance. These characteristics were small firm size (fewer than fifty employees), the percentage of low-wage workers (those earning less than $11.50 per hour),[10] separate effects for the percentage of low-wage workers depending on whether or not the firm was small, whether or not the establishment was less than ten years old, the industry category (white collar, blue collar, or service sector—sometimes called pink collar), the percentage of an establishment's employees who were female, the percentage of employees ages fifty and older, and any union presence. We controlled for local labor-market conditions by augmenting MEPS-IC data with 2014 county-level unemployment rates from the Bureau of Labor Statistics.

To explore the effect of state-level ACA policies, we used HIX 2.0 data from the Robert Wood Johnson Foundation[11] to determine if an establishment's state had its own state-based Marketplace. We used Henry J. Kaiser Family Foundation data to identify the state-level percentage-point change in the nonparent poverty-level eligibility threshold for Medicaid that occurred from 2013 to 2014.[12]

Finally, small employers in a majority of states faced significant changes in premium-setting practices with the introduction in 2014 of modified community rating: Insurers were prevented from varying premiums in the small-group market except on the basis of age, tobacco use, family size, and geographic area. Again using Kaiser Family Foundation data, we defined an indicator for whether the establishment's state had newly implemented modified community rating in the small-group market in 2014 (as opposed to having implemented it before the implementation of the ACA's reform of the small-group market in that year).[13]

Descriptive statistics and multivariate regression were used to examine independent associations between establishment, workforce, labor-market, and policy variables and the probability of an establishment's dropping or adding insurance between 2013 and 2014. Survey-weighted linear probability models were estimated using Stata, version 14.0/SE.

The study was subject to four potential limitations. First, the change in offers from 2013 to 2014 did not identify a causal effect of the ACA's implementation. However, we were able to investigate associations between change in offers, on one hand, and Marketplace type, change in Medicaid eligibility, and change in community rating regulation, on the other hand. Second, 2014 was the first year that MEPS-IC asked the question about offers in the previous year. Therefore, we had no exact baseline with which to compare our estimates. Third, there was a potential for recall bias regarding insurance status in the previous year. Fourth, our sample for bivariate and multivariate analyses excluded observations with nonresponses for at least one establishment or workforce composition variable, which reduced our sample size from approximately 26,400 to approximately 21,900 establishments.

Study Results

Offers of employer-sponsored insurance remained largely stable between 2013 and 2014. Of all establishments surveyed, only approximately 3.45 percent (95% confidence interval: 3.16, 3.74) dropped insurance, while 1.10 percent (95% CI: 0.94, 1.25) added it (Exhibit 1). The remaining establishments either offered insurance in both 2013 and 2014 (46.38 percent) or did not offer it in either year (49.08 percent).

Because US workers are disproportionately more likely to be employed by large establishments than by small ones, the share of workers in establishments that dropped coverage was only 1.5 percent, whereas the share in establishments that added coverage was 0.73 percent (data not shown).

When we compared establishments that did not offer insurance in either year to those that added coverage in 2014, we found that the latter group had a significantly younger workforce and a significantly lower percentage of low-wage workers (Exhibit 2). When we compared establishments that offered coverage in both years to those that dropped coverage in 2014, we found that the establishments in the latter group were much more likely to be small and to have a higher percentage of low-wage workers.

Next, we estimated two regression models to investigate the association of establishment and workforce attributes, labor-market conditions, and state-based ACA policies with two outcomes. The first was the probability that an establishment that had not offered coverage in 2013 would add it in 2014. The second was the probability that an establishment that had offered coverage in 2013 would drop it in 2014. Full model specifications are provided in the online Appendix.[14]

The state-level ACA policy variables—having a state-based Marketplace, the percentage-point change in the nonparent poverty-level eligibility threshold for Medicaid that occurred from 2013 to 2014, and the introduction of modified community rating—did not have a significant effect on either probability.

In the model corresponding to adding insurance, small firms and those with a higher percentage of workers ages fifty and older were less likely to add insurance compared to large firms and those with a younger workforce. In contrast, establishments having any union presence were more likely to add insurance than those without a union presence (data not shown).

Of course, the outcome of dropping insurance often receives more attention among policy makers than the outcome of adding insurance. Notably, establishments that were part of small firms were considerably more likely to have dropped insurance in 2014, compared to establishments associated with large firms (Exhibit 3). In addition, the positive effect of having low-wage work-

EXHIBIT 2

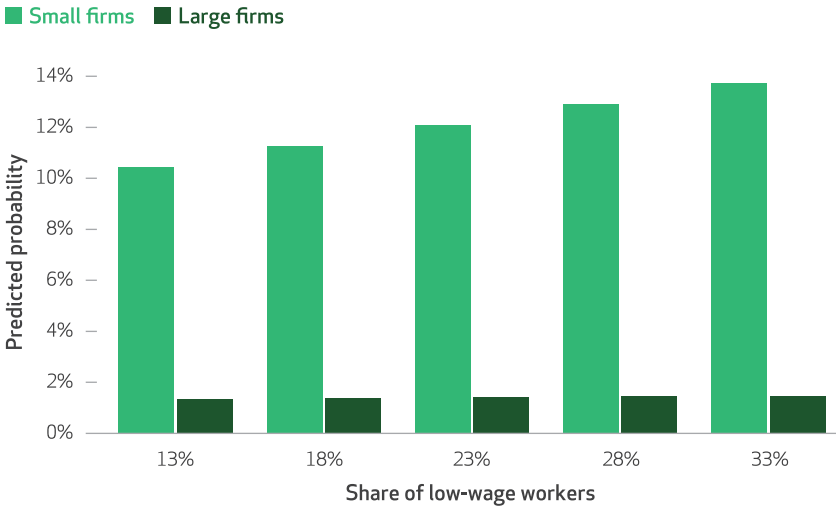
Characteristics of employers by whether or not they offered insurance in 2013–14

	All employers	Not offered in either year	Offered in 2014 only	Offered in both years	Offered in 2013 only
Approximate sample size	21,900	9,000	200	12,000	700
In state with a state-based Marketplace	36.83%	35.33%	34.43%	38.46%	38.83%
Mean change from 2013 to 2014 in nonparent FPL eligibility threshold for Medicaid (percentage points)	65.79	63.54	65.83	68.05	70.01
State implemented modified community rating in 2014[a]	60.75%	76.55%	64.97%***	41.8%	67.79%****
Mean share of workforce that is:					
Female	44.86%	43.76%	38.45%	46.24%	45.57%
Ages 50 and older	33.98	36.19	23.96****	31.59	35.3
Low wage[b]	31.82	39.66	30.63***	22.5	32.57****
Any union presence	4.96	1.16	4.59**	—[c]	—[c]
Mean county unemployment rate, 2014	6.10%	6.16%	6.20%	6.02%	6.15%
Mean share of firms that are:					
White collar	39.71%	34.65%	38.23%	45.51%	40.78%
Service sector	35.88	40.63	35.76	30.24	37.68***
Blue collar	24.24	24.71	26.01	24.25	21.54
Small firm[d]	81.03	98.48	90.30****	59.44	95.69****
Less than 10 years old	34.78	48.59	50.52	18.14	37.94****

SOURCE Authors' analysis of data for 2014 from the Medical Expenditure Panel Survey–Insurance Component (MEPS-IC), augmented with data for 2014 on county-level unemployment rates from the Bureau of Labor Statistics; and data from the following sources: Heberlein M, et al. Getting into gear for 2014 (Note 12 in text); and Leonard Davis Institute of Health Economics. Medicaid expansion and federal state division of responsibilities database (Note 11 in text). **NOTES** White-collar firms are professional services providers; religious, civil, and nonprofit organizations; and firms in the finance, insurance, real estate, and company management industries. Blue-collar firms are those in the manufacturing or mining, wholesale trade, transportation or utilities, construction, agriculture, forestry, fishing, and hunting industries. Service-sector firms are those that provide retail trade, accommodations, food service, entertainment, and recreational services. The sample was restricted to private-sector establishments without any nonresponse for the establishment and workforce characteristics related to workers' demand for insurance we identified in MEPS-IC. Significance for the "offered in 2014 only" column is calculated with respect to the "not offered in either year" column. Likewise, significance for the "offered in 2013 only" column is calculated with respect to the "offered in both years" column. FPL is federal poverty level. [a]Modified community rating is explained in the text. [b]Earning less than $11.50 per hour. [c]Data not shown because of risk of identification, as determined by the Census Bureau. [d]Fewer than fifty employees. **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

EXHIBIT 3

Predicted probability of an employer's dropping insurance from 2013 to 2014, by percentage of low-wage workers and firm size



SOURCE Authors' analysis of data for 2014 from the Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) augmented with data for 2014 on county-level unemployment rates from the Bureau of Labor Statistics; and data from the following sources: Heberlein M, et al. Getting into gear for 2014 (Note 12 in text); and Leonard Davis Institute of Health Economics. Medicaid expansion and federal state division of responsibilities database (Note 11 in text). **NOTES** The mean share of low-wage workers was 23 percent; the exhibit shows data in five-percentage-point increments at either side of the mean. Small firms are those with fewer than fifty employees. Large firms are those with at least fifty employees. The sample of approximately 21,900 employers was restricted to private-sector establishments without any nonresponse for establishment and workforce characteristics related to workers' demand for insurance we identified in MEPS-IC. Predicted probabilities were calculated using linear probability model parameter estimates and mean values for other explanatory variables. The online Appendix provides additional information about the model (see Note 14 in text).

ers on dropping insurance was stronger in small firms than in large ones.

The predicted probability of dropping insurance was higher for newer establishments than for older ones, and higher for those in the service sector than for those in blue- or white-collar industries (Exhibit 4).

Discussion

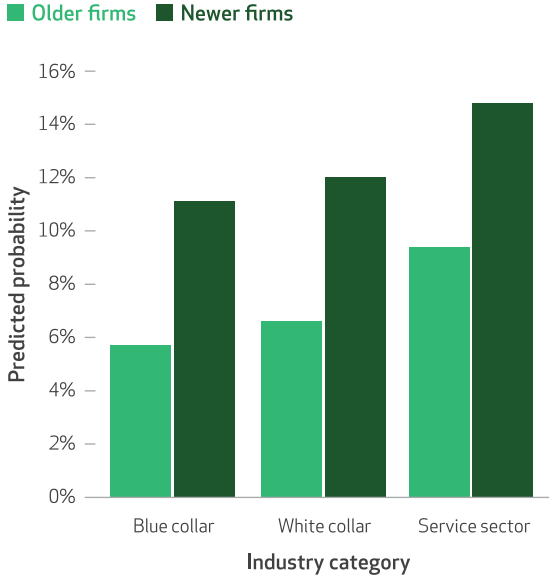
Our analysis does not support the hypothesis that the provisions of the ACA that were implemented in 2014 would lead to large-scale reductions in employer-sponsored insurance. Fewer than 3.5 percent of employers (affecting 1.5 percent of workers) reported dropping health insurance between 2013 and 2014, and more than 95 percent of employers either continued to offer or continued not to offer insurance in both years.

Because 2014 was the first year when MEPS-IC asked employers about insurance offerings in the previous year, we cannot compare our results directly to a trend. But we can compare the net change in employers' offering of –2.35 percent in 2014 (that is, the 3.45 percent that dropped coverage combined with the 1.10 percent that added coverage) to changes in previous years. Based on public MEPS-IC tables, the average annual net change in offer rates between 2010 and 2013 was –1.3 percent (data not shown), which was a smaller change than the one we found. However, the largest year-to-year change between 2010 and 2013 was the net change of –2.8 percent between 2010 and 2011. Since that was a somewhat larger change than the one we found, it suggests that our result was not an outlier.

We found no significant association between employers' dropping or adding coverage and any ACA-related policy variables. In contrast, workforce and employer characteristics were associ-

EXHIBIT 4

Predicted probability of a small firm's dropping insurance from 2013 to 2014, by industry category and age of firm



SOURCE Authors' analysis of data for 2014 from the Medical Expenditure Panel Survey–Insurance Component (MEPS-IC), augmented with data for 2014 on county-level unemployment rates from the Bureau of Labor Statistics; and data from the following sources: Heberlein M, et al. Getting into gear for 2014 (Note 12 in text); and Leonard Davis Institute of Health Economics. Medicaid expansion and federal state division of responsibilities database (Note 11 in text). **NOTES** Newer firms are less than ten years old. Older firms are at least ten years old. White-collar, blue-collar, and service-sector firms are defined in the Exhibit 2 Notes. The sample of approximately 21,900 employers was restricted to private-sector establishments without any nonresponse for establishment and workforce characteristics related to workers' demand for insurance we identified in MEPS-IC. Predicted probabilities were calculated using linear probability parameter estimates and mean values of other explanatory variables. The online Appendix provides additional information about the model (see Note 14 in text). All differences between older and newer firms and among firms in different sectors were significant ($p < 0.05$) except for the following: older white-collar firms versus older blue-collar firms, newer blue-collar firms versus older blue-collar firms, and older blue-collar firms versus older service-sector firms.

ated with an employer's decision to drop coverage. Small firms were more likely to drop coverage compared to large ones, as were those with more low-wage workers compared to those with fewer such workers, newer establishments compared to older ones, and those in the service sector compared to those in blue- and white-collar industries.

In the first year after implementation of the major ACA coverage provisions, we found that employer-sponsored insurance remained largely stable, with the vast majority of establishments not changing their offering status. However, adjustments to the new environment after reform are unlikely to be completed in only one year, and uncertainty about some reform provisions (including delays in assessing the penalty for not complying with the employer shared-responsibility requirement) may also have helped maintain the status quo.

Nonetheless, studies have found evidence suggesting that employers were not planning to drop insurance in the short term.[15] The monitoring of employers' provision of insurance should continue, to determine whether the general stability in the first year will persist. ■

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NOTES

1 Singhal S, Stueland J, Ungerman D. How US health care reform will affect employee benefits [Internet]. [place unknown]: McKinsey and Company; 2011 Jun [cited 2016 Sep 12]. Available from: http://www.mckinsey.com/industries/health-care-systems-and-services/our-insights/how-us-health-care-reform-will-affect-employee-benefits

2 The Census Bureau defines an *establishment* (a term we use as synonymous with *employer*) as a business unit operating in a single location. A *firm* may consist of one or more establishments (that is, business units in one or more locations) under common ownership or control. The Medical Expenditure Panel Survey–Insurance Component is an establishment-level survey that collects information on the number of workers at both the firm and establishment levels.

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5 The penalty was delayed to 2015 for large firms (those with 100 or more FTEs) and to 2016 for midsize firms (those with 50–99 FTEs).

6 Blavin F, Shartzer A, Long SK, Holahan J. An early look at changes in employer-sponsored insurance under the Affordable Care Act. Health Aff (Millwood). 2015;34(1):170–7.

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10 MEPS-IC collects data on the percentage of workers earning the following hourly amounts: less than $11.50, $11.50–$27.50, and more than $27.50.

11 Leonard Davis Institute of Health Economics, Wharton School, University of Pennsylvania. Medicaid expansion and federal state division of responsibilities dataset [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; [last updated 2014 Oct; cited 2016 Sep 12]. Available from: http://www.rwjf.org/en/library/research/2015/04/medicaid-expansion-dataset.html

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14 To access the Appendix, click on the Appendix link in the box to the right of the article online.

15 Goldstein A. Few employers dropping health benefits, surveys find. Washington Post. 2014 Nov 19.

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REGIONAL MARKETS / CROSS-SITE ANALYSIS OCTOBER 2016

Many Routes to the Top: Efforts to Improve Care Quality, Coordination, and Costs Through Provider Collaborations

In response to the federal Patient Protection and Affordable Care Act of 2010 (ACA) and a combination of broader market forces, hospitals, physicians, and other health care providers around the country have been increasingly collaborating among themselves and with public and private payers on efforts to reform care delivery systems and payment methods. While their structures vary widely, most of these initiatives share the overarching aims of slowing the growth of health care spending and improving the coordination and quality of patient care.

California providers have been particularly active in developing collaborations with other providers and with commercial health plans. Many of these provider partnerships have been driven in part by key market factors characteristic of many California communities — most notably the presence of large providers experienced in managing financial risk for patient care, as well as competitive pressure on both insurers and providers from the growing dominance of Kaiser Permanente's integrated delivery system and health plan.

The California Health Care Foundation's longitudinal Regional Markets Study of seven California health care markets provided a unique opportunity to track the development of collaborative relationships that hospital and physician organizations have formed in the state over the past several years. This paper describes major types of provider collaborations that have proliferated in California since 2013, highlights leading examples from the seven regions studied, discusses providers' key goals and strategies, and explores how market conditions spurred each major type of partnership and influenced their structure. The analysis also considers some of the key effects that these collaborations might have on cost, quality, and access to care in local health care markets. The intent of the paper is not to provide an exhaustive catalog of all collaborations undertaken by providers; instead, the focus is on those initiatives highlighted by hospital and physician executives, as well as market observers, as particularly important to the overall strategies and objectives of provider organizations.

The focus of this paper is on collaborations formed by mainstream health care providers — those that serve large populations of commercial and Medicare patients.

Integrating Care: Provider Collaborations to Form Region-Wide Integrated Care Networks

An increase in efforts by major providers — primarily hospital systems — to pursue population health strategies represents one of the most significant developments in several major California health care markets over the past few years. In response to policy changes and market forces that are moving both public and private payment away from fee-for-service toward value-based models that reward efficiency, providers are seeking to transform themselves into region-wide integrated systems of care. While these efforts vary widely in structure and organization, they share the common aim of building a care network that is broad and attractive enough to

purchasers and consumers to compete vigorously for sizable populations of well-insured patients while also achieving enough efficiency in managing patient care that providers can fare well financially in competition against the likes of Kaiser Permanente.

Not surprisingly, most of these efforts to develop region-wide population health strategies are taking place in major metropolitan markets with large populations of well-insured patients. In Northern California, these markets include the San Francisco Bay Area and Sacramento; in the southern part of the state, Los Angeles, Orange, and San Diego Counties all are seeing active efforts to develop integrated care networks. These are also markets that have large, financially strong hospital systems capable of making the capital investments in such ambitious initiatives. Many of these systems have long thrived as high-priced providers exercising strong leverage against commercial payers in a fee-for-service environment and still have a large proportion of their payments under lucrative volume-based arrangements. However, as one market observer noted, "Large systems [are] taking major, proactive steps to try to transform themselves into high-value regional systems of care . . . while [financial] margins are still strong . . . so they don't get left behind by a changing market."

Another key characteristic common to these markets is the strong and growing presence of Kaiser, whose HMO products emphasizing moderate premiums and out-of-pocket costs, combined with seamless access to services (especially primary care), has put pressure on competing providers and insurers to offer similar combinations of value and access.

Some large systems — most notably Sutter Health in Northern California and Sharp Healthcare San Diego — have sufficient breadth of services and geographic coverage to pursue regional population health strategies on their own, but a number of other prominent systems instead have chosen to team up with other systems in their own regions to build integrated, region-wide networks together. Systems that are taking a collaborative approach to their pursuit of population health are often those with a strong, even dominant, presence within a particular submarket but a more limited presence in the larger region. By aligning with one or more providers based elsewhere in the same region, systems are seeking to expand their clinical footprint to compete for patients over a significantly broader geographic area.

In seeking strategic partners for building a region-wide network, systems also have been seeking partners that possess complementary strengths, so that the combined entity can better compete for patients by offering a full range of clinical services efficiently across the region. For example, academic medical centers focused on high-end tertiary services tend to join forces with systems that have expertise in building physician networks (particularly of primary care physicians) and managing patient care — typically an area of relative weakness for AMCs.

Among the seven markets in this study, Orange County was particularly active in developing such population health collaborations. Two of the region's major systems, St. Joseph Health System and Hoag Health, embarked on a joint venture in 2013, forming a new operating company called St. Joseph Hoag Health (SJHH) to develop a system of care and work toward population health management. The two systems entered into a joint operating agreement — a "virtual merger" that aligned the two systems very closely but did not merge their assets.[1,2] This arrangement gave St. Joseph access to the very affluent coastal region, where Hoag has long been dominant, as well as to Hoag's well-known surgical specialty hospital in Irvine, a large, well-insured population center. The partnership reportedly gave Hoag an opportunity to diversify beyond its limited geographic base and its historic focus on high-cost specialty services by opening up access to St. Joseph's broad primary care base. In aligning with St. Joseph's, Hoag also sought to leverage the latter's foundation model to help launch Hoag's first medical group.

Also in 2013, another of Orange County's major providers, MemorialCare Health System, developed a partnership with the county's only academic medical center, UC Irvine Health. This affiliation represented the expansion of a

decades-old relationship between the two organizations surrounding teaching programs. Unlike St. Joseph and Hoag, MemorialCare and UC Irvine continue to operate as two independent entities. However, the partnership does share with SJHH the same overall goal of establishing a broader geographic network of integrated care delivery. Under the arrangement, MemorialCare supplies its primary care expertise while UC Irvine provides more specialty and tertiary services, backed by its 500-strong faculty practice.

One of the ways these Orange County partnerships are seeking to compete for commercial patients is by introducing new models for sharing risk with employers. Recently, SJHH and MemorialCare separately created tiered-network products for self-insured employers. Under these arrangements, the provider and employer jointly set a spending target for total cost of care for the employer's total covered lives, and share in savings or losses. While these arrangements are still quite new, with relatively low enrollment to date, in mid-2016 the MemorialCare Health Alliance (which includes not only MemorialCare and UC Irvine but also Torrance Memorial Health System and PIH Health) won a direct contract with large national employer Boeing. Under the arrangement, a new HMO product whose provider network consists of the MemorialCare Health Alliance partners will be offered to Boeing's Southern California employees, who are concentrated in Orange County and the adjacent Long Beach / South Bay areas of Los Angeles County. The new product is being offered to Boeing's employees and dependents in the region alongside existing options such as a Kaiser HMO.[3] Coverage is slated to begin in January 2017 for the new product, which offers incentives to enroll such as low premiums, zero out-of-pocket costs for primary care visits and generic drugs (after the deductible has been met), and increased Boeing contributions to health savings accounts for eligible employees.[4]

The San Francisco Bay Area — a region historically characterized by many segmented, distinct submarkets — also saw two of its key providers collaborating to build a region-wide integrated care network. In early 2015, the University of California, San Francisco Medical Center (now part of UCSF Health) formed a strategic partnership with John Muir Health, a system with a dominant presence in the East Bay's Contra Costa County. Initially known as the Bay Area Accountable Care Network, and recently renamed Canopy Health, the partnership aims to build a region-wide integrated network to compete with Kaiser and Sutter for commercial patients. UCSF and Muir also set up a separate but related development company, Bay Health, to build new ambulatory facilities and to integrate their clinical IT systems. Adding ambulatory capacity in submarkets such as North Oakland and Berkeley would allow Canopy Health to better compete for patients against Kaiser and Sutter — the two providers that have historically dominated that well-insured submarket. As with the Orange County collaborations, Muir and UCSF bring complementary strengths to their partnership: Muir's strong track record of building physician networks and managing care, and UCSF's substantial footprint and status as a premier destination for highly specialized services.

In mid-2016, it was announced that three IPAs (Hill Physicians Medical Group, Muir Medical Group IPA, and Meritage Medical Network) had joined Canopy's two founding hospital partners as both shareholders and participating providers.[5] Canopy Health also added seven hospitals to its network, including five in the East Bay and two in the North Bay.[6] Pending final state approval of a restricted insurance license, Canopy Health is expected to partner with health plans to offer HMO products to mid-sized and large groups. Open enrollment would begin in the fall of 2016 for coverage starting in 2017. One health plan contract already in place is an agreement between Health Net and Canopy Health for the latter to assume financial risk for about 13,000 University of California employees and dependents already covered by Health Net's HMO product.[7]

In Los Angeles and neighboring Orange County, a high-profile collaboration known as Vivity brought together one of California's largest commercial health plans, Anthem Blue

Cross, and seven health care systems — including renowned institutions such as Cedars-Sinai Medical Center and UCLA Health.[8] As one participant described it, Vivity's "uniqueness and novel nature . . . [stems from] the experiment of teaming up seven systems that previously competed quite strongly against each other, and still do compete outside of Vivity, and working to create one integrated entity . . . [that delivers] seamless and cost-efficient care." Each of the eight partners shares equal risk in the joint venture, which was announced in 2014 and began offering HMO products to select large groups in 2015. The most prominent of those groups was the California Public Employees' Retirement System (CalPERS), the state's largest purchaser of health benefits. In its first year, Vivity made very modest inroads in the CalPERS market, capturing just 1% of CalPERS members in the region.[9] However, Vivity's total enrollment of 24,000 in its first year of business, across all its large groups, exceeded its initial first-year projection of 15,000 enrollees.

Like other collaborations aimed at forming integrated systems of care, Vivity focuses on offering HMO products whose efficiency, as well as convenience and access for patients, can rival or surpass those of Kaiser. To achieve efficiency, Vivity is pursuing clinical integration aggressively, but is still in the early stages of pooling and integrating all the participants' clinical data — a task that one participant described as a "Herculean effort . . . with costs and challenges to match." The initiative also has a long way to go in attaining its eventual objective of creating a system of seamless referrals that would allow physicians to identify which providers within the broad network offer the best-in-class options for a given service and refer patients to those providers. As one market observer noted, "That's not only a big challenge from a clinical data standpoint . . . [but] it's a major paradigm shift for all these hospitals. . . . It remains to be seen whether docs [aligned with] hospital A will actually refer patients away from their own hospital and steer them to hospitals B, C, and D instead . . . if those [offer] higher value for, say, a hip replacement. It's a tall order, but that's what Vivity has to achieve if they're going to be cost-competitive in the long run."

Such challenges are not unique to Vivity. Indeed, they confront each of the initiatives seeking to transform providers rooted in conventional fee-for-service payment into integrated delivery systems prioritizing efficiency and value. This paradigm shift needs to occur both within each provider organization and across all providers within a collaboration, as pointed out by both providers and market observers. Within each provider organization, incentives and culture need to be shifted away from longstanding fee-for-service strategies under which many have thrived. How much, and how fast, to pivot away from these approaches is a debate of interest to all large systems pursuing population health strategies, whether they're doing so largely on their own, like Sutter Health in Northern California and Scripps Health in San Diego, or are doing so through major collaborations. (An exception is Scripps' major competitor, Sharp Healthcare, which has long embraced capitation and positioned itself as a reasonably priced, high-value provider in the San Diego market.)[10]

For providers collaborating with others in pursuit of an integrated network, these challenges are compounded by the need to balance potentially conflicting cultures, interests, and incentives across all the partners. As one participant in such a collaboration observed, "One of the biggest challenges we face in making [the collaboration] work is the reality that we're not one organization; we're separate organizations, with separate boards of directors [and] governance structures." This respondent also highlighted another key challenge: "The providers we're partnering with are our direct competitors [outside the collaboration], so we recognize we might, to a certain extent, be cannibalizing our own business in pursuing [this collaboration]." However, participation in joint ventures also has stimulated dialogue among partnering providers, leading to the opportunity for some new collaborations.

Several providers and observers pointed to yet another challenge faced by these partnerships: the fundamental trade-off that exists between provider network breadth on the one

hand, and the degree of care integration, coordination, and efficiency that can be achieved on the other. Although building a broad network composed of many provider partners may help achieve "greater access and convenience for consumers and better marketability [of the related insurance products], it amplifies the challenges of creating a single unified, high-value delivery system," as one hospital executive noted.

Reducing the Total Cost of Care:
Commercial ACO Collaborations Between Providers and Health Plans

In the last round of this study in 2011-12, a few large California providers had begun collaborating with major health plans to form commercial accountable care organizations (ACOs). These partnerships aim to better compete for commercial business by collaborating to control total health care costs, which in turn helps keep insurance premium increases in check. While commercial ACOs share some key objectives with the population health collaborations described above, they generally expose providers to far less financial risk for patient care and do not require the same level of system transformation.

California's first commercial ACO was launched in the Sacramento market as a 2010 pilot by Blue Shield and its provider partners — Dignity Health, a hospital system, and Hill Physicians, an IPA — in an effort to reduce premium trends in Blue Shield's HMO product for the state's largest purchaser, CalPERS. The arrangement, under which the three partners shared both upside and downside risk for the total cost of care, was successful enough in generating savings that Blue Shield soon expanded it to other purchasers and other regions, including the 2011 launch of two ACOs for the San Francisco Health Service System, which purchases benefits for employees of the City and County of San Francisco. Over the past few years, Blue Shield's ACO collaborations have expanded to include a growing number of provider partners as part of the health plan's Trio ACO HMO network, which is now offered to both large and small groups across many California markets.[11]

Along with Sacramento, San Diego was one of the first markets to see health plans and providers experimenting with commercial ACO collaborations. The Anthem Blue Cross ACO, introduced as a pilot in 2011, launched full-fledged commercial products in 2012. Anthem's first provider partners were Sharp Healthcare's physician organizations: Sharp Community Medical Group (Sharp's closely affiliated IPA) and Sharp Rees-Stealy (Sharp's multispecialty medical group). In contrast to Blue Shield, Anthem Blue Cross based its ACO on a PPO platform, attributing patients to primary care physicians (PCPs) based on past utilization patterns. Like most ACO PPO arrangements in other markets nationwide, PCPs continued to be paid on a fee-for-service basis but also received per-member, per-month care management fees for their attributed patients and were eligible to participate in a shared-savings pool.

In the years since those early ACO collaborations, the major national insurers Aetna, Cigna, and United Healthcare all have formed their own ACO collaborations with providers. Like Anthem, these insurers all based their ACOs on PPO platforms and share similar approaches to key program features such as patient attribution, care management fees, and shared savings, though the specifics of their methodologies differ. All ACOs — including Blue Shield's ACO HMO model — emphasize the exchange of data between health plan and providers as a critical part of managing patient care more efficiently.

By 2015, commercial ACOs had spread to all seven of the California regions in this study. Even Fresno, which historically has lagged behind other health care markets, saw the launch of its first commercial ACO when Santé Community Physicians, the market's largest IPA, began partnering with Anthem Blue Cross. Not surprisingly, in large markets where major providers have a long track record of successfully assuming financial risk for managing patient care, some large physician organizations participate in ACOs with multiple

health plans. In San Diego, for example, Sharp-Rees-Stealy and Sharp Community Medical Group currently take part in ACOs with Aetna, Anthem Blue Cross, and United. In the Bay Area, Brown & Toland Physicians, a large IPA, participates in ACOs with four health plans: Aetna, Anthem Blue Cross, Blue Shield, and Cigna.

Despite their growing participation in commercial ACOs, several large providers expressed reservations and frustrations about these initiatives. Some noted that sharing risk with health plans in ACOs is less advanced from a provider standpoint than accepting full risk under capitation — an arrangement that gives them much greater control over patient care. "In some ways, [ACOs] represent a frustrating step backward compared to our capitated business . . . where we've already built a strong infrastructure to manage care," an executive of a large physician organization commented. A fundamental limitation of the shared-savings approach common to ACOs is that it requires the partners to continue identifying new sources of savings over time in order to keep earning shared savings, after the "savings have already been wrung out of the low-hanging fruit" early in the initiative, as one health plan executive noted. This stands in contrast to capitation, which allows providers to be rewarded consistently from one contract to the next as long as they continue to manage care efficiently.

In addition, providers and health plans noted the many data and logistical challenges of ACO collaborations. While data-sharing between providers and health plans has progressed significantly since the earliest days of ACOs, the patient data currently available to providers for ACO lives are still not nearly as timely or comprehensive as the data that providers have for their capitated patients, according to several providers. Care management represents another key logistical challenge for ACOs, with health plans and providers often treading on each other's toes with separate programs whose lack of coordination not only reduces efficiency for the ACO partners, but also can lead to confusion and frustration for patients.

Despite these challenges, providers across most markets continue to explore ways to expand their ACO collaborations. As commercial capitation continues to erode slowly in most markets, participation in ACO PPOs is widely seen as a way for providers to increase (or at least maintain) their patient volumes. As one San Diego physician executive observed, "However clunky [ACOs] are . . . they allow us to reach people who have never been in, and will never be in, HMOs. . . . It gives us a chance to capture people who might not [otherwise] be our patients."

Consolidating Services:
Clinical Affiliations Between Hospitals

Clinical affiliations between hospitals have long been common, with the most typical partnerships being those between a large system or academic medical center and a smaller community hospital. These partnerships serve multiple objectives, ranging from traditional fee-for-service strategies to newer population health approaches that many hospitals have begun to pursue in recent years. A longstanding and still critical motivation for clinical affiliations has always been to drive tertiary and other specialty referrals to the large system or AMC. The affiliation also expands the range of clinical expertise available to the community hospital, thus potentially enhancing its brand and increasing its patient volume. In addition to increasing mutually beneficial referrals, these affiliations can enhance efficiency by directing care to the most appropriate setting — keeping routine secondary care in community hospitals (which may also increase convenience and access for patients) while allowing the AMC or other large tertiary hospital to focus on more highly specialized services. In recent years, this has become a more central focus as large systems increasingly pursue population health strategies, as described above. As a result, their existing affiliations with community hospitals have tightened, as the systems seek to incorporate these smaller hospitals into new region-wide clinically integrated networks. Large systems also have been forming new

affiliations with more community hospitals, both within and beyond their immediate geographic markets.

San Diego is among the markets to experience a recent surge in clinical affiliations. In 2015, UC San Diego Health (UCSD) announced an affiliation with Tri-City Medical Center, a district hospital that had struggled in recent years to compete against larger rivals encroaching on its geographic service area. In addition, UCSD and Scripps both reached beyond the boundaries of San Diego County to form affiliations with district hospitals in neighboring Imperial County — and in UCSD's case, with a hospital in Riverside County as well.

In the Los Angeles market, UCLA has been particularly active in expanding its partnerships with community hospitals. In large part, these affiliations are intended to relieve capacity constraints at UCLA's flagship, Ronald Reagan UCLA Medical Center, which has been consistently operating at or near full capacity. Developing a full network of affiliated community hospitals to which more routine inpatient care can be directed allows Reagan to focus on the tertiary and quaternary services for which it is widely known, and allocates resources more efficiently across inpatient settings — a key consideration as the UCLA system prepares to take on greater financial risk for more patients. By the fall of 2016, the number of community hospitals affiliating with UCLA will have risen to 10. UCLA has established hospitalist programs in each of these affiliated hospitals to oversee care for its own patients.

In the Bay Area, numerous affiliations formed in the past few years, including Muir's joint venture with San Ramon Regional Medical Center and UCSF's partnerships with Washington Hospital Healthcare System in Alameda County and Marin General Hospital in Marin County. These affiliated hospitals were recently announced as participating providers in the Canopy Health network led by UCSF and Muir.

In addition to these affiliations, the Bay Area also saw some hospital acquisitions, including deep-pocketed Stanford Health Care and UCSF each acquiring an East Bay hospital. Across the markets in this study, however, there were few recent instances of large hospitals acquiring smaller ones. Instead, most hospital systems have been pursuing an array of different affiliations that expose their organizations to far lower costs and fewer risks — and less regulatory scrutiny — than outright acquisitions. Respondents pointed to the need for all inpatient facilities to meet stringent state seismic standards as a particular deterrent to hospital acquisitions. More broadly, respondents agreed that the continuing decline in inpatient use over time — the result of advances in medical technology as well as changes in payment incentives — makes inpatient facilities less attractive as acquisition targets.

A particular type of clinical affiliation that has gained prominence in recent years is a partnership between a pediatric hospital and another hospital in the same region — either a large hospital focusing on adult medicine, or a smaller community hospital. Given the limited size of the market for inpatient and specialty pediatrics, this collaborative approach helps avoid needless duplication of pediatric services. These collaborations allow the pediatric hospital to expand its geographic reach while keeping costly capital investments in check, and gives partnering hospitals access to a prestigious pediatric brand and specialized pediatric expertise. By making pediatric specialists and services available at more locations throughout a region, these partnerships can also improve convenience and access for patients.

The most prominent examples of these affiliations come from the Bay Area, where highly regarded pediatric hospitals at both Stanford and UCSF expanded their geographic reach through multiple partnerships. Stanford Children's Health (Lucile Packard Children's Hospital) developed separate partnerships with Sutter's California Pacific Medical Center and John Muir Health, allowing pediatric patients to be seen by Packard specialists in both San Francisco and Contra Costa Counties. In 2015, Muir and Packard jointly launched a pediatric intensive care unit at Muir's Walnut Creek flagship hospital. Meanwhile, UCSF extended its reach into the North Bay by partnering with Marin General and Santa Rosa

hospitals as well as expanding into the East Bay by acquiring Children's Hospital Oakland.

Preventing Unnecessary Hospital Use: Collaborations Between Hospital Systems and Social Service / Safety-Net Providers

In common with hospitals nationwide, California hospitals have become more focused on reducing preventable readmissions since the Centers for Medicare and Medicaid Services (CMS) began levying financial penalties for excessive Medicare readmissions in 2012. In San Diego, four of the county's five largest hospital systems (Palomar Health, Scripps, Sharp, and UCSD) joined forces with the county government in an initiative known as the San Diego Care Transitions Partnership, aimed at reducing readmissions for high-risk Medicare patients discharged from hospitals into the community. Part of a nationwide CMS demonstration project, the San Diego program has proved successful at reducing readmissions and costs for CMS since its 2013 launch.

Although CMS is likely discontinuing the program nationwide in late 2016 to focus on other payment reforms, the local participants in the San Diego collaboration reportedly plan to continue some of the program's most effective interventions. These include a bundle of "care enhancement" social services provided by the county to a subset of frail patients deemed most at risk for readmissions, with funding to be provided by the four systems to replace discontinued CMS funding. One hospital executive observed that, before the collaboration, most hospitals had not been aware of how cost-effective the targeted provision of social services could be in reducing readmissions and other costly outcomes.

California hospitals also have paid increasing attention to preventing avoidable hospital utilization by Medi-Cal and other low-income patients. Since the beginning of 2014, when the ACA provision to expand Medicaid eligibility took effect, hospitals in most communities experienced surges in the use of their emergency departments (EDs) by newly insured Medi-Cal enrollees. This increased demand led to serious ED capacity constraints in some communities. In response, hospitals have stepped up collaborations with safety-net providers in an effort to reduce avoidable use of EDs and other hospital services and to connect low-income patients with a medical home that can provide them with the primary and urgent care for which many people seek ED treatment. Typically, hospitals collaborate with Federally Qualified Health Centers (FQHCs) — community health centers that receive federal grants and enhanced, cost-based payments for serving Medi-Cal patients. While hospital-FQHC collaborations can take many forms, one common arrangement has been for a hospital to provide an FQHC funding to establish a clinic site, or expand capacity of an existing clinic site, on or near the hospital campus.

Competing on Price, Access, and Convenience: Collaborations by Hospital Systems to Expand Ambulatory Care

Consistent with trends seen across the country, hospital systems in California have expanded their presence in a wide variety of ambulatory settings. These ambulatory expansions include the development of physician networks through many outright acquisitions of independent practices, as well as various affiliations with physician organizations. Systems also have been very active in adding a wide variety of ambulatory facilities to their networks, ranging from convenience clinics to ambulatory surgery centers and imaging centers — often in collaboration with a variety of other organizations. Two types of ambulatory facilities where providers have engaged in the most collaborative activity are highlighted here.

Convenience/retail clinics. Hospital systems in multiple California markets have launched several forms of convenience care — most notably health clinics located in retail stores. Most of these clinics, typically staffed by nurse practitioners, provide basic preventive services and treat uncomplicated minor conditions on a walk-in basis, often with extended hours. For consumers, these clinics offer the potential to increase access, convenience, price transparency,

and low-cost options for a basic set of primary and preventive services. For providers, the clinics can offer a way of boosting visibility for their brands in the community and gaining new patients, as well as expanding convenient options for existing patients.

The growth of convenience clinics has been most pronounced in San Diego, where most of the major systems have formed partnerships to operate clinics at busy retail locations. Since 2008, Palomar Health has partnered with the Albertsons grocery and pharmacy chain to run clinics located in Albertsons stores, but the retail clinic phenomenon gained real traction only over the past few years. San Diego's largest system, Sharp, began partnering with CVS/MinuteClinic in 2013, followed by Kaiser affiliating with Target in 2014. Within the past year, Scripps launched its first convenience clinic, taking a somewhat different approach: partnering with a commercial real estate firm, The Irvine Company, to open a health clinic in an office tower near a large shopping mall. In addition to the usual set of convenience care services, the new clinic partners with employers to offer wellness services. The Irvine Company's partnership with Scripps is similar to affiliations the company has formed with other prominent providers in the state, including St. Joseph Hoag Health in Orange County and Stanford Health in Santa Clara.[12] In the past year, the number of California providers partnering with CVS/MinuteClinic has expanded to include Sutter and Muir in Northern California.[13]

Freestanding ambulatory facilities. Hospital systems increasingly have been bringing more freestanding facilities such as ambulatory surgery centers (ASCs) and imaging centers into their networks, with some transactions structured as joint ventures and others as outright acquisitions. These freestanding facilities have long provided services at substantially lower prices than either hospital inpatient or outpatient departments. Under the traditional fee-for-service payment methods that prevailed in past decades, it was a common strategy for hospitals to acquire these facilities and then promptly absorb them into hospital outpatient departments, thus increasing the number of ambulatory sites that could charge higher outpatient-department unit prices to both commercial payers and Medicare.

Over the past several years, however, hospitals' primary motivations and strategies for bringing these freestanding facilities into their own networks have undergone a dramatic reversal. As hospitals have come under pressure to compete on value, the attribute of freestanding facilities that now appeals the most to hospitals is their low cost structure. As a result, hospitals are "focused on keeping the facilities they acquire [or affiliate with] staffed and operating as before, to maintain cost-efficiency. . . . It's quite a turnaround from what we saw hospitals doing 10, 15, 20 years ago," commented a market observer.

This approach of adding low-cost ambulatory facilities to their networks helps hospital systems manage the cost of care for the growing number of patients for whom they are taking on varying degrees of financial risk, in arrangements varying from bundled payments to ACOs to provider-sponsored health plans. Having ambulatory facilities with a lower cost structure also helps systems better compete for the many privately insured patients covered by high-deductible health plans: patients who have strong incentives to minimize their own out-of-pocket costs by price-shopping and choosing a lower-priced provider over a hospital outpatient department. In addition, expanding the number of locations in the community where patients can receive services such as imaging tests or ambulatory surgeries helps the systems better compete on the basis of access and convenience.

Several of California's historically high-priced hospital systems have formed partnerships with freestanding facilities in the past few years. Sutter Health has been particularly active in this regard. The system not only has engaged in numerous joint ventures with physician-owned ASCs throughout its home base of Northern California, but is accumulating a growing network of ASCs in Southern California as well.[14] In the Los Angeles market, UCLA Health also is engaging in ASC joint ventures, partnering with a national company with

an established track record in operating freestanding surgical facilities. In San Diego, after Scripps Health acquired a chain of radiology centers in 2015, it kept the facilities' brand name (Imaging Healthcare Specialists) and operations unchanged, and continues to use the same independent radiologists who had staffed the facilities previously.

Supporting Continuity of Care:
Collaborations Between Acute Care Providers and Post-Acute Care Providers

Rehabilitation hospitals. Acute rehabilitation hospitals, also known as inpatient rehabilitation facilities, occupy a key space in the care continuum between acute care hospitals and post-acute providers such as skilled nursing facilities (SNFs). These facilities often are the most appropriate setting for many patients recovering from conditions such as major strokes, brain and spinal cord injuries, and joint replacements, who can be discharged from a tertiary setting but require more intensive rehabilitation and physician oversight than SNFs can provide. Because most communities lack sufficient acute rehab capacity, many patients who could be discharged to such facilities continue occupying beds in tertiary hospitals for longer periods, and at higher cost, than necessary, according to hospital executives.

To meet the dual goals of freeing up tertiary beds for sicker patients and providing more cost-efficient care for patients needing intensive rehab, major hospital systems are forming partnerships to create more acute rehab capacity. In Los Angeles, the two most prominent hospital systems, Cedars-Sinai Medical Center and UCLA Health, jointly collaborated with Select Medical, a national company specializing in long-term acute care and rehab services, to develop the California Rehabilitation Institute, a 138-bed facility that opened in 2016. Select Medical's reputation and track record of being able to operate acute rehab facilities efficiently is reported to have made the company an especially attractive partner for Cedars-Sinai and UCLA. Major hospitals in other California markets reportedly are exploring similar partnerships to expand acute rehab capacity.

Post-acute care providers. Some large providers — such as the physician organizations Healthcare Partners and Heritage Provider Network, both based in Southern California — have long taken full risk for sizable Medicare Advantage populations. As a result, they have focused on the efficiency and value of care provided along the entire care continuum, including post-acute care. Because Medicare Advantage plans — in contrast to Medicare fee-for-service providers — are permitted to limit their provider networks, providers accepting full risk can develop relationships with a subset of affiliated SNFs and other post-acute providers to whom they send their Medicare Advantage patients. These network providers are selected based on cost and quality metrics as well as geographic service areas. To oversee care for their Medicare Advantage patients in the post-acute setting, Healthcare Partners, Heritage, and other providers taking full risk also have long placed their own physicians and other clinicians in SNFs to oversee care for their patients. Care by these "SNFists" (also referred to as "post-acute hospitalists" by some organizations) often helps reduce SNF lengths of stay and prevent hospital readmissions, and improves the overall quality and frequency of clinical oversight for SNF patients.[15]

In contrast to Medicare Advantage plans, fee-for-service providers — even those subject to partial financial risk under Medicare ACOs or bundled payments — must allow Medicare patients the freedom to select the post-acute provider of their choice.[16] Hospitals and physician organizations accepting partial risk may develop networks of preferred SNFs for their patients, but the process is intended to guide, rather than dictate, patient choice of a SNF. Some fee-for-service providers use "soft steering" approaches such as describing to patients and their families the relative merits of preferred facilities (e.g., higher quality, better coordinated care), but ultimately, Medicare fee-for-service patients retain their right to choose any accredited facility, whether or not it is included in the preferred network.

Hospital systems and physician organizations expressed uncertainty and frustration at what they viewed as lack of clear CMS guidelines on the extent to which preferred networks and soft steering are permitted. Providers also pointed out that they are increasingly being exposed to more risk under Medicare payment reforms ranging from readmission penalties to bundled payment programs. As a result, several providers suggested that CMS change current rules to allow providers who are subject to partial financial risk to establish limited networks to steer Medicare fee-for-service patients to high-value SNFs and other post-acute providers — much in the way Medicare Advantage plans are already able to.

According to some providers, CMS rules do not pose the only barrier to developing effective SNF networks. Another key limitation stems from the limited pool of high-quality, low-cost SNFs that are available to serve as strong partners for acute care providers. "Here in Southern California, there are lots of skilled nursing beds — the sector is probably overbedded overall — but our problem is finding enough good facilities to partner with: the ones that are well managed . . . financially stable, have appropriate standards of clinical care, [and] are amenable to working with us on care protocols," a hospital executive said.

Hospital systems and large physician organizations have focused the most attention on relationships with SNFs — in large part because these facilities represent the largest share of post-acute spending — but acute care providers also have been forming or exploring affiliations with the full range of post-acute providers, including home health agencies and palliative care / hospice organizations. For example, in 2015 UCSF formed an affiliation with Hospice by the Bay aimed at expanding high-value care for seriously and terminally ill patients. Other large acute care providers expressed the need for their own organizations to form similar partnerships with providers along all parts of the care continuum if they are to be successful in increasingly taking on full or substantial financial risk for patients — as UCSF is slated to do in its Canopy Health venture.

Developing New Primary Care Practice Models: Collaborations Between IPAs and Other Organizations

Over the last few years, the physician sector saw the continuation of an ongoing trend: small, independent practices becoming a progressively less viable option for primary care physicians. Driving this trend nationally has been a combination of low reimbursement from public and private payers, along with the long and unpredictable work hours required in independent practice. In addition, specific to California, most physicians have long relied on the capitated HMO model — which pays better than PPO fee schedules — to sustain their practices financially. As commercial HMO products continue losing ground to high-deductible PPOs, financial strains on primary care practices have worsened to the point that many have been joining large system-affiliated groups, while some PCPs have retired without being able to sell their practice. New PCPs coming out of residency programs are overwhelmingly choosing the stability, security, and predictable work hours of the employment model over the autonomy of private practice.

This continuing decline of the small, independent primary care practice model poses major challenges for IPAs, whose core business is based on providing HMO contracting and practice support services to these practices. One San Diego provider even described the situation as an "existential threat to IPAs." If current trends continue, IPA physician membership and patient volumes are almost inevitably going to continue shrinking, and membership will skew more toward older physicians and specialists.

Some of California's largest IPAs are responding to these challenges by seeking to develop sustainable new models of primary care practice that can attract PCPs and prove financially viable for them. These new models are envisioned as smaller-scale, integrated group practices that aim to accommodate physicians seeking to practice part-time, keep practice overhead costs manageable and predictable, and provide physicians with clinical and administrative support without subjecting them to the bureaucracy of large groups.

Because IPAs lack the capital to pursue the development of these new models on their own, they have been forming or exploring partnerships with other organizations to gain access to capital.[17] In 2014, Hill Physicians, which has networks of independent physicians in several of Northern California's largest markets, began partnering with two of the state's largest health plans, Anthem Blue Cross and Blue Shield of California. Under the arrangement, the two plans provided Hill with capital by purchasing ownership stakes in PriMed, Hill's management services organization. Brown & Toland, a large IPA based in San Francisco and serving the Bay Area, reportedly has been exploring joint ventures and other affiliations with a range of partners but had not finalized any plans at the time of the site visits for these reports.

San Diego saw the emergence of a different type of collaboration — between one of the market's largest systems, Sharp Healthcare, and its tightly aligned IPA, Sharp Community Medical Group (SCMG) — to develop a new practice model for PCPs seeking employment. The new entity, SharpCare Medical Group, is to be rolled out in 2016 under Sharp's medical foundation. SharpCare is organized along very different lines than Sharp's large integrated group model, Sharp Rees-Stealy. The new medical group aims to retain some key attributes of small community-based practices that many independent physicians are reluctant to give up, while also offering physicians the stability and security of employment. Members would practice in relatively small offices with only about 3 to 10 primary care practitioners per site and would be able to continue referring patients to community-based specialists. At the same time, they would receive clinical support from the Sharp system — including from care management nurses, pharmacists, and other clinicians rotating among the primary care sites. Within the Sharp system, SharpCare would be most closely aligned with SCMG and would be a member of SCMG for HMO contracting and ACO participation. Fee-for-service PPO contracting for SharpCare will be done through Sharp Healthcare, which would have the leverage to obtain higher rates than small practices would receive on their own.

Discussion and Implications

Among the many types of provider collaborations that have proliferated in California over the past few years, by far the most ambitious — and potentially the most far-reaching in impact — are the initiatives aimed at creating region-wide integrated care networks. These efforts seek to transform the culture, incentives, and operations of provider organizations built largely to compete in a fee-for-service environment, and develop them into virtual Kaiser-like integrated systems emphasizing efficiency and value.

As noted above, the markets where most of these population health initiatives have been launched share some common characteristics: the presence of large, well-insured commercial populations; competitive pressure from a strong and expanding Kaiser; and large, deep-pocketed systems with strong infrastructure and sufficient capital to make major investments in building clinical integration, ambulatory capacity, and other essential elements of an integrated network. Markets with these traits tend to be the large population centers in more affluent communities, primarily along the coast. Although providers in other regions — such as the Inland Empire market in Riverside and San Bernardino Counties — also have begun to take tentative steps to establish integrated delivery systems, those efforts are more nascent, in part because key infrastructure such as medical foundations — essential for building strong physician networks — have only recently been launched.

Except for a handful of major systems that are pursuing population health management largely as a "go-it-alone" strategy, most large systems are partnering with other large systems to create integrated networks within their region. One key reason is that many systems, on their own, may not have a large enough clinical footprint to compete effectively for patients throughout an entire regional market, either in terms of geographic location of facilities or clinical expertise

and reputation. As a result, several systems have formed affiliations with other systems that can both add key geographic submarkets and bring complementary clinical strengths to the partnership. Compared to outright mergers and acquisitions, these collaborations allow systems to maintain greater autonomy, and subjects them to less regulatory scrutiny and lower costs and risks.

Many of the collaborations highlighted above whose scope and objectives are more limited — such as partnerships between hospital systems and providers of ambulatory or post-acute care — also play an important role in the larger population management strategies pursued by large systems. These partnerships can help fill key gaps along parts of the care continuum that hospitals had little incentive to focus on under a traditional fee-for-service environment — but that now become critical under arrangements rewarding coordinated and efficient care. At the same time, many of these collaborations also support hospital systems' ability to pursue other, more traditional strategies. For example, adding lower-cost freestanding ambulatory facilities to their networks helps systems better compete for the large population of price-conscious consumers whose insurance coverage subjects them to significant out-of-pocket costs. Several providers noted that the ability of certain collaborations to serve multiple, differing strategies in this way was particularly valued by their organizations as they seek to navigate a course between the two worlds of fee-for-service and value-based payment. Given the uncertainty about how much, and how fast, they will be able to transform their own care delivery systems to achieve population health management, investing in collaborations that can also serve other strategies allows large providers to "hedge their bets somewhat . . . [instead of] staking everything on [a strategy] that might not ultimately come to fruition . . . or might take a lot longer than anticipated to get there," a market observer noted.

As providers increasingly explore and engage in a range of partnerships and affiliations with other providers (and with health plans), the web of relationships among providers has become more complex. One market expert described providers in several large markets as taking a "more pluralistic approach to collaborations [and] avoiding getting locked into exclusive arrangements that might cause them . . . to miss out on the volume . . . and the opportunities . . . that other collaborations can bring."

An example is MemorialCare Health System, which is pursuing population health opportunities with different, though overlapping, sets of partners in Los Angeles and Orange Counties. As a member of Vivity, MemorialCare is sharing full risk for large groups with seven other systems and Anthem Blue Cross; at the same time, its MemorialCare Health Alliance (which includes two other Vivity members as well as UC Irvine, which is not part of Vivity) is pursuing risk contracts with other large groups and recently signed a contract with large employer Boeing. Meanwhile, in the Bay Area, John Muir Health is engaging in simultaneous, separate strategic partnerships with UCSF and Stanford for adult medicine and pediatrics, respectively — another example of how the web of provider linkages has grown, and become more complex, over the past few years.

If the new region-wide integrated networks being launched by large providers succeed in gaining widespread traction, they could help revive commercial capitation — which has long been in slow decline relative to high-deductible PPOs and Kaiser HMOs across major markets in the state. The new networks also are expected to intensify price competition and expand the range of choices of insurance products and provider networks available to purchasers and consumers. Some markets have felt these beneficial impacts already, as the launch or expansion of provider-sponsored health plans has led to strong competition with Kaiser, resulting in reduced premiums (or at least a moderation of premium trends) for some purchasers.

However, increased provider competition and its resulting benefits to purchasers and consumers will prove sustainable only if providers can continue lowering their cost structures and moving toward truly integrated and efficient care

delivery. Currently, some providers appear to be undercutting Kaiser premiums and gaining market share only by subsidizing their new HMO products substantially — clearly not a viable approach beyond the short term. Most systems are still in the very early stages of the long and difficult journey toward clinical integration, a journey complicated by conflicting incentives both within their own organizations and across partnering providers.

Several observers also expressed concern that growing provider consolidation — even in the form of affiliations and joint ventures rather than outright mergers — would increase the market clout held by large providers, which would ultimately raise the potential for reduced competition and higher prices in health care markets.

ABOUT THE AUTHOR

Ha Tu of **Mathematica Policy Research.** Mathematica is dedicated to improving public well-being by conducting high-quality, objective data collection and research. More information is available at **www.mathematica-mpr.com.**

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Background on Regional Markets Study

In 2015, a team of researchers from Mathematica Policy Research visited seven California regions to understand these markets' local health care systems and capture change since 2011/2012, the prior round of this Regional Market Study, funded by the California Health Care Foundation. The purpose of the study is to gain insights into the organization, delivery, and financing of health care in California and to understand differences across regions and over time. The seven markets included in the project — Fresno (including Fresno, Tulare, Kings, Madera, and Mariposa Counties), Los Angeles County, Orange County*, Riverside and San Bernardino Counties, Sacramento (including Sacramento, Yolo, El Dorado, and Placer Counties), San Diego County, and the San Francisco Bay Area (including San Francisco, Alameda, Contra Costa, Marin, and San Mateo Counties) — together are home to three-quarters of California residents and reflect a range of economic, demographic, health care delivery, and financing conditions in California. Mathematica researchers interviewed over 200 respondents for this study. Respondents included executives from hospitals, physician organizations, community health centers and other community clinics, Medi-Cal health plans, and other local health care leaders. For this cross-site analysis, researchers conducted follow-up interviews with select respondents (primarily market observers and executives from hospital systems and physician organizations) and tracked local media sources to capture updates since the site-visit interviews.

▶ FOR THE ENTIRE REGIONAL MARKETS SERIES, VISIT WWW.CHCF.ORG/ALMANAC/REGIONAL-MARKETS.

*Orange County was added to this study in 2015; the research team had familiarity with this market through the prior Community Tracking Study conducted by the Center for Studying Health System Change (HSC), which merged with Mathematica in January 2014.

ENDNOTES

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3. Chad Terhune, "Boeing Contracts Directly with California Health System for Employee Benefits," *Kaiser Health News*, June 21, 2016, **khn.org**.

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10. Unlike other systems described in this section, which are developing population health strategies for the first time, Sharp has long pursued these strategies. Since 2014, Sharp has expanded the patient populations for whom it competes directly through its own health plan; these now include CalPERS members and Covered California (public insurance marketplace) enrollees.

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15. Paula S. Katz, "Walking the Walk in Transitional Care," *Today's Hospitalist*, February 2012, **www.todayshospitalist.com**.

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17. Because IPAs must distribute all surplus earnings to their members at the end of each year, they tend to lack sufficient capital internally to fund such initiatives.

ISSUE BRIEF
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The COMMONWEALTH FUND

The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch

Sara R. Collins, David C. Radley, Munira Z. Gunja, and Sophie Beutel

ABSTRACT

Issue: Although predictions that the Affordable Care Act (ACA) would lead to reductions in employer-sponsored health coverage have not been realized, some of the law's critics maintain the ACA is nevertheless driving higher premium and deductible costs for businesses and their workers. **Goal:** To compare cost growth in employer-sponsored health insurance before and after 2010, when the ACA was enacted, and to compare changes in these costs relative to changes in workers' incomes. **Methods:** The authors analyzed federal Medical Expenditure Panel Survey data to compare cost trends over the 10-year period from 2006 to 2015. **Key findings and conclusions:** Compared to the five years leading up to the ACA, premium growth for single health insurance policies offered by employers slowed both in the nation overall and in 33 states and the District of Columbia. There has been a similar slowdown in growth in the amounts employees contribute to health plan costs. Yet many families feel pinched by their health care costs: despite a recent surge, income growth has not kept pace in many areas of the U.S. Employee contributions to premiums and deductibles amounted to 10.1 percent of U.S. median income in 2015, compared to 6.5 percent in 2006. These costs are higher relative to income in many southeastern and southern states, where incomes are below the national average.

BACKGROUND

Most of the conversation around health insurance costs has been focused on health plans sold through the Affordable Care Act's marketplaces, but far more Americans get their coverage through employers. In 2015, more than half (57%) of the U.S. population under age 65, about 154 million people, had insurance through their own job or a family member's job.[1] In contrast, only about 10 million people are covered by a health plan purchased in the marketplaces.[2]

Contrary to early predictions that many employers would stop offering health insurance in response to the ACA's new coverage options, there has in fact been little change in the share of the nonelderly population covered by employer plans since the law went into effect in 2010.

While the law has not triggered losses of employer coverage, some of the law's critics have suggested that the ACA has increased the cost of health insurance, both for businesses and their workers. As evidence, they point to U.S. families being increasingly squeezed by their premiums and deductibles. To examine this claim, we use the

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most recent data from the federal Medical Expenditure Panel Survey on national and state trends in the costs of employer health insurance premiums and deductibles faced by U.S. businesses and by employees and their families. We compare cost trends over the period 2006 to 2015, five years before and five years after the ACA took effect. (See How This Study Was Conducted.)

FINDINGS

Premiums Rose at a Slower Pace in the Five Years Following the ACA Compared to the Prior Five Years

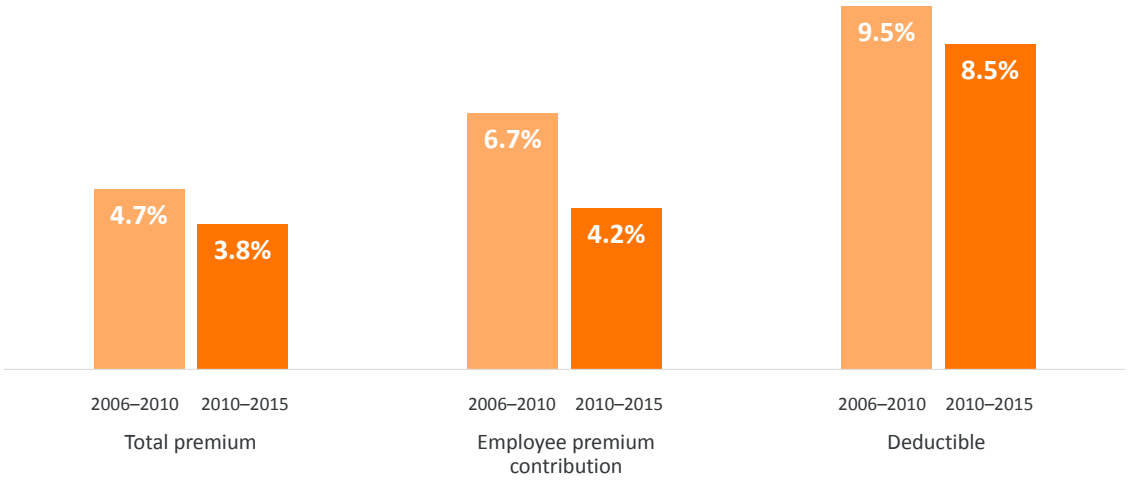
Annual premium growth rates for employer-sponsored health plans have slowed on average since 2010, the year the Affordable Care Act was enacted. For single-person plans, or those that cover only the employee and not any family members, average premium growth rates slowed to 3.8 percent per year from 2010 to 2015 compared with an average 4.7 percent from 2006 to 2010 (Exhibit 1, Table 1a).

At the state level, 33 states and the District of Columbia experienced slower premium increases for single policies since 2010 compared to earlier years (Exhibit 2, Table 1a). Louisiana experienced the largest slowdown: average annual premium growth ticked down from 7.8 percent per year from 2006 to 2010 to 2.4 percent from 2010 to 2015. Nine other states (Florida, Maine, Minnesota, Mississippi, Nebraska, Nevada, Oregon, Tennessee, and Wisconsin) and the District of Columbia saw a decline in annual premium growth of at least three percentage points.

Premium growth rates remained high in eight states (Alaska, Hawaii, Idaho, Kentucky, Maryland, New Hampshire, New York, and Utah). These states experienced average growth rates from 2010 to 2015 of 5 percent per year or higher. Five of these states—Alaska, Hawaii, Idaho, Kentucky, and Maryland—also had increases in the years leading up to 2010 above the national average (Table 1a).

Exhibit 1

Average Annual Rate of Growth in Employer Insurance Costs for Single-Person Plans Before and After Implementation of the Affordable Care Act

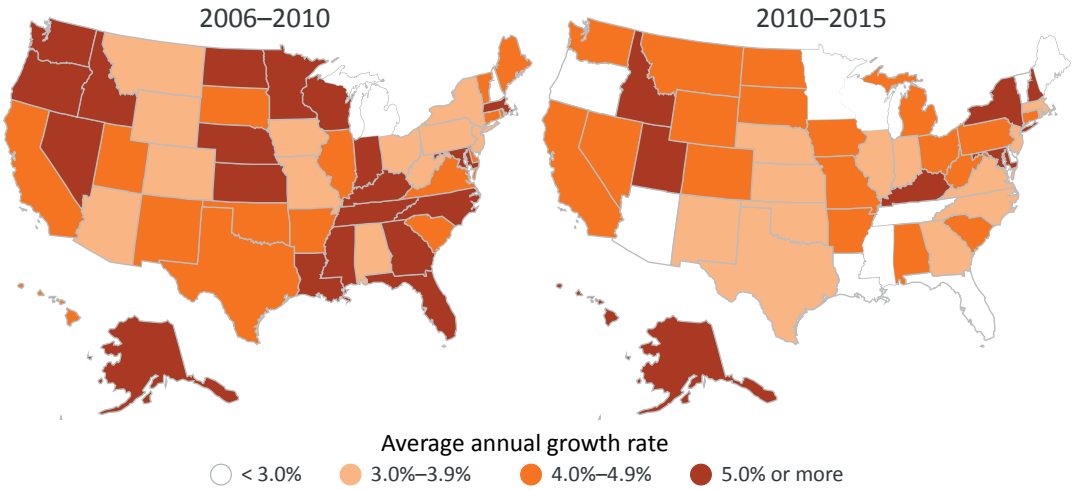


Data: Medical Expenditure Panel Survey–Insurance Component, 2006, 2010, and 2015.

Exhibit 2

Growth in Employer Premiums for Single-Person Plans, by State, 2006–2010 and 2010–2015

33 states and D.C. experienced slower average annual growth in premiums after the ACA became law in 2010 than prior to the law's passage



Note: Growth rates are calculated as average annual compound growth rate.
Data: Medical Expenditure Panel Survey–Insurance Component, 2006, 2010, and 2015.

The actual size of employer premiums also ranged widely. Annual family premiums averaged $17,322 nationally in 2015, ranging from $14,218 to $15,959 in the five states with the lowest costs (Alabama, Arkansas, Hawaii, Michigan, and Tennessee) to $18,920 to $21,089 in the four highest-cost states (Alaska, Delaware, New Hampshire, and New York) and the District of Columbia. (Exhibit 3, Table 1b). Annual family premiums exceeded $18,000 in nine states and the District of Columbia.

Growth in Employees' Premium Contributions Climbing Slowly, but Income Is Barely Keeping Pace

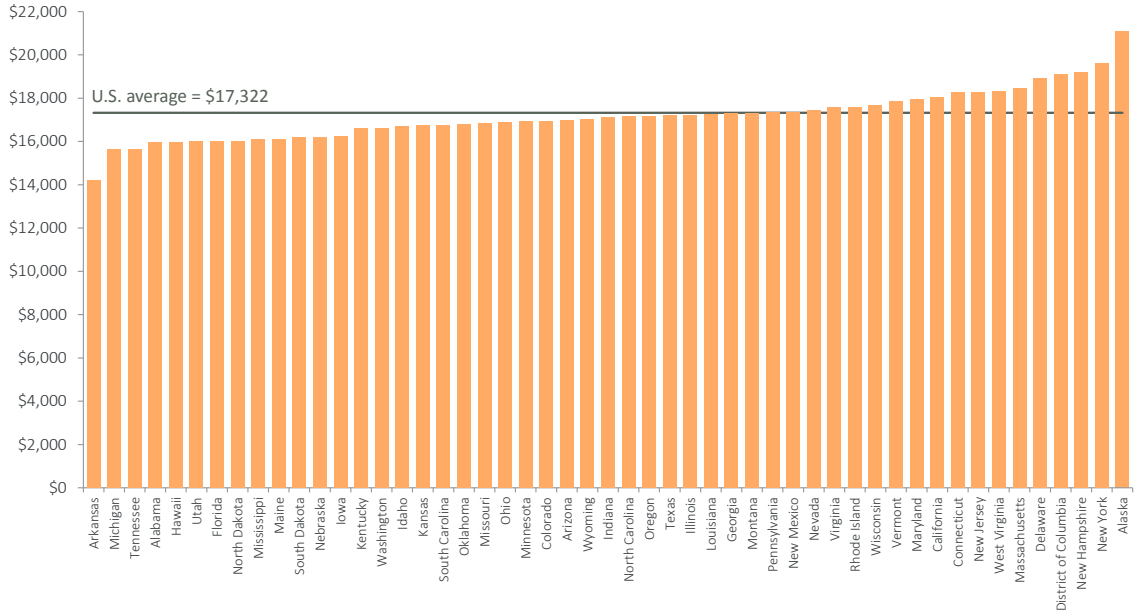
People with employer health insurance policies contributed an average of 21 percent of the total annual premium cost for a single policy, or $1,255, in 2015 (Exhibit 4, Table 2a). This percentage has not changed since 2010 but is up from 19 percent in 2006, when the average contribution was $788. In 11 states—Connecticut, Kansas, Louisiana, Maryland, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, South Dakota, and Tennessee—workers are paying 24 percent or more of their premiums on average, with costs ranging as high as $1,652 annually for a single plan in Connecticut.

Workers pay more for family coverage, shouldering 27 percent of the cost or $4,710, nationally (Table 2b). Again, the share is the same as in 2010 but up from 25 percent in 2006, when the average contribution was $2,890. Employees contribute 30 percent or more of the total premium cost for employer plans in 16 states. Families in Maryland contribute the most—an average of $6,365—to their plans.

As with the total cost of employer premiums, employees' contributions for both single and family policies have grown more slowly since passage of the ACA compared to the prior five years.

Exhibit 3

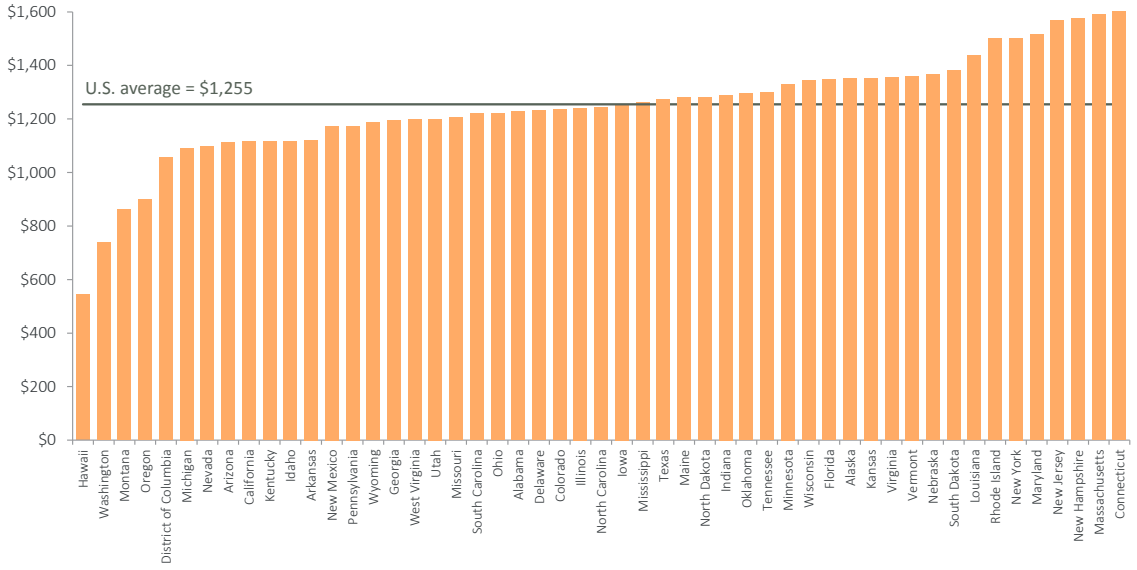
Average Total Premium for Family Coverage, by State, 2015



Data: Medical Expenditure Panel Survey–Insurance Component, 2015.

Exhibit 4

Average Annual Employee Premium Contribution for Single Coverage, by State, 2015



Data: Medical Expenditure Panel Survey–Insurance Component, 2015.

Single-premium contributions grew 4.2 percent annually from 2010 to 2015, compared with 6.7 percent from 2006 to 2010 (Exhibit 1, Table 2a). Contributions to family policies grew 4.8 percent annually in the most recent period compared to 6.5 percent in the five years before the ACA (Table 2b).

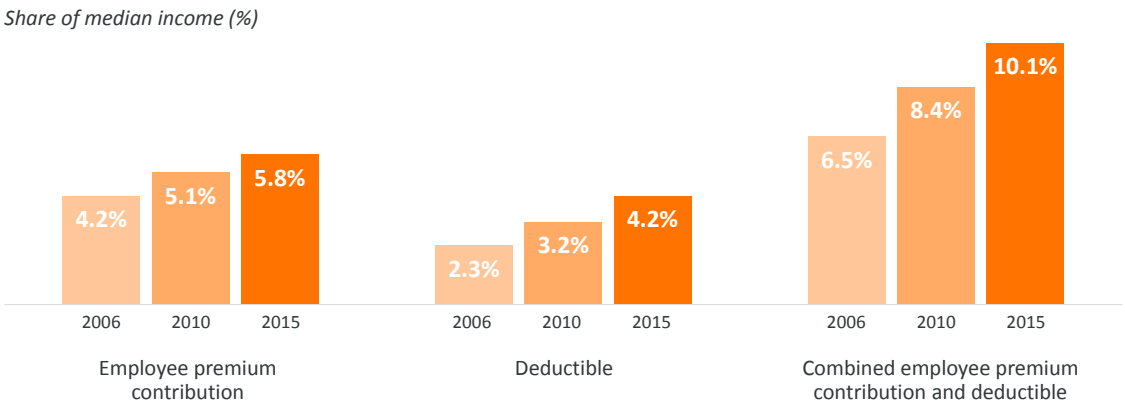
After the passage of the ACA, employee premium contributions for single plans grew at a slower pace in 31 states and the District of Columbia; for family plans, contributions grew at a slower pace in 30 states and the District of Columbia (Tables 2a and 2b). In the remaining states, growth in employee premium contributions were the same or higher for single and family plans. In New York, for instance, the pace of growth in premium contributions ticked up to 6.7 percent annually for single plans between 2010 and 2015; the rate between 2006 and 2010 was 3 percent.

Despite this overall relative slowdown in employee premium contributions, continued slow wage growth through 2014 (albeit with a modest recovery in 2015) means people still contributed more to their premiums as a share of income than in earlier years.[3] Total employee premium contributions for single and family plans accounted for 5.8 percent of median household income in 2015, compared to 4.2 percent in 2006 (Exhibit 5, Table 5).[4] Total employee contributions ranged from 4.2 percent of median income in Hawaii to 9 percent of median income in Mississippi in 2015. Contributions were greater than 7 percent in seven additional states (Alabama, Arizona, Florida, Louisiana, New Mexico, Oklahoma, and Texas).

On a positive note, growth in employee contributions for single policies slowed to less than 2 percent per year between 2014 and 2015 (data not shown). This means that, on average, at least in the most recent period, median income grew faster nationally than did premium costs for people with single policies.

Exhibit 5

Employee Premium Contribution and Deductible as Percent of Median Household Income, 2006–2015



Note: Single and family premium contributions and deductibles are combined and weighted for the distribution of single-person and family households. Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), which revised its income questions in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimates from 2014 are derived from the revised income questions. Household incomes are averaged over two years, and have been adjusted for the likelihood that people in a residence purchase health insurance together.

Data: Medical Expenditure Panel Survey–Insurance Component (employee premium share and deductible, 2006, 2010, and 2015); Current Population Survey (median income, 2006–07, 2010–11, and 2015–16).

Deductibles Are Climbing Faster Than U.S. Median Income

The number of employer plans requiring deductibles, as well as the size of those deductibles, has grown over the past decade. In 2015, 85 percent of single-person health plans had deductibles, compared with 66 percent in 2006 (Table 3). The spread of deductibles occurred across most states, with 95 percent or more of single-person plans having deductibles in 14 states (Alaska, Idaho, Indiana, Iowa, Kansas, Missouri, Minnesota, Montana, Nebraska, North Dakota, Oklahoma, South Carolina, South Dakota, and Washington). Hawaii is an exception: only 44 percent of plans included a deductible in 2015.

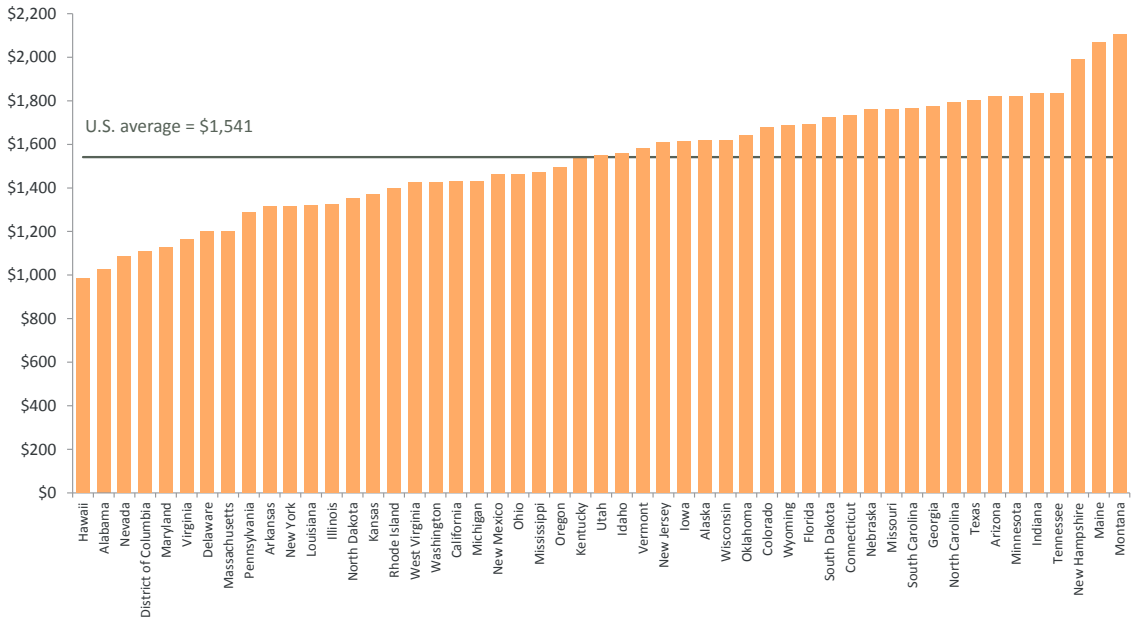
High deductibles are the norm in employer plans. Nationally, the average single-person plan deductible was $1,541 in 2015, more than double the average of $714 in 2006 (Exhibits 6 and 7, Table 3). In 2006, there were no states where the average deductible exceeded $1,000, but by 2015 all states—with the exception of Hawaii ($986)—had average deductibles higher than $1,000. Average deductibles exceeded $2,000 in Maine and Montana.

Nationally, the average annual rate of growth in deductibles has slowed since 2010, compared to the five years before the ACA, but it remains high. Deductibles in single-person plans grew 8.5 percent annually between 2010 and 2015, compared with 9.5 percent between 2006 and 2010 (Exhibit 1, Table 3).

In 27 states, deductibles grew at a slower pace in the years after the ACA's passage compared to the years leading up to it, but at a faster pace in 22 states and the District of Columbia. There was considerable variation. In Hawaii, single-person plan deductibles declined on average by 4 percent per year on average between 2006 and 2010 and then grew at an average rate of 13.7 percent from 2010 to 2015, although Hawaii has the lowest single deductible nationally. At the other end of the spectrum, deductibles in Maryland grew at an average annual rate of 17.1 percent in the years before the ACA and then climbed at a rate of 4 percent in the years following.

Exhibit 6

Average Single-Person Plan Deductible, by State, 2015

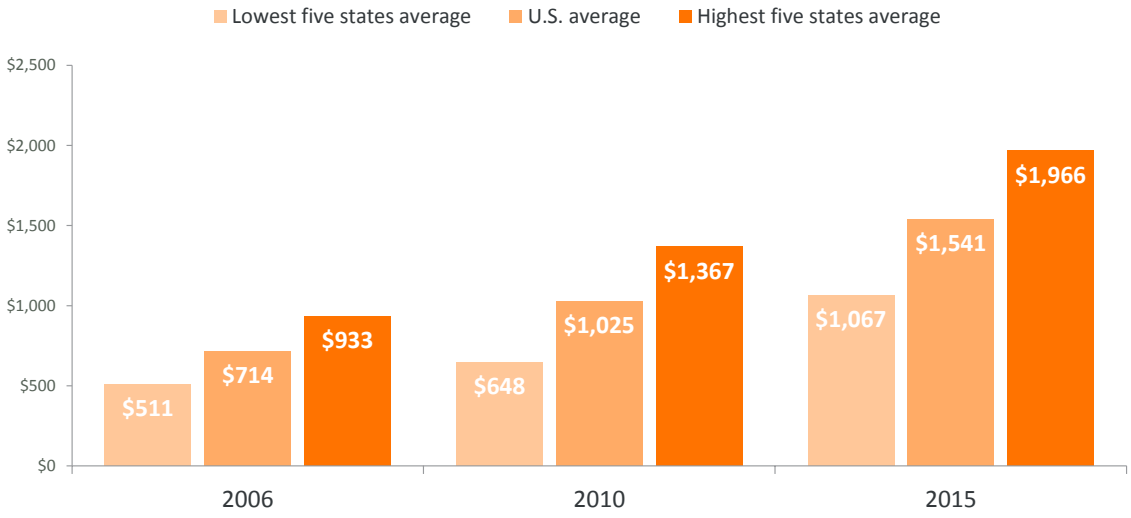


Data: Medical Expenditure Panel Survey–Insurance Component, 2015.

Exhibit 7

Average Single-Person Plan Deductible, 2006–2015

Dollars per year for single coverage paid by employees



Data: Medical Expenditure Panel Survey–Insurance Component, 2006, 2010, and 2015.

As with premium contributions, employees' deductibles are comprising a growing share of income. Average single-person and family deductibles amounted to 4.2 percent of median household income in 2015 nationally, nearly double the amount (2.3%) in 2006 (Exhibit 5, Table 5).[5] Deductibles ranged from 2.3 percent of median income in Maryland to 5.7 percent of median income in Mississippi in 2015. Average deductibles were 5 percent or more of median income in 11 additional states (Arizona, Florida, Georgia, Indiana, Maine, Montana, New Mexico, North Carolina, South Carolina, Tennessee, and Texas).

Family Costs for Premiums and Deductibles Rise as Share of Income

When premium contributions and deductibles are combined, U.S. families with employer coverage had an average potential health care cost burden of $6,422 in 2015, up from $3,531 in 2006 (Exhibit 8, Table 4). Families with moderate incomes were at risk of spending 10.1 percent of their earnings on health insurance and health care in 2015, compared to 6.5 percent a decade earlier (Exhibit 5, Table 5).

In 2015, the combined cost of premiums and deductibles as a share of income was 12 percent or higher in seven states (Arizona, Florida, Mississippi, New Mexico, Oklahoma, Tennessee, and Texas). Workers in Mississippi had the largest burden on average, at 14.7 percent of median income. Families in the District of Columbia and Massachusetts had the lowest costs as a share of income (6.8% and 7.3%, respectively) (Table 5).

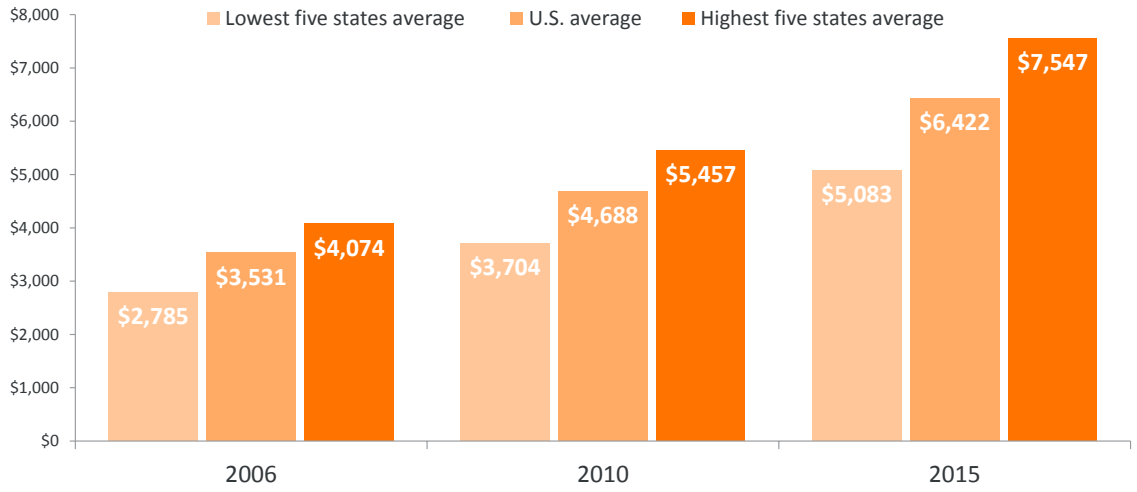
Widening Inequality Across States in Family Premium and Deductible Costs as Share of Income

Over the decade, differences across states have widened, leading to increasing inequality in families' health care cost burdens. In 2006, the difference between the share of median family income necessary to cover premium costs and deductibles in the five states with the highest burden and the five states

Exhibit 8

Average Combined Employee Premium Contribution and Deductible, 2006–2015

Average employee share of premium plus average deductible



Note: Single and family premium contributions and deductibles are combined and weighted for the distribution of single-person and family households.
Data: Medical Expenditure Panel Survey–Insurance Component, 2006, 2010, and 2015.

with the lowest burden was 3.7 percentage points (8.6% vs. 4.9%) (Exhibit 9, Table 5). By 2015, that difference had widened to 5.7 percentage points (13.2% vs. 7.5%). With the exception of Arizona, the states with the highest burdens in 2015 (Florida, Mississippi, Oklahoma, and Texas) were in the Southeast or South. In contrast, the lowest-burden states (Hawaii, Maryland, Massachusetts, and Pennsylvania, along with the District of Columbia), are scattered across the country. In the following sections, we take a closer look at what may be driving these differences.

Highest-cost-burden states: Arizona, Florida, Mississippi, Oklahoma, Texas

Families living in states with the highest burdens tended to have both less generous health plans (Table 3) and lower incomes (Table 6). While total premiums were lower than or near the national average in each of these states (Tables 1a and 1b), employees contributed a larger share of the premium for family and single coverage (except for single plans in Arizona) than the national average (Tables 2a and 2b). Consequently, all but Arizona were in the top eight for the dollar amount of family premium contributions nationally.[6] Oklahoma had the second-highest average family premium contribution in the nation (Table 2b). Four of the five states (Arizona, Florida, Oklahoma, and Texas) were in the top half of all states in single-person deductibles (Table 3).[7] Each of these states was in the bottom half of all states in median household income. Mississippi is the lowest-income state (Table 6).

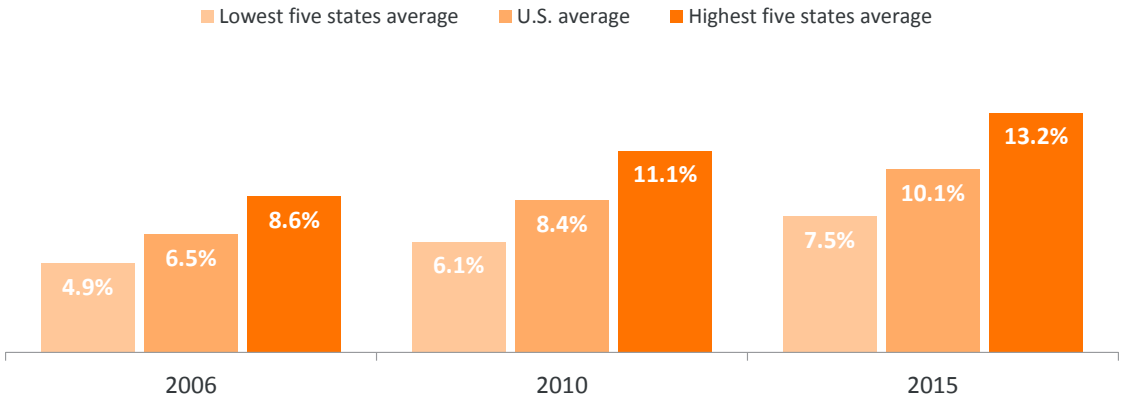
Lowest-cost-burden states: District of Columbia, Hawaii, Maryland, Massachusetts, Pennsylvania

For the states with the lowest burdens, the opposite was true: plans tended to be more generous and median incomes were higher. Three of the four lowest-burden states (Maryland, Massachusetts, and Pennsylvania) and the District of Columbia were in the top half of all states in median household income (Table 6). At the same time, all five states had average single-person deductibles that were

Exhibit 9

Combined Employee Premium Contribution and Deductible as a Share of Median Family Income

Average employee share of premium plus average deductible as percent of median state incomes



Note: Single and family premium contributions and deductibles are combined and weighted for the distribution of single-person and family households. Estimates of median household income used in the denominator for this ratio come from the Current Population Survey (CPS), which revised its income questions in 2013. The denominator in our ratio estimates prior to 2014 is derived from the traditional CPS income questions, while ratio estimates from 2014 are derived from the revised income questions. Household incomes are averaged over two years, and have been adjusted for the likelihood that people in a residence purchase health insurance together.

Data: Medical Expenditure Panel Survey–Insurance Component (employee premium share and deductible, 2006, 2010, and 2015); Current Population Survey (median income, 2006–07, 2010–11, and 2015–16).

below the national average (Table 3). Three of the states were in the bottom half of all states in family premium contributions (Hawaii, Massachusetts, and Pennsylvania) (Table 2b).[8] Maryland workers, however, contributed more than one-third (35%) of the cost of their family premiums, the highest percentage in the country.

Hawaii's low employee costs stem from its mandate, established in 1974, that requires employers to offer health care coverage. Employers of any size are required to offer coverage to anyone working at least 20 hours per week; this coverage can cost no more than 1.5 percent of a worker's income.[9] As a result, people in employer plans in Hawaii have among the lowest costs in the country relative to income.

CONCLUSION

This analysis finds a sustained slowdown in premium growth rates in a majority of states since the Affordable Care Act was enacted in 2010, likely reflecting the nationwide deceleration in health care costs.[10] These findings also support the conclusion that the law's employer requirements have been absorbed relatively easily by U.S. companies, including the coverage mandate for large companies, the provision that allows young adults to stay on parents' policies, and the requirement that plans cover preventive care without cost-sharing.

But the findings also offer evidence as to why many insured Americans view their health care costs as unaffordable.[11] While growth in employee premium contributions have slowed along with premiums, deductibles continue to proliferate and their annual growth rate exceeds premium growth by a wide margin. Compounding this trend, growth in median family incomes—despite a recent surge—has lagged health insurance cost growth. Middle-income families continue to see a

growing share of their household budgets going to health care. Where employees have less generous health plans as well as lower median incomes, the combination is particularly toxic. People with high deductibles relative to income are far more likely to avoid getting needed care than those with more affordable out-of-pocket costs.[12] For those who do get health care, large medical bills can quickly exceed assets.

Continued income gains in the future will help reduce the burden placed on low- and moderate-income families. But so too would innovations in health plan design that encourage—rather than dissuade—people to get the care they need. In addition, public policy solutions, like fixing the "family coverage glitch" in the ACA, could address the problem of high consumer costs in private health plans.[13] Finally, because the fundamental driver of premiums across all health insurance markets is the underlying growth rate in medical costs, ongoing systemwide efforts to slow medical spending will be critical.

HOW THIS STUDY WAS CONDUCTED

This issue brief analyzes state-by-state trends in private sector employer-based health insurance premiums and deductibles for the under-65 population from 2006 to 2015. The data on insurance premiums and deductibles come from the federal government's annual surveys of employers, conducted for the insurance component of the Medical Expenditure Panel Survey (MEPS). The premiums presented represent the average total annual cost of private group health insurance premiums for employer-sponsored coverage, including both the employer and employee shares. We also examine trends in the share of premiums that employees pay and average deductibles for single-person and family plans.

We compared employees' average out-of-pocket costs for premiums and average deductibles to median income in states to illustrate the potential cost burden of each, as well as the total if the worker/family incurred these average costs. To do this, we compare premium contributions with median household incomes for the under-65 population in each state, using a weighted average of single and family premium contributions compared with single and family median household incomes. We take a similar approach for deductibles. Income data come from the U.S. Census Bureau's Current Population Survey (CPS) of households. The CPS revised its income questions in 2013, affecting the denominator in our ratio estimates. Prior to 2014, this is derived from the traditional CPS income questions, while ratio estimates from 2014 are derived from the revised income questions. Two years of CPS data are averaged to generate reliable state-level income estimates.

The tables provide state-specific data. This analysis updates previous Commonwealth Fund analyses of state health insurance premium and deductible trends.[14]

Notes

[1] Analysis of 2015 Current Population Survey by Sherry Glied and Ougni Chakraborty of New York University for The Commonwealth Fund.

[2] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "First Half of 2016 Effectuated Enrollment Snapshot" (CMS, Oct. 19, 2016).

[3] Median income is calculated as a two-year average given small sample sizes in some states. See How This Study Was Conducted.

[4] Single and family premium contributions are combined and weighted for the distribution of single-person and family households.

[5] As with premium contributions, the average of single-person and family deductible is weighted for the distribution of single-person and family households.

[6] Single premium contributions were near the national average in Florida, Mississippi, Oklahoma, and Texas.

[7] Only in Texas, however, was the average deductible statistically different from the national average.

[8] In dollar amounts, only Pennsylvania had family premium contributions that were statistically lower than the national average.

[9] "About Prepaid Health Care" (State of Hawaii Disability Compensation Division, 2016).

[10] S. R. Collins and D. Blumenthal, "New U.S. Health Care Spending Estimates Reflect ACA Coverage Expansions and Higher Drug Costs," *To the Point,* The Commonwealth Fund, Dec. 4. 2015.

[11] S. R. Collins, M. Z. Gunja, M. M. Doty, and S. Beutel, *How High Is America's Health Care Cost Burden? Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, July–August 2015* (The Commonwealth Fund, Nov. 2015).

[12] S. R. Collins, P. W. Rasmussen, S. Beutel, and M. M. Doty, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey* (The Commonwealth Fund, May 2015).

[13] For example, presidential candidate Hillary Clinton has proposed fixing the Affordable Care Act's "family coverage glitch." Under current law, families with access to employer coverage are eligible for tax credits in the marketplace only if the worker's premium contribution for single enrollee coverage exceeds the affordability threshold. Fixing the family glitch would peg unaffordable coverage in employer plans to family policies rather than single polices, which would allow families to enroll in the marketplaces with premium tax credits if their family policies are considered unaffordable. Clinton has also proposed providing refundable tax credits, up to $2,500 for an individual and $5,000 for a family, to help insured Americans pay for qualifying out-of-pocket costs that exceed 5% of their income; see http://www.commonwealthfund.org/publications/other/2016/sep/2016-candidates-health-proposals.

[14] C. Schoen, J. Lippa, S. R. Collins, and D. C. Radley, *State Trends in Premiums and Deductibles, 2003–2011: Eroding Protection and Rising Costs Underscore the Need for Action* (The Commonwealth Fund, Dec. 2012); C. Schoen, A.-K. Fryer, S. R. Collins, and D. C. Radley, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs* (The Commonwealth Fund, Nov. 2011); C. Schoen, K. Stremikis, S. K. H. How, and S. R. Collins, *State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits* (The Commonwealth Fund, Dec. 2010); and C. Schoen, J. L. Nicholson, and S. D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes—State Health Insurance Premium Trends and the Potential of National Reform* (The Commonwealth Fund, Aug. 2009).

	2006	2010	2013	2014	2015	($)	
	$4,118	$4,940	$5,571	$5,832	$5,963	4.7%	3.8%
Alabama	3,943	4,571 *	5,204 *	5,526	5,733	3.8%	4.6%
Alaska	4,539 *	6,085 *	7,369 *	7,099 *	7,807 *	7.6%	5.1%
Arizona	4,280	4,958	5,343	5,356 *	5,668	3.7%	2.7%
Arkansas	3,567 *	4,178 *	4,536 *	4,846 *	5,119 *	4.0%	4.1%
California	4,036	4,811	5,581	5,841	5,938	4.5%	4.3%
Colorado	4,024	4,630 *	5,668	5,848	5,794	3.6%	4.6%
Connecticut	4,402 *	5,302 *	6,002 *	6,223	6,478 *	4.8%	4.1%
Delaware	4,712 *	5,653 *	5,934 *	6,145	6,288 *	4.7%	2.2%
	4,540 *	5,644 *	6,018 *	6,097	6,409 *	5.6%	2.6%
Florida	3,936 *	5,120	5,383	5,767	5,839	6.8%	2.7%
Georgia	3,873	4,786	5,374	5,570	5,565 *	5.4%	3.1%
Hawaii	3,549 *	4,294 *	5,103 *	5,316 *	5,522 *	4.9%	5.2%
Idaho	3,573 *	4,502	5,019 *	4,978 *	5,820	5.9%	5.3%
Illinois	4,245	5,067	5,824 *	6,126	6,055	4.5%	3.6%
Indiana	3,989	5,015	6,099 *	6,041	5,868	5.9%	3.2%
Iowa	3,916	4,440 *	5,207 *	5,557	5,571 *	3.2%	4.6%
Kansas	3,833 *	4,710	5,432	5,365 *	5,558	5.3%	3.4%
Kentucky	3,791 *	4,683 *	5,257	5,914	5,984	5.4%	5.0%
Louisiana	3,938	5,310	5,300	5,700	5,973	7.8%	2.4%
Maine	4,663 *	5,554 *	5,865	5,903	5,979	4.5%	1.5%
Maryland	3,930	4,799	5,730	6,059	6,229	5.1%	5.4%
Massachusetts	4,448 *	5,413 *	6,290 *	6,348 *	6,519 *	5.0%	3.8%
Michigan	4,446	4,713	5,319	5,610	5,771	1.5%	4.1%
Minnesota	3,981	4,964	5,274 *	5,832	5,651 *	5.7%	2.6%
Mississippi	3,704 *	4,694	4,961 *	5,443	5,420 *	6.1%	2.9%
Missouri	3,958	4,603 *	5,442	5,517	5,726	3.8%	4.5%
Montana	4,144	4,822	5,654	5,876	5,932	3.9%	4.2%
Nebraska	3,890	4,992	5,268	5,557	5,788	6.4%	3.0%
Nevada	3,583 *	4,771	5,168 *	5,426 *	5,800	7.4%	4.0%
	4,622 *	5,162	6,249 *	6,336 *	6,573 *	2.8%	5.0%
	4,471 *	5,153	6,200 *	6,447 *	6,248	3.6%	3.9%
	4,037	4,787	5,250	5,725	5,759	4.4%	3.8%
	4,605 *	5,220 *	6,156 *	6,307 *	6,801 *	3.2%	5.4%
	4,027	4,980	5,218 *	5,593	5,774	5.5%	3.0%
	3,787 *	4,719	5,330	5,521 *	5,920	5.7%	4.6%
Ohio	4,054	4,669 *	5,679	5,930	5,939	3.6%	4.9%
Oklahoma	3,967	4,658	5,129 *	5,649	5,608 *	4.1%	3.8%
Oregon	4,122	5,186	5,449	5,707	5,822	5.9%	2.3%
Pennsylvania	4,277	4,959	5,582	5,888	6,286 *	3.8%	4.9%
	4,595 *	5,557 *	5,968 *	6,156 *	6,509 *	4.9%	3.2%
	4,013	4,835	5,426	5,850	5,880	4.8%	4.0%
	3,938	4,735	5,876	5,859	5,816	4.7%	4.2%
Tennessee	3,747 *	4,753	5,146 *	5,310 *	5,329 *	6.1%	2.3%
Texas	4,133	4,951	5,386	5,740	5,847	4.6%	3.4%
Utah	3,849 *	4,501 *	5,309	5,538 *	5,796	4.0%	5.2%
Vermont	4,322	5,170	5,764	6,180 *	5,861	4.6%	2.5%
Virginia	4,091	4,960	5,408	5,422 *	5,978	4.9%	3.8%
Washington	4,056	4,981	5,690	5,910	6,053	5.3%	4.0%
	4,349	4,935	5,940 *	6,149	6,081	3.2%	4.3%
Wisconsin	4,241	5,384 *	5,730	5,868	6,011	6.1%	2.2%
Wyoming	4,605 *	5,204	6,301 *	5,840	6,420	3.1%	4.3%

						($)	
	2006	2010	2013	2014	2015		
	$11,381	$13,871	$16,029	$16,655	$17,322	5.1%	4.5%
Alabama	10,571 *	12,409 *	13,477 *	14,352 *	15,953	4.1%	5.2%
Alaska	12,198	14,232	20,715 *	19,713 *	21,089 *	3.9%	8.2%
Arizona	11,549	13,871	15,183	15,535 *	16,999	4.7%	4.2%
Arkansas	9,928 *	11,816 *	13,516 *	14,143 *	14,218 *	4.4%	3.8%
California	11,493	13,819	16,691	17,444 *	18,045	4.7%	5.5%
Colorado	11,195	13,393	16,636	15,932	16,940	4.6%	4.8%
Connecticut	12,416 *	14,888 *	16,874	18,123 *	18,269	4.6%	4.2%
Delaware	12,601 *	14,671 *	16,102	17,514 *	18,920 *	3.9%	5.2%
	12,262 *	15,206 *	17,262 *	17,039	19,104 *	5.5%	4.7%
Florida	11,046	15,032 *	16,070	15,915	16,009 *	8.0%	1.3%
Georgia	10,793	13,114 *	14,762 *	16,209	17,307	5.0%	5.7%
Hawaii	9,426 *	12,062 *	14,382 *	14,848 *	15,959 *	6.4%	5.8%
Idaho	10,775	11,379 *	14,036 *	14,729 *	16,691	1.4%	8.0%
Illinois	11,781	14,703	16,928 *	17,193	17,227	5.7%	3.2%
Indiana	11,454	13,884	15,724	17,223	17,121	4.9%	4.3%
Iowa	10,550 *	13,240	14,415 *	15,899	16,257 *	5.8%	4.2%
Kansas	11,048	13,460	15,658	15,652 *	16,740	5.1%	4.5%
Kentucky	9,864 *	13,352	15,463	16,711	16,622	7.9%	4.5%
Louisiana	10,796	13,230	15,548	15,928	17,242	5.2%	5.4%
Maine	12,363 *	14,576	16,332	16,514	16,117 *	4.2%	2.0%
Maryland	11,272	13,952	15,820	17,232	17,961	5.5%	5.2%
Massachusetts	12,290 *	14,606 *	17,424 *	17,702 *	18,454 *	4.4%	4.8%
Michigan	11,452	13,148	15,242	15,608	15,628 *	3.5%	3.5%
Minnesota	11,395	13,903	14,820 *	16,361	16,925	5.1%	4.0%
Mississippi	9,769 *	13,740	14,053 *	15,092 *	16,081	8.9%	3.2%
Missouri	11,171	12,754 *	15,160	15,493 *	16,849	3.4%	5.7%
Montana	11,068	12,312 *	15,152	15,005 *	17,317	2.7%	7.1%
Nebraska	10,777	13,221 *	14,616 *	16,139	16,201	5.2%	4.1%
Nevada	9,746 *	12,496 *	14,682 *	16,152	17,434	6.4%	6.9%
	12,686 *	15,204 *	17,024	18,126	19,208 *	4.6%	4.8%
	12,233 *	14,058	17,396 *	19,143 *	18,280	3.5%	5.4%
	11,279	14,083	15,207	15,766	17,349	5.7%	4.3%
	12,075 *	14,730 *	17,530 *	17,396	19,630 *	5.1%	5.9%
	10,950	13,643	15,023 *	16,210	17,141	5.7%	4.7%
	10,060 *	12,544 *	14,995	15,446 *	16,020 *	5.7%	5.0%
Ohio	10,967	13,083 *	15,955	15,974	16,900	4.5%	5.3%
Oklahoma	10,592	12,900	15,106	16,280	16,811	5.1%	5.4%
Oregon	11,613	13,756	15,856	16,330	17,141	4.3%	4.5%
Pennsylvania	11,794	13,550	16,019	16,328	17,344	3.5%	5.1%
	11,934	14,812	16,077	16,419	17,590	5.5%	3.5%
	10,956	13,234	15,506	16,044	16,764	4.8%	4.8%
	9,875 *	12,542 *	15,780	16,352	16,194	6.2%	5.2%
Tennessee	9,996 *	12,729 *	15,214 *	16,001	15,635 *	6.2%	4.2%
Texas	11,690	14,526	16,049	16,967	17,216	5.6%	3.5%
Utah	10,975	12,618 *	15,341	15,963	15,998 *	3.5%	4.9%
Vermont	11,631	13,588	16,311	16,659	17,835	4.0%	5.6%
Virginia	11,497	13,907	15,917	16,601	17,566	4.9%	4.8%
Washington	11,423	14,188	15,721	17,445	16,627	5.6%	3.2%
	11,282	14,194	17,105	17,433	18,322	5.9%	5.2%
Wisconsin	11,658	14,542	16,665	17,209	17,662	5.7%	4.0%
Wyoming	12,087	13,899	17,130	16,299	17,015	3.6%	4.1%

	2006		2010		2013		2014		2015		($)	
	19%	$788	21%	$1,021	21%	$1,170	21%	$1,234	21%	$1,255	6.7%	4.2%
Alabama	23	891	24	1,092	27	1,379	25	1,362	21	1,228	5.2%	2.4%
Alaska	16	714	14	832 *	15	1,078	18	1,286	17	1,351	3.9%	10.2%
Arizona	19	803	18	891	20	1,078 *	21	1,096	20	1,113	2.6%	4.5%
Arkansas	20	699	21	885 *	21	956 *	20	958 *	22	1,121	6.1%	4.8%
California	16	658 *	22	1,048	20	1,091	19	1,129	19	1,116 *	12.3%	1.3%
Colorado	18	717	19	883	21	1,162	21	1,244	21	1,235	5.3%	6.9%
Connecticut	20	862	23	1,234 *	25	1,502	21	1,305	26	1,652 *	9.4%	6.0%
Delaware	16	735	21	1,180	24	1,427	20	1,237	20	1,232	12.6%	0.9%
	15	699	19	1,080	20	1,171	20	1,197	17	1,057 *	11.5%	
Florida	22	860	21	1,073	26	1,408 *	24	1,394 *	23	1,348	5.7%	4.7%
Georgia	22	862	20	965	23	1,219	22	1,203	22	1,194	2.9%	4.4%
Hawaii	10	366 *	10	436 *	8	431 *	9	460 *	10	544 *	4.5%	4.5%
Idaho	16	565 *	19	832 *	19	975	21	1,039	19	1,117	10.2%	6.1%
Illinois	19	822	22	1,120	22	1,301	21	1,306	21	1,241	8.0%	2.1%
Indiana	21	833	23	1,127	19	1,134	22	1,347	22	1,289	7.8%	2.7%
Iowa	20	784	21	930	23	1,197 *	24	1,353	23	1,252	4.4%	6.1%
Kansas	20	765	20	925	20	1,081 *	20	1,072	24	1,353	4.9%	7.9%
Kentucky	18	691	19	886 *	23	1,215	22	1,314	19	1,116	6.4%	4.7%
Louisiana	19	755	23	1,241	23	1,214	23	1,302	24	1,437	13.2%	3.0%
Maine	23	1,072	22	1,207 *	19	1,119	20	1,176	21	1,279	3.0%	1.2%
Maryland	23	898	23	1,080	23	1,308	24	1,422 *	24	1,515 *	4.7%	7.0%
Massachusetts	23	1,011 *	22	1,200 *	26	1,646 *	25	1,588 *	24	1,590 *	4.4%	5.8%
Michigan	15	682	20	951	22	1,152	23	1,315	19	1,091 *	8.7%	2.8%
Minnesota	20	810	21	1,023	23	1,232	21	1,217	24	1,331	6.0%	5.4%
Mississippi	20	727	22	1,030	22	1,097	21	1,154	23	1,261	9.1%	4.1%
Missouri	18	703	21	965	19	1,036	23	1,243	21	1,207	8.2%	4.6%
Montana	14	598 *	22	1,043	16	882 *	17	1,024	15	863 *	14.9%	
Nebraska	23	873	22	1,084	22	1,164	24	1,322	24	1,365	5.6%	4.7%
Nevada	15	551 *	16	767 *	25	1,302	22	1,204	19	1,098	8.6%	7.4%
	22	1,004	21	1,086	23	1,415 *	23	1,481 *	24	1,575 *	2.0%	7.7%
	20	902	21	1,098	20	1,254	20	1,293	25	1,569 *	5.0%	7.4%
	18	726	25	1,179	21	1,117	24	1,354	20	1,174	12.9%	
	21	965	21	1,086	21	1,291	19	1,223	22	1,503 *	3.0%	6.7%
	18	704	19	926	20	1,064	21	1,151	22	1,243	7.1%	6.1%
	18	675	19	891	18	970	21	1,136	22	1,280	7.2%	7.5%
Ohio	19	781	20	952	19	1,053	21	1,260	21	1,221	5.1%	5.1%
Oklahoma	16	650	22	1,043	21	1,062	20	1,154	23	1,294	12.5%	4.4%
Oregon	13	547 *	16	848 *	15	804 *	16	914 *	15	898 *	11.6%	1.2%
Pennsylvania	21	881	19	954	19	1,074	19	1,141	19	1,174	2.0%	4.2%
	19	862	21	1,147	24	1,401 *	24	1,459 *	23	1,499 *	7.4%	5.5%
	20	810	21	1,006	21	1,137	23	1,332	21	1,220	5.6%	3.9%
	18	718	20	948	23	1,347	21	1,213	24	1,380	7.2%	7.8%
Tennessee	20	745	20	970	23	1,167 *	27	1,409	24	1,300	6.8%	6.0%
Texas	18	728	21	1,036	21	1,135	21	1,211	22	1,273	9.2%	4.2%
Utah	22	826	24	1,086	21	1,089	23	1,297	21	1,200	7.1%	2.0%
Vermont	17	738	21	1,099	20	1,170	21	1,281	23	1,361	10.5%	4.4%
Virginia	24	981 *	23	1,114	23	1,244	24	1,296	23	1,354	3.2%	4.0%
Washington	15	623 *	15	746 *	12	680 *	16	937 *	12	739 *	4.6%	
	19	825	19	933	18	1,052	21	1,297	20	1,199	3.1%	5.1%
Wisconsin	21	885	22	1,174	21	1,220	21	1,257	22	1,345	7.3%	2.8%
Wyoming	14	655	15	802 *	17	1,059	20	1,139	19	1,187	5.2%	8.2%

	2006		2010		2013		2014		2015		($)	
	25%	$2,890	27%	$3,721	28%	$4,421	27%	$4,518	27%	$4,710	6.5%	4.8%
Alabama	28	2,958	30	3,758	28	3,791	30	4,278	35	5,606	6.2%	8.3%
Alaska	24	2,870	22	3,079 *	23	4,759	22	4,229	21	4,409	1.8%	7.4%
Arizona	28	3,267	30	4,133	31	4,774	31	4,741	30	5,008	6.1%	3.9%
Arkansas	32	3,183	34	3,967	29	3,951 *	26	3,609 *	30	4,269	5.7%	1.5%
California	27	3,073	28	3,845	27	4,518	28	4,955	26	4,646	5.8%	3.9%
Colorado	26	2,851	27	3,618	26	4,327	28	4,502	29	4,848	6.1%	6.0%
Connecticut	24	2,947	26	3,824	33	5,522	22	4,027	30	5,484 *	6.7%	7.5%
Delaware	20	2,522	29	4,267	31	4,958	24	4,209	24	4,478	14.0%	1.0%
	21	2,543	25	3,822	30	5,159	25	4,324	27	5,120	10.7%	6.0%
Florida	33	3,600 *	31	4,685 *	35	5,653 *	33	5,215 *	34	5,474 *	6.8%	3.2%
Georgia	27	2,909	28	3,702	30	4,435	27	4,448	28	4,859	6.2%	5.6%
Hawaii	26	2,480 *	26	3,155	22	3,131 *	22	3,227 *	26	4,150	6.2%	5.6%
Idaho	20	2,168	33	3,701	26	3,598	30	4,447	29	4,856	14.3%	5.6%
Illinois	23	2,743	27	3,928	27	4,478	28	4,750	23	3,890 *	9.4%	
Indiana	23	2,685	25	3,462	27	4,300	26	4,476	24	4,108	6.6%	3.5%
Iowa	25	2,651	29	3,781	28	4,047	27	4,227	30	4,804	9.3%	4.9%
Kansas	27	2,923	24	3,257	27	4,164 *	26	4,109	30	5,079	2.7%	9.3%
Kentucky	25	2,469 *	23	3,060 *	25	3,898	26	4,259	24	3,980 *	5.5%	5.4%
Louisiana	28	3,029	30	3,962	30	4,604	32	5,054	33	5,696 *	6.9%	7.5%
Maine	30	3,660 *	31	4,465 *	29	4,766	25	4,094	29	4,657	5.1%	0.8%
Maryland	27	2,990	27	3,728	29	4,512	30	5,221 *	35	6,365 *	5.7%	11.3%
Massachusetts	25	3,128	24	3,444	26	4,570	27	4,834	24	4,487	2.4%	5.4%
Michigan	21	2,411	22	2,879 *	26	3,968	25	3,858	23	3,646 *	4.5%	4.8%
Minnesota	27	3,099	23	3,233	28	4,210	26	4,170	30	5,083	1.1%	9.5%
Mississippi	31	3,028	30	4,105	31	4,376	31	4,678	33	5,307	7.9%	5.3%
Missouri	23	2,543 *	26	3,280	29	4,455 *	25	3,872 *	25	4,186	6.6%	5.0%
Montana	25	2,759	24	2,992	23	3,495	29	4,280	24	4,212	2.0%	7.1%
Nebraska	28	3,041	28	3,703	31	4,476	27	4,385	33	5,257	5.0%	7.3%
Nevada	22	2,144 *	27	3,379	31	4,556	26	4,212	23	3,991	12.0%	3.4%
	26	3,318 *	25	3,849	27	4,592	27	4,899	25	4,878	3.8%	4.9%
	24	2,981	29	4,010	26	4,486	23	4,310	27	4,916	7.7%	4.2%
	26	2,961	28	3,952	26	4,009	29	4,555	26	4,567	7.5%	2.9%
	22	2,620	25	3,630	24	4,232	24	4,159	26	5,190	8.5%	7.4%
	26	2,871	26	3,492	31	4,685	29	4,647	26	4,493	5.0%	5.2%
	30	3,056	28	3,492	26	3,842	26	3,985 *	33	5,249	3.4%	8.5%
Ohio	23	2,488	25	3,286 *	23	3,631 *	22	3,572 *	22	3,725 *	7.2%	2.5%
Oklahoma	29	3,081	29	3,715	33	5,015	28	4,609	34	5,730 *	4.8%	9.1%
Oregon	28	3,294	28	3,888	27	4,327	28	4,555	28	4,729	4.2%	4.0%
Pennsylvania	24	2,787	22	3,013 *	25	4,017 *	22	3,598 *	22	3,803 *	2.0%	4.8%
	20	2,368	22	3,308	26	4,245	29	4,681	26	4,495	8.7%	6.3%
	27	2,999	28	3,641	29	4,482	26	4,110	29	4,771	5.0%	5.6%
	26	2,552	30	3,793	31	4,905	29	4,730	31	4,940	10.4%	5.4%
Tennessee	28	2,764	27	3,461	29	4,361 *	33	5,255 *	28	4,299	5.8%	4.4%
Texas	26	3,024	31	4,500 *	31	4,892 *	32	5,344 *	31	5,409 *	10.4%	3.7%
Utah	24	2,617	28	3,545	24	3,609	29	4,642	27	4,286	7.9%	3.9%
Vermont	23	2,619	22	2,997 *	27	4,340	25	4,216	28	4,900	3.4%	10.3%
Virginia	31	3,600 *	32	4,477 *	31	4,889 *	32	5,289 *	28	4,949	5.6%	2.0%
Washington	25	2,886	26	3,685	25	3,930	26	4,505	26	4,265	6.3%	3.0%
	22	2,426	22	3,139	17	2,931	24	4,219	25	4,580	6.7%	7.8%
Wisconsin	21	2,426 *	23	3,359	23	3,897 *	22	3,791 *	25	4,475	8.5%	5.9%
Wyoming	19	2,284	23	3,178	22	3,812	26	4,276	29	4,960	8.6%	9.3%

	2006		2010		2013		2014		2015		($)	
	Deductible	$ (single)	%	$	%	$	%	$	%	$		
	66%	$714	78%	$1,025	81%	$1,273	84%	$1,353	85%	$1,541	9.5%	8.5%
Alabama	73	505 *	83	544 *	90	670 *	80	925 *	91	1,026 *	1.9%	13.5%
Alaska	82	602	98	1,122	93	1,157	92	1,442	95	1,616	16.8%	7.6%
Arizona	79	760	84	1,259 *	84	1,441 *	89	1,651 *	91	1,819	13.4%	7.6%
Arkansas	89	685	93	846 *	92	986 *	93	1,233	90	1,313 *	5.4%	9.2%
California	52	692	59	1,051	62	1,194	66	1,270	67	1,428	11.0%	6.3%
Colorado	66	960 *	88	1,232	86	1,382	90	1,453	93	1,680	6.4%	6.4%
Connecticut	52	700	68	1,201	78	1,598	74	1,547 *	83	1,733	14.4%	7.6%
Delaware	36	727	63	860	90	1,074	91	1,106 *	91	1,202 *	4.3%	6.9%
	52	513 *	59	648 *	61	767 *	68	766 *	68	1,108 *	6.0%	11.3%
Florida	67	746	85	961	84	1,346	88	1,447	91	1,691	6.5%	12.0%
Georgia	75	697	79	998	93	1,164	94	1,295	91	1,776 *	9.4%	12.2%
Hawaii	24	612	31	519 *	36	698 *	31	637 *	44	986 *		13.7%
Idaho	89	831	92	1,171	94	1,295	96	1,454	95	1,558	9.0%	5.9%
Illinois	74	693	80	885	85	1,301	80	1,279	87	1,323 *	6.3%	8.4%
Indiana	81	782	90	920	89	1,274	92	1,425	98	1,834 *	4.1%	14.8%
Iowa	92	733	96	967	96	1,393	96	1,424	95	1,614	7.2%	10.8%
Kansas	81	779	86	1,007	90	1,377	96	1,354	95	1,369	6.6%	6.3%
Kentucky	90	659	92	1,054	90	1,491	90	1,373	93	1,543	12.5%	7.9%
Louisiana	85	787	85	1,131	86	1,137	91	1,233	92	1,320 *	9.5%	3.1%
Maine	59	802	80	1,327 *	96	1,784 *	95	2,081 *	91	2,067 *	13.4%	9.3%
Maryland	50	494 *	65	929	77	1,075 *	77	1,010 *	83	1,128 *	17.1%	4.0%
Massachusetts	37	603	61	793 *	66	1,134 *	74	1,165 *	72	1,202 *	7.1%	8.7%
Michigan	64	571 *	71	983	84	1,123	88	1,280	88	1,431	14.5%	7.8%
Minnesota	73	722	83	1,155	89	1,384	95	1,419	96	1,819 *	12.5%	9.5%
Mississippi	91	842 *	95	1,054	97	1,102	98	1,454	89	1,470	5.8%	6.9%
Missouri	69	780	86	1,005	90	1,374 *	92	1,541	95	1,762	6.5%	11.9%
Montana	92	903 *	89	1,309 *	94	1,633	96	1,533	98	2,104 *	9.7%	10.0%
Nebraska	84	713	97	1,042	98	1,220	96	1,375	96	1,760 *	9.9%	11.1%
Nevada	66	566 *	83	849	79	1,121	72	1,374	84	1,087 *	10.7%	5.1%
	60	671	85	1,184	90	1,621 *	93	1,894 *	91	1,988 *	15.3%	10.9%
	52	752	69	1,161	68	1,311	74	1,239	81	1,608	11.5%	6.7%
	66	752	78	864 *	84	1,123 *	84	1,175	83	1,461	3.5%	11.1%
	47	717	55	891 *	62	1,112 *	72	1,212 *	74	1,317 *	5.6%	8.1%
	75	859 *	92	1,181	94	1,367 *	94	1,515	92	1,794 *	8.3%	8.7%
	92	540 *	94	737 *	94	1,030 *	95	1,167	97	1,354 *	8.1%	12.9%
Ohio	78	632	88	1,008	91	1,293	91	1,408	92	1,461	12.4%	7.7%
Oklahoma	86	719	91	890 *	93	1,227	95	1,491	98	1,639	5.5%	13.0%
Oregon	74	678	84	1,065	90	1,295	88	1,274	91	1,496	12.0%	7.0%
Pennsylvania	54	517 *	75	849 *	81	1,108	79	1,148 *	77	1,289 *	13.2%	8.7%
	50	528 *	61	1,024	85	1,161	96	1,363	86	1,400	18.0%	6.5%
	86	797	91	1,139	95	1,314	96	1,343	97	1,767	9.3%	9.2%
	89	870 *	96	1,172	96	1,610	99	1,619	99	1,725	7.7%	8.0%
Tennessee	82	790	87	1,066	93	1,484 *	91	1,883 *	94	1,836 *	7.8%	11.5%
Texas	74	901 *	89	1,247 *	90	1,543	92	1,515 *	93	1,802 *	8.5%	7.6%
Utah	75	647 *	86	965	87	1,195	93	1,238	89	1,549	10.5%	9.9%
Vermont	73	936 *	87	1,463 *	87	1,727 *	88	1,687 *	88	1,583	11.8%	1.6%
Virginia	59	600 *	65	1,004	69	1,173	82	1,303	81	1,162 *	13.7%	3.0%
Washington	78	587 *	88	975	91	1,127 *	93	1,075 *	96	1,426	13.5%	7.9%
	80	747	91	838	86	1,142	92	1,231	91	1,423	2.9%	11.2%
Wisconsin	83	649	87	1,145	86	1,335	92	1,464	94	1,617	15.2%	7.1%
Wyoming	84	964 *	90	1,479	98	1,173	93	1,474	90	1,689	11.3%	2.7%

	Average employee premium contribution*			Average employee deductible*			Average combined employee premium contribution and deductible*		
	2006	2010	2015	2006	2010	2015	2006	2010	2015
	$2,345	$2,975	$3,849	$1,186	$1,713	$2,573	$3,531	$4,688	$6,422
Alabama	2,480	3,033	4,506	902	1,075	1,736	3,382	4,108	6,242
Alaska	2,344	2,474	3,725	988	1,790	2,464	3,332	4,263	6,189
Arizona	2,644	3,292	4,074	1,309	2,082	2,779	3,953	5,374	6,853
Arkansas	2,622	3,163	3,519	1,217	1,571	2,253	3,838	4,734	5,772
California	2,391	3,011	3,714	1,103	1,676	2,358	3,495	4,687	6,072
Colorado	2,299	2,862	3,879	1,441	1,977	2,691	3,740	4,839	6,570
Connecticut	2,397	3,135	4,623	1,242	2,013	3,031	3,639	5,148	7,654
Delaware	2,002	3,425	3,597	1,316	1,687	1,952	3,318	5,112	5,548
	1,702	2,427	3,229	797	1,003	1,634	2,499	3,430	4,863
Florida	2,812	3,611	4,378	1,331	1,594	2,811	4,142	5,205	7,188
Georgia	2,366	2,975	3,969	1,172	1,653	2,727	3,537	4,628	6,696
Hawaii	1,758	2,226	2,941	1,212	1,302	1,894	2,970	3,528	4,836
Idaho	1,815	3,103	4,076	1,125	2,421	2,805	2,940	5,525	6,881
Illinois	2,250	3,109	3,217	1,164	1,635	2,300	3,414	4,744	5,517
Indiana	2,248	2,873	3,465	1,386	1,623	3,024	3,635	4,495	6,490
Iowa	2,240	3,081	4,089	1,335	1,640	2,947	3,575	4,721	7,036
Kansas	2,407	2,657	4,208	1,252	1,559	2,105	3,659	4,215	6,313
Kentucky	2,018	2,485	3,248	1,046	1,735	2,445	3,064	4,220	5,693
Louisiana	2,453	3,315	4,449	1,333	1,857	2,318	3,786	5,172	6,767
Maine	2,975	3,551	3,809	1,253	2,014	3,253	4,228	5,565	7,062
Maryland	2,433	2,929	5,175	860	1,451	1,873	3,293	4,381	7,048
Massachusetts	2,532	2,792	3,622	1,002	1,393	2,054	3,534	4,185	5,677
Michigan	1,993	2,384	2,979	908	1,563	2,528	2,901	3,947	5,507
Minnesota	2,562	2,632	4,197	1,252	1,903	3,136	3,814	4,534	7,333
Mississippi	2,512	3,391	4,340	1,413	1,789	2,546	3,925	5,180	6,887
Missouri	2,072	2,680	3,514	1,293	1,850	3,004	3,365	4,530	6,518
Montana	2,205	2,454	3,375	1,468	2,023	3,006	3,673	4,477	6,381
Nebraska	2,571	3,060	4,359	1,192	1,718	2,777	3,763	4,778	7,137
Nevada	1,672	2,595	3,161	966	1,303	1,606	2,639	3,898	4,767
	2,764	3,130	4,042	1,355	2,011	3,703	4,118	5,141	7,745
	2,447	3,197	4,087	1,167	1,858	2,683	3,614	5,056	6,771
	2,406	3,225	3,705	1,284	1,604	2,434	3,691	4,829	6,139
	2,134	2,811	4,164	1,108	1,458	2,261	3,243	4,269	6,425
	2,353	2,850	3,751	1,411	1,744	2,753	3,764	4,594	6,504
	2,483	2,801	4,124	963	1,249	2,365	3,446	4,050	6,489
Ohio	2,069	2,683	3,150	1,056	1,834	2,486	3,125	4,517	5,636
Oklahoma	2,513	3,054	4,701	1,352	1,708	2,725	3,865	4,762	7,425
Oregon	2,553	3,017	3,716	1,167	1,911	2,336	3,720	4,928	6,052
Pennsylvania	2,293	2,433	3,172	947	1,422	2,271	3,239	3,855	5,444
	1,967	2,659	3,659	979	1,706	2,507	2,946	4,365	6,165
	2,417	2,924	3,883	1,261	2,054	2,616	3,677	4,978	6,499
	2,139	3,088	4,118	1,398	1,820	2,764	3,537	4,908	6,881
Tennessee	2,252	2,827	3,564	1,293	1,791	2,913	3,546	4,618	6,477
Texas	2,494	3,598	4,526	1,404	2,013	3,049	3,898	5,612	7,575
Utah	2,268	3,029	3,746	1,328	1,661	2,960	3,596	4,690	6,705
Vermont	2,118	2,477	3,964	1,728	2,408	2,864	3,846	4,885	6,828
Virginia	2,892	3,576	4,019	957	1,635	1,929	3,849	5,211	5,948
Washington	2,301	2,867	3,329	1,083	1,634	2,424	3,383	4,501	5,754
	2,045	2,578	3,732	1,039	1,231	2,246	3,084	3,809	5,978
Wisconsin	2,048	2,754	3,774	1,236	2,177	3,225	3,285	4,931	6,999
Wyoming	1,914	2,581	4,127	1,643	1,997	3,077	3,557	4,578	7,204

	Average employee contribution as percent of median household income for under-65 population*			Average deductible as percent of median household income for under-65 population*			Average combined employee contribution and deductible as percent of median household income for under-65 population*		
	2006	2010	2015[a]	2006	2010	2015[a]	2006	2010	2015[a]
	4.2%	5.1%	5.8%	2.3%	3.2%	4.2%	6.5%	8.4%	10.1%
Alabama	5.2%	5.9%	7.8%	2.0%	2.2%	3.4%	7.1%	8.2%	11.2%
Alaska	3.6%	3.6%	5.0%	1.7%	2.9%	3.7%	5.2%	6.5%	8.7%
Arizona	5.6%	6.9%	7.4%	2.9%	4.9%	5.6%	8.5%	11.9%	13.0%
Arkansas	5.6%	5.8%	6.4%	2.8%	3.1%	4.4%	8.4%	8.9%	10.8%
California	4.3%	5.7%	5.8%	2.2%	3.5%	4.1%	6.6%	9.1%	9.9%
Colorado	3.6%	4.1%	5.4%	2.6%	3.2%	4.1%	6.2%	7.3%	9.5%
Connecticut	3.3%	3.9%	5.6%	1.8%	2.7%	3.9%	5.1%	6.6%	9.5%
Delaware	3.4%	5.5%	5.2%	2.4%	2.9%	3.1%	5.8%	8.4%	8.3%
	3.8%	4.4%	4.3%	1.9%	1.9%	2.4%	5.6%	6.4%	6.8%
Florida	5.2%	6.6%	7.8%	2.7%	3.3%	5.4%	7.9%	9.9%	13.3%
Georgia	4.5%	5.3%	6.6%	2.4%	3.2%	5.0%	6.9%	8.5%	11.6%
Hawaii	2.7%	3.8%	4.2%	2.2%	2.4%	3.2%	4.9%	6.2%	7.4%
Idaho	3.3%	4.8%	6.6%	2.4%	4.0%	4.9%	5.7%	8.8%	11.6%
Illinois	3.6%	5.2%	4.6%	2.0%	2.9%	3.5%	5.7%	8.1%	8.2%
Indiana	4.1%	5.4%	5.6%	2.7%	3.3%	5.3%	6.7%	8.7%	11.0%
Iowa	3.8%	5.5%	5.4%	2.4%	3.2%	4.2%	6.3%	8.7%	9.6%
Kansas	4.2%	4.6%	6.1%	2.4%	2.9%	3.4%	6.7%	7.5%	9.6%
Kentucky	4.0%	4.8%	5.7%	2.3%	3.7%	4.7%	6.4%	8.5%	10.4%
Louisiana	5.5%	6.0%	7.6%	3.3%	3.6%	4.3%	8.8%	9.6%	11.9%
Maine	5.7%	5.9%	5.9%	2.6%	3.8%	5.6%	8.4%	9.7%	11.5%
Maryland	3.5%	3.9%	5.6%	1.3%	2.2%	2.3%	4.8%	6.1%	7.9%
Massachusetts	3.6%	3.7%	4.6%	1.6%	2.0%	2.7%	5.2%	5.7%	7.3%
Michigan	3.3%	4.0%	4.6%	1.7%	2.9%	4.2%	5.0%	6.9%	8.9%
Minnesota	3.6%	3.9%	5.1%	1.9%	3.0%	4.2%	5.5%	6.9%	9.4%
Mississippi	5.5%	7.7%	9.0%	3.4%	4.4%	5.7%	8.9%	12.1%	14.7%
Missouri	3.7%	4.8%	5.1%	2.5%	3.5%	4.7%	6.2%	8.3%	9.8%
Montana	4.7%	4.2%	5.3%	3.5%	3.8%	5.4%	8.3%	8.1%	10.6%
Nebraska	4.4%	4.9%	6.0%	2.2%	3.0%	4.2%	6.5%	7.9%	10.3%
Nevada	3.1%	4.8%	5.9%	2.0%	2.7%	3.3%	5.1%	7.5%	9.1%
	3.9%	3.9%	4.7%	2.0%	2.8%	4.6%	5.9%	6.7%	9.3%
	3.2%	4.0%	5.3%	1.7%	2.7%	3.8%	5.0%	6.7%	9.1%
	5.3%	6.6%	7.2%	3.1%	3.5%	5.1%	8.4%	10.0%	12.3%
	3.9%	4.8%	6.2%	2.2%	2.7%	3.6%	6.1%	7.6%	9.9%
	4.4%	5.3%	6.2%	2.9%	3.6%	5.0%	7.2%	8.9%	11.3%
	4.3%	4.2%	5.4%	1.9%	2.1%	3.4%	6.2%	6.3%	8.8%
Ohio	3.6%	4.7%	5.1%	2.0%	3.4%	4.3%	5.5%	8.1%	9.4%
Oklahoma	5.1%	5.8%	7.6%	3.0%	3.4%	4.9%	8.1%	9.2%	12.5%
Oregon	4.6%	5.1%	5.7%	2.4%	3.7%	4.1%	7.1%	8.8%	9.7%
Pennsylvania	4.0%	4.0%	4.5%	1.7%	2.5%	3.5%	5.7%	6.5%	8.0%
	3.3%	4.2%	5.4%	1.7%	2.9%	3.9%	5.0%	7.1%	9.3%
	4.9%	5.4%	6.8%	2.8%	4.1%	5.1%	7.7%	9.6%	11.9%
	3.9%	5.3%	5.6%	2.8%	3.5%	4.2%	6.7%	8.8%	9.8%
Tennessee	4.4%	5.5%	6.4%	2.8%	3.8%	5.6%	7.2%	9.3%	12.0%
Texas	5.1%	7.1%	7.3%	3.2%	4.4%	5.3%	8.3%	11.4%	12.6%
Utah	4.0%	4.6%	5.4%	2.4%	2.7%	4.5%	6.4%	7.3%	9.9%
Vermont	3.4%	4.0%	5.4%	3.0%	4.2%	4.2%	6.5%	8.2%	9.6%
Virginia	4.5%	4.8%	5.4%	1.7%	2.5%	2.9%	6.2%	7.2%	8.3%
Washington	3.5%	4.2%	4.6%	1.8%	2.7%	3.9%	5.4%	6.9%	8.5%
	4.5%	5.1%	6.8%	2.5%	2.7%	4.5%	7.1%	7.9%	11.3%
Wisconsin	3.5%	4.5%	5.3%	2.2%	3.7%	4.8%	5.8%	8.2%	10.1%
Wyoming	3.2%	4.0%	5.5%	3.0%	3.6%	4.5%	6.3%	7.6%	10.0%

[a]

	Median income for single-person household (under age 65)*			Median income for family household (all under age 65)*			Median income for all households (all under age 65)*		
	2005–06	2009–10	2014–15	2005–06	2009–10	2014–15	2005–06	2009–10	2014–15
	$25,000	$25,345	$30,000	$63,879	$67,357	$74,000	$50,470	$51,410	$57,764
Alabama	$21,630	$21,400	$24,602	$54,157	$60,000	$64,006	$45,438	$42,756	$48,018
Alaska	$25,892	$30,000	$29,884	$75,338	$78,000	$85,124	$62,060	$61,250	$71,800
Arizona	$25,000	$20,052	$27,040	$51,500	$53,088	$59,002	$42,564	$40,787	$47,440
Arkansas	$20,212	$25,000	$27,000	$51,400	$60,100	$60,000	$41,715	$47,578	$47,068
California	$25,345	$25,200	$30,000	$61,467	$61,162	$70,619	$47,699	$48,000	$55,000
Colorado	$26,780	$28,300	$33,006	$72,832	$80,901	$81,040	$56,485	$61,600	$62,506
Connecticut	$30,000	$30,940	$32,101	$85,700	$100,000	$96,528	$65,854	$75,520	$76,258
Delaware	$26,939	$29,000	$30,000	$69,010	$70,060	$80,138	$53,706	$55,000	$57,500
	$32,960	$38,000	$46,525	$49,028	$62,610	$84,080	$39,140	$46,000	$60,000
Florida	$24,720	$25,001	$28,800	$61,450	$61,642	$60,999	$48,000	$48,000	$48,501
Georgia	$25,700	$24,746	$29,087	$59,200	$64,500	$65,168	$46,352	$50,000	$51,000
Hawaii	$26,922	$28,200	$30,000	$71,751	$63,100	$76,130	$51,520	$48,488	$52,500
Idaho	$22,721	$25,000	$26,720	$60,500	$72,000	$66,613	$51,010	$57,183	$55,926
Illinois	$26,780	$27,000	$31,000	$71,387	$70,050	$80,168	$55,286	$53,615	$64,440
Indiana	$25,238	$21,982	$26,000	$62,188	$63,096	$70,243	$50,881	$53,258	$55,004
Iowa	$25,477	$24,860	$30,000	$65,252	$62,000	$83,814	$53,784	$50,002	$70,000
Kansas	$23,690	$27,290	$27,746	$64,066	$65,760	$78,010	$51,578	$51,499	$61,200
Kentucky	$21,424	$22,400	$26,235	$57,165	$60,000	$64,080	$44,548	$46,200	$50,000
Louisiana	$19,570	$23,000	$27,900	$50,200	$64,402	$65,826	$41,189	$49,699	$49,000
Maine	$23,263	$24,500	$27,650	$60,000	$71,650	$73,504	$48,804	$54,224	$57,554
Maryland	$30,000	$32,000	$35,200	$82,400	$90,170	$106,066	$63,416	$65,000	$80,217
Massachusetts	$27,000	$30,500	$35,000	$88,810	$96,016	$98,538	$63,200	$69,001	$73,015
Michigan	$25,700	$24,010	$26,600	$68,020	$70,780	$75,783	$54,392	$54,000	$58,729
Minnesota	$28,000	$29,020	$32,000	$82,143	$80,877	$93,372	$65,812	$61,475	$74,801
Mississippi	$20,600	$19,203	$23,000	$49,643	$48,900	$52,768	$39,928	$39,243	$42,335
Missouri	$24,892	$24,425	$29,600	$63,860	$65,000	$78,000	$49,809	$49,865	$64,018
Montana	$20,052	$25,000	$28,000	$51,716	$69,991	$70,500	$40,814	$51,600	$55,500
Nebraska	$25,055	$26,010	$32,277	$66,065	$72,400	$79,803	$54,590	$56,517	$66,647
Nevada	$25,750	$25,863	$27,976	$60,000	$60,400	$60,010	$45,069	$47,050	$48,500
	$28,697	$30,251	$35,000	$82,922	$95,000	$101,225	$67,500	$78,201	$80,554
	$30,000	$30,000	$30,001	$89,600	$95,962	$93,038	$67,505	$68,355	$70,130
	$21,007	$23,800	$26,007	$50,000	$55,131	$56,508	$40,294	$44,000	$45,500
	$26,780	$28,500	$32,000	$64,170	$67,986	$76,000	$49,218	$50,000	$58,616
	$23,694	$23,500	$27,000	$60,000	$60,680	$66,709	$48,043	$48,001	$53,006
	$23,000	$28,011	$35,000	$64,100	$75,400	$86,152	$51,521	$60,500	$68,405
Ohio	$25,200	$25,000	$26,945	$67,088	$66,140	$70,176	$53,818	$52,003	$56,983
Oklahoma	$21,424	$25,000	$26,000	$54,017	$59,010	$68,000	$45,800	$48,570	$54,019
Oregon	$23,481	$24,000	$28,714	$60,000	$67,056	$72,089	$47,133	$51,008	$56,200
Pennsylvania	$25,750	$27,000	$30,035	$67,267	$72,000	$80,727	$54,411	$55,471	$65,002
	$25,753	$26,010	$30,060	$71,658	$81,261	$80,655	$55,000	$57,500	$61,780
	$22,100	$22,000	$26,390	$56,650	$63,659	$63,575	$45,000	$48,000	$50,865
	$23,381	$24,501	$30,000	$61,175	$66,000	$83,232	$51,461	$51,610	$67,251
Tennessee	$22,660	$21,000	$27,277	$57,482	$60,000	$62,000	$46,350	$45,000	$49,800
Texas	$22,005	$24,000	$30,000	$53,560	$56,029	$66,664	$43,260	$44,040	$55,000
Utah	$24,000	$27,240	$27,500	$63,767	$75,012	$76,020	$55,620	$63,900	$65,442
Vermont	$25,240	$26,010	$32,600	$72,019	$75,500	$84,025	$56,126	$59,135	$67,800
Virginia	$26,788	$30,000	$31,001	$74,000	$86,922	$86,022	$57,045	$66,600	$66,182
Washington	$27,810	$30,000	$30,000	$72,512	$76,500	$78,814	$57,322	$59,625	$62,004
	$20,800	$21,947	$24,528	$51,500	$57,715	$62,081	$42,009	$48,077	$48,058
Wisconsin	$25,956	$27,000	$31,000	$67,520	$73,230	$79,838	$55,209	$56,899	$65,288
Wyoming	$24,308	$27,000	$30,000	$67,054	$73,466	$83,100	$55,178	$58,700	$70,016

About the Authors

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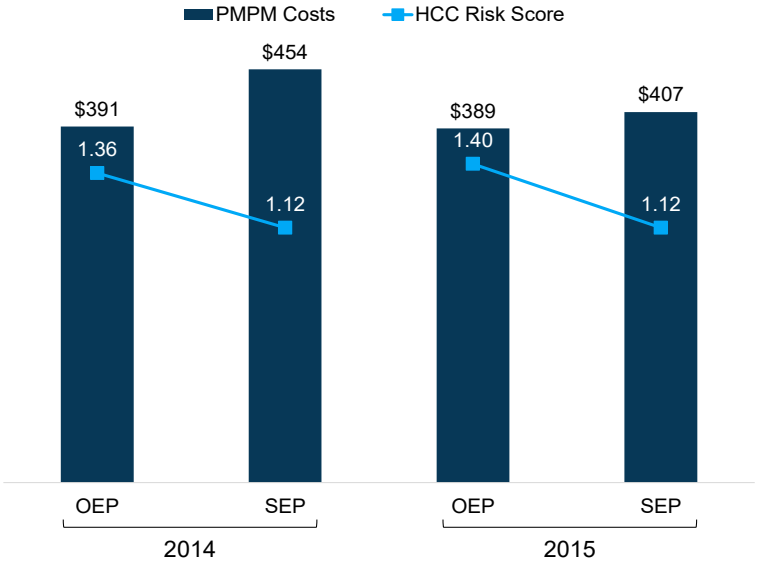
Consumers Enrolling in Exchanges through Special Enrollment Periods Have Higher Costs, Lower Risk Scores, than Open Enrollment Consumers

A new analysis from Avalere finds that individuals who enroll in exchange coverage during special enrollment periods (SEP) have higher costs and lower risk scores than open enrollment period (OEP) consumers. Specifically, 2015 SEP enrollees have 5 percent higher per-member, per-month (PMPM) costs, but risk scores that are 20 percent lower on average than those choosing a plan during the OEP. Risk scores represent a measure of predicted healthcare costs assigned as part of the risk adjustment program.

The Affordable Care Act (ACA) established an annual OEP when individuals can enroll in coverage at the same time every year. The law also allows for enrollment outside of the OEP, through SEPs. Consumers qualify for SEPs under a range of scenarios, including loss of health coverage, changes in household size, changes in residence, changes in exchange eligibility or income, enrollment or plan errors, and other qualifying events. Enrollment through SEPs has been significant. Specifically, in the first half of 2015, approximately 940,000 individuals, or 15 percent of year-end federal exchange enrollment, enrolled in coverage on the federal exchange through a SEP. In 2015, consumers enrolling through SEPs were enrolled in their plan for a shorter period of time (7.8 months for OEP enrollees vs. 3.6 months for SEP enrollees) than their OEP counterparts.

“Consumers enrolling through special enrollment periods have higher healthcare spending than those picking a plan during open enrollment, and they are staying in the program for shorter periods of time,” said Dan Mendelson, President of Avalere. “This is one of many technical problems that is presently destabilizing this program, and should be fixed by the Administration and the Congress to ensure continuity for patients.

Figure 1: Average PMPM Healthcare Costs and Average Hierarchical Condition Categories (HCC) Risk Scores for OEP and SEP Enrollees, 2014 and 2015



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“The shorter enrollment duration of individuals enrolling through special enrollment periods may lead to risk scores that are not reflective of expected costs,” said Elizabeth Carpenter, senior vice president at Avalere. “As a result, plans may not be compensated appropriately for these consumers.”

In light of these concerns, the Centers for Medicare & Medicaid Services (CMS) has proposed in its annual exchange rulemaking, also known as the Notice of Benefit and Payment Parameters (NBPP), to adjust risk scores beginning in 2017 for individuals enrolled in insurance for part of the year. In addition, CMS continues to seek comment in the proposed rule on how to balance appropriate access through SEPs with concerns regarding risk pool impact.

The findings described above are part of a report entitled “The State of Exchanges: A Review of Trends and Opportunities to Grow and Stabilize the Market.” The paper identifies the key challenges facing exchanges and considers a range of potential policy options that could be combined to improve the sustainability of the market into the future.

The full report can be found here.

Funding for this analysis was provided by Aetna. Avalere maintained full editorial control.

Sources and Methodology:

Avalere analysis of exchange enrollee costs, enrollment duration, and risk scores is based on Inovalon’s Medical Outcomes Research for Effectiveness and Economics Registry® (MORE²) from 2014 and 2015.

SEP enrollment figures are based on February 23 – June 30, 2015 SEP enrollment and 2015 year-end exchange enrollment data released by the Centers for Medicare & Medicaid Services (CMS), August 2015 and March 2016. Figures include enrollment through the federal exchange, HealthCare.gov.

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Marketplace Grace Periods Working as Intended

Restrictions Would Increase Number of Uninsured

By Tara Straw

People who receive subsidies to help pay for coverage in health insurance marketplaces have a three-month window, called a grace period, to pay overdue premiums before insurers can terminate their coverage. Without this opportunity to catch up on their share of the premiums, enrollees who miss a payment would quickly become uninsured — and barred from reenrolling in private coverage until the next open enrollment period or until they have a life event that qualifies them for a "special enrollment period."

Some insurers and health reform critics claim that enrollees are abusing the grace period to get 12 months of coverage for nine months of premium payments. There is, however, no evidence that this is the case. Moreover, this view misunderstands how grace periods work. If a person has not caught up on *all* overdue premiums by the end of the grace period, coverage is terminated *retroactively* to the end of the first month of the grace period. The enrollee must repay the advance premium tax credit that the insurer received for the first month of the grace period, owes the insurer the outstanding premium for that month, is responsible for the full cost for any medical bills incurred in months two and three, and may owe the individual responsibility payment for the second and third months and any subsequent months he or she was uninsured. It's far from a free ride for an enrollee losing coverage for non-payment.

Insurers recently have advocated to change the law to reduce the grace period from three months to the time otherwise specified in each state's health insurance laws, which is generally 30 days or less. *That short window often would not allow adequate time for enrollees to resolve billing issues, identify payment problems between their health plans and banks, or catch up on a missed premium payment.* Insurers are also calling for changes to current federal regulations, which if adopted would prevent people from reenrolling during open enrollment if they previously lost coverage for nonpayment, until they paid any back premiums they owe.

Reducing the grace period to one month would create harsh consequences for low- and moderate-income individuals and families who miss a payment or even part of a payment for any of a series of reasons, such as a costly car repair so the individual can continue to get to work or the need for a sudden large payment for an essential home repair such as a major roof leak. It also threatens to weaken the marketplace risk pool by increasing "churn" as people exit and reenter the market. Since often-healthy young people — who are more likely to miss bill payments, in general — may be those

most likely to lose coverage, this could leave older or sicker people as a bigger share of the marketplace risk pool. That would raise premiums and further discourage healthy people from enrolling in marketplace plans.

How Grace Periods Work

Some insurers have claimed that enrollees in marketplace health insurance can get 12 months of coverage for paying nine months of premiums. But these claims reflect a serious misunderstanding of how the marketplace grace periods work and enrollees' financial obligations. The regulations governing the three-month grace period do not allow three free months of coverage and are actually quite favorable to insurers.[1]

Marketplace enrollees owe monthly insurance premiums by the due date established by the insurer, often the first day of the month. State laws have grace-period provisions that generally give consumers 30 days to catch up on a late payment before insurers are allowed to discontinue coverage. But the health reform law gives people who are eligible for and receive an advance premium tax credit (APTC) for insurance purchased in state or federal marketplaces a three-month grace period for nonpayment.

Enrollees enter the grace period after their first missed payment. The insurer notifies the consumer about the consequences of missing his or her payment and tells health care providers that the consumer is in a grace period. The insurer still collects the APTC from the federal government on the enrollee's behalf, which covers an average of 73 percent of the premium,[2] and covers the enrollee's medical bills during the first month of nonpayment. In the second and third months of the grace period, the insurer *postpones paying medical claims* but continues to receive the APTC on the consumer's behalf.

If the enrollee doesn't fully catch up on premiums by the end of the third month, coverage is *retroactively* terminated as of the last day of the first month of the grace period. The insurer must return the second and third months' APTC to the federal government and is not responsible for paying any claims it was holding for medical care that the enrollee received during those months. The insurer keeps the APTC from the first month.

The enrollee who loses coverage faces a number of costs at the end of the grace period, which in many cases will exceed the missed premium payments. The consumer still owes the first month's premium to the insurer and is responsible for all medical bills incurred in the second and third months of the grace period as well as any uninsured months that follow. At tax filing, the consumer must repay the APTC the insurer received in the first month of the grace period, and, unless a coverage exemption applies, the taxpayer will be responsible for an individual responsibility payment

[1] See generally, 45 CFR §155.430(b)(2) and 45 CFR §156.270.

[2] "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS), March 11, 2016, p. 15, https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf. (Figure refers to HealthCare.gov enrollees only.)

(penalty) for the second and third months of the grace period and any subsequent uninsured months.[3]

Finally, many people enter or exhaust grace periods for insubstantial premium deficiencies that even the issuers themselves believe shouldn't warrant termination. In fact, insurers supported a provision in the 2017 Notice of Benefit and Payment Parameters, which updates marketplace rules annually, to allow the continuation of coverage without requiring people to enter a grace period in the case of insignificant premium shortfalls.[4] The recommended threshold is 95 percent, meaning that a person who pays 95 percent of his or her share of the premium won't trigger the start of a grace period, and if the person is in a grace period, this minor deficiency at the end of three months would not cause coverage to terminate. Thus, if an insurer has a 95 percent premium payment threshold, for example, and an enrollee pays $97 of a $100 monthly premium, the enrollee falls within the threshold. The enrollee still owes $3, and future premium payments will cover that deficiency first, but for this month, a grace period is not triggered.

Reasons for Premium Nonpayment

Enrollees may stop paying their share of the premiums for many reasons. Many simply forget. Enrollees can also fail to pay their portion of their premiums if they experience errors with their bank or billing issues with their insurer, or they make a mistake such as transposing numbers on a check.

In some cases people intentionally stop paying their premiums because their eligibility changes and they don't understand the need to terminate their old plan or can't figure out how to do it. One-quarter of low-income adults had at least one health insurance enrollment change in 2015, a recent study showed.[5] Confusion is inevitable because when and how to end a plan vary across Medicaid, marketplace plans, employer-sponsored plans, and other forms of coverage. For example, a person who starts the year in marketplace coverage but then becomes eligible for and enrolls in Medicaid or the Children's Health Insurance Program (CHIP) may believe that because the marketplace made both eligibility determinations, it would automatically terminate the original plan. This is not the case, however, despite the fact that marketplaces are single points of entry for multiple coverage programs.

Other families miss premium payments because they are unable to pay in a particular month. More than 80 percent of enrollees in the most recent open enrollment period had income below 250 percent of the federal poverty line ($29,425 for an individual and $50,225 for a family of three).[6] These families are often at risk of financial hardship from one missed paycheck or an unanticipated expense. A recent survey of enrollees found that 67 percent of people in the individual insurance market reported that they could not meet basic expenses, barely met basic expenses, or met basic

[3] No premium tax credit is available for any month in which the full premium was not paid. 26 CFR 1.36B-3(c).

[4] 45 CFR 155.400(g)

[5] Benjamin D. Sommers, *et al.*, "Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower than Expected but Still harmful for Many," *Health Affairs*, October 2016, pp. 1816-1824, http://content.healthaffairs.org/content/35/10/1816.

[6] "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," p. 29.

expenses with little left over.[7] One-third reported that they had difficulty paying for food, housing, or utilities. The grace period gives families experiencing temporary financial difficulties an opportunity to catch up on their missed premium payments and stay covered.

No Evidence That Consumers Abuse Grace Periods

There are no national data quantifying how many people enter a premium payment grace period or how many grace periods end in termination, but data from Washington State illustrate how critical the grace period is in helping people maintain coverage — and how a statutory or regulatory change restricting grace periods could affect many marketplace enrollees.

In Washington, more than half of subsidized enrollees in 2014 and 2015 entered a grace period at some point.[8] Of those who entered a grace period in 2015, 62 percent paid at least one premium after falling into the grace period.[9] On average, enrollees made a payment within 20 days of entering the grace period. This is consistent with payment delays due to forgetfulness or a temporary cash flow issue, not abuse of the grace period. Only 14 percent of those who landed in a grace period were eventually terminated for nonpayment.

The available data do not substantiate the contention that people are abusing grace periods. One consumer survey showed that 21 percent of respondents reported stopping premium payments in 2015, and that many of them reenrolled in coverage through the marketplace the following year.[10] The survey doesn't differentiate, however, between people who entered a grace period for nonpayment and those who voluntarily terminated their plans; nor does it show that payment stoppage was inappropriate. For instance, 36 percent of payment stoppers did so because they gained other coverage; another quarter of respondents reported they had trouble affording premiums. It's also not surprising that many people who stopped payments in one year returned to the marketplace in the next. People reenroll for insurance on an annual basis. A person whose change in income causes them to leave the marketplace for Medicaid in one year could easily return to the marketplace the next year based on a projection of higher income.

Enrollment data also refute the notion that large numbers of people drop coverage late in the year to take advantage of three "free" months of care in the grace period, then immediately reenroll for the following year. Rather, Centers for Medicare and Medicaid Services (CMS) data show an initial drop in the first few months of enrollment as some people lose coverage due to unresolved data matching issues after the 90-day period for resolving those issues runs out. After that,

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[7] "Survey of Non-Group Health Insurance Enrollees, Wave 3," Kaiser Family Foundation, May 20, 2016, http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/.

[8] "Annual Grace Period Report: Subsidized Qualified Health Plan Enrollees, Report to the Legislature," Washington Health Benefit Exchange, December 1, 2015, http://www.wahbexchange.org/wp-content/uploads/2013/05/Annual-Grace-Period-Report-2015.pdf.

[9] The data for 2015 are as of September 25, 2015. The 62 percent number reflects people in the grace period who made premium payments before that date; others may have made payments after that date. In 2014, 76 percent of people in the grace period made at least one premium payment by November 18.

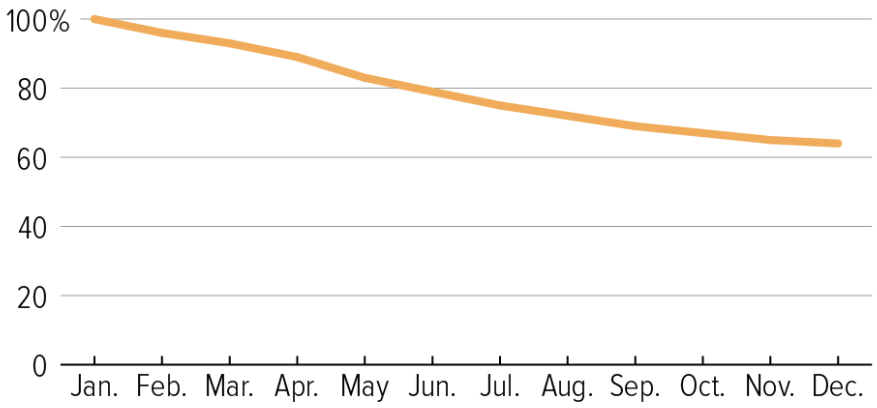
[10] "2016 OEP: Reflections on Enrollment," McKinsey & Company, May 2016, http://healthcare.mckinsey.com/sites/default/files/McK%202016%20OEP%20Consumer%20Survey%20Infographic_vF.pdf.

enrollment declines gradually throughout the year. (See Figure 1.) This pattern of falling enrollment makes sense as enrollees leave the market during the year for many reasons, including obtaining other coverage, while entry is restricted to people who qualify for special enrollment periods.

FIGURE 1

Enrollees Leave Marketplace Health Plans Gradually Throughout the Year

Monthly participation rate of those who enrolled in federal marketplace health insurance coverage during open enrollment, 2015



Note: Does not include new entrants after open enrollment, which occurred November 15, 2014-February 15, 2015.

Grace period = People who receive subsidies to help pay for coverage have a three-month window to catch up on overdue premiums before insurers can discontinue their coverage.

Source: CBPP analysis of Centers for Medicare and Medicaid services data, as presented as presented by Keri Apostle at: https://academyhealth.confex.com/academyhealth/2016arm/meetingapp.cgi/Session/4923

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There is little to be gained by gaming the grace period. The average single enrollee with coverage terminated for nonpayment would owe one month of APTC on his or her tax return and possibly an individual responsibility payment. Using marketplace average figures, a single person who fails to pay premiums for three months would owe $464 at tax filing ($290 in APTC plus $174 in penalties).[11] That's *more* than the $318 it would have cost to pay the premiums owed to maintain coverage for those months ($106 per person per month).

[11] During open enrollment for 2016 coverage, enrollees in states that use the federally facilitated marketplace had monthly premiums averaging $396 per person, with an average advance premium tax credit of $290 and an average net (i.e., out-of-pocket) premium of $106. "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," p. 15. The individual responsibility payment for 2016 is the *greater of* $695 per adult ($347.50 per child) or 2.5 percent of income above the filing threshold, with either amount prorated for the number of uninsured months. Because marketplace enrollees generally have lower income, most would pay a flat penalty of $695, or roughly $58 per month, per adult.

Grace Periods: A Case Study

Consider an illustrative case of how the grace period could work for an enrollee in marketplace coverage. Angela enrolled in the marketplace for coverage starting January 1, 2015, was determined eligible for an APTC of $360 per month, and was responsible for a monthly premium of $60 per month.[12] She paid her premium on time until she incurred a significant car repair in August and couldn't afford to pay September's premium by the August 31 due date.

Her insurer alerted her that she was in the three-month grace period and would lose coverage if she didn't pay her overdue premium by the end of the three months. In September, Angela paid $20 toward her premium — all she could afford at the time. She made no other payments. At the end of November, her coverage ended retroactive to September 30. She remained uninsured in December.

Enrollee Would Owe More for Non-Payment Than for 4th Quarter Premiums

$40	In-full September premium payment due to insurer	**$60** x 4	September through December premium
+$300	Advance premium tax credit for September repaid on tax return (subject to cap)	**-$20**	September partial premium payment
+$58 x 3	Individual responsibility payment for October, November, and December on tax return		
Total: $514		**Total: $220**	

The insurer received $3,740 of the $3,780 in premiums billed for nine months of coverage. This includes $360 per month of APTC for January through September (APTC from October and November was received but returned after the retroactive termination) and $60 per month from Angela's share of premiums for eight months and the partial premium of $20 for September. The insurer received no payment for October and November but also paid no claims for those months.

In January 2016, in preparation for tax filing, Angela received a Form 1095-A from the marketplace for use in preparing her tax return. It showed she had insurance coverage in January through August and that she received APTC in September. She owes an additional $300 on her tax return to repay September's APTC to the IRS, since she failed to pay the full premium for that month.[a] Because she didn't qualify for an exemption from the individual responsibility payment, she also owes $58 a month for October, November, and December. Angela owes $474 ($300 in APTC plus $174 for three months of the individual responsibility payment). Separately, she still owes $40 to the insurer for September's coverage, bringing her total amount owed to $514. It would have cost only $220 to pay her premium for the remainder of the year, and she would have had coverage for any medical care she received and wouldn't owe a penalty.

[a] Her APTC was $360, but repayment is capped at $300 for a single tax filer with income below 200 percent of the poverty line.

[12] This example uses the estimated premium tax credit and silver plan premium cost for a 55-year-old non-smoker in McLennan County, Texas, with income of $17,500 (150 percent of the federal poverty level). Data are from the Kaiser Family Foundation 2015 Health Insurance Marketplace Calculator. Numbers are rounded for clarity. See http://kff.org/interactive/subsidy-calculator-2015/.

Reducing the Grace Period Would Weaken the Marketplace

Hastily terminating coverage for late payment could end coverage for a large number of marketplace enrollees who simply forgot to pay on time. This would push them out of the insurance marketplace until the following year unless they had a life change qualifying them for a special enrollment period. To the extent that a bigger pool improves risk, this diminishing overall enrollment could negatively impact others' marketplace premiums.

If one missed premium payment leads to a loss of coverage, the marketplace risk pool as a whole may suffer from the departure of healthy people and their inability to reenroll. While we don't have data on the characteristics of late-payers or the health status of people whose coverage is discontinued due to nonpayment, it stands to reason that sicker people will make the greatest efforts to maintain their coverage whereas healthier people may believe that they have less to lose by letting insurance lapse. If this is true, we would expect the people who exit the marketplace due to nonpayment to be healthier, on average. And because young adults — who also tend to be healthier — are 25 percent likelier to pay bills late than older adults,[13] those exiting enrollees may skew younger and healthier as well.

Conclusion

Shortening the premium grace period to only 30 days would leave well-intentioned consumers with too little time to catch up on premiums when other basic expenses cause them to fall behind and would lock people out of coverage for the rest of the year. That would add to the ranks of the uninsured and weaken the marketplace risk pool. The current three-month grace period strikes the right balance by giving people who fall behind on premiums extra time while limiting the financial liability for insurers, providers, and the federal government.

[13] Fiserv, *Sixth Annual Billing Household Survey*, 2013, p. 4, https://www.fiserv.com/resources/413-13-17891-COL_2.5_RP_SixthAnnualBHS-2013_HR_121013.pdf.

Estimates of Eligibility for ACA Coverage among the Uninsured in 2016

Oct 18, 2016 | **Rachel Garfield** (http://kff.org/person/rachel-garfield/), Anthony Damico, **Cynthia Cox** (http://kff.org/person/cynthia-cox/) (https://twitter.com/cynthiaccox), **Gary Claxton** (http://kff.org/person/gary-claxton/), and **Larry Levitt** (http://kff.org/person/larry-levitt/) (https://twitter.com/larry_levitt)

Data Note

The Affordable Care Act (ACA) extends health insurance coverage to people who lack access to an affordable coverage option. Under the ACA, as of 2014, Medicaid coverage is extended to poor and near poor adults in states that have opted to expand eligibility, and tax credits are available for low and middle-income people who purchase coverage through a health insurance Marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate has dropped to the lowest level ever recorded.[1] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-1) However, millions of others are still uninsured. Some remain ineligible for coverage, and others may be unaware of the availability of new coverage options or still find coverage unaffordable even with financial assistance.

This analysis updates national and state-by-state estimates of eligibility for ACA coverage options among those who remained uninsured. It is based on Kaiser Family Foundation estimates based on the 2016 Current Population Survey, combined with other data sources. We estimate coverage and eligibility as of 2016. An overview of the methodology underlying the analysis can be found in the Methods box at the end of the data note, and more detail is available in the Technical Appendices available here (http://kff.org/report-section/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016-appendix-a-household-construction).

Background: How Does the ACA Expand Health Coverage?

The ACA fills historical gaps in Medicaid eligibility by extending Medicaid to nearly all nonelderly adults with incomes at or below 138% of the federal poverty level (FPL) ($27,821 for a family of three in 2016).[2] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-2) With the June 2012 Supreme Court ruling, the Medicaid expansion essentially became optional for states, and as of July 2016, 31 states and DC had expanded Medicaid eligibility under the ACA. Under rules in place before the ACA, all states already extended public coverage to poor and low-income children, with a median income eligibility level of 255% of poverty in 2016.[3] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-3) The ACA also established Health Insurance Marketplaces

where individuals can purchase insurance and allows for federal tax credits for such coverage for people with incomes from 100% to 400% FPL ($20,090 to $80,360 for a family o three in 2015).[4] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the uninsured-in-2016/view/footnotes/#footnote-200524-4)[5] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-5) Tax credits are generally only available to people who are not eligible for other coverage.

Because the ACA envisioned low-income people receiving coverage through Medicaid, people with incomes below poverty are not eligible for Marketplace subsidies. Thus, in the 19 states not implementing the Medicaid expansion, some adults fall into a "coverage gap" of earning too much to qualify for Medicaid but not enough to qualify for premium tax credits. In addition, undocumented immigrants are ineligible for Medicaid coverage and barred from purchasing coverage through a Marketplace. In most cases, lawfully present immigrants are subject to a five-year waiting period before they may enroll in Medicaid, though they can purchase coverage through a Marketplace and may receive tax credits for such coverage.

How Many Uninsured Are Eligible for Assistance under the ACA?

We estimate that, as of 2016, approximately 27 million nonelderly people lacked health coverage in the U.S. Nationally, we estimate 43% of this population, or 11.7 million people, i eligible for financial assistance to gain coverage through either Medicaid or subsidized Marketplace coverage (Figure 1). Nearly a quarter are either adults eligible for Medicaid[6] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-6) (3.8 million, or 14%) or children eligible for Medicaid or the Children's Health Insurance Program (CHIP) (2.6 million, or 10%). Those who are Medicaid eligible include people who were previously eligible as well as those newly eligible under the ACA. One in five (5.3 million, or 19%) of the nonelderly uninsured is eligible for premium tax credits to purchase coverage through the Marketplace.[7] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-7), [8] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-8)

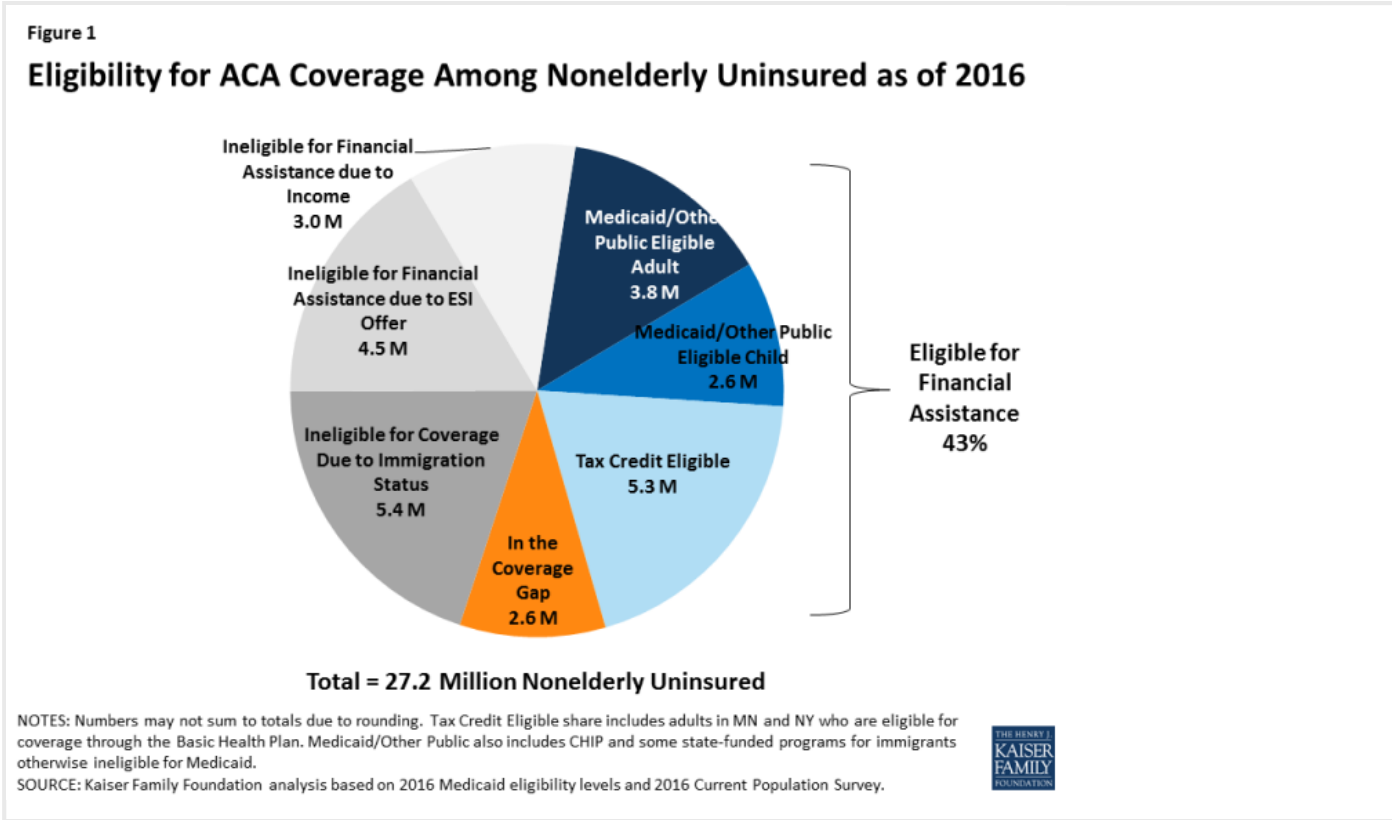


Figure 1: Eligibility for ACA Coverage Among Nonelderly Uninsured as of 2016

One in ten uninsured people (2.6 million) falls into the coverage gap due to their state's decision not to expand Medicaid, and 20% of the uninsured (5.4 million) are undocumented immigrants who are ineligible for ACA coverage under federal law.

The remainder of the uninsured either has an offer of ESI (4.5 million, or 16%) or has an income above the limit for premium tax credits but could purchase unsubsidized Marketplace coverage (3.0 million, or 11%). We cannot determine from available survey data if the offer of ESI would be considered unaffordable under the law, which would make the individual eligible for a Marketplace premium subsidy.

Patterns of eligibility vary by state, depending on state decisions about expanding Medicaid premiums in the exchange, and underlying demographic factors such as poverty rates and access to employer coverage. In states that expanded Medicaid, 35% of the nonelderly uninsured population is eligible for Medicaid, versus just 13% in states that have not expanded Medicaid (Figure 2). No one in Medicaid expansion states falls into a coverage gap; in non-expansion states, nearly one in five (19%) uninsured people falls into the coverage gap, a larger share than the share who are eligible for Medicaid under pathways in place before the ACA. Because adults with incomes from 100% to 138% of poverty in non expansion states can receive tax credits for Marketplace coverage, a larger share of the uninsured population in those states is eligible for Marketplace tax credits than in expansion states (23% versus 16%).

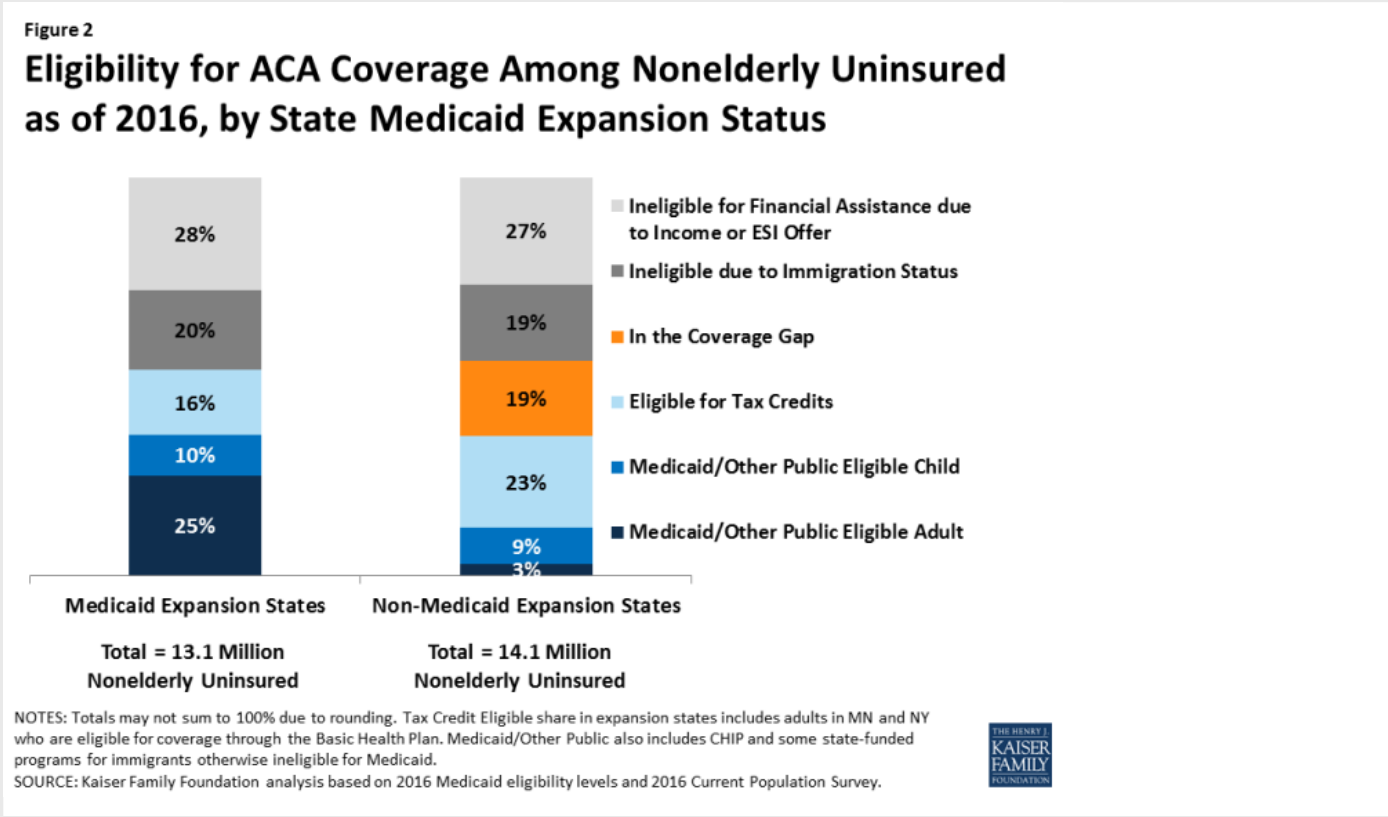
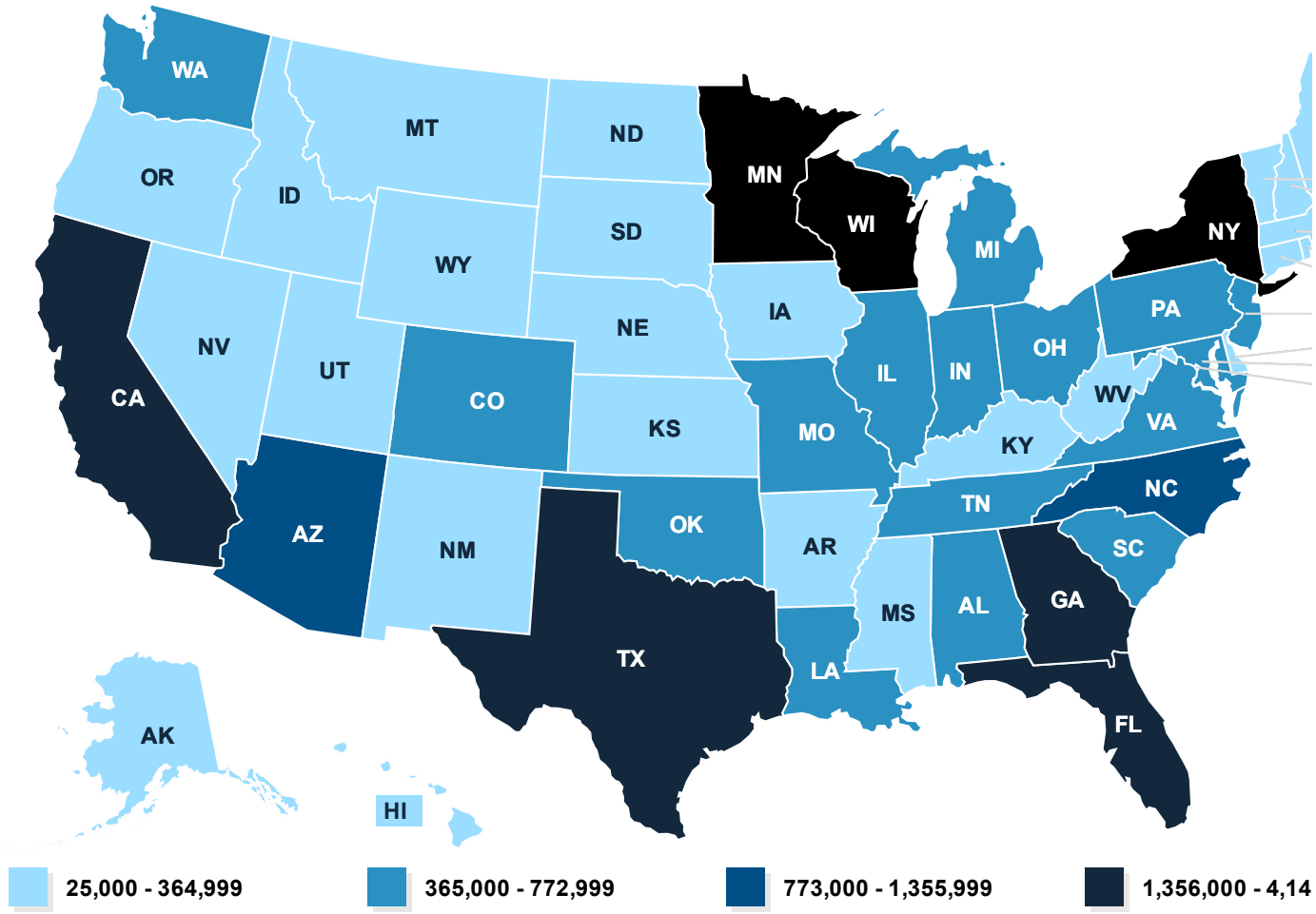


Figure 2: Eligibility for ACA Coverage Among Nonelderly Uninsured as of 2016, by State Medicaid Expansion Status

For state-by-state estimates, see the table below.

View Map By:

Total Number of Uninsured ▾



Number of Nonelderly People Eligible for ACA Coverage Among those Remaining Uninsured as of 2016

Location	Total Number of Uninsured	Share Who Are Medicaid Eligible	Share Who Are Tax Credit Eligible	Share Who Are Ineligible for Financial Assistance due to Income, ESI Offer, or Citizenship	Share Who Are In the Coverage Gap
United States	**27,178,000**	**24%**	**19%**	**47%**	**10%**
Alabama	498,000	11%	27%	37%	25%
Alaska	82,000	50%	13%	37%	-
Arizona	773,000	42%	14%	43%	-
Arkansas	249,000	41%	19%	40%	-
California	2,764,000	31%	15%	54%	-
Colorado	436,000	29%	20%	51%	-
Connecticut	200,000	26%	16%	58%	-
Delaware	62,000	27%	17%	56%	-
District of Columbia	25,000	59%	N/A	39%	-
Florida	2,409,000	10%	26%	45%	19%
Georgia	1,356,000	14%	17%	46%	23%
Hawaii	64,000	37%	N/A	51%	-
Idaho	178,000	7%	26%	49%	19%
Illinois	741,000	28%	16%	56%	-
Indiana	561,000	44%	18%	38%	-
Iowa	157,000	44%	17%	39%	-
Kansas	271,000	N/A	29%	41%	21%
Kentucky	246,000	45%	N/A	44%	-
Louisiana	464,000	49%	18%	33%	-
Maine	59,000	N/A	42%	32%	N/A
Maryland	365,000	28%	12%	61%	-
Massachusetts	271,000	22%	N/A	68%	-
Michigan	519,000	28%	25%	46%	-
Minnesota^	304,000	40%	20%	39%	-
Mississippi	359,000	15%	25%	31%	29%
Missouri	508,000	13%	29%	39%	19%
Montana	94,000	37%	28%	35%	-
Nebraska	151,000	16%	25%	47%	13%
Nevada	295,000	31%	14%	55%	-

New Hampshire	61,000	27%	20%	54%	-
New Jersey	660,000	27%	13%	60%	-
New Mexico	228,000	43%	13%	44%	-
New York^	1,183,000	36%	18%	46%	-
North Carolina	1,049,000	12%	29%	38%	21%
North Dakota	57,000	34%	25%	41%	-
Ohio	628,000	47%	15%	37%	-
Oklahoma	491,000	13%	25%	45%	17%
Oregon	261,000	29%	16%	54%	-
Pennsylvania	660,000	45%	11%	44%	-
Rhode Island	47,000	N/A	24%	58%	-
South Carolina	491,000	8%	26%	38%	28%
South Dakota	71,000	22%	27%	32%	19%
Tennessee	676,000	15%	26%	46%	14%
Texas	4,146,000	11%	17%	56%	17%
Utah	287,000	17%	25%	46%	11%
Vermont	29,000	37%	28%	35%	-
Virginia	725,000	16%	25%	41%	19%
Washington	460,000	36%	14%	49%	-
West Virginia	104,000	43%	27%	30%	-
Wisconsin†	353,000	35%	23%	42%	-
Wyoming	50,000	14%	29%	41%	16%

NOTES: Numbers may not sum to totals due to rounding. Medicaid/Other Public also includes CHIP and some state-funded programs for immigrants otherwise ineligible for Medicaid. Tax credit-eligible population in Minnesota and New York include uninsured adults who are eligible for coverage through the Basic Health Plan. Wisconsin covers adults up to 100% FPL in Medicaid under a waiver but did not adopt the ACA expansion. Cells marked "N/A" indicate that point estimates do not meet minimum standards for statistical reliability.
SOURCE: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.

Distribution of Nonelderly Eligibility for ACA Coverage Among those Remaining Uninsured as of 2016

Location	Total Number of Uninsured	Number Who Are Medicaid Eligible	Number Who Are Tax Credit Eligible	Number Who Are Ineligible for Financial Assistance due to Income, ESI Offer, or Citizenship	Number Who Are In the Coverage Gap
United States	**27,178,000**	**6,405,000**	**5,271,000**	**12,876,000**	**2,625,000**
Alabama	498,000	55,000	135,000	182,000	126,000
Alaska	82,000	41,000	11,000	30,000	-
Arizona	773,000	328,000	110,000	335,000	-
Arkansas	249,000	102,000	47,000	99,000	-
California	2,764,000	868,000	402,000	1,494,000	-
Colorado	436,000	128,000	88,000	221,000	-
Connecticut	200,000	52,000	N/A	116,000	-
Delaware	62,000	17,000	11,000	35,000	-
District of Columbia	25,000	15,000	N/A	10,000	-
Florida	2,409,000	246,000	614,000	1,082,000	467,000
Georgia	1,356,000	192,000	236,000	619,000	309,000
Hawaii	64,000	24,000	N/A	33,000	-
Idaho	178,000	13,000	46,000	86,000	33,000
Illinois	741,000	206,000	118,000	417,000	-
Indiana	561,000	245,000	100,000	215,000	-
Iowa	157,000	69,000	N/A	62,000	-
Kansas	271,000	N/A	79,000	112,000	56,000
Kentucky	246,000	111,000	N/A	109,000	-
Louisiana	464,000	229,000	82,000	153,000	-
Maine	59,000	N/A	25,000	19,000	N/A
Maryland	365,000	101,000	N/A	221,000	-
Massachusetts	271,000	60,000	N/A	185,000	-
Michigan	519,000	148,000	130,000	241,000	-
Minnesota	304,000	123,000	61,000	120,000	-
Mississippi	359,000	52,000	91,000	113,000	103,000
Missouri	508,000	68,000	146,000	198,000	96,000
Montana	94,000	35,000	27,000	32,000	-
Nebraska	151,000	24,000	37,000	71,000	19,000
Nevada	295,000	91,000	43,000	162,000	-

New Hampshire	61,000	16,000	N/A	33,000	-
New Jersey	660,000	177,000	84,000	399,000	-
New Mexico	228,000	98,000	31,000	100,000	-
New York	1,183,000	423,000	214,000	545,000	-
North Carolina	1,049,000	128,000	301,000	400,000	219,000
North Dakota	57,000	19,000	14,000	23,000	-
Ohio	628,000	297,000	97,000	233,000	-
Oklahoma	491,000	65,000	122,000	221,000	82,000
Oregon	261,000	76,000	42,000	142,000	-
Pennsylvania	660,000	299,000	72,000	289,000	-
Rhode Island	47,000	N/A	N/A	27,000	-
South Carolina	491,000	40,000	126,000	188,000	136,000
South Dakota	71,000	16,000	19,000	23,000	14,000
Tennessee	676,000	98,000	175,000	310,000	93,000
Texas	4,146,000	456,000	696,000	2,310,000	684,000
Utah	287,000	50,000	73,000	132,000	32,000
Vermont	29,000	11,000	8,000	10,000	-
Virginia	725,000	113,000	180,000	296,000	136,000
Washington	460,000	167,000	67,000	226,000	-
West Virginia	104,000	45,000	28,000	31,000	-
Wisconsin	353,000	124,000	82,000	147,000	-
Wyoming	50,000	7,000	14,000	20,000	8,000

NOTES: Numbers may not sum to totals due to rounding. Medicaid/Other Public also includes CHIP and some state-funded programs for immigrants otherwise ineligible for Medicaid. Tax credit-eligible population in Minnesota and New York include uninsured adults who are eligible for coverage through the Basic Health Plan. Wisconsin covers adults up to 100% FPL in Medicaid under a waiver but did not adopt the ACA expansion. Cells marked "N/A" indicate that point estimates do not meet minimum standards for statistical reliability.
SOURCE: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.

Discussion

Though millions of people have gained coverage under the ACA and the uninsured rate has dropped to the lowest level ever recorded, many remain uninsured.[9] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-

2016/view/footnotes/#footnote-200524-9) The ACA provides new coverage options across the income spectrum for low and moderate-income people, and more than four in ten of the uninsured population appear to be eligible for Medicaid or subsidized Marketplace coverage. For these individuals, outreach and education about coverage and financial assistance may be important to continuing coverage gains that were seen in the first two years of full ACA implementation. Data from other sources indicate that misperceptions about cost, lack of awareness of financial assistance, and confusion about eligibility rules were barriers to gaining coverage for some eligible uninsured.[10] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-10)[11] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-fo aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-11)[12] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-12) Others report that they found coverage to be too expensive, even with the availability of financial assistance.

Nearly a third of the remaining uninsured population is outside the reach of the ACA due to either their immigration status or their state's decision not to expand Medicaid. People in the coverage gap would be eligible for Medicaid should their state opt to expand Medicaid but are otherwise likely to remain uninsured, as they have limited incomes, are unlikely to have an affordable offer of coverage from an employer, and do not have access to affordable coverage options under the ACA. Many undocumented immigrants also will likely remain uninsured.[13] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-13) As more eligible people enroll in coverage over time, those ineligible for coverage will account for a larger share of the remaining uninsured.

Approximately a quarter of the uninsured population is not eligible for any assistance under the ACA because they have access to employer coverage that may be considered affordable or have incomes too high to qualify for Medicaid or Marketplace subsidies. Some of these people may face a financial penalty under the ACA's so-called "individual mandate (http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/)." It is possible that, upon facing these penalties when filing their 2016 tax returns, more people will opt to purchase coverage.

As the beginning of open enrollment for 2017 Marketplace coverage approaches, there are still substantial opportunities to increase coverage by reaching those who are eligible for help under the ACA, particularly among children and the low-income population, who are eligible for the greatest assistance. However, many of those who remain without coverage may be difficult to reach and could still remain uninsured.

Rachel Garfield, Cynthia Cox, Gary Claxton, and Larry Levitt are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

Table 3: Number and Distribution of Nonelderly Uninsured Ineligible for Financial Assistance due to Income, Offers of Employer Coverage, or Citizenship Status as of 2016, in States with Sufficient Sample Size

State	Number of Nonelderly Uninsured Ineligible due to:				% of Nonelderly Uninsured Ineligible due to:			
	Total Ineligible Due to Income, ESI Offer, or Citizenship	Income	Employer Offer	Citizenship	Total Ineligible Due to Income, ESI Offer, or Citizenship	Income	Employer Offer	Citizenship
US Total	**12,876,000**	**3,003,000**	**4,462,000**	**5,411,000**	**47%**	**11%**	**16%**	**20%**
Alabama	182,000	65,000	94,000	23,000	37%	13%	19%	5%
Arizona	335,000	67,000	112,000	156,000	43%	9%	15%	20%
Arkansas	99,000	29,000	38,000	33,000	40%	12%	15%	13%
California	1,494,000	316,000	279,000	898,000	54%	11%	10%	32%
Colorado	221,000	68,000	68,000	85,000	51%	16%	16%	20%
Florida	1,082,000	255,000	353,000	473,000	45%	11%	15%	20%
Georgia	619,000	119,000	244,000	257,000	46%	9%	18%	19%
Idaho	86,000	14,000	43,000	30,000	49%	8%	24%	17%
Illinois	417,000	105,000	127,000	184,000	56%	14%	17%	25%
Indiana	215,000	64,000	91,000	60,000	38%	11%	16%	11%
Louisiana	153,000	41,000	79,000	34,000	33%	9%	17%	7%
Massachusetts	185,000	58,000	90,000	36,000	68%	21%	33%	13%
Nevada	162,000	33,000	49,000	80,000	55%	11%	17%	27%
New Jersey	399,000	88,000	92,000	219,000	60%	13%	14%	33%
New Mexico	100,000	27,000	29,000	44,000	44%	12%	13%	19%
New York	545,000	128,000	201,000	216,000	46%	11%	17%	18%
North Carolina	400,000	63,000	157,000	180,000	38%	6%	15%	17%
Pennsylvania	289,000	108,000	128,000	54,000	44%	16%	19%	8%
South Carolina	188,000	64,000	86,000	38,000	38%	13%	18%	8%
Tennessee	310,000	87,000	114,000	109,000	46%	13%	17%	16%
Texas	2,310,000	418,000	699,000	1,192,000	56%	10%	17%	29%
Utah	132,000	37,000	51,000	45,000	46%	13%	18%	16%

NOTES: States not included above do not have sufficient sample size to show distribution of uninsured nonelderly ineligible for financial assistance in at least one of the three categories (income, ESI, and/or citizenship). Numbers may not sum to totals due to rounding.
SOURCE: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.

Methods

This analysis uses data from the 2016 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United Sates population and specific subpopulations. Importantly, the

CPS ASEC provides detailed data on families and households, which we use to determine income and household composition for ACA eligibility purposes.
Medicaid and Marketplaces have different rules about household composition and income for eligibility. For this analysis, we calculate household membership and income for both Medicaid and Marketplace premium tax credits for each person individually, using the rule for each program. For more detail on how we construct Medicaid and Marketplace households and count income, see the detailed technical Appendix A available here (http://kff.org/report-section/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016-appendix-a-household-construction).

Undocumented immigrants are ineligible for federally-funded Medicaid and Marketplace coverage. Since CPS data do not directly indicate whether an immigrant is lawfully present, we draw on the methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et. al.[14] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-14)[15] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-15) This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to CPS, controlling to state-level estimates of total undocumented population from Department of Homeland Security. For more detail on the immigration imputation used in this analysis, see the technical Appendix B available here (http://kff.org/report-section/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016-appendix-b-immigration-status-imputation).

Individuals in tax-filing units with access to an affordable offer of Employer-Sponsored Insurance are still potentially MAGI-eligible for Medicaid coverage, but they are ineligible for advance premium tax credits in the Health Insurance Exchanges. Since CPS data indicate whether a worker held an offer of ESI at the time of interview (for the 2016 CPS, February, March, or April 2016) but not during the prior year (which serves as our basis for type of insurance coverage), we developed a model that predicts offer of ESI for any individuals with a change in employment status across the period. For more detail on the offer imputation used in this analysis, see the technical Appendix C available here (http://kff.org/report-section/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016-appendix-c-imputation-of-offer-of-employer-sponsored-insurance).

The CPS asks respondents about coverage at the time of the interview as well as throughout the preceding calendar year. People who report any type of coverage throughout the preceding calendar year are counted as “insured.” Thus, the calendar year measure of the uninsured population captures people who lacked coverage for the entirety of 2015 (and thus were uninsured at the start of 2016). We use this measure of insurance coverage in 2015, rather than the measure of coverage at the time of interview, because the latter lacks detail about coverage type that is used in our model. Based on other survey data, as well as administrative data on ACA enrollment, it is likely that a small number of people included in that population gained coverage in 2016; therefore, we controlled our uninsured

estimates to CDC early release statistics from the National Health Interview Survey for 2016 For more detail on how we calibrated our uninsured counts, see detailed technical Appendix D available here (http://kff.org/report-section/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016-appendix-d-uninsured-calibration).

As of January 2014, Medicaid financial eligibility for most nonelderly adults is based on modified adjusted gross income (MAGI). To determine whether each individual is eligible for Medicaid, we use each state's reported eligibility levels as of January 1, 2016, updated to reflect state Medicaid expansion decisions as of September 2016 and 2016 Federal Poverty Levels.[16] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-16) Some nonelderly adults with incomes above MAGI levels may be eligible for Medicaid through other pathways; however, we only assess eligibility through the MAGI pathway.[17] (http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/#footnote-200524-17)

An individual's income is likely to fluctuate throughout the year, impacting his or her eligibility for Medicaid. Our estimates are based on annual income and thus represent a snapshot of the number of people in the coverage gap at a given point in time. Over the course of the year, a larger number of people are likely to move and out of the coverage gap as their income fluctuates.

Appendix A: Household Construction (http://kff.org/report-section/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016-appendix-a-household-construction/) ›

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Why Do Millions of U.S. Adults Remain Uninsured?

Tags: Affordable Care Act (/publications/features-and-lists#f:tagsfacet=[Affordable Care Act])

October 21, 2016

Since the health care reform law went into effect, the share of the U.S. population under age 65 without health insurance has fallen to an historic low of 11.9 percent. Yet about 24 million people still lack coverage. The U.S. Department of Health and Human Services is currently reaching out to the millions of uninsured who are eligible for subsidies as it prepares for the next marketplace open enrollment period, which begins on Nov. 1, 2016. The Commonwealth Fund's Affordable Care Act (ACA) Tracking Survey (http://acatracking.commonwealthfund.org/) looked at the reasons why so many Americans still lack health insurance.

1 The ACA excludes undocumented immigrants.

People who are not legal U.S. residents are barred from Medicaid or marketplace coverage.

2 Nineteen states have not expanded Medicaid eligibility.

A 2012 Supreme Court decision made the ACA's Medicaid expansion for people with incomes up to about $16,000 optional for the states. Nineteen states have chosen not to expand eligibility, although several of these are considering doing so.

3 Many people still don’t know about the health insurance marketplaces.

Of those still uninsured, only 52 percent are aware they can shop for plans on the health insurance marketplaces.

4 Affordability is a concern.

Nearly two-thirds of uninsured adults who are aware of the marketplaces said they had not shopped for a health plan because they didn’t think they would be able to afford the coverage.

5 Selecting a plan can be difficult.

Fewer than half of people who have not enrolled said it was easy to compare plans based on covered benefits covered, out-of-pocket costs, and provider networks.

6 Many aren’t getting the help they need.

People who enrolled were much more likely to have received assistance—through a telephone hotline, insurance broker, or health care navigator—than those who did not enroll.

2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces

Oct 24, 2016 | Cynthia Cox (http://kff.org/person/cynthia-cox/) (https://twitter.com/cynthiaccox), **Michelle Long (http://kff.org/person/michelle-long/)**, **Ashley Semanskee (http://kff.org/person/ashley-semanskee/)**, **Rabah Kamal (http://kff.org/person/rabah-kamal/)**, **Gary Claxton (http://kff.org/person/gary-claxton/)**, and **Larry Levitt (http://kff.org/person/larry-levitt/)** (https://twitter.com/larry_levitt)
Updated: Nov 01, 2016

Health insurance premiums on the Affordable Care Act's marketplaces (also called exchanges) are expected to increase faster in 2017 than in previous years due to a combination of factors, including substantial losses experienced by many insurers in this market and the phasing out of the ACA's reinsurance program. We analyzed 2017 premiums and insurer participation made available through Healthcare.gov on October 24, 2017, as well as data collected from states that run their own exchange websites.

Changes in the Second-Lowest Silver Premium

The second-lowest silver plan is one of the most popular plan choices on the marketplace and is also the benchmark that is used to determine the amount of financial assistance individuals and families receive. The table below shows these premiums for a major city in each state with available data. (We have been reporting premiums in these cities since the launch of the ACA's exchanges in 2014 (http://kff.org/health-reform/issue-brief/an-early-look-at-premiums-and-insurer-participation-in-health-insurance-marketplaces-2014/); similar analyses for 2015 (http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/) and 2016 (http://kff.org/health-reform/fact-sheet/analysis-of-2016-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/) are also available.)

Across these major cities in 2016, the second-lowest silver premium for a 40-year-old non-smoker ranged from $186 per month in Albuquerque, NM to $719 in Anchorage, AK, before accounting for the tax credit that most enrollees in this market receive. In 2017, the second-lowest silver premium for a 40-year-old non-smoker living in these cities will range from $229 in Louisville, KY and Cleveland, OH to $904 in Anchorage, AK, before accounting for the tax credit.

Of these major cities, the places with the largest increases in the unsubsidized second-lowest silver plan were Phoenix, AZ (up 145% from $207 to $507 per month for a 40-year-old non-smoker), Birmingham, AL (up 71% from $288 to $492) and Oklahoma City, OK (up 67% from $295 to $493). Meanwhile, unsubsidized premiums for the second-lowest silver premiums will decrease in Indianapolis, IN (down -4% from $298 to $286 for a 40-year-old

non-smoker), Cleveland, OH (down -2% from $234 to $229), Boston, MA (down -1% from $250 to $247), and Providence, RI (down -1% from $263 to $261) and increase just 1% in Little Rock, AR (from $310 to $314).

Most enrollees in the marketplaces receive a tax credit to lower their premium. In most parts of the country in 2016, a 40-year-old adult making $30,000 per year would pay about $208 per month for the second-lowest-silver plan. If this person is willing to switch to whatever the new second lowest-cost silver plan is in 2017, they will pay a similar amount (the after-tax credit payment for a similar person in 2017 is $207 per month or a change of 0%). In some parts of the country (for example, in Albuquerque, NM), premiums for a 40-year-old are so low in 2016 that an enrollee making $30,000 may not have qualified for a subsidy. In these places, an increase in the benchmark silver premium may make them newly-eligible for financial assistance.

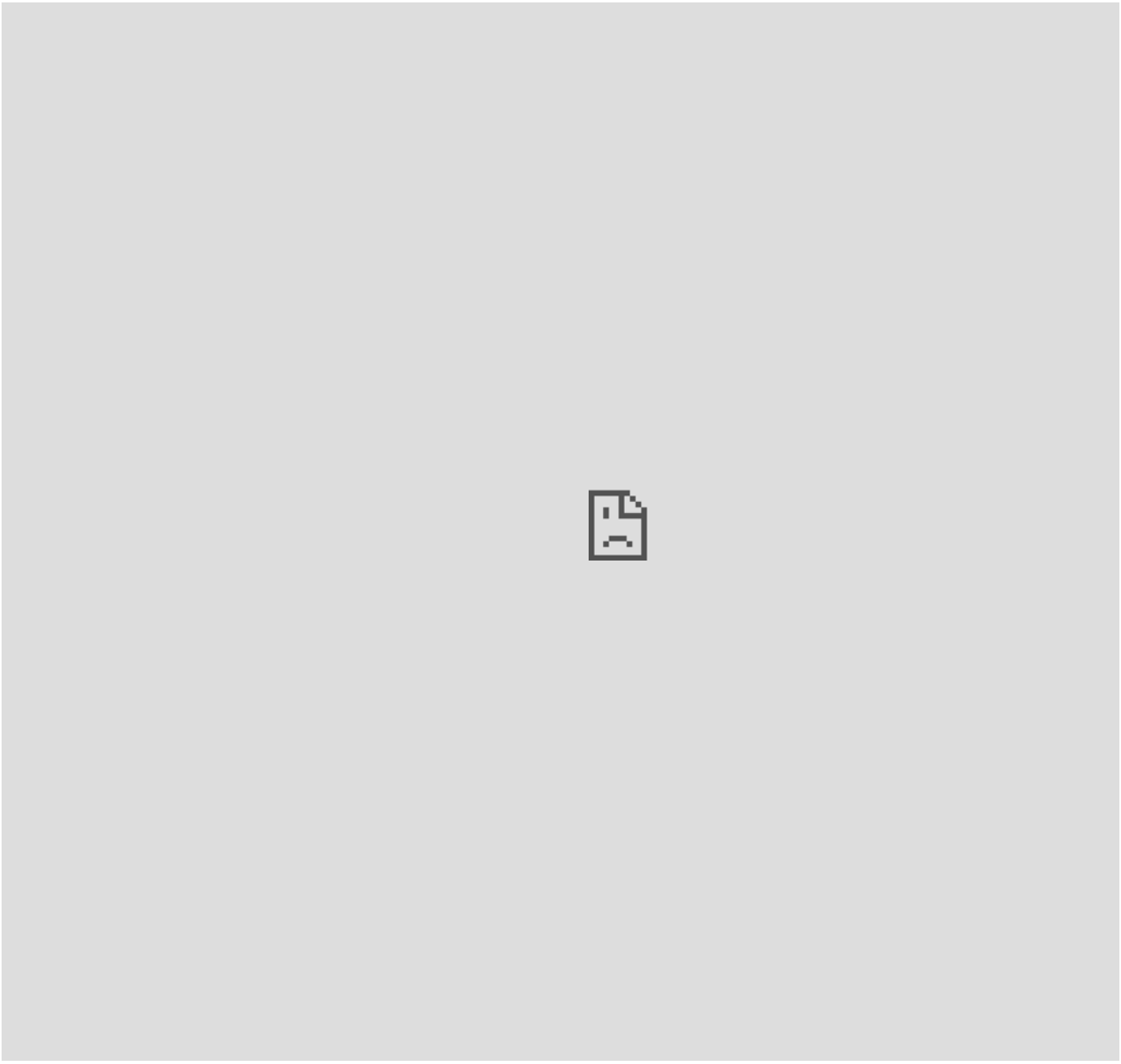
Table 1: Monthly Silver Premiums and Financial Assistance for a 40 Year Old Non-Smoker Making $30,000 / Year										
State	Major City	2nd Lowest Cost Silver Before Tax Credit			2nd Lowest Cost Silver After Tax Credit			Amount of Premium Tax Credit		
		2016	2017	% Change from 2016	2016	2017	% Change from 2016	2016	2017	% Change from 2016
Alabama	Birmingham	$288	$492	71%	$208	$207	0%	$80	$285	256%
Alaska	Anchorage	$719	$904	26%	$164	$163	-1%	$555	$741	33%
Arizona	Phoenix	$207	$507	145%	$207	$207	0%	$0	$300	N/A
Arkansas	Little Rock	$310	$314	1%	$208	$207	0%	$102	$107	4%
California	Los Angeles	$245	$258	5%	$208	$207	0%	$37	$51	38%
Colorado	Denver	$278	$313	12%	$208	$207	0%	$70	$106	51%
Connecticut	Hartford	$318	$404	27%	$208	$207	0%	$110	$196	79%
Delaware	Wilmington	$356	$423	19%	$208	$207	0%	$148	$216	46%
DC	Washington	$244	$298	22%	$208	$207	0%	$36	$91	153%
Florida	Miami	$262	$306	17%	$208	$207	0%	$54	$99	84%
Georgia	Atlanta	$254	$286	13%	$208	$207	0%	$46	$79	72%
Hawaii	Honolulu	$262	$347	32%	$179	$178	-1%	$83	$169	104%
Idaho	Boise	$273	$348	27%	$208	$207	0%	$65	$141	117%
Illinois	Chicago	$198	$291	48%	$198	$207	5%	$0	$84	N/A
Indiana	Indianapolis	$298	$286	-4%	$208	$207	0%	$90	$79	-12%
Iowa	Cedar Rapids	$284	$301	6%	$208	$207	0%	$76	$94	25%
Kansas	Wichita	$248	$361	46%	$208	$207	0%	$40	$154	287%
Kentucky	Louisville	$223	$229	3%	$208	$207	0%	$15	$22	47%
Louisiana	New Orleans	$332	$373	13%	$208	$207	0%	$124	$166	34%
Maine	Portland	$288	$341	19%	$208	$207	0%	$80	$134	68%
Maryland	Baltimore	$249	$309	24%	$208	$207	0%	$41	$102	152%
Massachusetts	Boston	$250	$247	-1%	$208	$207	0%	$42	$40	-5%
Michigan	Detroit	$226	$237	5%	$208	$207	0%	$18	$29	65%
Minnesota	Minneapolis	$235	$366	55%	$208	$207	0%	$27	$159	481%
Mississippi	Jackson	$283	$352	25%	$208	$207	0%	$75	$145	95%
Missouri	St Louis	$287	$310	8%	$208	$207	0%	$79	$103	31%
Montana	Billings	$322	$425	32%	$208	$207	0%	$114	$218	92%
Nebraska	Omaha	$313	$368	18%	$208	$207	0%	$105	$161	54%
Nevada	Las Vegas	$261	$282	8%	$208	$207	0%	$53	$75	41%
New Hampshire	Manchester	$261	$267	2%	$208	$207	0%	$53	$60	14%
New Jersey	Newark	$330	$353	7%	$208	$207	0%	$122	$146	19%
New Mexico	Albuquerque	$186	$258	39%	$186	$207	11%	$0	$51	N/A
New York	New York City	$369	$456	24%	$208	$207	0%	$161	$249	55%

North Carolina	Charlotte	$409	$572	40%	$208	$207	0%	$201	$364	82%
North Dakota	Fargo	$304	$331	9%	$208	$207	0%	$96	$124	29%
Ohio	Cleveland	$234	$229	-2%	$208	$207	0%	$26	$22	-17%
Oklahoma	Okla. City	$295	$493	67%	$208	$207	0%	$87	$286	230%
Oregon	Portland	$261	$312	20%	$208	$207	0%	$53	$105	98%
Pennsylvania	Philadelphia	$276	$418	51%	$208	$207	0%	$68	$211	209%
Rhode Island	Providence	$263	$261	-1%	$208	$207	0%	$55	$54	-2%
South Carolina	Columbia	$314	$404	29%	$208	$207	0%	$106	$197	85%
South Dakota	Sioux Falls	$309	$448	45%	$208	$207	0%	$101	$241	138%
Tennessee	Nashville	$281	$419	49%	$208	$207	0%	$73	$212	192%
Texas	Houston	$256	$288	13%	$208	$207	0%	$48	$81	69%
Utah	Salt Lake City	$244	$292	20%	$208	$207	0%	$36	$85	139%
Vermont	Burlington	$468	$492	5%	$208	$207	0%	$260	$285	9%
Virginia	Richmond	$276	$296	7%	$208	$207	0%	$68	$89	31%
Washington	Seattle	$227	$238	5%	$208	$207	0%	$19	$31	62%
West Virginia	Huntington	$341	$419	23%	$208	$207	0%	$132	$212	60%
Wisconsin	Milwaukee	$326	$379	16%	$208	$207	0%	$117	$172	46%
Wyoming	Cheyenne	$426	$464	9%	$208	$207	0%	$218	$257	18%

NOTES: In areas in which the two lowest-cost silver plans have the same premium, the next lowest-cost silver plan is used as the "second-lowest" silver plan. In some cases, a portion of the second lowest-cost silver plan is for non-essential health benefits so these values may differ from the benchmark used to determine subsidies.
SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators. For more information see "Early Look at 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces" Jul 2016.

Changes in Insurer Participation

As a result of losses in this market, some insurers like UnitedHealth and Aetna have announced their withdrawal (http://kff.org/health-reform/issue-brief/preliminary-data-on-insurer-exits-and-entrants-in-2017-affordable-care-act-marketplaces/) from the ACA marketplaces or the individua market in some states. In 2016, the number of insurers participating in each state (grouped by parent company) ranged from 1 in Wyoming to 16 in Texas. In states that use Healthcare.gov, the average number of insurers participating in the marketplace will be 3.9 in 2017 (down from 5.4 companies per state in 2016, 5.9 in 2015 and 4.5 in 2014). Marketplace insurer participation in states using Healthcare.gov in 2017 ranges from 1 company in Alabama, Alaska, Oklahoma, South Carolina, and Wyoming, to 15 companies in Wisconsin.



2016 Insurer Participation
2017 Insurer Participation
Net Change in Insurer Participation, 2016 - 2017

Table 2: Total Number of Insurers by State, 2014 – 2017				
	Total Number of Issuers in the Marketplace			
State	2014	2015	2016	2017
Alabama	2	3	3	1
Alaska	2	2	2	1
Arizona	8	11	8	2
Arkansas	3	4	4	3
California	11	10	12	NA
Colorado	10	10	8	NA
Connecticut	3	4	4	NA
Delaware	2	2	2	2
DC	3	3	2	NA
Florida	8	10	7	5
Georgia	5	9	8	5
Hawaii	2	2	2	2
Idaho	4	5	5	NA
Illinois	5	8	7	5
Indiana	4	8	7	4
Iowa	4	4	4	4
Kansas	3	3	3	3
Kentucky	3	5	7	3
Louisiana	4	5	4	3
Maine	2	3	3	3
Maryland	4	5	5	NA
Massachusetts	10	10	10	NA
Michigan	9	13	11	9
Minnesota	5	4	5	NA
Mississippi	2	3	3	2
Missouri	3	6	6	4
Montana	3	4	3	3
Nebraska	4	4	4	2
Nevada	4	5	3	3
New Hampshire	1	5	5	4
New Jersey	3	5	5	2
New Mexico	4	5	4	4
New York	16	16	15	NA
North Carolina	2	3	3	2
North Dakota	3	3	3	3

Ohio	11	15	15	11
Oklahoma	4	4	2	1
Oregon	11	10	10	6
Pennsylvania	7	9	7	6
Rhode Island	2	3	3	NA
South Carolina	3	4	3	1
South Dakota	3	3	2	2
Tennessee	4	5	4	3
Texas	11	14	16	10
Utah	6	6	4	3
Vermont	2	2	2	NA
Virginia	5	6	7	9
Washington	7	9	9	NA
West Virginia	1	1	2	2
Wisconsin	13	15	16	15
Wyoming	2	2	1	1
HealthCare.gov Average	4.5	5.9	5.4	3.9
US Average	5	6.1	5.7	NA

SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators. For more information see "Early Look at 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces" Jul 2016.
NOTES: Insurers are grouped by parent company or group affiliation, which we obtained from HHS Medical Loss Ratio public use files and supplemented with additional research. For 2017, the number of insurers in non-Healthcare.gov states is not yet available.

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UCLA CENTER FOR HEALTH POLICY RESEARCH

Health Policy Brief

October 2016

Community Health Centers Play a Critical Role in Caring for the Remaining Uninsured in the Affordable Care Act Era

Steven P. Wallace, Maria-Elena Young, Michael A. Rodríguez, Amy Bonilla, Nadereh Pourat

"There's a general perception that everybody has insurance now…{but} 17 percent of our patients are still uninsured and undocumented."

– New York CHC director

SUMMARY: Federally Qualified Health Centers[1]—commonly referred to as Community Health Centers (CHCs)—serve as a safety net for people who did not gain health insurance under the Affordable Care Act (ACA), including those immigrants not eligible for Medicaid or health insurance exchange coverage. ACA-driven changes in health insurance coverage, funding, and related policy have created new challenges for these safety net organizations.

This policy brief reports the findings from analyses of the U.S. HRSA Uniform Data System and interviews conducted in 2014-16 with the leadership of 31 CHCs. The CHCs were located in communities with high concentrations of immigrants and uninsured residents, in states that either expanded Medicaid (California and New York) or that chose not to expand it (Georgia and Texas). The study found that most CHCs now see more patients, including significant numbers without insurance. The ACA has brought new resources to CHCs but has also reinforced challenges, including the need for stable revenue streams, sufficient staffing support, and assistance in leveraging new reimbursement mechanisms. Policy recommendations to address these challenges include continuing core federal funding, insuring the remaining uninsured, addressing workforce challenges, and preparing CHCs for alternative payment mechanisms.

CHCs are primary care providers with a mission to serve low-income and underserved communities. Nationally, more than 6 million CHC patients (28 percent) were uninsured in 2014,[2] accounting for about one-third of all low-income uninsured persons nationally. Significant numbers of uninsured patients are served by CHCs in the four states examined in this analysis: California, New York, Georgia, and Texas. Of the two states that did not expand Medicaid (Georgia and Texas), almost half (46 percent) of those served by CHCs were uninsured (Exhibit 1). CHCs in the expansion states of New York and California also had significant numbers of uninsured patients (19 percent and 27 percent, respectively).

CHCs Have Served More Insured Patients Post-ACA

Prior to ACA, some predicted that newly insured persons would leave CHCs for private providers. Instead, the number of insured patients served has increased over time, both nationally and in this study's sample of CHCs in immigrant communities. Nationally, the number of insured patients using CHCs rose from 12 million in 2010 to 16.5 million in 2014, an increase of 35 percent.[3] In all four states studied, the total number of insured patients increased as well, with the greatest growth in California (from 1.67 million to 2.70 million, a 61 percent increase), followed by New York (1.05 to 1.44 million, 37 percent increase); Texas (440,000 to 630,000, 43

The COMMONWEALTH FUND

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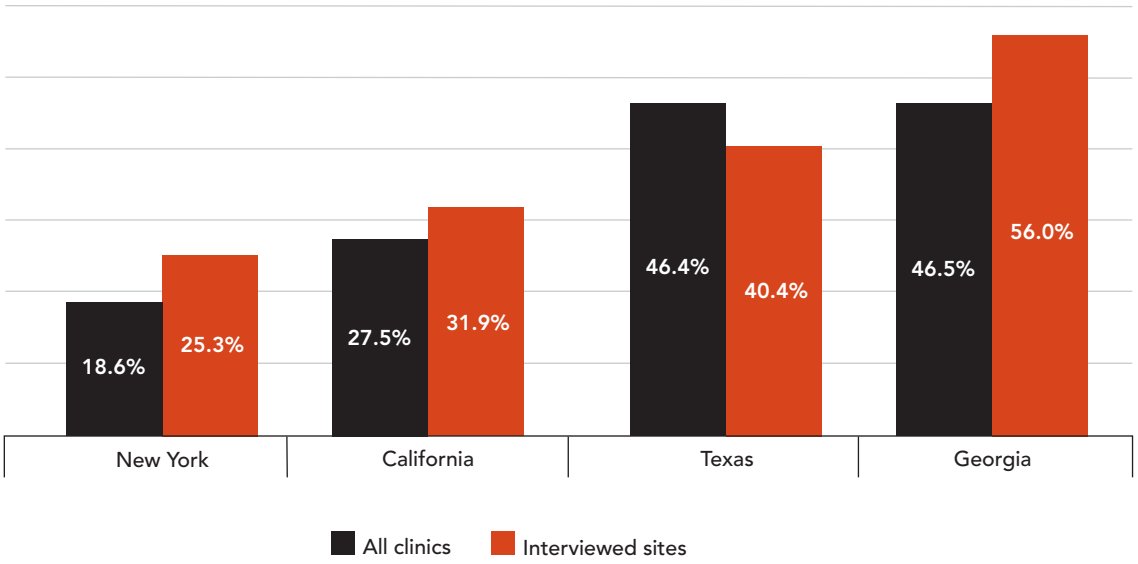
Exhibit 1

Mean Percent of Federally Qualified Health Center Patients Who Were Uninsured, New York, California, Texas, and Georgia, 2014



Source: U.S. HRSA, Uniform Data System[2]

"It's difficult to have these conversations with patients and try to tell them that they are too poor to benefit [from the ACA]."

– Georgia CHC director

percent increase); and Georgia (157,000 to 198,000, 26 percent increase) (Exhibit 2).

The data shown in Exhibit 2 suggest that the demand for safety net services remains high in both expansion and nonexpansion states. Most CHCs saw an increase in the number of insured patients, both because they retained previous patients who became insured and because they attracted new insured patients. Interview respondents shared examples in which newly insured, long-time patients chose to continue seeking care at their organizations because of long-standing relationships and rapport. One respondent reported that some newly insured patients had tried out different providers and had returned to the CHC because of the perceived better quality of care.

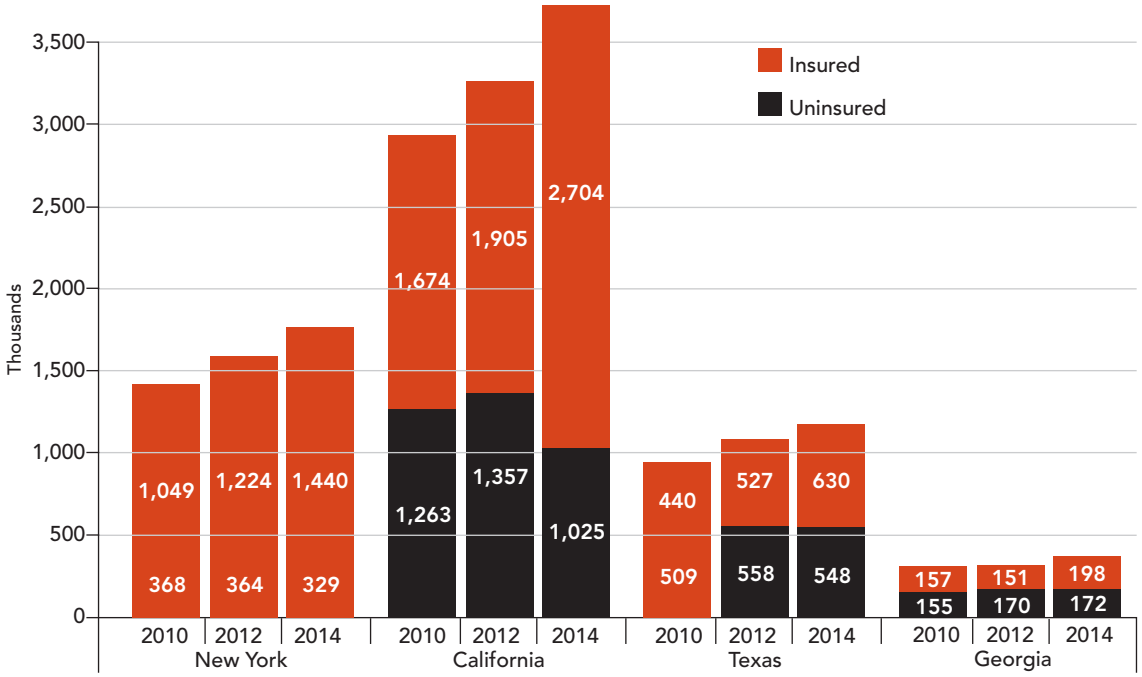
CHCs Continue to Serve Large Numbers of Patients Who Remain Uninsured

The numbers of uninsured CHC patients are substantial across all four states in our study. In the nonexpansion states of Georgia and Texas, the total number of uninsured CHC patients increased from 2010 to 2014, while New York experienced a modest decline. Only California showed a significant decline in the number of uninsured served by CHCs, but more than 1 million patients remained uninsured (Exhibit 2).

In Georgia and Texas, interview respondents pointed out that many of their current citizen or documented immigrant patients had incomes that were too high for them to qualify for Medicaid, but not high enough that they could qualify for federal marketplace subsidies because their states did not expand Medicaid.[4] Likewise, some of those newly insured through the exchanges had high-deductible policies, which meant that they continued to use the subsidized primary care services of CHCs.

Number of Insured and Uninsured Patients (in Thousands) Served at Federally Qualified Health Centers, New York, California, Texas, and Georgia, 2010, 2012, 2014

Exhibit 2



Source: U.S. HRSA, Uniform Data System[2]

CHCs Continue to Serve Many Uninsured Immigrants

Across all four states studied, CHCs reported that a common reason that patients were ineligible for insurance was their legal status. Over half of all immigrants nationally are not citizens and face barriers to coverage because of their legal status.[5] Respondents in all four study states served individuals who were undocumented. In addition, in Georgia and Texas, some documented immigrants —such as recently arrived Lawful Permanent Residents and immigrants with Deferred Action for Childhood Arrivals (DACA)—also remained ineligible for insurance. Using the proportion of patients "best served in a language other than English" as a rough proxy for all immigrant patients,[6] we found that immigrants were an increasingly larger share of patients served by CHCs. Between 2010 to 2014, the population of these patients grew from 4.7 million to 5.3 million persons nationally, a 12 percent increase. CHCs in our study states have estimated proportions of immigrants in their patient populations that are similar or higher to the proportions of immigrants in those states' low-income populations[7] (Exhibit 3).

Short-Term Boost in Federal Grants Provided CHCs with Needed Support

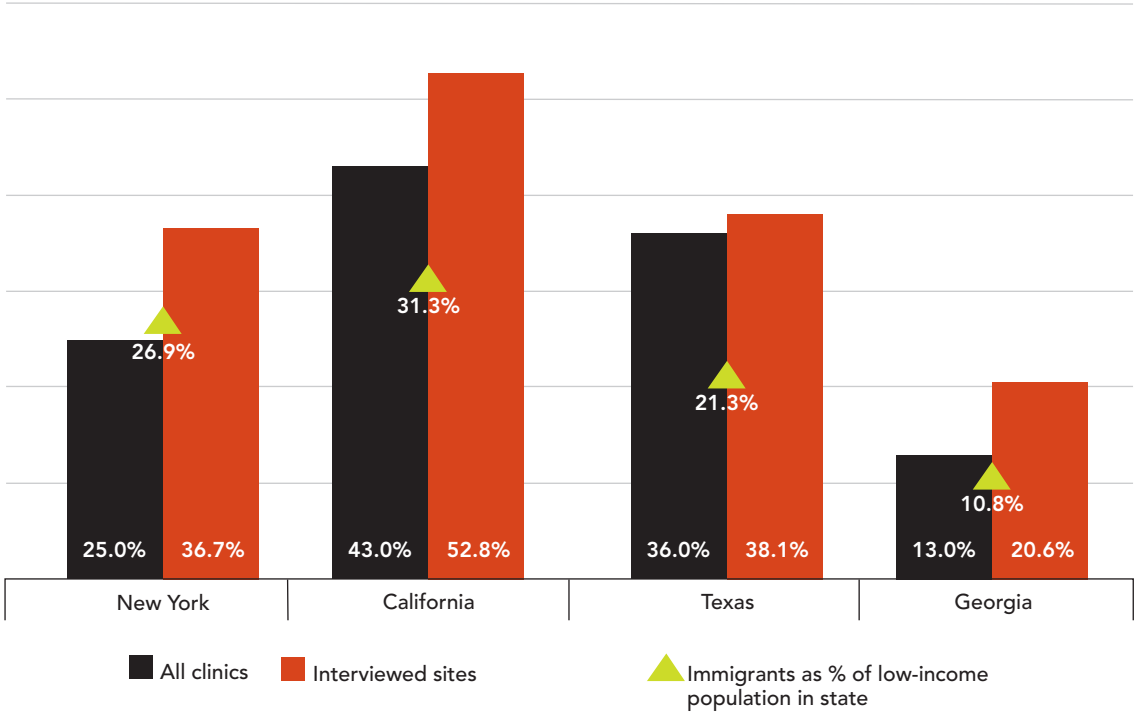
Both prior to the ACA and currently, the federal core grant[7] for FQHCs from HRSA has been a primary source of funding to offset the costs of care for uninsured patients who pay on a sliding fee scale. A few CHCs have also received additional federal funding—such as family planning and Ryan White funds—that helps pay for the uninsured.

"There was a tremendous amount of publicity and buzz around the rollout of the ACA.... So a combination of the information out there and the fact that there was a huge expansion allowed us to see more of the uninsured and the undocumented who were seeking services."

– California CHC director

Exhibit 3

Mean Percent of Federally Qualified Health Center Patients Best Served In a Language Other Than English, and Immigrants as a Percent of Low-Income Population, New York, California, Texas, and Georgia, 2014



Source: U.S. HRSA, Uniform Data System[2] and U.S. Census American Community Survey[5]

"{We} look at that balance of making sure that we're providing services for the population we serve in the right capacity and the right amount…but also making sure we're financially sustainable."

– Texas CHC director

However, one of the most significant impacts of the ACA for CHCs was the influx of new targeted federal grants. Across all four states, but especially in nonexpansion states, these grants provided a needed infusion of resources for conducting outreach and meeting the ongoing needs of patients.

CHCs reported that service and infrastructure expansion grants increased capacity for new clinical services, such as pharmacy, behavioral health, and dental health. At some CHCs, these grants provided the opportunity to establish or expand services that were likely to increase revenue, such as pediatrics or obstetrics and gynecology, since children and pregnant women were more likely to have coverage under Medicaid. Grants were also used to recruit nonclinical staff in charge of supporting and growing community outreach, patient education, and care coordination.

Despite new and ongoing sources of funding, CHCs face significant financial challenges. Few CHCs have contingency plans for the reduction in enhanced funding scheduled to occur in 2017, as there is no ready source of replacement funds nor any simple way to reduce expenditures without impairing the ability to serve existing patients. Further, it is unclear what the financial impact may be on CHCs if Medicaid changes from a cost-based reimbursement to a capitation or health outcome-based reimbursement. Respondents reported that their organizations are not prepared for a shift from current payment systems that are based largely on patient visits to value-based payment systems that focus more on patient outcomes.[8]

ACA Funding Enabled CHCs to Expand Outreach and Enroll Uninsured Patients in Health Insurance Programs

CHCs increased their numbers of insured patients through outreach and enrollment activities aimed at both their existing uninsured patients and new patients. Some CHCs reported that they previously had not dedicated significant resources to outreach and enrollment, but that they used ACA funding to participate in community events to enroll significant numbers of new and existing patients in health insurance, at the same time increasing their visibility in the community. Many CHCs reported that the passage of the ACA resulted in increased public awareness about available health insurance. Even in states that did not expand Medicaid, CHCs successfully enrolled many children and adults who were previously eligible for Medicaid or CHIP (Children's Health Insurance Program) but were not enrolled.

CHCs Continue to Face Infrastructure and Financial Capacity Limits

Many CHCs reported that limitations in infrastructure, including clinical space and equipment, posed an obstacle to expanding services. Some of the smaller CHCs reported that the limited availability of capital funding grants and the competition for them created a barrier to expanding physical capacity. A significant challenge for CHCs was that expansion of services required new funding, but generating new funding often required increased revenue-generating services. And growth had its own costs, such as the need for increased administrative capacity to enroll more patients in insurance and to implement organizational policies (e.g., the use of electronic health records for monitoring quality and outcome indicators). Each CHC pursued financial strategies tailored to its organizational needs. These included engaging in strategic planning, developing systems for long-term planning, conducting financial modeling using the CHC's own data, growing financial reserves, and improving billing and reimbursement processes.

CHCs Must Carefully Balance Their Payer Mix and Services

While HRSA core grants are essential to CHCs, most seek Medicaid, Medicare, and private insurance patients, as well as and public and private grants. Many CHCs mentioned that adult primary care receives the least amount of federal funding and is also the most difficult service area in which to obtain additional foundation grants. To maximize the number of uninsured patients they can afford to serve, many CHCs share resources among those clinic sites that have more insured patients and services and those that have higher levels of uncompensated care. Services that were revenue generators in some states were revenue losers in others; for example, Medicaid coverage for dental services is different in each state. As a result, the optimal balance of payer mix and services was specific to organizations as well as sites.

CHCs Faced Workforce Recruitment and Retention Challenges

CHCs across all four states reported that challenges to recruiting and retaining staff led to more financial and capacity challenges. One of the most common difficulties was the ability to provide competitive salaries for hiring and retaining clinical staff,[9] who were being recruited by private sector providers increasing staffing due to an influx of insured patients. Because of the low-income and often immigrant patient populations of CHCs, respondents noted that they had the additional challenge of identifying employees who were culturally competent and embraced the CHC's mission. Workforce shortages often prevented or delayed the expansion of services, even when there was adequate space and patient demand. Some sites reported using per diem providers to fill in gaps or sharing providers with a local hospital or another CHC.

> *"We provide care regardless of someone's ability to pay. The elimination of {enhanced federal funding} would impact {our}…being able to afford the appropriate and qualified staff to provide the quality of services that we want to provide, that we believe the community deserves."*
>
> – Georgia CHC director

"If you want to do it right, you have to have the proper staffing for it."

– California CHC director

CHCs faced challenges in hiring sufficient administrative staff for effective billing and reimbursement, documenting and tracking service quality and patient outcome indicators, and grant writing. New IT systems increased the data available but also created new specialized staffing needs. Several CHCs reported that responding to grant opportunities required staff to collect data and prepare reports on top of their daily workload. Increased patient loads also required administrative staff to take on more intake duties, care coordination, and case management. On the other hand, ACA funds for marketplace navigators and outreach staff relieved some financial pressure on many organizations. In some cases, it freed up discretionary funds that had been used for outreach and enrollment to be used for other high-priority services.

Policy Implications and Solutions

CHCs continue to be key providers of primary care to the remaining uninsured in the ACA era. Fostering a robust CHC delivery system requires continued public policy effort, including the following:

Maintain and enhance CHC core funding. The ACA temporarily provided enhanced funding for CHCs to help them expand services, under the assumption that having more insured patients would make a long-term boost unnecessary. The enhanced funding, which accounts for 70 percent of direct federal funding to CHCs,[7] is set to end after Fiscal Year 2017. But the large numbers of uninsured patients still served by CHCs makes a permanent boost in the federal core grant necessary to avoid cuts to services available to the remaining uninsured.

Expand Medicaid in all states. The expansion of Medicaid is critical to the financial stability of CHCs. More insured patients translate into more stable revenue streams, allowing CHCs to provide and expand needed services rather than devoting resources to fundraising. Respondents in nonexpansion states reported that any Medicaid expansion, whether through a waiver or state plan amendment, is the most important policy change needed by their organizations.

Extend insurance coverage for currently ineligible immigrants. Even in expansion states, coverage should be extended to those who are currently ineligible due to their legal status. State and local policies to expand coverage are needed, such as for undocumented children (e.g., New York State's Child Health Plus and California's Health4AllKids) or for the remaining uninsured who are not eligible for other coverage (such as Healthy San Francisco, My Health L.A., and the new ActionHealthNYC).[10]

Increase workforce availability. Challenges in recruiting and retaining clinicians and the lack of reimbursement of many nonclinical services limit the service capacity of CHCs. Respondents reported that changes in the scope of practice laws could significantly increase their capacity. In Georgia, respondents noted that current law made it difficult for small CHC sites to provide full services when a supervising physician is temporarily not available, even though a nurse practitioner (NP) could provide needed care.[11] In addition, reimbursement for services such as care coordination and language interpretation will increase CHC revenues and service capacity. Finally, covering volunteer providers under the Federal Tort Claims Act (FTCA) for malpractice coverage will make it easier for CHCs to expand capacity.[12]

Prepare CHCs to move away from traditional volume-based reimbursement. Most CHCs are not adequately prepared for a value-based reimbursement system and fear being penalized for serving a sicker and more disadvantaged patient mix. However, most payers are moving toward alternative payment models that require accountability for patient outcomes. Some CHCs are preparing for these changes by using patient data to monitor increasing numbers of health outcomes, improving care coordination, creating team-based models of care, partnering with private providers, and establishing formal collaborative agreements among themselves. CHCs require further time, resources, and new expertise to successfully transition to new payment models.[8]

Methodology

We collected in-depth information from 31 CHCs representing four states, focusing on two regions within each state. The states were two Medicaid expansion states with the largest immigrant populations (CA and NY) and two nonexpansion states, one with the largest number of immigrants (TX) and one with a large number of immigrants and a policy climate hostile to both the ACA and undocumented immigrants (GA). For each state we selected the largest city and one other region with significant concentrations of noncitizen residents. Finally, we selected CHCs within each region that served a patient population of whom at least 10 percent were best served in a language other than English. The final sample included CHCs in the following locations: Los Angeles (n=6) and Fresno (n=3), California; New York City (n=5) and the Hudson Valley region (n=3), New York; Atlanta (n=4) and South and East (n=4), Georgia; and Houston (n=5) and South Texas (n=1). Community Health Center data were drawn from U.S. HRSA Uniform Data System 2010, 2012, and 2014 and the American Community Survey 2014. For additional details about the methodology, please see *http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/Methods_FQHCPB_10-26-16.pdf*.

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Endnotes

1 Our analysis is limited to CHCs regulated by the U.S. Health Resources and Services Administration (HRSA), which includes the vast majority but not all FQHCs.

2 Data from 2015 show the number of uninsured CHC patients remaining relatively constant at 5.9 million, or one-third of all low-income uninsured persons in the U.S., but the proportion of all CHC patients uninsured declined to 24.4% as a result of more insured patients at CHCs. (2015 Health Center Data, HRSA: *http://bphc.hrsa.gov/uds/datacenter.aspx*)

3 In 2015, the numbers continued to increase, rising to 18.4 million insured nationally. The number of insured CHC patients in California was 3.15 million; New York, 1.59 million; Texas, 706,000; and Georgia, 233,000. See reference 2.

4 For example, in Texas, adults with dependent children must have incomes below 15% of the Federal Poverty Level (FPL) to qualify for Medicaid, and adults without dependents are not eligible at all. See *https://www.medicaid.gov/medicaid-chip-program-information/by-state/texas.html*. Federal subsidies on the exchange are available only to those with incomes of 100-400% of the FPL, leaving an estimated 684,000 uninsured Texans in the "gap" between Medicaid eligibility levels and eligibility levels for subsidized private coverage in the exchange. See *http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/*.

> *"...{With} the ups and downs of whether you're going to get more funding here or there—it's been hard to plan. Half of the volatility {comes} from our federal funding side, not our everyday patient population."*
>
> – Georgia CHC director

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5 See the Migration Policy Institute for demographic information on the immigrant and noncitizen population: *http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states*

6 See U.S. Census, *American Community Survey*. From IPUMS-USA, University of Minnesota, *https://usa.ipums.org/usa/cite.shtml*. About three-quarters of low-income noncitizens and half of naturalized immigrant citizen adults speak English less than "very well," making "best served in a language other than English" (the only clinic data available) a reasonable proxy but probably an underestimate of the immigrant population at clinics. Few who are U.S.-born are in this category.

7 See: Heisler EJ. 2015. Congressional Research Service. *The Community Health Center Fund: In Brief*. *http://digital.library.unt.edu/ark:/67531/metadc503374/m1/1/high_res_d/R43911_2015Feb12.pdf*. Some health centers also receive funding that targets uninsured special populations, such as the homeless and migrant workers. See *http://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/specialpopulations/index.html*

8 See: Rosenbaum S, Shin P, Sharac J. 2016. Community Health Centers and the Evolution of Medicaid Payment Reform. *To the Point* (Commonwealth Fund), and companion report: *http://www.commonwealthfund.org/publications/blog/2016/oct/community-health-centers-medicaid-payment-reform*.

9 Similar findings of staffing challenges are reported from a national survey of CHCs. See: National Association of Community Health Centers. 2016. *Staffing the Safety Net: Building the Primary Care Workforce at America's Health Centers*. *http://nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf*

10 For statewide coverage for children in New York, see *http://www.wnylc.com/health/entry/53/*. For a local example, see: Marrow HB. 2012. Deserving to a Point: Unauthorized Immigrants in San Francisco's Universal Access Health Care Model. *Soc Sci Med* 74(6):846-54. doi:10.1016/j.socscimed.2011.08.001; and *http://www.latimes.com/local/lanow/la-me-ln-remaining-uninsured-los-angeles-20141006-story.html*.

11 For more details, see: Stephens B. 2015. Perspectives on Advanced Practice Registered Nursing in Georgia. *Georgia Watch*. *http://www.georgiawatch.org/wp-content/uploads/2015/01/APRN01072015WEB.pdf*. For a more general discussion of this issue, see: Ku L, Frogner BK, Steinmetz E, Pittman P. 2015. Community Health Centers Employ Diverse Staffing Patterns, Which Can Provide Productivity Lessons for Medical Practices. *Health Aff* (Millwood). 34(1):95-103.

12 See Family Health Care Accessibility Act of 2015, S.2151, 114th Cong. (2015). *https://www.congress.gov/bill/114th-congress/senate-bill/2151*

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT

November 2016

The Uninsured: A Primer

KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED IN THE ERA OF HEALTH REFORM

Prepared by:

Rachel Garfield, Melissa Majerol, Anthony Damico, and Julia Foutz
Kaiser Family Foundation

Table of Contents

Executive Summary

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance, and the number of uninsured Americans grew over time, particularly during economic downturns. By 2013, the year before the major coverage provisions of the Affordable Care Act (ACA) went into effect, more than 43 million people lacked coverage.[1] Poor and low-income adults were particularly likely to lack coverage, and the main reason that most people said they lacked coverage was inability to afford the cost.[2]

Under the ACA, as of 2014, Medicaid coverage has been expanded to nearly all adults with incomes at or below 138% of poverty in states that have adopted the expansion, and tax credits are available for people with incomes up to 400% of poverty who purchase coverage through a health insurance marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate has dropped to a historic low. Coverage gains were particularly large among low-income people living in states that expanded Medicaid.

Still, millions of people—28 million nonelderly people as of the end of 2015— remain without coverage.[3] Groups with historically high uninsured rates continue to be at highest risk of being uninsured, including low-income individuals, adults, and people of color. Cost continues to pose a major barrier to coverage with nearly half (46%) of the uninsured in 2015 saying that the main reason they lacked coverage was because it was too expensive.[4]

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected. While the safety net of public hospitals, community clinics and health centers, and local providers provide a crucial health care safety net for uninsured people, it does not close the access gap for the uninsured.

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs, like housing, food, and transportation to work, and many uninsured adults report difficulty paying basic monthly expenses such as rent, food, and utilities.[5] When uninsured people use health care, they may be charged for the full cost of that care (versus insurers, who negotiate discounts) and often face difficulty paying medical bills and potential medical debt. Providers absorb some of the cost of care for the uninsured, and while uncompensated care funds cover some of those costs, these funds do not fully offset the cost of care for the uninsured.

Even with the ACA, the nation's system of health insurance continues to have many gaps that currently leave millions of people without coverage. Over half (57%) of the remaining uninsured are outside the reach of the ACA either because their state did not expand Medicaid, they are subject to immigrant eligibility restrictions, or their income makes them ineligible for financial assistance. The remainder are eligible for assistance under the law but may still struggle with affordability and knowledge of options and require targeted outreach to help them gain coverage. For both eligible and ineligible remaining uninsured people, health care needs persist regardless of insurance status, underscoring the importance of safety net providers and community health clinics to serve this population.[6]

Introduction

Despite record coverage gains under the 2010 Affordable Care Act (ACA), millions of people in the United States still lack health insurance. The ACA builds on the foundation of employer-based coverage and fills in historic gaps in insurance availability and affordability by expanding Medicaid for adults with incomes at or below 138% of the federal poverty level (about $16,394 per year for an individual in 2016)[7] and providing premium tax credits to make private insurance in the individual market more affordable for many with incomes between 100-400% of poverty (between $11,770 and $47,080 per year for an individual in 2015). Most of the ACA's major coverage provisions went into effect in 2014, and millions of people have gained coverage under the law. However, many people continue to lack coverage for a variety of reasons. For example, Medicaid eligibility for adults remains limited in states that have not adopted the expansion, some people remain ineligible for financial assistance for private coverage, and some still find coverage unaffordable even with financial assistance.

The gaps in our health insurance system affect people of all ages, races and ethnicities; however, those with the lowest incomes face the greatest risk of being uninsured. Being uninsured affects people's ability to access needed medical care and their financial security. As a result, uninsured people are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact can also be severe. Uninsured families struggle financially to meet basic needs, and medical bills can quickly lead to medical debt.

The Uninsured: A Primer provides information on how insurance has changed under the ACA, how many people remain uninsured, who they are, and why they lack health coverage. It also summarizes what we know about the impact that a lack of insurance can have on health outcomes and personal finances and the difference health insurance can make in people's lives.

How has health insurance coverage changed under the ACA?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance, and the number of uninsured Americans grew over time, particularly during economic downturns. By 2013, the year before the major coverage provisions of the ACA went into effect, more than 43 million people lacked coverage.[8] Under the ACA, as of 2014, Medicaid coverage has been expanded to nearly all adults with incomes at or below 138% of poverty in states that have adopted the expansion, and tax credits are available for people with incomes up to 400% of poverty who purchase coverage through a health insurance marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate has dropped to a historic low. Coverage gains were particularly large among low-income people living in states that expanded Medicaid. Still, millions of people—more than 27 million in 2016[9]—remain without coverage.

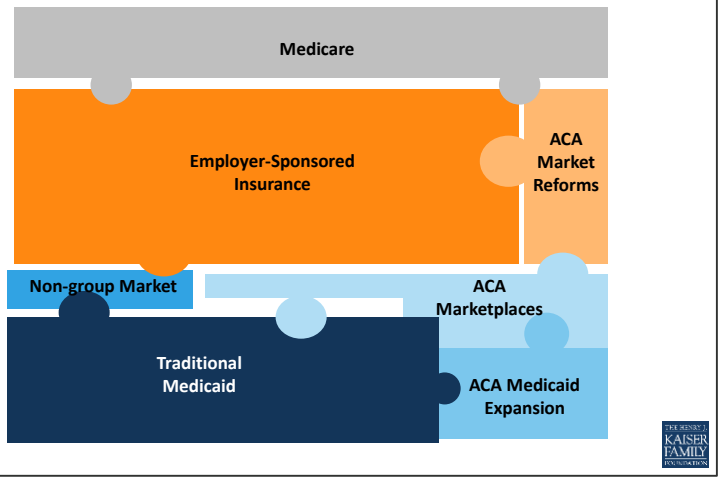
Health Insurance Coverage before the ACA

The ACA's coverage provisions built on and attempted to fill gaps in a piecemeal insurance system that left many without affordable coverage. This system had built up over time and included employer-based coverage for many—but not all—workers and their families, public coverage for some low-income people, and directly-purchased coverage for a small number of people who bought policies on the non-group market (Figure 1). (Medicare covers most people over age 65 as well as some younger people with disabilities.) Under this system, many were ineligible for coverage or could only access coverage that was too costly for them to afford. In 2013, 44.3 million nonelderly people in the U.S. lacked health insurance.[10] Poor and low-income adults were particularly likely to lack coverage, and the main reason that most people said they lacked coverage was inability to afford the cost.[11]

Figure 1

The ACA fills in gaps in a piecemeal insurance system.

Major Sources of Coverage in the United States



Historically, the majority of employers offered group health insurance policies to their employees and to their employees' families, but not all workers had access to or could afford such coverage. In 2013, 57% of firms offered employee coverage, with workers in low-wage and small firms less likely than other workers to be offered coverage.[12] Many low- and moderate-income workers who were offered employer coverage found their share of the premium unaffordable, especially if they needed more expensive family coverage.[13]

The availability of employer-sponsored coverage and the share of the population with this type of coverage declined over time. From 1999 to 2013, the share of firms that offered workers health benefits declined from 66% to 57%, primarily due to fewer small firms offering coverage.[14] Also during this period, health insurance premiums and the employee's share of those premiums nearly doubled, outpacing growth in workers' earnings and overall inflation.[15] The share of the nonelderly population with employer-sponsored coverage declined between 2000 and 2007,[16] even during years when the economy was strong and growth in health insurance premiums was slow. The Great Recession caused an even steeper drop in employer coverage

from 2008 to 2010 due to rising unemployment. As the economy began to stabilize from 2010 to 2013, the decline in employer coverage slowed, but rates of employer coverage remained below pre-recession levels.[17]

Very few people were covered by non-group health insurance policies prior to the ACA. Private policies directly purchased in the non-group, or individual, market (i.e., outside of employer-sponsored benefits) covered only 5% of people under age 65 in 2013.[18] Though, on average, non-group insurance premiums were lower than those for employer-sponsored coverage, enrollees paid 100% of the cost because they could not share that premium expense with an employer. Further, premiums in the non-group market could vary by age or health status, and people with health problems or at risk for health problems could be charged high rates, offered only limited coverage, or denied coverage altogether.

Medicaid and CHIP have been important sources of coverage for low-income children and people with disabilities, but in the past, coverage for adults without disabilities was limited. In 2013, Medicaid and CHIP covered just under a fifth (19%) of the nonelderly population[19] by primarily covering four categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities.[20] Prior to the ACA, federal law required state Medicaid programs to cover school age children up to 100% of the poverty level (133% for infants and preschool children), and states took up options to expand coverage to children in families with higher incomes through both Medicaid and CHIP. In contrast, the role of Medicaid for nonelderly, nondisabled adults remained very limited. In most states, parent eligibility remained very limited, often below 50% of the poverty level, and adults without dependent children—regardless of how poor—were ineligible for Medicaid.

Insurance coverage varied by state depending on the income distribution in the state, the nature of employment in the state, and the reach of state Medicaid programs. Insurance market regulations and the availability of jobs with employer-sponsored coverage also influenced the insurance rate in each state.[21] Massachusetts had the lowest uninsured rate in the country in 2013 (4%), due in part to health reform legislation enacted in 2006, while four states (Nevada, Texas, Arizona and Florida) had uninsured rates above 20%.[22]

ACA Coverage Provisions

The ACA expanded Medicaid eligibility to adults with incomes at or below 138% of poverty, but the 2012 Supreme Court ruling effectively made the expansion a state option. In addition to Medicaid's traditional role of covering low-income children, parents, pregnant women, and people with disabilities (as well as some low-income elderly), the ACA expanded Medicaid to nearly all adults with incomes at or below 138% of the poverty level (including low-income adults without dependent children who had historically had no path to coverage). Under the law, the federal government provided 100 percent of the cost of expansion from calendar years 2014-2016, and the federal share of costs gradually phases down to (and remains at) 90 percent by 2020. As of October 2016, 32 states, including DC, had adopted the Medicaid expansion.[23] Among states that have implemented the expansion, median income eligibility levels for parents and childless adults are now 138% of poverty.[24] Eligibility for children is higher, with 48 states covering children at or above 200% of poverty and 19 states covering children at or above 300% of poverty as of January 2016.[25] There is no deadline for states to expand Medicaid under the ACA, and discussion about the Medicaid expansion continues in other states.

The ACA established health insurance marketplaces where individuals and small employers can purchase insurance. Health insurance marketplaces operate in each state, but only some states run their own marketplace.[26] These marketplaces are designed to ensure a more level competitive environment for insurers and to provide consumers with information on cost and quality to help them choose among plans. To help make coverage purchased in these new marketplaces more affordable, the federal government provides tax credits for people with incomes between 100% and 400% of poverty ($20,090 to $80,360 for a family of three in 2015).[27,28] These tax credits are available on a sliding scale based on income and limit premium costs to a share of income. In addition, the federal government also provides cost-sharing subsidies to reduce what people with incomes between 100% and 250% of poverty have to pay out-of-pocket to access health services.

Coverage for immigrants remains limited under the ACA. Lawfully-present immigrants can receive coverage through the ACA coverage expansions, although they continue to face eligibility restrictions in Medicaid that have been in place since prior to the ACA. Specifically, many lawfully present non-citizens who would otherwise be eligible for Medicaid remain subject to a five-year waiting period before they may enroll.[29] Lawfully present immigrants are eligible for tax credits for coverage purchased through a marketplace, regardless of the number of years they have been in the U.S.[30] In addition, lawfully present immigrants who would be eligible for Medicaid but are in a five-year waiting period are also eligible for tax credits for marketplace coverage. Undocumented immigrants are ineligible for Medicaid and are prohibited from purchasing coverage through a marketplace or receiving tax credits.

The ACA includes provisions to promote coverage in small firms. Recognizing the challenges that small employers, especially those with low-wage workers, face in providing coverage to their employees, the ACA established the Small Business Health Options Program (SHOP) marketplace, where employers with no more than 50 full-time equivalent (FTE) employees can purchase coverage. Beginning in January 2016, states had the option to expand the SHOP to include employers with 100 or fewer FTEs.[31] Small employers with no more than 25 FTE employees and annual wages of less than $50,000 that purchase coverage through the SHOP may be eligible for tax credits to reduce the cost of that coverage.[32] Eligible employers may take the tax credits for a maximum of two years.[33]

The ACA also extends dependent coverage in the private market. As of 2010, young adults may remain on their parents' private plans (including non-group and employer-based plans) until age 26. This provision led to significant declines in the number and rate of uninsured young adults beginning in 2010.[34]

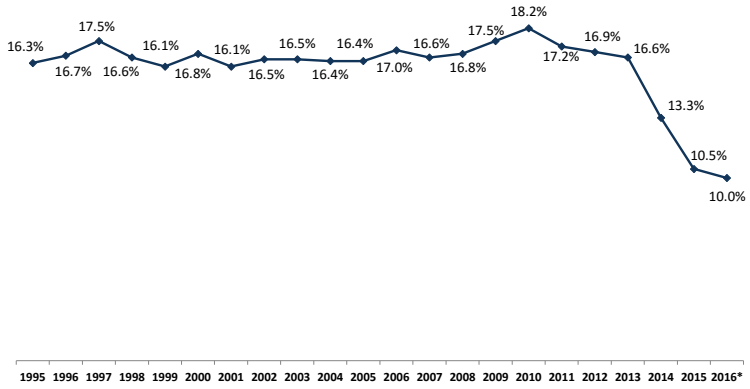
Large and medium-size employers now face penalties for not offering affordable coverage to full-time employees. As of January 2015**,** employers with 100 or more employees are assessed a fee up to $2,000 per full-time employee (in excess of 30 employees) if they do not offer affordable coverage and have at least one employee who receives a marketplace premium tax credit. As of January 2016, this provision also applies to employers with 50 to 99 full-time or full-time equivalent employees (FTEs). To avoid penalties, employers must offer insurance that pays for at least 60% of covered health care expenses, and the employee's share of the individual premium must not exceed 9.5% of family income.[35]

Changes in The Number of Uninsured Under the ACA

Under the ACA, the uninsured rate has declined to a historic low. The share of the nonelderly population that lacked insurance coverage hovered around 16% between 1995 and 2007, then peaked during the ensuing economic recession (Figure 2). As early provisions of the ACA went into effect in 2010, and as the economy improved, the uninsured rate began to drop. With the implementation of the major ACA coverage provisions in 2014, the uninsured rate dropped dramatically and continued to fall in 2015 and early 2016. In 2016, the nonelderly uninsured rate was 10.0%, the lowest rate ever recorded.

Figure 2

Uninsured Rate Among the Nonelderly Population, 1995-2016

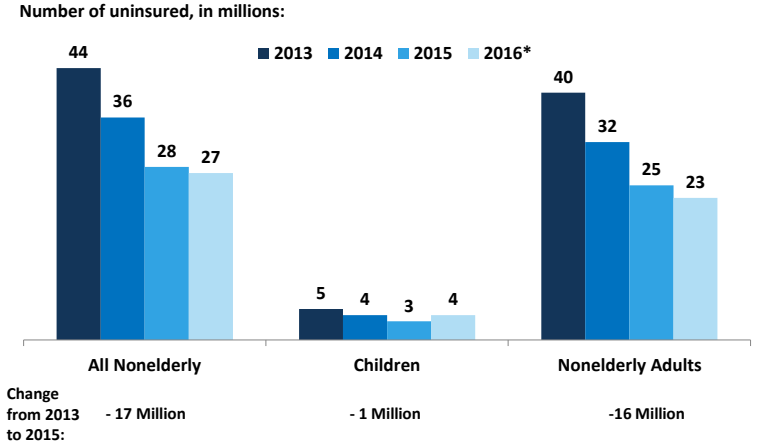


Note: 2016 data is for Q1 only.
Source: CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 and https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf

Over 17 million more people have health coverage in 2016 compared to 2013. Corresponding with implementation of the ACA's coverage provisions, the total number of nonelderly uninsured individuals nationally dropped from 44 million in 2013 to 27 million in 2016, with the biggest decline in the first two years of ACA implementation.[36] Because the expansions are largely targeted to adults, who have historically had higher uninsured rates than children, nearly the entire decline in the number of uninsured people under the ACA has occurred among adults (Figure 3).

Figure 3

Change in Number of Uninsured Nonelderly, 2013-2016

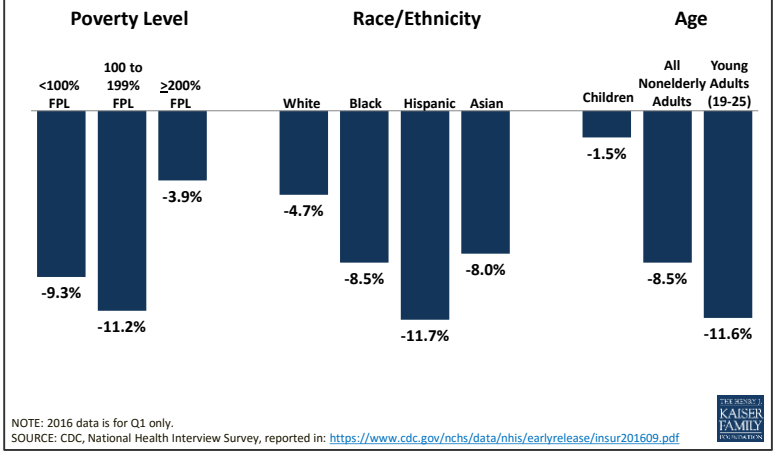


NOTE: 2016 data is for Q1 only. Subtotals may not sum to total nonelderly due to rounding.
SOURCE: CDC, National Health Interview Survey, reported in: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf

Coverage gains have been largest among low-income people, people of color, and young adults—groups that had high uninsured rates prior to 2014. While uninsured rates decreased across all income groups from 2013 to 2016, they declined most sharply for poor and near-poor people, dropping by 9.3 percentage points and 11.2 percentage points, respectively. Also during this period, the uninsured rate declined by 11.6 percentage points for adults age 19-25. Among racial and ethnic groups, Hispanics, Blacks, and Asian Americans had particularly large declines in uninsured rates, with each group seeing a drop of over 8 percentage points from 2013 to 2016 (Figure 4).[37]

Figure 4

Percentage Point Change in Uninsured Rate among the Nonelderly Population by Selected Characteristics, 2013-2016



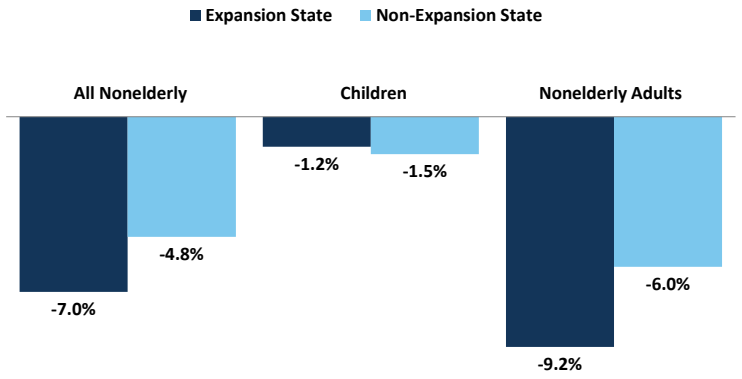
NOTE: 2016 data is for Q1 only.
SOURCE: CDC, National Health Interview Survey, reported in: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf

Growth in Medicaid and directly-purchased coverage accounted for much of the decline in the uninsured rate. As of June 2016, national enrollment in Medicaid and CHIP had grown by over 15 million people since October 2013 (before the ACA Medicaid expansion), a 27% increase in monthly Medicaid enrollment.[38] In addition, as of March 2016, over 11 million individuals were enrolled in a marketplace plan, the vast majority of whom (85%) received premium subsidies.[39]

States that expanded Medicaid had larger gains in coverage than states that did not. Uninsured rates dropped nearly immediately in expansion states following implementation of the ACA's coverage provisions, with sharp declines among the low-income population widely attributed to gains in Medicaid coverage. Uninsured rates among the low-income population dropped somewhat in non-expansion states as well, in part as a result of the availability of ACA subsidies for private insurance to those with incomes above poverty, increased participation among those eligible but not enrolled in Medicaid, and increased outreach and enrollment efforts surrounding the ACA in all states; however, reductions in non-expansion states were far more limited than the substantial declines observed in expansion states.[40] Among nonelderly adults, Medicaid expansion states had a 9.2 percentage point drop in uninsured rates between 2013 and 2016, versus a 6.0 point drop in non-expansion states (Figure 5).

Figure 5

Percentage Point Change in Uninsured Rate by Age and State Medicaid Expansion Status, 2013-2016



NOTE: 2016 data is for Q1 only.
SOURCE: CDC, National Health Interview Survey, reported in: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf

Some people continue to purchase non-group coverage outside the marketplace. Among the entire non-group market in winter 2016, nearly two-thirds of individuals (64%) reported having coverage obtained from a state or federal marketplace, 19% have ACA-compliant coverage purchased outside of the marketplace, and 12% have non-ACA-compliant plans (those that have been in effect since before January 1, 2014). People purchasing coverage outside the marketplace are not eligible for ACA premium tax credits.

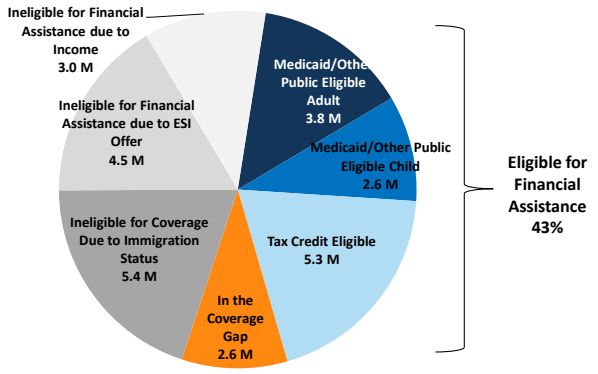
Offer, eligibility, and take-up rates of employer sponsored insurance are largely unchanged since 2013. Over half (56%) of all firms offered health benefits in 2016, a rate similar to that in 2013 (57%).[41] Similarly, the percentage of workers eligible for health benefits at offering firms in 2016 (79%) is similar to 2013 (77%), and take-up rates have also remained steady, with 79% of eligible workers taking up offered coverage in 2016 compared to 80% in 2013.[42]

Even with the ACA, many remain uninsured. Of those estimated to be uninsured at the start of 2016, over one in four (11.7 million, or 43%) are eligible for financial assistance through either Medicaid or subsidized marketplace coverage. However, a majority of uninsured people remain outside the reach of the ACA. Some (5.4 million, or 20%) are ineligible due to their immigration status, and others (2.6 million, or 10%) are ineligible due to their state's decision not to expand Medicaid. The remainder of the uninsured either has an offer of coverage through an employer or has income above the limit for marketplace tax credits (Figure 6). These patterns of eligibility vary by state.[43]

In the nineteen states that had not expanded Medicaid as of October 2016, 2.6 million poor adults fall into a "coverage gap."[44] These adults have incomes above Medicaid eligibility limits in their state but below the lower limit for marketplace premium tax credits, which begin at 100% of poverty. In non-expansion states, the median income eligibility level for parents is 44% of poverty and 0% for childless adults.[45] People in the coverage gap are concentrated in Southern states, with the largest number of people in the coverage gap in Texas (676,000 people, or 26%) followed by Florida (468,000, or 18%), Georgia (312,000, or 12%), and North Carolina (208,000, or 8%).[46]

Figure 6

Eligibility for ACA Coverage Among Nonelderly Uninsured as of 2016



Total = 27.2 Million Nonelderly Uninsured

NOTES: Numbers may not sum to totals due to rounding. Tax Credit Eligible share includes adults in MN and NY who are eligible for coverage through the Basic Health Plan. Medicaid/Other Public also includes CHIP and some state-funded programs for immigrants otherwise ineligible for Medicaid.
SOURCE: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.

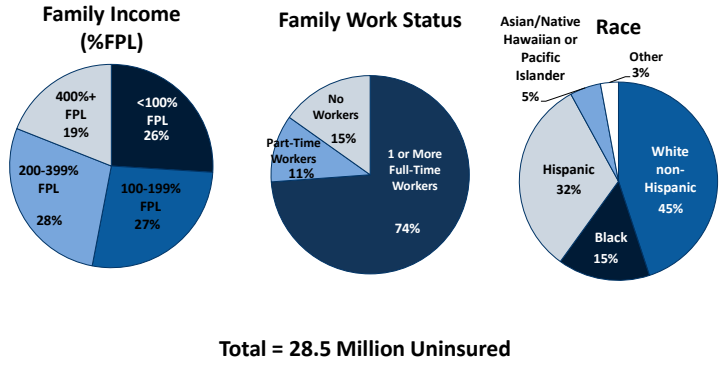
Who remains uninsured after the ACA and why do they lack coverage?

Even after the ACA, over 28 million nonelderly people in the United States were uninsured as of the end of 2015.[47] Despite coverage gains, groups with historically high uninsured rates continue to be at highest risk of being uninsured, including low-income individuals, adults, and people of color. Cost continues to pose a major barrier to coverage with nearly half (46%) of the uninsured in 2015 saying that the main reason they lacked coverage was because it was too expensive.[48]

Though provisions in the ACA aim to make coverage more affordable for low and moderate-income families, these income groups still make up the vast majority of the uninsured. More than half of the remaining uninsured population (53%) has family income at or below 200% of poverty ($19,078 for a family with two adults and one child in 2015)[49] and another 28% has family income between 200 and 399% of poverty (Figure 7). Low-income individuals are at the highest risk of being uninsured.[50]

Figure 7

Characteristics of the Nonelderly Uninsured, 2015



Total = 28.5 Million Uninsured

NOTES: The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,078 in 2015. Data may not total 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the CPS.

A majority of the remaining uninsured population is in a family with at least one worker, and many uninsured workers continue to lack access to coverage through their job. As of the end of 2015, over seven in ten (74%) of the uninsured have at least one full time worker in their family, and an additional 11% have a part-time worker in their family (Figure 7).[51] As in the past, low-income workers and those who work in blue-collar jobs (versus white-collar jobs) are more likely than other workers to be uninsured.[52] Uninsured adults report that access to coverage through a job remains limited or unaffordable.[53] While the ACA's employer offer requirements may help many uninsured individuals with a worker in their family, nearly half (49%) of uninsured workers in 2015 worked in firms with fewer than 50 employees, which are not required to offer affordable insurance coverage.[54]

People of color are at higher risk of being uninsured than Whites. While a plurality (45%) of the uninsured are non-Hispanic Whites, people of color are disproportionately likely to be uninsured: they make up 41% of the overall U.S. population but account for over half of the total uninsured population (Figure 7). Hispanics account for nearly a third (32%) of the uninsured, and non-Hispanic Blacks account for 15%.[55] Differences in coverage by race/ethnicity likely reflect a combination of factors, including language and immigration barriers, income and work status, and state of residence.

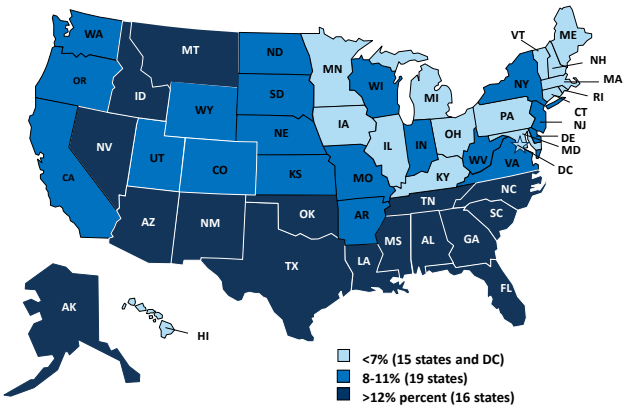
Adults are still more likely than children to be uninsured. Nonelderly adults were more than twice as likely as children (13% vs. 5%) to be uninsured in 2015.[56] This disparity reflects ongoing differences in eligibility for public coverage. While the ACA has increased Medicaid eligibility levels for adults, states have expanded coverage for children even higher through CHIP, while adults without children are excluded from Medicaid in all but one non-expansion state.[57]

Uninsured rates for children are low, and most uninsured children are eligible for Medicaid or CHIP. Largely due to expanded eligibility for public coverage under Medicaid and CHIP, the uninsured rate for children is relatively low: in 2015, 5% of children nationwide were uninsured.[58] Two-thirds (66%) of uninsured children are eligible for Medicaid, CHIP, or other public programs.[59] Some of these children may be reached by covering their parents, as research has found that parent coverage in public programs is associated with higher enrollment of eligible children.[60,61]

Insurance coverage continues to vary by state and region, with individuals living in the South and West the most likely to be uninsured (Figure 8). In 2014, the 16 states with the highest uninsured rates were all in the South and West,[62] reflecting state Medicaid expansion status, demographic characteristics, economic conditions, availability of employer-based coverage, and state outreach efforts under the ACA.

Figure 8

Uninsured Rates Among the Nonelderly by State, 2015



SOURCE: Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the CPS.

While most of the uninsured are U.S. citizens, non-citizens continue to be at much higher risk of being uninsured. In 2015, nearly three out of four (73%) uninsured nonelderly individuals were citizens. However, non-citizens (including those who are lawfully present and those who are undocumented) are more likely than citizens to be uninsured in 2015. Among citizens, 9% were uninsured in 2015, compared to 28% of non-citizens.[63]

Cost still poses a major barrier to coverage for the uninsured. Nearly half (46%) of uninsured adults in 2015 said that the main reason they lacked coverage was because it was too expensive.[64] Though financial assistance is available to many of the remaining uninsured under the ACA,[65] not everyone who is uninsured is eligible for free or subsidized coverage. In addition, affordability of ACA Marketplace coverage remains a concern for some people. In 2016, 40% of people with Marketplace coverage said they were dissatisfied with their monthly premium and nearly half (46%) were dissatisfied with their deductible.

Some individuals may remain uninsured because they are not aware of coverage options or face barriers to enrollment, even though they may be eligible for financial assistance under the ACA. In 2015, about one in five uninsured nonelderly adults said they remained uninsured because they didn't know about the requirement to have health insurance (7%) or didn't think the requirement applied to them (13%) (some in fact may be exempt under specific provisions of the law). About one in ten said they tried to get coverage but were unable (11%),[66] though many enrollment barriers encountered in the first year of ACA coverage have been addressed.

Most people who remained uninsured in 2015 were uninsured for more than a year. Though the share of uninsured who lacked coverage for more than a year decreased from 81% in 2013 to 76% in 2015,[67] the vast majority of uninsured people were still long-term uninsured. People who have been without coverage for long periods may be particularly hard to reach through outreach and enrollment efforts.

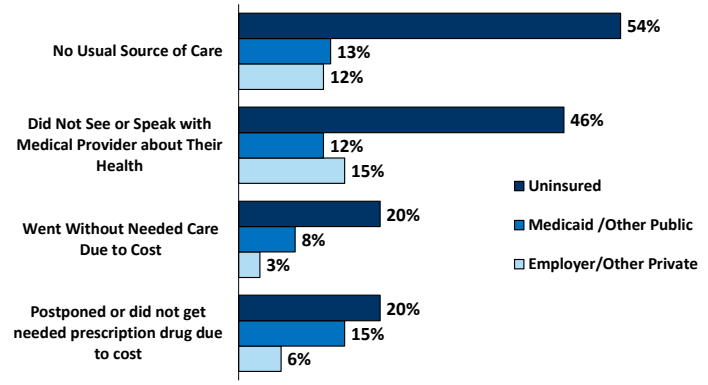
How does lack of insurance affect access to health care?

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Compared to those who have health coverage, people without health insurance are more likely to skip preventive services and report that they do not have a regular source of health care. Adults who are uninsured are three times more likely than insured adults to say they have not seen or spoken with a medical provider about their health in the past year (Figure 9). They are also less likely to receive recommended screening tests such as blood pressure checks, cholesterol checks, blood sugar screening, pap smear or mammogram (among women), and colon cancer screening.[68] Part of the reason for poor access among the uninsured is that most (54%) do not have a regular place to go when they are sick or need medical advice, while most insured people do have a regular source of care (Figure 9).[69]

Figure 9

Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2015

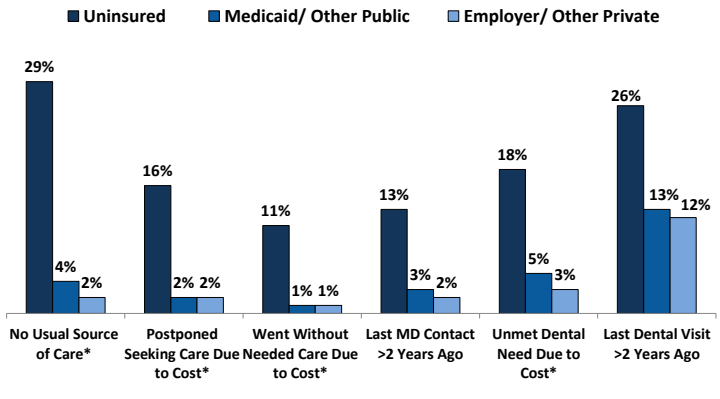


NOTE: Includes barriers experienced in past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between uninsured and insurance groups are statistically significant (p<0.05).
SOURCE: Kaiser Family Foundation analysis of 2015 National Health Interview Survey.

Uninsured people are more likely than those with insurance to report problems getting needed medical care. One in five (20%) uninsured adults say that they went without care in the past year because of cost compared to 3% of adults with private coverage and 8% of adults with public coverage. Many uninsured people do not obtain the treatments their health care providers recommend for them. In 2015, 20% of uninsured adults said they delayed or did not get a needed prescription drug due to cost, compared to 15% with public coverage and 6% with private coverage.[70] And while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care from their doctors, people without health coverage are less likely than those with coverage to obtain all the recommended services.[71,72]

Figure 10

Children's Access to Care by Health Insurance Status, 2015



NOTES: * In past 12 months . Questions about dental care were analyzed for children age 2-17. All other questions were analyzed for all children under age 18. MD contact includes other health professionals. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05).
SOURCE: Kaiser Family Foundation analysis of 2015 National Health Insurance Survey (NHIS) data.

Because uninsured people are less likely than those with insurance to have regular outpatient care, they are more likely to have negative health consequences. Because uninsured patients are less likely than those with insurance to receive necessary follow-up screenings,[73] they have an increased risk of being diagnosed at later stages of diseases, including cancer, and have higher mortality rates than those with insurance.[74,75,76] In addition, when

uninsured people are hospitalized, they receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.[77,78,79,80]

Uninsured children also face problems getting needed care. Uninsured children are more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance (Figure 10).[81] Further, uninsured children with common childhood illnesses and injuries do not receive the same level of care as others and are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.[82,83] Among children with special health care needs, those without health insurance have worse access to care, including specialist care, than those with insurance.[84]

Lack of health coverage, even for short periods of time, results in decreased access to care. Research has shown that adults who experience gaps in their health insurance coverage are less likely to have a regular source of care or to be up to date with blood pressure or cholesterol checks than those with continuous coverage.[85] Research also indicates that children who are uninsured for part of the year have more access problems than those with full-year coverage.[86,87] Similarly, adults who lack insurance for an entire year have poorer access to care than those who have coverage for at least part of the year, suggesting that even a short period of coverage can improve access to care.[88]

Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care than their counterparts who did not gain coverage.[89] Gaining Medicaid increased the likelihood of having an outpatient visit by approximately 35%, increased the likelihood of prescription drug utilization by 15%, and decreased the likelihood of depression and stress. Findings two years out from the expansion showed significant improvements in access, utilization, and self-reported health, and virtual elimination of catastrophic out-of-pocket medical spending among the adults who gained coverage.[90] In addition, a large body of research on the impact of Medicaid expansion under the ACA demonstrates that gains in Medicaid coverage positively impact access to care and utilization of health care services.[91] Research also shows that individuals who gained marketplace coverage in 2014 were far more likely than those who remained uninsured to obtain a usual source of care and receive preventive care services.[92]

Public hospitals, community clinics and health centers, and local providers provide a crucial health care safety net for uninsured people; however, the safety net does not close the access gap for the uninsured. Safety net providers, including public and community hospitals, community health centers, rural health centers, and local health departments, provide care to many people without health coverage. In addition, nearly all other hospitals and some private, office-based physicians provide some charity care. However, safety net providers have limited resources and service capacity, and not all uninsured people have geographic access to a safety net provider.[93,94] The ACA has led to significant growth in the number of health centers and their service capacity through both a large financial investment in community health centers to help meet the increasing demand for primary care as coverage expands and new patient revenues due to expanded coverage.[95] However, this impact has been more limited in states not expanding Medicaid, where a much larger share of health center patients remains uninsured than in states that did expand.[96] In addition, regardless of their state's Medicaid expansion decision, health centers report that securing needed specialty care for their uninsured patients is a major challenge.[97]

What are the financial implications of lacking insurance?

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs, like housing, food, and transportation to work, and many uninsured adults report difficulty paying basic monthly expenses such as rent, food, and utilities.[98] When uninsured people use health care, they may be charged for the full cost of that care (versus insurers, who negotiate discounts) and often face difficulty paying medical bills. Providers absorb some of the cost of care for the uninsured, and while uncompensated care funds cover some of those costs, these funds do not fully offset the cost of care for the uninsured.

Most uninsured people do not receive health services for free or at reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.[99, 100] In 2014, only 40% of uninsured adults who received health care services reported receiving free or reduced cost care.[101]

Uninsured people often must pay "up front" before services will be rendered. When people without health coverage are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or be turned away.[102] Among uninsured adults who received health care in 2013, nearly a third (31%) were asked to pay for the full cost of medical care before they could see a doctor.[103]

People without health insurance have lower medical expenditures than those with insurance, but they pay a much larger portion of their medical costs out-of-pocket. Compared to insured nonelderly people with full-year coverage, whose average per capita medical expenditures were $4,876 in 2013, nonelderly people who were full-year uninsured used health care services valued at about half that amount, or just $2,443 per capita in 2013.[104] Despite lower overall medical spending, people without insurance pay nearly as much out-of-pocket as insured people.[105]

The uncompensated costs of care for the uninsured amounted to about $84.9 billion in 2013. Funding from a number of sources, totaling $53.3 billion in 2013, helps providers defray the costs associated with uncompensated care. Most of these funds (62%) came from the federal government through a variety of programs including Medicaid and Medicare, the Veterans Health Administration, the Indian Health Service, the Community Health Centers block grant, and the Ryan White CARE Act. States and localities provided $19.8 billion, and the private sector provided $0.7 billion. While substantial, these payments to providers for uncompensated care amount to a small slice of total health care spending in the U.S.[106]

The burden of uncompensated care varies across providers. Hospitals, community providers (such as clinics and health centers), and office-based physicians all provide care to the uninsured. Given the high cost of hospital-based care, the majority (60%) of the cost of uncompensated care is incurred in hospitals. Community-based providers that receive public funds provide a little over a quarter (26%) of total uncompensated care, and the remainder of uncompensated care, 14%, is provided by office-based physicians.[107]

With the expansion of coverage under the ACA, providers in states that expanded Medicaid are seeing reductions in uncompensated care costs. For example, between 2013 and 2014, total uncompensated care costs for hospitals (including charity care costs and bad debt) dropped from $34.9 billion to $28.9 billion, a $6 billion or 17% drop, with nearly all of the decrease occurring in expansion states. In non-

expansion states, the change in uncompensated care was nearly flat between 2013 and 2014, dropping just 1% in 2014.[108]

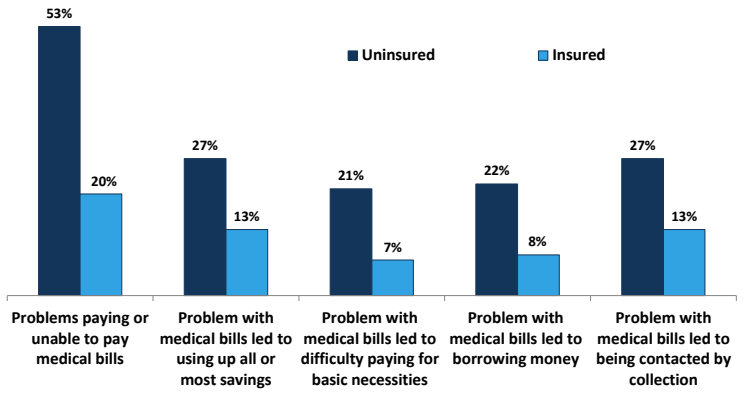
Many safety net hospitals that serve a large number of Medicaid and low-income uninsured individuals receive Medicaid disproportionate share hospital payments (DSH); however, federal DSH payments are scheduled to be cut beginning in FY 2018.[109] Federal law requires that state Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Unlike other Medicaid payments, federal DSH funds are capped and each state receives a capped allotment. DSH allotments vary across states and totaled about $11.9 billion in FY 2015.[110] Anticipating fewer uninsured and lower levels of uncompensated care, the ACA called for a reduction in federal Medicaid DSH payments. Cuts were originally scheduled to begin in 2014 but were delayed to FY 2018. These reductions will amount to $43 billion between 2018 and 2025.[111] The HHS Secretary is required to develop a methodology to allocate the reductions that must take into account factors outlined in the law.[112] While safety-net hospitals across the country will be affected, hospitals in states that do not expand Medicaid may face cuts without additional revenues from new coverage.

Being uninsured leaves individuals at an increased risk of financial strain due to medical bills. Uninsured people are more likely than those with insurance (53% vs. 20%) to report having trouble paying or being unable to pay medical bills in the past year. Medical bills may also lead to serious financial strain. In 2015, 27% of uninsured adults reported that medical bills caused them to use up all or most of their savings, 21% said they led to difficulties paying for basic necessities, 22% said it led them to borrow money, and 27% said it led to being contacted by a collection agency. These rates were significantly higher than those among individuals with insurance (Figure 11).

Figure 11

Problems Paying Medical Bills by Health Insurance Status, 2015

Among non-elderly adults:



NOTES: Respondents were asked about their experiences with medical bills and the consequences that may have resulted from them in the last 12 months. Includes adults ages 18-64. All differences between uninsured and insured groups are statistically significant (p<0.05).

SOURCE: Kaiser Family Foundation/New York Times Medical Bills Survey (conducted August 28-September 28, 2015.)

Most uninsured people have few, if any, savings or assets they can easily use to pay health care costs. The average uninsured household has no net assets,[113] and half of uninsured families living below 200% of poverty have no savings.[114,115] The uninsured are much more likely than those with insurance to say they are worried or very worried about paying medical bills if they get sick or get into an accident (79% vs. 45%).[116]

Uninsured people are at risk of medical debt. Like any bill, when medical bills are not paid or are paid off too slowly, they are turned over to a collection agency. In 2015, uninsured adults were three times as likely as insured adults to say they owed money on at least one medical bill (45% vs. 16%).[117] Medical debts contribute to over half (52%) of debt collections actions that appear on consumer credit reports in the United States,[118] and uninsured people are at higher risk of falling into medical bankruptcy than people with insurance.[119]

Conclusion

The ACA led to historic drops in the uninsured rate, with millions of previously uninsured Americans now insured and gaining access to health services and protection from catastrophic health costs. Prior to the ACA, the options for the uninsured population were limited in the individual market, as coverage was often expensive and insurers could deny coverage based on health status. Medicaid and CHIP have provided coverage to many families, but pre-2014 eligibility levels were low for parents and few states provided coverage to adults without dependent children. The ACA fills in many of these gaps by expanding Medicaid to low-income adults and providing subsidized coverage to people with incomes from 100 to 400% of poverty in the marketplaces.

Nonetheless, even with the ACA, the nation's system of health insurance continues to have many gaps that currently leave millions of people without coverage. Over half (57%) of the remaining uninsured are outside the reach of the ACA either because their state did not expand Medicaid, they are subject to immigrant eligibility restrictions, or their income makes them ineligible for financial assistance. The remainder are eligible for assistance under the law but may still struggle with affordability and knowledge of options and require targeted outreach to help them gain coverage. For both eligible and ineligible remaining uninsured people, health care needs persist regardless of insurance status, underscoring the importance of safety net providers and community health clinics to serve this population.[120]

The ACA has provided coverage to millions of people in the United States in its first three years and has the potential to reach many more, ensuring that fewer individuals and families will face the health and financial consequences of not having health insurance.

Rachel Garfield and Julia Foutz are with the Kaiser Family Foundation. Melissa Majerol was previously with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

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Access to Employer-Sponsored Health Coverage for Same-Sex Spouses

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Employer-sponsored health insurance (ESI) covered over half of the non-elderly population in the U.S. in 2015, half of whom received coverage as a dependent.[1,2] In fact, nearly all employees who have access to health insurance also have access to opposite-sex spousal coverage.[3] However, for same-sex couples, this route to coverage has historically been limited. Two recent Supreme Court rulings (*United States v Windsor* in 2013 and *Obergefell v Hodges* in 2015) significantly changed the legal landscape for same-sex couples and paved the way for greater access to health insurance through the workplace. Using data collected through the most recent Kaiser Family Foundation and the Health Research & Educational Trust (HRET) Employer Health Benefits Survey (http://kff.org/health-costs/report/2016-employer-health-benefits-survey/), we provide the first national estimates of same-sex spousal health coverage, looking at both the share of firms offering such coverage as well as the share of covered workers with access to spousal benefits.

Background

Prior to the *Windsor* and *Obergefell* decisions, same-sex couples faced limited options for obtaining spousal coverage through an employer and when they did, this benefit was treated differently under federal law from benefits received by heterosexually married couples. While some employers offered domestic partner benefits for same-sex partners[4] and a growing number of states began to recognize same-sex marriage[5], in 2012, less than half of all workers with health coverage had access to same-sex health benefits.[6] In addition, because the federal government did not recognize same-sex marriages, where such benefits were offered, they were not considered tax exempt which meant that same-sex couples faced higher tax burdens compared to heterosexual counterparts.

In June 2013, in *Windsor,* the Supreme Court overturned a major portion of the Defense of Marriage Act (DOMA) which had, for federal purposes, defined marriage as between a man and a woman. The *Windsor* decision required federal recognition of same-sex marriages, even if a couple lived in a state that did not recognize same-sex marriage. As a result, employer-sponsored health benefits provided to legally married same-sex couples were now considered tax exempt.[7] *Windsor*, however, did not require states to issue same-sex marriage licenses or recognize those performed elsewhere, leading to a patchwork of recognition across the U.S. and lack of access to legal same-sex marriage for many couples where they lived. In 2015, the Supreme Court's ruling in *Obergefell* legalized same-sex

marriage nationwide, requiring all states to recognize same-sex marriages and issue marriage licenses to same-sex couples. While neither decision required private employers to offer same-sex spousal coverage if they offered coverage to opposite-sex spouses[8], it was expected that wider access to marriage would lead to greater access to coverage. In fact, one study found that the legalization of same-sex marriage in New York was associated with an increase in employer-sponsored insurance among same-sex couples.[9] In addition, an increasing number of states (21 states and DC) have protections in place that prohibit employers from discriminating against individuals based on sexual orientation, and presumably would require employers offering opposite-sex spousal coverage to extend that benefit to same-sex spouses. Furthermore, it is likely that employers who refuse to offer same-sex spousal coverage if they offer coverage to opposite-sex spouses would face legal challenges.[10] Still, given that employers are not required to provide same-sex spousal coverage parity to their employees, assessing such coverage is important for understanding the interplay between legal recognition of same-sex marriage and health insurance access within the workplace.

Findings

FIRMS OFFERING

In 2016, less than half (43%) of firms offering health insurance coverage to opposite-sex spouses, also provided coverage to same-sex spouses and 16% did not provide this coverage. Another 41% reported they had not encountered this as a benefits issue. This was driven by small employers (those with fewer than 200 workers), who represent the majority of employers overall (98%)[11] and are less likely to offer same-sex spousal coverage. Indeed, the likelihood of employers offering same-sex spousal coverage increased with firm size.

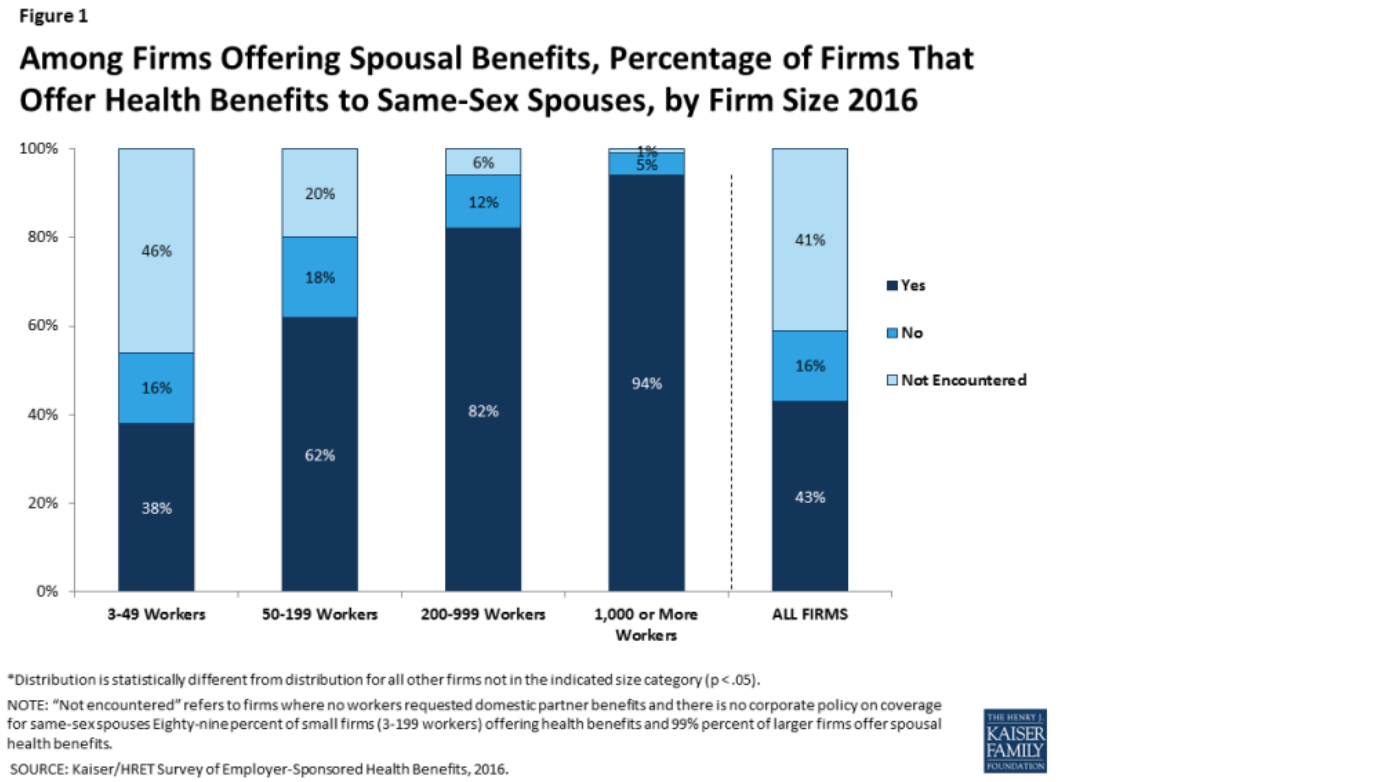

Figure 1: Among Firms Offering Spousal Benefits, Percentage of Firms That Offer Health Benefits to Same-Sex Spouses, by Firm Size 2016

Among firms offering opposite-sex spousal coverage, large firms (those with 200 or more employees) were more likely to also offer this benefit to same-sex spouses than smaller firms (85% vs 41%). More than eight in ten (85%) large firms with opposite-sex spousal coverage offered such coverage, 10% did not, and 5% reported they had not encountered this benefits issue. Among the largest firms (those with more than 1,000 workers), 94% offered coverage to same-sex couples. By contrast, just 41% of small employers (3-199 workers) offered coverage to same-sex spouses. Sixteen percent did not and 43% said they had not encountered it.

COVERED WORKERS

While the majority of firms in the United States are small, and most do not offer same-sex spousal ESI, the majority of workers are employed by large firms (2oo or more workers) (70%), most of whom do offer this benefit. In 2016, among employees who worked at firms offering opposite-sex spousal health benefits, 84% also had access to same-sex spousal coverage; 8% did not have access to this benefit, and 8% worked at firms who reported they had not encountered this benefits issue.[12]

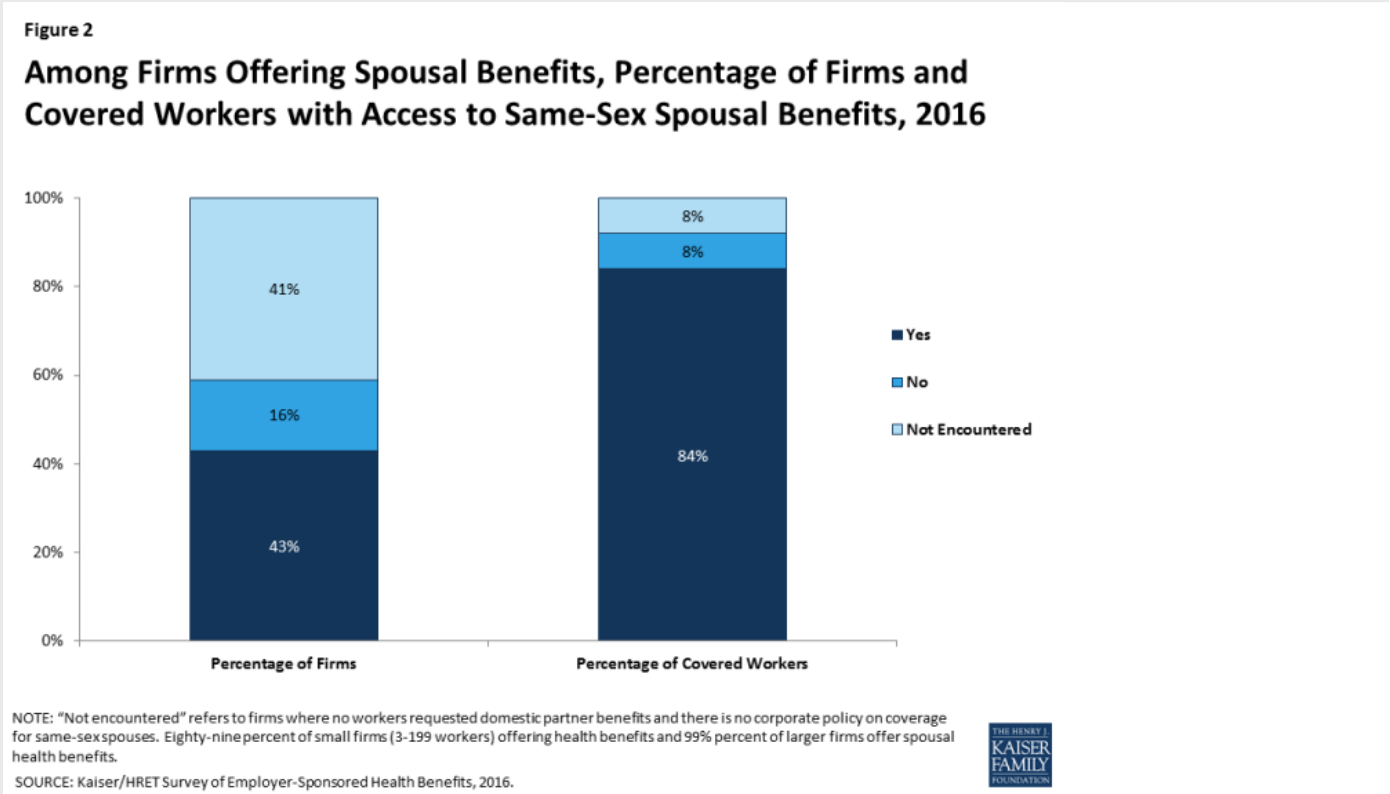

Figure 2: Among Firms Offering Spousal Benefits, Percentage of Firms and Covered Workers with Access to Same-Sex Spousal Benefits, 2016

Most at large firms (those with 200 or more employees) who have access to opposite-sex spousal coverage also have access to same-sex spousal coverage (94%). Just 5% did not, and 1% worked at firms that reported they had not encountered the issue. Among workers at the largest firms (1,000+ workers), virtually all (97%) had access to same-sex spousal coverage.

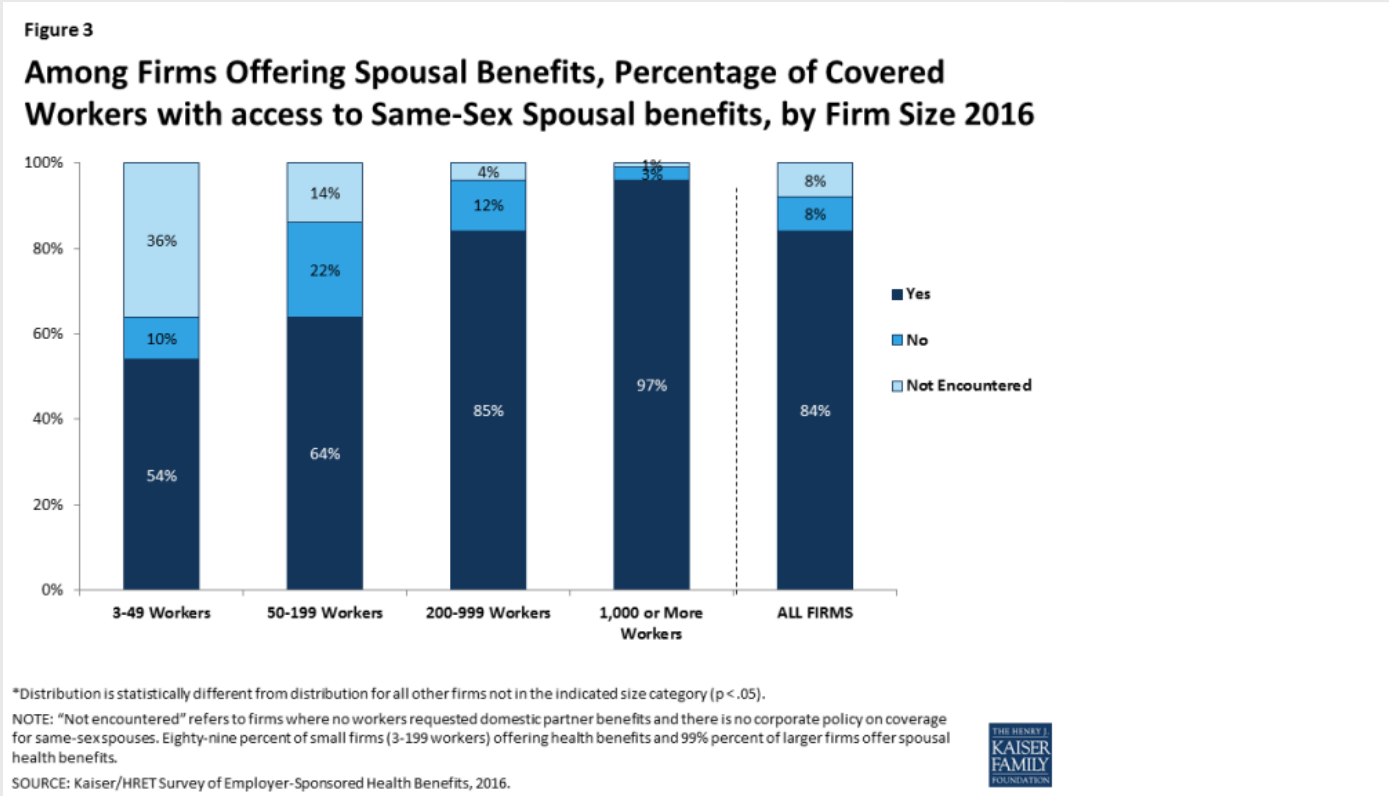

Figure 3: Among Firms Offering Spousal Benefits, Percentage of Covered Workers with access to Same-Sex Spousal benefits, by Firm Size 2016

Workers at small firms offering opposite-sex spousal coverage were less likely to have access to health insurance benefits for same-sex spouses, though a majority did (59%). Sixteen percent did not have access to this benefit and another 26% worked at firms that report they have not encountered this issue.

DOMESTIC PARTNER BENEFITS

As mentioned above, prior to the recent Supreme Court decisions guaranteeing the right to marriage for same-sex couples, domestic partnership benefits provided an important way for same-sex couples to gain access to coverage. Some have raised questions about whether federal and state recognition of same-sex marriage would diminish domestic-partnership benefits but data from the Employee Health Benefits Survey show no statistical difference between the share of firms offering same-sex domestic partner health coverage in 2016 compared to 2013, among all firms offering health benefits.[13] Further, the survey found tha 99% of large firms offering same-sex domestic partner health benefits also offer same-sex spousal benefits and 58% of large firms offering same-sex spousal coverage offer same-sex domestic partner coverage.

Conclusion

These findings indicate that in 2016, while less than half of firms offering opposite-sex spousal coverage also offer coverage to same-sex spouses, the majority of covered workers (84%) had access to these benefits. Still, not all do and this varies significantly by employer size, with employees at small firms being less likely to have access to same-sex spousal coverage. In some cases, lack of access to this benefit could be a policy decision (16% of firms providing opposite-sex spousal coverage reported that they do not offer coverage for same-sex spouses). In addition, many firms (41%), especially the smallest firms, say they have not encountered this benefits issue. This could be because many of these small firms are likely to be individually or family-run small businesses that may have genuinely not been approached about this as a benefits issues, reflect the relatively recent nature of federal marriage recognition, and/or reflect the reluctance of some employees to proactively seek such benefits, particularly at small firms. Going forward, it will be important to monitor access to same-sex spousal coverage in the workplace over time and against changes in the legal landscape.

Methods

The Kaiser Family Foundation/Health Research & Educational Trust (Kaiser/HRET) 2016 Annual Employer Health Benefits Survey is based on a telephone survey of 1,933 randomly selected non-federal public and private employers with three or more workers. Researcher at HRET, NORC at the University of Chicago, and the Kaiser Family Foundation designed and analyzed the survey. National Research, LLC conducted the fieldwork between January and June 2016. In 2016, the response rate among firms which offer health benefits was 40%. Fo fuller methods see The Kaiser Family Foundation/Health Research & Educational Trust (Kaiser/HRET) 2016 Annual Employer Health Benefits Survey (2016) available here: http://kff.org/health-costs/report/2016-employer-health-benefits-survey/ (http://kff.org/health-costs/report/2016-employer-health-benefits-survey/).

Endnotes

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   ← Return to text (http://kff.org/disparities-policy/issue-brief/access-to-employer-sponsored-health-coverage-for-same-sex-spouses/#endnote_link_202256-1)
2. Kaiser Family Foundation's analysis of the Current Population Survey.
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3. See Exhibit 2.11, *Among Firms Offering Health Benefits, Percentage of Firms That Offer to Spouses, Dependents and Partners, 2016* from The Kaiser Family Foundation/Health Research & Educational Trust (Kaiser/HRET) 2016 Annual Employer Health Benefits Survey (2016). Exhibit available here: https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-2-111.png

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5. Massachusetts became the first state to recognize same-sex marriage in 2003. By June 2013, 12 states and the District of Columbia recognized gay marriage. (See Honan, E. June 26, 2013. "Factbox: List of states that legalized gay marriage." *Reuters.* Retrieved from: http://www.reuters.com/article/us-usa-court-gaymarriage-states-idUSBRE95P07A20130626 (http://www.reuters.com/article/us-usa-court-gaymarriage-states-idUSBRE95P07A20130626).)

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6. See exhibit 2.13 *Among Firms Offering Health Benefits, Percent of Firms that Offer to Unmarried Same-sex and Opposite-sex Domestic Partners, by Firm Size, 2008-2016,* from The Kaiser Family Foundation/Health Research & Educational Trust (Kaiser/HRET) 2016 Annual Employer Health Benefits Survey (2016). Exhibit available here: https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-2-13.png (https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-2-13.png)

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8. However, the *Windsor* decision ensures federal employees and contractor employees, have access to same-sex spousal coverage at parity with opposite-sex spousal coverage offerings and the *Obergefell* ruling means that spousal coverage benefits should be extended to state and municipal employees across the nation to the same degree as their heterosexual counterparts.

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11. See exhibit M.2, *Distribution of Employers, Workers, and Workers covered by Health Benefits, by firm size, 2016* from The Kaiser Family Foundation/Health Research & Educational Trust (Kaiser/HRET) 2016 Annual Employer Health Benefits Survey (2016). Exhibit available here: https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-m-2.png (https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-m-2.png)

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12. See exhibit M.2, *Distribution of Employers, Workers, and Workers covered by Health Benefits, by firm size, 2016* from The Kaiser Family Foundation/Health Research & Educational Trust (Kaiser/HRET) 2016 Annual Employer Health Benefits Survey (2016). Exhibit available here: https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-m-2.png (https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-m-2.png)

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13. See exhibit 2.13 *Among Firms Offering Health Benefits, Percent of Firms that Offer to Unmarried Same-sex and Opposite-sex Domestic Partners, by Firm Size, 2008-2016,* from The Kaiser Family Foundation/Health Research & Educational Trust (Kaiser/HRET) 2016 Annual Employer Health Benefits Survey (2016). Exhibit available here: https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-2-13.png (https://kaiserfamilyfoundation.files.wordpress.com/2016/09/8905-exhibit-2-13.png)

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