SURVEY BRIEF
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Health Insurance Coverage Eight Years After the ACA:

Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured

Sara R. Collins
Vice President
The Commonwealth Fund

Herman K. Bhupal
Program Associate
The Commonwealth Fund

Michelle M. Doty
Vice President
The Commonwealth Fund

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What does health insurance coverage look like for Americans today, more than eight years after the Affordable Care Act's passage? In this brief, we present findings from the Commonwealth Fund's latest Biennial Health Insurance Survey to assess the extent and quality of coverage for U.S. working-age adults. Conducted since 2001, the survey uses three measures to gauge the adequacy of people's coverage:

- whether or not they have insurance
- if they have insurance, whether they have experienced a gap in their coverage in the prior year
- whether high out-of-pocket health care costs and deductibles are causing them to be underinsured, despite having continuous coverage throughout the year.

As the findings highlighted below show, the greatest deterioration in the quality and comprehensiveness of coverage has occurred among people in employer plans. More than half of Americans under age 65 — about 158 million people — get their health insurance through an employer, while about one-quarter either have a plan purchased through the individual insurance market or are enrolled in Medicaid.[1] Although the ACA has expanded and improved coverage options for people without access to a job-based health plan, the law largely left the employer market alone.[2]

SURVEY HIGHLIGHTS

- Today, 45 percent of U.S. adults ages 19 to 64 are inadequately insured — nearly the same as in 2010 — though important shifts have taken place.
- Compared to 2010, many fewer adults are uninsured today, and the duration of coverage gaps people experience has shortened significantly.
- Despite actions by the Trump administration and Congress to weaken the ACA, the adult uninsured rate was 12.4 percent in 2018 in this survey, statistically unchanged from the last time we fielded the survey in 2016.

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- More people who have coverage are underinsured now than in 2010, with the greatest increase occurring among those in employer plans.
- People who are underinsured or spend any time uninsured report cost-related problems getting care and difficulty paying medical bills at at higher rates than those with continuous, adequate coverage.
- Federal and state governments could enact policies to extend the ACA's health coverage gains and improve the cost protection provided by individual-market and employer plans.

The 2018 Commonwealth Fund Biennial Heath Insurance Survey included a nationally representative sample of 4,225 adults ages 19 to 64. SSRS conducted the telephone survey between June 27 and November 11, 2018.[3] (See "How We Conducted This Study" for more detail.)

WHO IS UNDERINSURED?

In this analysis, we use a measure of underinsurance that accounts for an insured adult's reported out-of-pocket costs over the course of a year, not including insurance premiums, as well as his or her plan deductible. (The measure was first used in the Commonwealth Fund's 2003 Biennial Health Insurance Survey.*) These actual expenditures and the potential risk of expenditures, as represented by the deductible, are then compared with household income. Specifically, we consider people who are insured all year to be underinsured if:

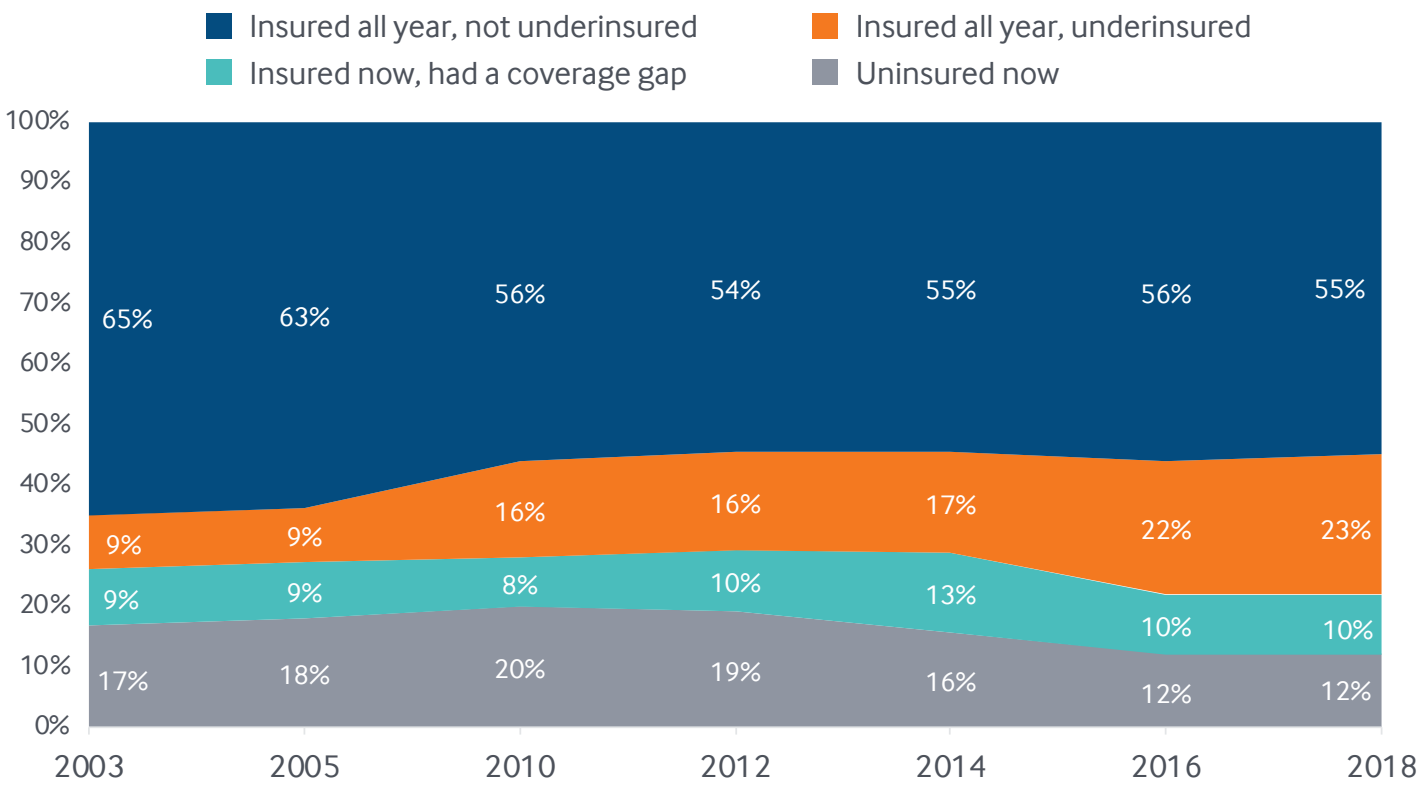
- their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; or
- their out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 5 percent or more of household income for individuals living under 200 percent of the federal poverty level ($24,120 for an individual or $49,200 for a family of four); or
- their deductible constitutes 5 percent or more of household income.

The out-of-pocket cost component of the measure is only triggered if a person uses his or her plan to obtain health care. The deductible component provides an indicator of the financial protection the plan offers and the risk of incurring costs before someone gets health care. The definition does not include other dimensions of someone's health plan that might leave them potentially exposed to costs, such as copayments or uncovered services. It therefore provides a conservative measure of underinsurance in the United States.

* Cathy Schoen et al., "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, published online June 14, 2005.

Since the ACA, Fewer Adults Are Uninsured, but More Are Underinsured

Percent of adults ages 19–64



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

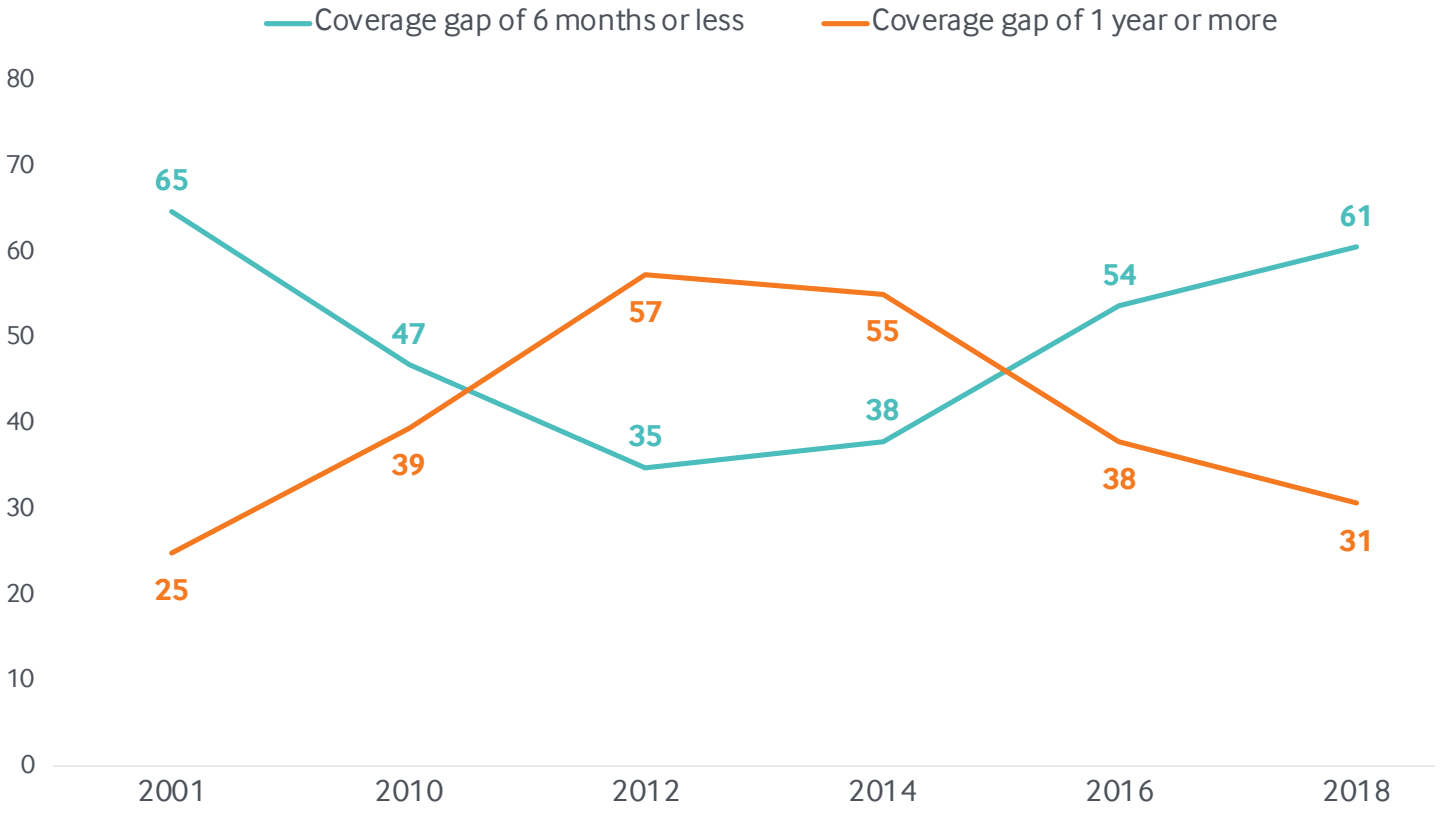
Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

Compared to 2010, when the ACA became law, fewer people today are uninsured, but more people are underinsured. Of the 194 million U.S. adults ages 19 to 64 in 2018, an estimated 87 million, or 45 percent, were inadequately insured (see Tables 1 and 2).

Despite actions by the Trump administration and Congress to weaken the ACA, our survey found no statistically significant change in the adult uninsured rate by late 2018 compared to 2016 (Table 3). This finding is consistent with recent federal surveys, but other private surveys (including other Commonwealth Fund surveys) have found small increases in uninsured rates since 2016 (see Changes in U.S. Uninsured Rates Since 2013).

Since the ACA, Gaps in People's Coverage Have Been Shorter

Percent of adults ages 19–64 insured now but had a coverage gap in past year

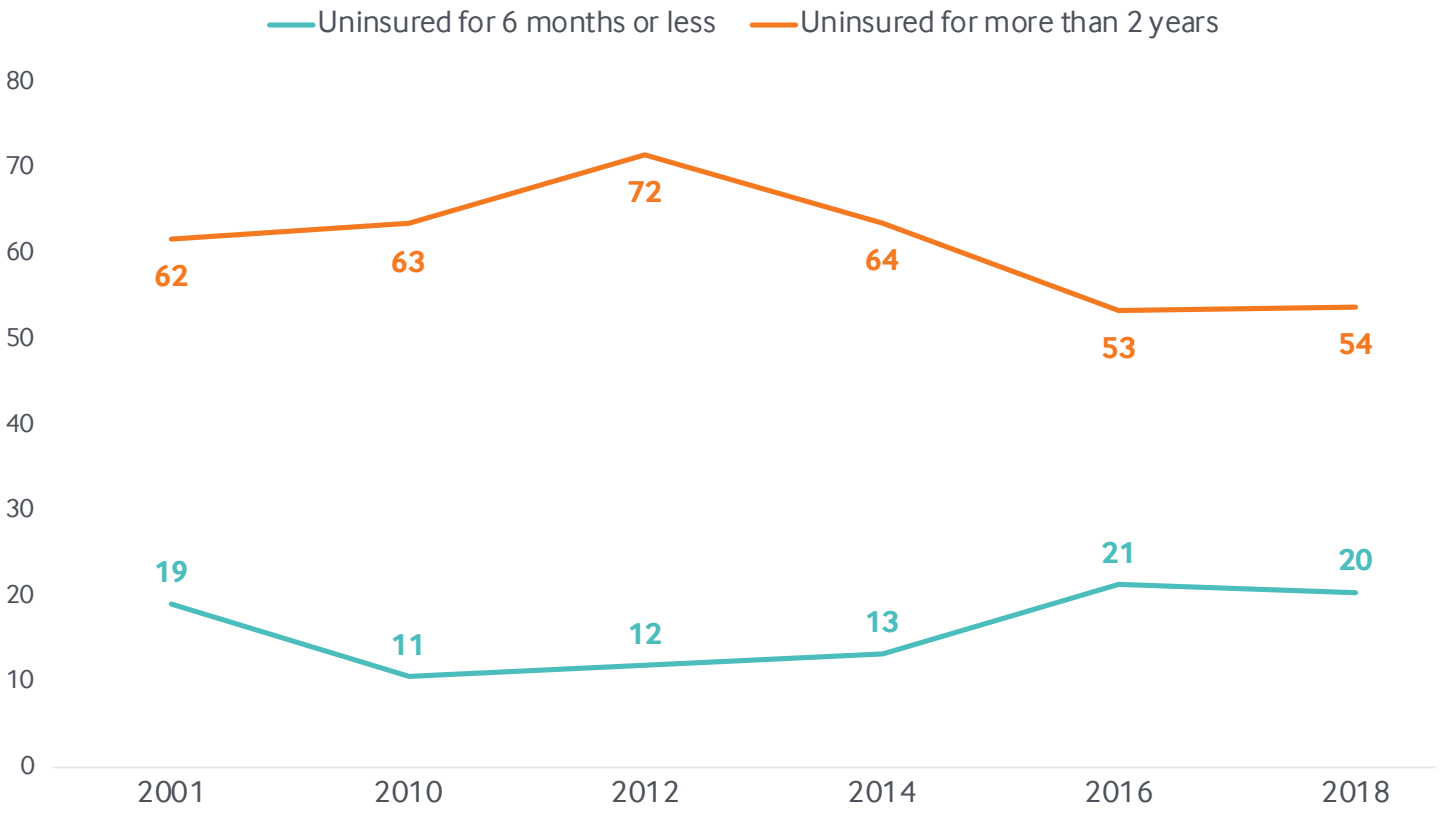


Data: Commonwealth Fund Biennial Health Insurance Surveys (2001, 2010, 2012, 2014, 2016, 2018).

While there has been no change since 2010, statistically speaking, in the proportion of people who are insured now but have experienced a recent time without coverage, these reported gaps are of much shorter duration on average than they were before the ACA. In 2018, 61 percent of people who reported a coverage gap said it has lasted for six months or less, compared to 31 percent who said they had been uninsured for a year or longer. This is nearly a reverse of what it was like in 2012, two years before the ACA's major coverage expansions. In that year, 57 percent of adults with a coverage gap reported it was for a year or longer, while one-third said it was a shorter gap.

There Has Been Some Improvement in Long-Term Uninsured Rates

Percent of adults ages 19–64 who are uninsured now

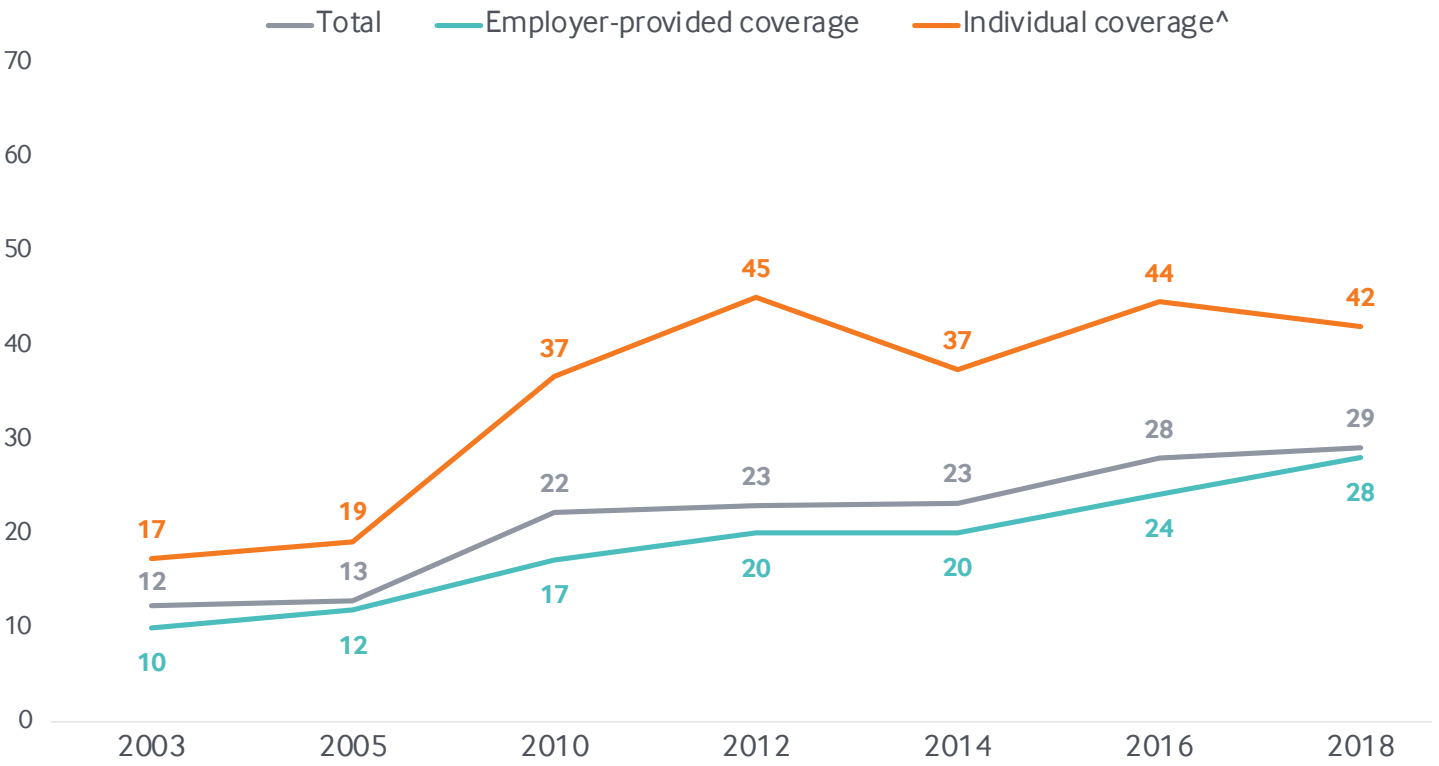


Data: Commonwealth Fund Biennial Health Insurance Surveys (2001, 2010, 2012, 2014, 2016, 2018).

There also has been some improvement in long-term uninsured rates. Among adults who were uninsured at the time of the survey, 54 percent reported they had been without coverage for two years or longer, down from 72 percent before the ACA coverage expansions went into effect. The share of those who had been uninsured for six months or less climbed to 20 percent, nearly double the rate prior to the coverage expansions.

More Adults Are Underinsured, with the Greatest Growth Occurring Among Those with Employer Coverage

Percent of adults ages 19–64 insured all year who were underinsured



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. Total includes adults with coverage through Medicaid and Medicare. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace.

Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

Of people who were insured continuously throughout 2018, an estimated 44 million were underinsured because of high out-of-pocket costs and deductibles (Table 1). This is up from an estimated 29 million in 2010 (data not shown). The most likely to be underinsured are people who buy plans on their own through the individual market including the marketplaces. However, the greatest growth in the number of underinsured adults is occurring among those in employer health plans.

Why Are Insured Americans Spending So Much of Their Income on Health Care Costs?

Several factors may be contributing to high underinsured rates among adults in individual market plans and rising rates in employer plans:

1. **Although the Affordable Care Act's reforms to the individual market have provided consumers with greater protection against health care costs, many moderate-income Americans have not seen gains.** The ACA's essential health benefits package, cost-sharing reductions for lower-income families, and out-of-pocket cost limits have helped make health care more affordable for millions of Americans. But while the cost-sharing reductions have been particularly important in lowering deductibles and copayments for people with incomes under 250 percent of the poverty level (about $62,000 for a family of four), about half of people who purchase marketplace plans, and all of those buying plans directly from insurance companies, do not have them.[4]

2. **The bans against insurers excluding people from coverage because of a preexisting condition and rating based on health status have meant that individuals with greater health needs, and thus higher costs, are now able to get health insurance in the individual market.** Not surprisingly, the survey data show that people with individual market coverage are somewhat more likely to have health problems than they were in 2010, which means they also have higher costs.

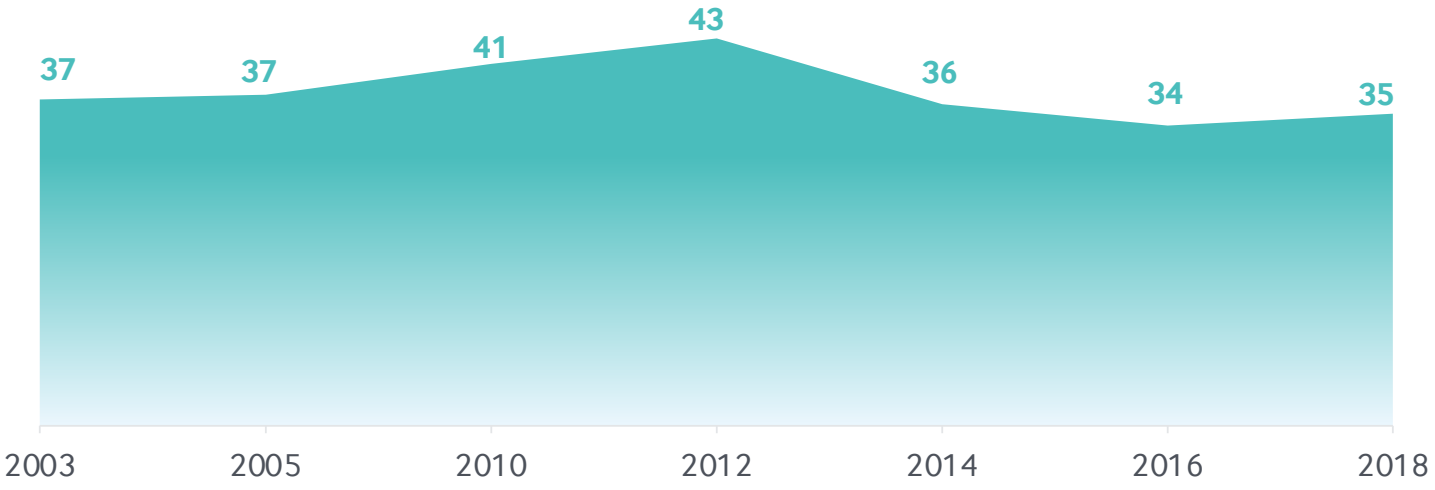
3. **While plans in the employer market historically have provided greater cost protection than plans in the individual market, businesses have tried to hold down premium growth by asking workers to shoulder an increasing share of health costs, particularly in the form of higher deductibles.**[5] While the ACA's employer mandate imposed a minimum coverage requirement on large companies, the requirement amounts to just 60 percent of typical person's overall costs. This leaves the potential for high plan deductibles and copayments.

4. **Growth in Americans' incomes has not kept pace with growth in health care costs.** Even when health costs rise more slowly, they can take an increasingly larger bite out of incomes.

Fewer Adults Report Not Getting Needed Care Because of Costs, but Gains Have Stalled in Recent Years

Percent of adults ages 19–64 who reported any of the following cost-related access problems in the past year:

- *Had a medical problem but did not visit doctor or clinic*
- *Did not fill a prescription*
- *Skipped recommended test, treatment, or follow-up*
- *Did not get needed specialist care*

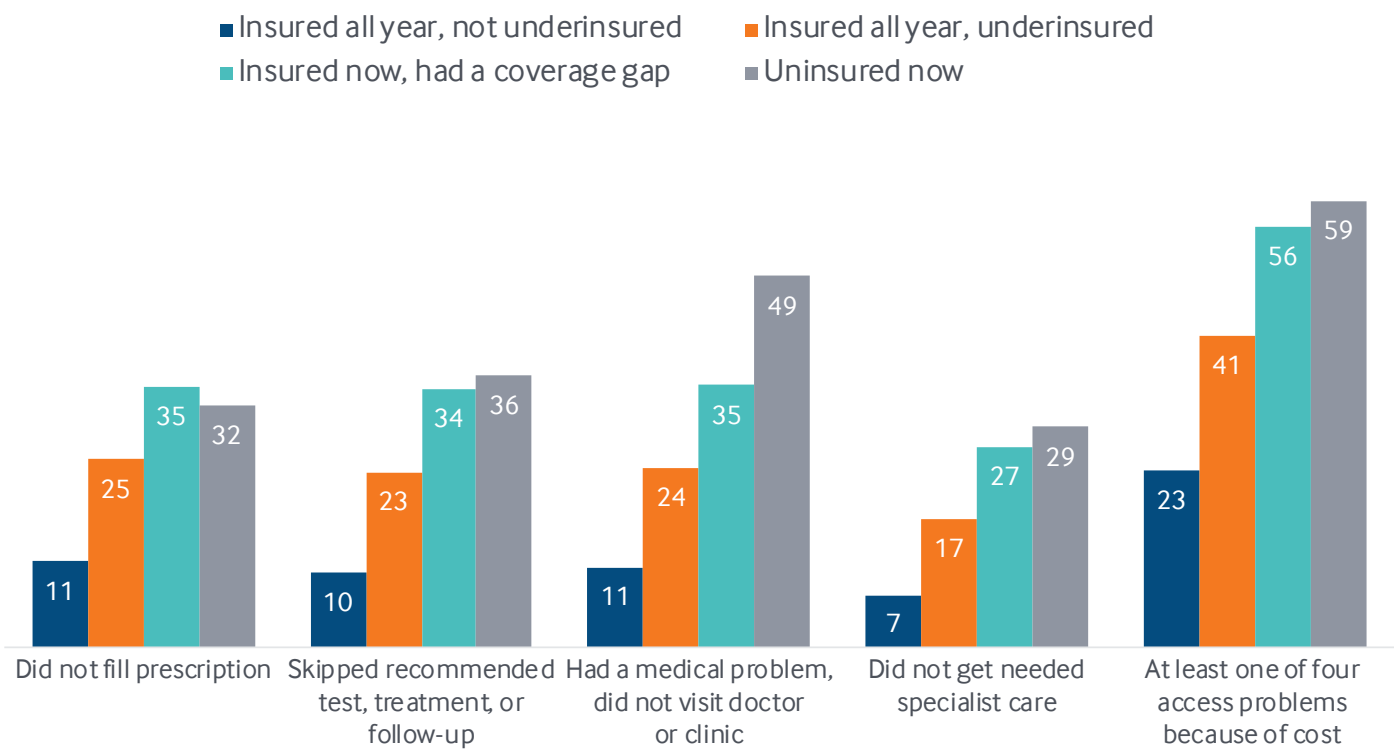


Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

It is well documented that people who gained coverage under the ACA's expansions have better access to health care as a result.[6] This has led to overall improvement in health care access, as indicated by multiple surveys.[7] In 2014, the year the ACA's major coverage expansions went into effect, the share of adults in our survey who said that cost prevented them from getting health care that they needed, such as prescription medication, dropped significantly (Table 4). But there has been no significant improvement since then.

Inadequate Coverage Is Associated with More Cost-Related Problems Getting Needed Care

*Percent of adults ages 19–64 who had any of four access problems in past year because of cost**



Notes: * Includes any of the following because of cost: did not fill a prescription; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic; did not see a specialist when needed. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

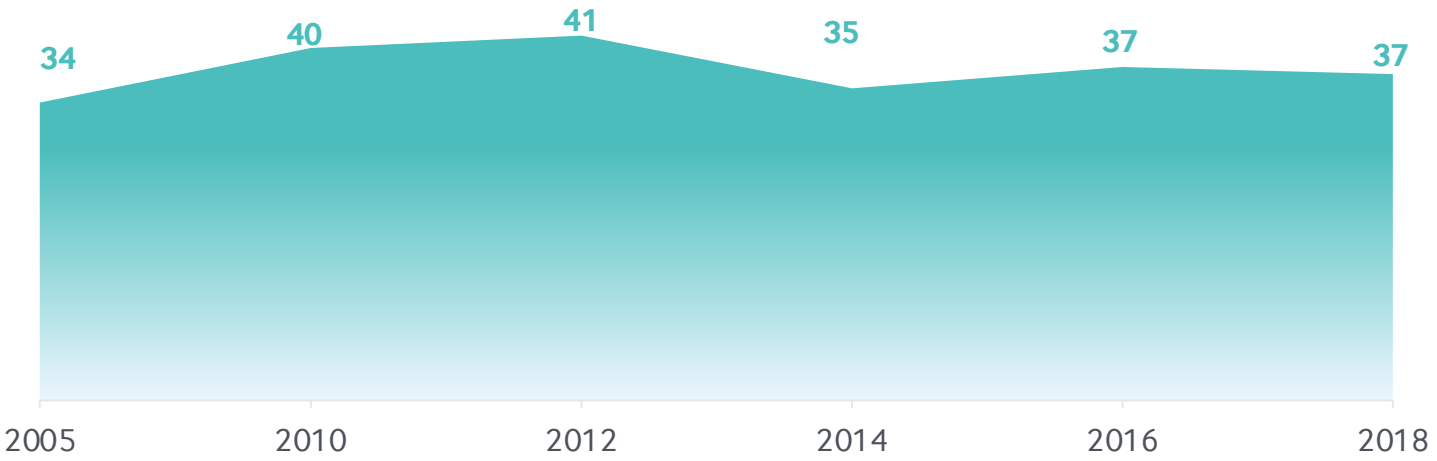
Data: Commonwealth Fund Biennial Health Insurance Survey (2018).

The lack of continued improvement in overall access to care nationally reflects the fact that coverage gains have plateaued, and underinsured rates have climbed. People who experience any time uninsured are more likely than any other group to delay getting care because of cost (Table 5). And among people with coverage all year, those who were underinsured reported cost-related delays in getting care at nearly double the rate of those who were not underinsured.

Fewer Adults Have Difficulty Paying Their Medical Bills, but the Improvement Has Stalled

Percent of adults ages 19–64 who reported any of the following medical bill or debt problems in the past year:

- *Had problems paying or unable to pay medical bills*
- *Contacted by a collection agency for unpaid medical bills*
- *Had to change way of life to pay bills*
- *Medical bills/debt being paid off over time*

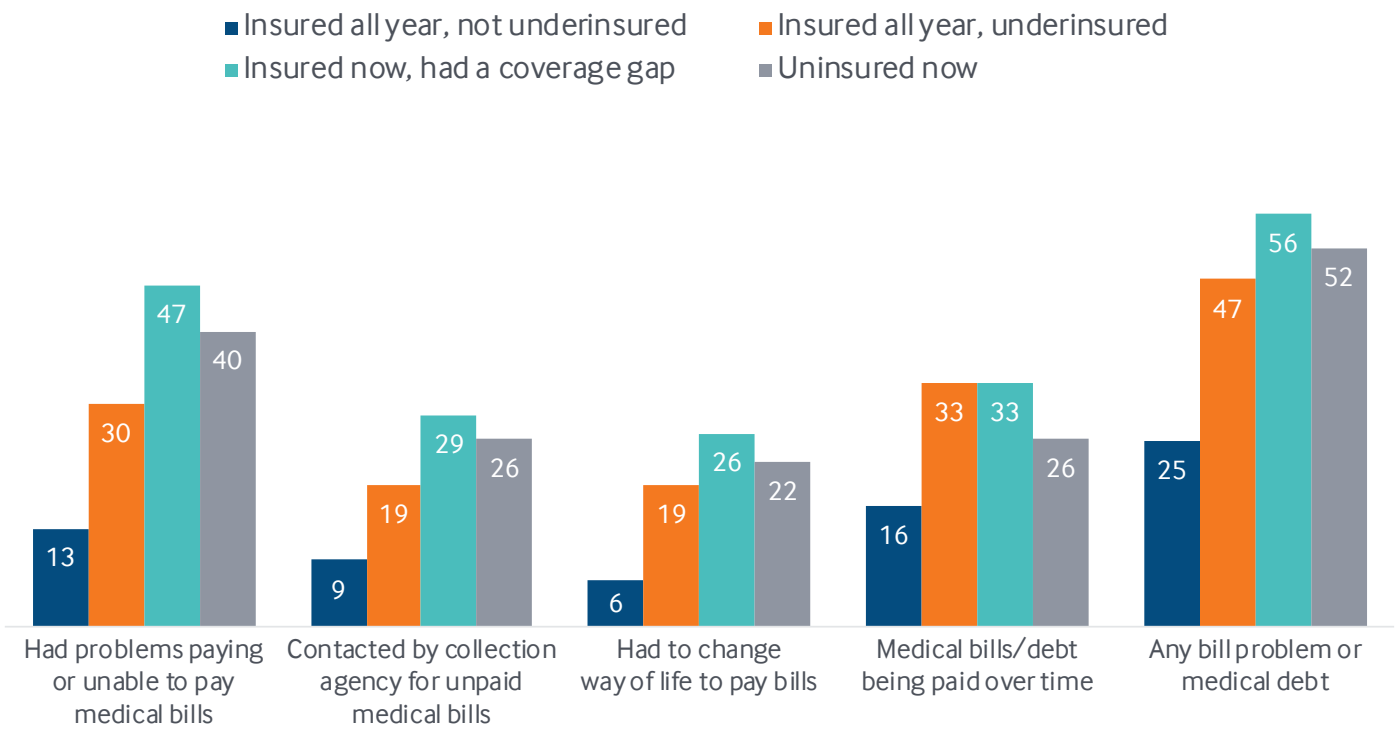


Data: Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, 2014, 2016, 2018).

There was modest but significant improvement following the ACA's coverage expansions in the proportion of all U.S. adults who reported having difficulty paying their medical bills or said they were paying off medical debt over time (Table 4). Federal surveys have found similar improvements.[8] However, those gains have stalled.

Inadequate Coverage Is Associated with More Problems Paying Medical Bills

*Percent of adults ages 19–64 who had medical bill or debt problems in past year**



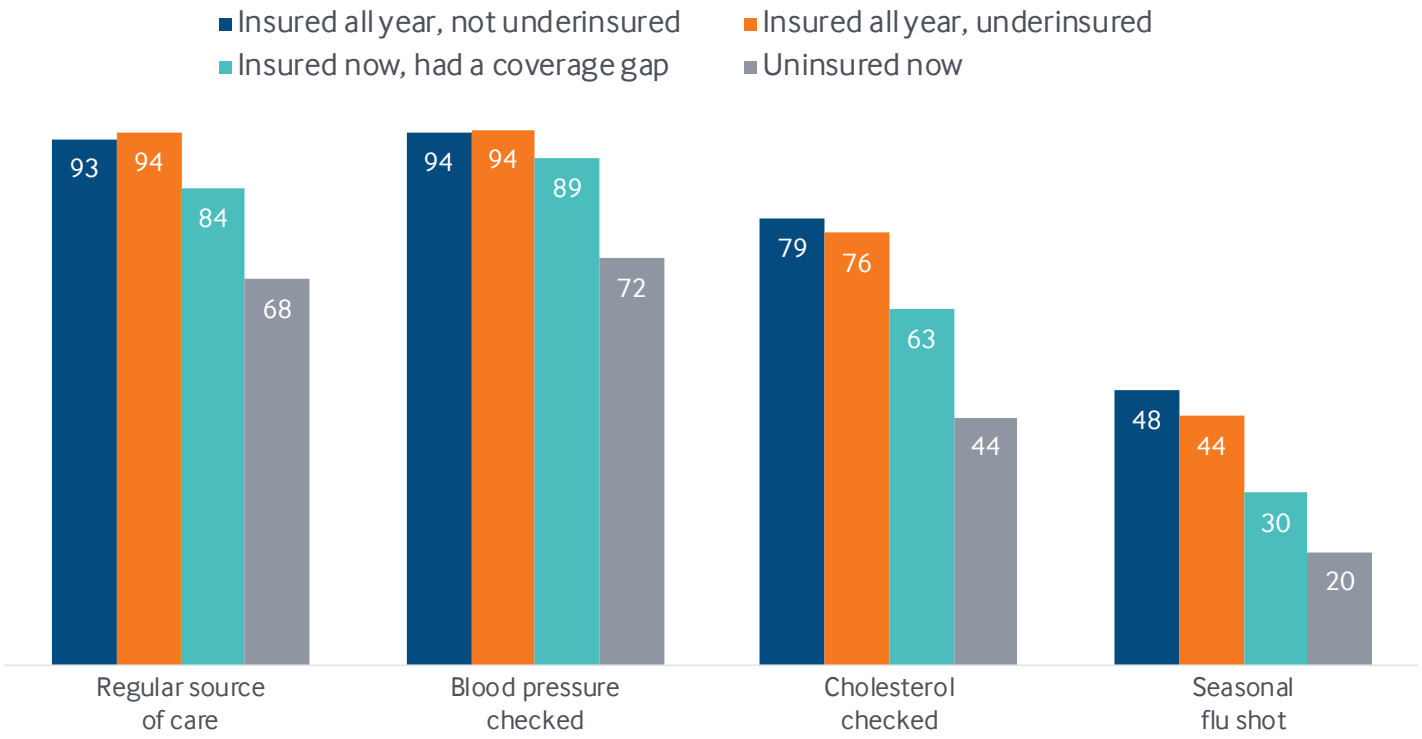
Notes: * Includes any of the following: had problems paying or unable to pay medical bills; contacted by collection agency for unpaid medical bills; had to change way of life to pay bills; medical bills/debt being paid over time. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).

Inadequate insurance coverage leaves people exposed to high health care costs, and these expenses can quickly turn into medical debt. More than half of uninsured adults and insured adults who have had a coverage gap reported that they had had problems paying medical bills or were paying off medical debt over time (Table 6). Among people who had continuous insurance coverage, the rate of medical bill and debt problems is nearly twice as high for the underinsured as it is for people who are not underinsured.

Continuously Insured Adults, Including Those Underinsured, Are More Likely to Get Preventive Care

Percent of adults ages 19–64



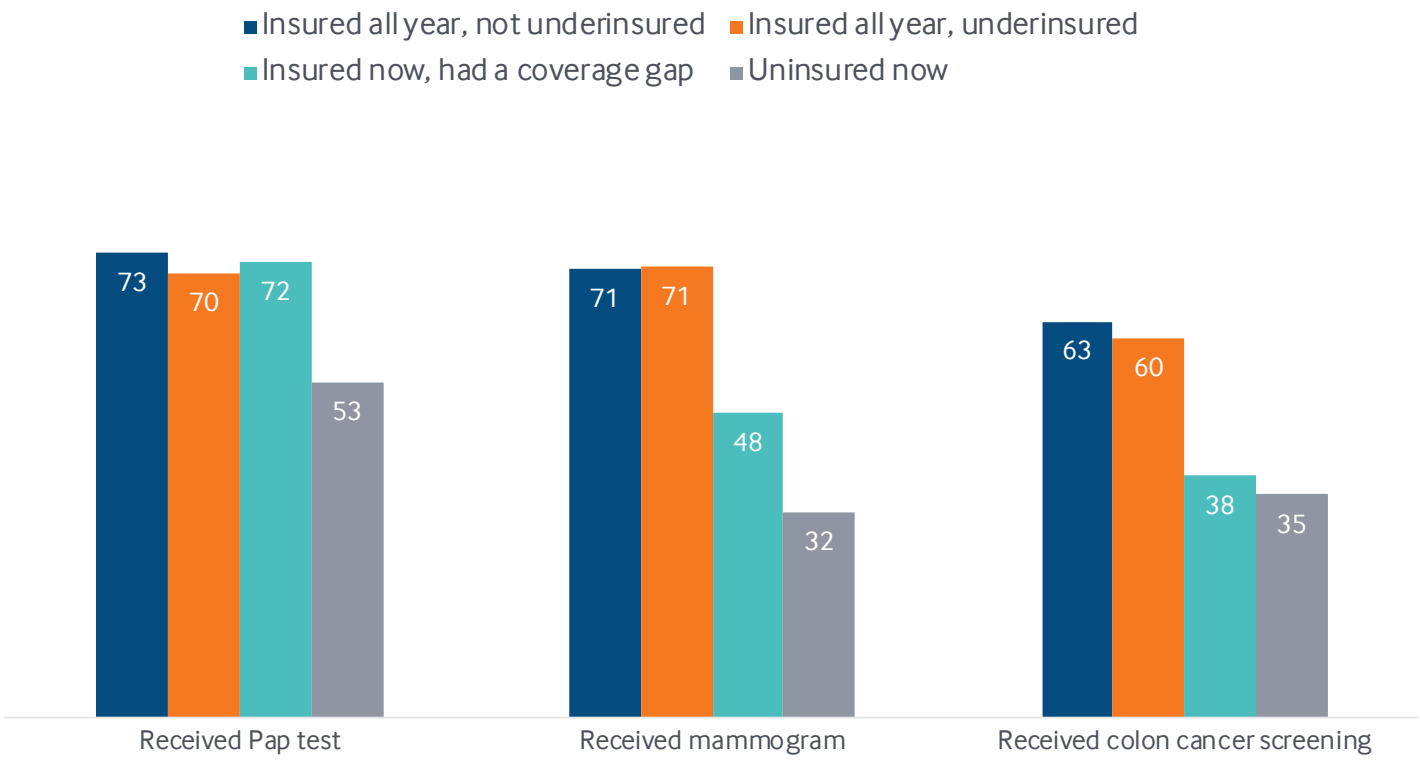
Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey. Respondents were asked if they: had their blood pressure checked within the past two years (in past year if has hypertension or high blood pressure); had their cholesterol checked in past five years (in past year if has hypertension, heart disease, or high cholesterol); and had their seasonal flu shot within the past 12 months.

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).

Having continuous coverage makes a significant difference in whether people have a regular source of care, get timely preventive care, or receive recommended cancer screenings. Adults with coverage gaps or those who were uninsured when they responded to the survey were the least likely to have gotten preventive care and cancer screenings in the recommended time frame.

Continuously Insured Adults, Including Those Underinsured, Are More Likely to Get Cancer Screenings

Percent of adults ages 19–64



Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date. "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey. Respondents were asked if they: received a Pap test within the past three years for females ages 21–64, received a mammogram within the past two years for females ages 40–64, and received a colon cancer screening within the past five years for adults ages 50–64.

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).

Being underinsured, however, does not seem to reduce the likelihood of having a usual source of care or receiving timely preventive care or cancer screens — provided a person has continuous coverage. This is likely because the ACA requires insurers and employers to cover recommended preventive care and cancer screens without cost-sharing. Even prior to the ACA, a majority of employer plans provided predeductible coverage of preventive services.[9]

CONCLUSION AND POLICY IMPLICATIONS

U.S. working-age adults are significantly more likely to have health insurance since the ACA became law in 2010. But the improvement in uninsured rates has stalled. In addition, more people have health plans that fail to adequately protect them from health care costs, with the fastest deterioration in cost protection occurring in the employer market. The ACA made only minor changes to employer plans, and the erosion in cost protection has taken a bite out of the progress made in Americans' health coverage since the law's enactment.

Both the federal government and the states, however, have the ability to extend the law's coverage gains and improve the cost protection of both individual-market and employer plans. Here is a short list of policy options:

Increase Coverage

- ***Expand Medicaid without restrictions.*** The 2018 midterm elections moved as many as five states closer to joining the 32 states that, along with the District of Columbia, have expanded eligibility for Medicaid under the ACA.[10] As many as 300,000 people may ultimately gain coverage as a result.[11] But, encouraged by the Trump administration, several states are imposing work requirements on people eligible for Medicaid — a move that could reverse these coverage gains. So far, the U.S. Department of Health and Human Services (HHS) has approved similar work-requirement waivers in seven states and is considering applications from at least seven more. Arkansas imposed a work requirement last June, and, to date, more than 18,000 adults have lost their insurance coverage as a result.
- ***Ban or place limits on short-term health plans and other insurance that doesn't comply with the ACA.*** The Trump administration loosened regulations on short-term plans that don't comply with the ACA, potentially leaving people who enroll in them exposed to high costs and insurance fraud. These plans also will draw healthier people out of the marketplaces, increasing premiums for those who remain and federal costs of premium subsidies. Twenty-three states have banned or placed limits on short-term insurance policies. Some lawmakers have proposed a federal ban.
- ***Reinsurance, either state or federal.*** The ACA's reinsurance program was effective in lowering marketplace premiums. After it expired in 2017, several states implemented their own reinsurance programs.[12] Alaska's program reduced premiums by 20 percent in 2018. These lower costs particularly help people whose incomes are too high to qualify for ACA premium tax credits. More states are seeking federal approval to run programs in their states. Several congressional bills have proposed a federal reinsurance program.
- ***Reinstate outreach and navigator funding for the 2020 open-enrollment period.*** The administration has nearly eliminated funding for advertising and assistance to help people enroll in marketplace plans.[13] Research has found that both activities are effective in increasing enrollment.[14] Some lawmakers have proposed reinstating this funding.
- ***Lift the 400-percent-of-poverty cap on eligibility for marketplace tax credits.*** This action would help people with income exceeding $100,000 (for a family of four) better afford marketplace plans. The tax credits work by capping the amount people pay toward their premiums at 9.86 percent. Lifting the cap has a built in phase out: as income rises, fewer people qualify, since premiums consume an increasingly smaller share of incomes. RAND researchers estimate that this policy change would increase enrollment by 2 million and lower marketplace premiums by as much as 4 percent as healthier people enroll. It would cost the federal government an estimated $10 billion annually.[15] Legislation has been introduced to lift the cap.

- ***Make premium contributions for individual market plans tax deductible.*** People who are self-employed are already allowed to do this.[16]
- ***Fix the so-called family coverage glitch.*** People with employer premium expenses that exceed 9.86 percent of their income are eligible for marketplace subsidies, which trigger a federal tax penalty for their employers. There's a catch: this provision applies only to single-person policies, leaving many middle-income families caught in the "family coverage glitch." Congress could lower many families' premiums by pegging unaffordable coverage in employer plans to family policies instead of single policies.[17]

Reduce Coverage Gaps

- ***Inform the public about their options.*** People who lose coverage during the year are eligible for special enrollment periods for ACA marketplace coverage. Those eligible for Medicaid can sign up at any time. But research indicates that many people who lose employer coverage do not use these options.[18] The federal government, the states, and employers could increase awareness of insurance options outside the open-enrollment periods through advertising and education.
- ***Reduce churn in Medicaid.*** Research shows that over a two-year period, one-quarter of Medicaid beneficiaries leave the program and become uninsured.[19] Many do so because of administrative barriers.[20] By imposing work requirements, as some states are doing, this involuntary disenrollment is likely to get worse. To help people stay continuously covered, the federal government and the states could consider simplifying and streamlining the enrollment and reenrollment processes.
- ***Extend the marketplace open-enrollment period.*** The current open-enrollment period lasts just 45 days. Six states that run their own marketplaces have longer periods, some by as much as an additional 45 days. Other states, as well as the federal marketplace, could extend their enrollment periods as well.

Improve Individual-Market Plans' Cost Protections

- ***Fund and extend the cost-sharing reduction subsidies.*** The Trump administration eliminated payments to insurers for offering plans with lower deductibles and copayments. Insurers, which by law must still offer reduced-cost plans, are making up the lost revenue by raising premiums. But this fix, while benefiting enrollees who are eligible for premium tax credits, has distorted both insurer pricing and consumer choice.[21] In addition, it is unknown whether the administration's support for the fix will continue in the future, creating uncertainty for insurers.[22] Congress could reinstate the payments to insurers and consider making the plans available to people with higher earnings.
- ***Increase the number of services excluded from the deductible.*** Most plans sold in the individual market exclude certain services from the deductible, such as primary care visits and certain prescriptions.[23] As the survey data suggest, these types of exclusions appear to be important in ensuring access to preventive care among people who have coverage but are underinsured. In 2016, HHS provided a standardized plan option for insurers that excluded eight health services — including mental health and substance-use disorder outpatient visits and most prescription drugs — from the deductible at the silver and gold level.[24] The Trump administration eliminated the option in 2018. Congress could make these exceptions mandatory for all plans.

Improve Employer Plans' Cost Protections

- ***Increase the ACA's minimum level of coverage.*** Under the ACA, people in employer plans may become eligible for marketplace tax credits if the actuarial value of their plan is less than 60 percent, meaning that under 60 percent of health care costs, on average, are covered. Congress could increase this to the 70 percent standard of silver-level marketplace plans, or even higher.
- ***Require deductible exclusions.*** Congress could require employers to increase the number of services that are covered before someone meets their deductible. Most employer plans exclude at least some services from their deductibles.[25] Congress could specify a minimum set of exclusions for employer plans that might resemble the standardized-choice options that once existed for ACA plans.
- ***Refundable tax credits for high out-of-pocket costs.*** Congress could make refundable tax credits available to help insured Americans pay for qualifying out-of-pocket costs that exceed a certain percentage of their income.[26]
- ***Protect consumers from surprise medical bills.*** Several states have passed laws that protect patients and their families from unexpected medical bills, generally from out-of-network providers.[27] A bipartisan group of U.S. senators has proposed federal legislation to protect consumers, including people enrolled in employer and individual-market plans.

Health care costs are primarily what's driving growth in premiums across all health insurance markets. Employers and insurers have kept premiums down by increasing consumers' deductibles and other cost-sharing, which in turn is making more people underinsured. This means that policy options like the ones we've highlighted above will need to be paired with efforts to slow medical spending. These could include changing how health care is organized and providers are paid to achieve greater value for health care dollars and better health outcomes.[28] The government also could tackle rising prescription drug costs[29] and use antitrust laws to combat the growing concentration of insurer and provider markets.[30]

HOW WE CONDUCTED THIS STUDY

The Commonwealth Fund Biennial Health Insurance Survey, 2018, was conducted by SSRS from June 27 to November 11, 2018. The survey consisted of telephone interviews in English and Spanish and was conducted among a random, nationally representative sample of 4,225 adults ages 19 to 64 living in the continental United States. A combination of landline and cellular phone random-digit dial samples was used to reach people. In all, 725 interviews were conducted with respondents on landline telephones and 3,500 interviews were conducted on cellular phones.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. Statistical results are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau's 2017 Annual Social and Economic Supplement.

The resulting weighted sample is representative of the approximately 193.9 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level. The RDD landline portion of the survey achieved a 8.4 percent response rate and the RDD cellular phone component achieved a 5.2 percent response rate.

We also report estimates from the 2001, 2003, 2005, 2010, 2012, 2014, and 2016 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy that was used in 2018, except the 2001, 2003, and 2005 surveys did not include a cellular phone random-digit dial sample. In 2001, the survey was conducted from April 27 through July 29, 2001, and included 2,829 adults ages 19 to 64; in 2003, the survey was conducted from September 3, 2003, through January 4, 2004, and included 3,293 adults ages 19 to 64; in 2005, the survey was conducted from August 18, 2005, to January 5, 2006, among 3,352 adults ages 19 to 64; in 2010, the survey was conducted from July 14 to November 30, 2010, among 3,033 adults ages 19 to 64; in 2012, the survey was conducted from April 26 to August 19, 2012, among 3,393 adults ages 19 to 64; in 2014, the survey was conducted from July 22 to December 14, 2014, among 4,251 adults ages 19 to 64; and in 2016, the survey was conducted from July 12 to November 20, 2016, among 4,186 adults ages 19 to 64.

CHANGES IN U.S. UNINSURED RATES SINCE 2013

Uninsured Rate for Adults Compared to Other Surveys Since 2013

Survey	Pre-implementation uninsured rate (%) [95% CI]	Lowest uninsured rate (%) [95% CI]	Current uninsured rate (%) [95% CI]
Commonwealth Fund Biennial Health Insurance Survey[a]	19.3% [17.5%–21.3%]	12.0% [10.7%–13.52%] (July–Nov. 2016)	12.4% [11.2%–13.7%]
Commonwealth Fund Affordable Care Act Tracking Survey[b]	19.9% [18.5%–21.4%]	12.7% [11.5%–14.0%] (Feb.–Apr. 2016)	15.5% [13.7%–17.5%]
National Health Interview Survey (NHIS) (2016)[c]	20.4% [19.7%–21.1.%]	12.4% [11.7%–13.1%] (2016)	12.5% [11.6%–13.4%]
Current Population Survey (CPS)[d]	18.3%	11.9% (2016)	12.1%
Gallup Healthways Well-Being Index[e,f]	20.8%	13.1% (Q4 2016)	16.3%
Urban Institute Health Reform Monitoring Survey[g]	17.4%	9.8% (Q1 2016)	10.8%

Methodological Differences Between Surveys

Survey	Population	Time Frame	Sample Frame	Response Rate
Commonwealth Fund Biennial Health Insurance Survey	U.S. adults ages 19–64	Apr.–Aug 2012 to June–Nov. 2018	Dual-frame, RDD telephone survey	2012: 22% landline, 19% cell; 2018: 8.4% landline, 5.2% cell
Commonwealth Fund Affordable Care Act Tracking Survey	U.S. adults ages 19–64	July–Sept. 2013 to Feb.–Mar. 2018	Dual-frame, RDD telephone survey	2013: 20.1%; 2018: 7.5%
National Health Interview Survey (NHIS) (2016)[h,i]	U.S. adults ages 18–64	2013 to Jan.–June 2018	Multistage area probability design	70%
Current Population Survey (CPS)[d]	U.S. adults ages 18–64	Mar. 2013–2017	Probability-selected sample; personal and telephone interviews[j]	2018: 85%[k]; 2014: 79.6%[l]
Gallup Healthways Well-Being Index[m]	U.S. adults ages 18–64	2013 to Oct.–Dec. 2018	Before 2018: dual-frame RDD telephone survey; 2018: address-based sampling frame with web survey	
Urban Institute Health Reform Monitoring Survey[n]	U.S. adults ages 18–64	July–Sept. 2013 to Jan.–Mar. 2018	KnowledgePanel-probability-based internet panel of 55,000 households	~5%

[a] Commonwealth Fund Biennial Health Insurance Survey, Apr.–Aug. 2012, July–Nov. 2016, June–Nov. 2018.
[b] Commonwealth Fund Affordable Care Act Tracking Survey, July–Sept. 2013, Feb.–Apr. 2016, Feb.–Mar. 2018.
[c] Emily P. Zammitti, Robin A. Cohen, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, Jan.–June 2017* (National Center for Health Statistics, Nov. 2017); and Michael E. Martinez, Emily P. Zammitti, and Robin A. Cohen, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, Jan.–June 2018* (National Center for Health Statistics, Nov. 2018).
[d] U.S. Census Bureau, 2013, 2016, and 2017 *Current Population Reports*; for 2013, see https://www.census.gov/cps/data/cpstablecreator.html.
[e] Stephanie Marken, "U.S. Uninsured Rate at 11.4% in Second Quarter," *Gallup News*, July 10, 2015.
[f] Dan Witters, "U.S. Uninsured Rate Rises to Four-Year High," *Gallup News*, Jan. 23, 2019.
[g] Jennifer Haley et al., "Adults' Uninsurance Rates Increased by 2018, Especially in States That Did Not Expand Medicaid — Leaving Gaps in Coverage, Access, and Affordability," *Health Affairs Blog*, Sept. 26, 2018.
[h] Martinez, Zammitti, and Cohen, *Health Insurance Coverage*, 2018.
[i] National Center for Health Statistics, "About the National Health Interview Survey," fact sheet (NCHS, last updated Jan. 19, 2019).
[j] U.S. Census Bureau, "Current Population Survey (CPS): Methodology," Census Bureau, n.d.
[k] U.S. Census Bureau, "Current Population Survey (CPS): Non-Response Rates," Census Bureau, n.d.
[l] U.S. Census Bureau, "Current Population Survey, 2014 ASEC Technical Documentation," Census Bureau, 2014.
[m] Gallup, "How Does the Gallup National Health and Well-Being Index Work?," Gallup, n.d.
[n] Urban Institute Health Policy Center, "Health Reform Monitoring Survey: HRMS Frequently Asked Questions," Urban, n.d.

Table 1. Insurance Status by Demographics, 2018 (base: adults ages 19–64)

	Total (19–64)	Insured all year	Insured all year, not underinsured	Insured all year, underinsured	Insured now, had a coverage gap	Uninsured now
Total (millions)	**193.9**	**150.6**	**106.8**	**43.8**	**19.3**	**24.0**
Percent distribution	**100.0%**	**77.7%**	**55.1%**	**22.6%**	**10.0%**	**12.4%**
Unweighted n	4225	3254	2272	982	416	555
Gender						
Female	52	78	56	22	11	11
Male	48	77	54	23	9	14
Age						
19–34	32	69	48	21	14	17
35–49	30	79	58	21	9	12
50–64	35	84	59	26	7	8
Race/Ethnicity						
Non-Hispanic White	59	83	58	25	8	9
Black	12	73	56	18	16	11
Latino	18	62	45	17	14	24
Asian/Pacific Islander	4	81	61	21	8	10
Other/Mixed	5	77	51	26	9	14
Poverty status						
Below 133% poverty	25	68	37	31	14	18
133%–249% poverty	19	69	45	24	14	17
250%–399% poverty	19	80	57	23	10	10
400% poverty or more	29	91	75	16	5	3
Below 200% poverty	39	67	39	28	15	18
200% poverty or more	53	86	67	19	7	7
Fair/Poor health status, or any chronic condition*	50	78	54	24	10	12
Adult work status						
Full-time	53	81	59	22	9	10
Part-time	14	67	47	20	16	17
Not currently employed	33	77	52	25	9	14
Employer size**						
1–19 employees	23	66	44	21	10	24
20–49 employees	11	79	59	20	9	13
50–99 employees	8	74	57	17	14	13
100 or more employees	56	85	62	22	10	6

NOTES

"Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

* At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

** Base: Full- and part-time employed adults ages 19–64.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2018).

Table 2. Insurance Status, 2003–2018 (base: adults ages 19–64)

	2003	2005	2010	2012	2014	2016	2018
Total (millions)	**172.0**	**172.5**	**183.6**	**183.9**	**182.8**	**187.4**	**193.9**
Percent distribution	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Unweighted n	3293	3352	3033	3393	4251	4186	4225
Insured all year	74	72	72	70	72	78	78
Insured all year, not underinsured	65	63	56	54	55	56	55
Insured all year, underinsured	9	9	16	16	17	22	23
Insured now, had a coverage gap	9	9	8	10	13	10	10
Uninsured now	17	18	20	19	16	12	12

NOTES

"Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

DATA

Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

Table 3. Uninsured Rate by Demographics, 2003–2018 (base: adults ages 19–64)

	2003	2005	2010	2012	2014	2016	2018
Total (millions uninsured)	**29.8**	**31.6**	**37.1**	**35.5**	**28.7**	**22.6**	**24.0**
Percent distribution	**17%**	**18%**	**20%**	**19%**	**16%**	**12%**	**12%**
Unweighted n	643	716	590	650	685	520	555
Gender							
Female	17	18	20	17	13	11	11
Male	17	18	20	22	19	13	14
Age							
19–34	24	26	27	23	19	15	17
35–49	15	19	20	22	17	14	12
50–64	11	10	13	13	11	8	8
Race/Ethnicity							
Non-Hispanic White	13	13	15	14	10	7	9
Black	23	19	24	20	18	12	11
Latino	37	48	39	40	34	28	24
Asian/Pacific Islander	14	9	9	8	7	4	10
Other/Mixed	17	18	29	29	22	16	14
Poverty status							
Below 133% poverty	—	—	38	35	26	21	18
133%–249% poverty	—	—	26	22	19	14	17
250%–399% poverty	—	—	8	11	11	6	10
400% poverty or more	—	—	4	5	3	3	3
Below 200% poverty	34	39	36	32	24	19	18
200% poverty or more	7	9	7	9	7	4	7
Fair/Poor health status, or any chronic condition*	17	22	22	20	15	13	12
Adult work status							
Full-time	11	14	12	12	11	9	10
Part-time	26	22	32	26	23	16	17
Not currently employed	26	27	28	27	19	15	14
Employer size**							
1–19 employees	28	27	—	25	28	24	24
20–49 employees	17	26	—	30	22	14	13
50–99 employees	14	19	13	12	15	12	13
100 or more employees	7	6	8	9	5	4	6

NOTES

"Uninsured" refers to adults who reported being uninsured at the time of the survey.

— Data not collected or collected differently for that year.

** Base: Full- and part-time employed adults ages 19–64.

DATA

Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

Table 4. Cost-Related Access Problems and Medical Bill Problems by Year (base: adults ages 19–64)

	Percent							Estimated millions						
	2003	2005	2010	2012	2014	2016	2018	2003	2005	2010	2012	2014	2016	2018
Total (adults ages 19–64)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**172.0**	**172.5**	**183.6**	**183.9**	**182.8**	**187.4**	**189.7**
Access problems in past year														
Went without needed care in past year because of cost:														
Did not fill prescription	23	25	26	27	19	19	19	39	43	48	50	35	36	37
Skipped recommended test, treatment, or follow-up	19	20	25	27	19	18	19	32	34	47	49	35	34	36
Had a medical problem, did not visit doctor or clinic	22	24	26	29	23	20	21	38	41	49	53	42	37	40
Did not get needed specialist care	13	17	18	20	13	13	14	22	30	34	37	23	25	27
At least one of four access problems because of cost	37	37	41	43	36	34	35	63	64	75	80	66	63	68
Delayed or did not get dental care	27	—	38	39	32	31	33	46	—	69	72	58	57	65
Medical bill problems in past year														
Had problems paying or unable to pay medical bills	23	23	29	30	23	23	24	40	39	53	55	43	43	46
Contacted by collection agency	21	21	23	22	20	21	22	35	36	42	41	37	38	42
Contacted by collection agency for unpaid medical bills	—	13	16	18	15	14	15	—	22	30	32	27	25	30
Contacted by collection agency because of billing mistake	—	7	5	4	4	5	5	—	11	9	7	8	9	10
Had to change way of life to pay bills	15	14	17	16	14	14	13	26	24	31	29	26	26	26
*Any bill problem**	—	28	34	34	29	29	29	—	48	62	63	53	53	57
Medical bills/debt being paid off over time	—	21	24	26	22	24	23	—	37	44	48	40	46	45
*Any bill problem or medical debt**	—	34	40	41	35	37	37	—	58	73	75	64	70	71

NOTES

— Data not collected for that year.

* Does not include adults who reported being contacted by a collection agency because of a billing mistake..

DATA

Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

Table 5. Cost-Related Access Problems and Preventive Care by Insurance Continuity, Insurance Status, and Poverty

(base: adults ages 19–64)

	Insurance status						Insurance type**				Federal poverty level			
			Insured all year											
	Total 19–64	Insured all year	Insured all year, not underinsured	Insured all year, underinsured	Insured now, had a coverage gap	Uninsured now	Employer	Individual*	Medicaid	Medicare (under age 65, disabled)	Below 133% poverty	133%–249% poverty	250%–399% poverty	400% poverty or more
Total (millions)	**193.9**	**150.6**	**106.8**	**43.8**	**19.3**	**24.0**	**102.6**	**15.8**	**22.5**	**15.8**	**47.8**	**37.5**	**37.4**	**57.1**
Percent distribution	**100%**	**78%**	**55%**	**23%**	**10%**	**12%**	**53%**	**8%**	**12%**	**8%**	**25%**	**19%**	**19%**	**29%**
Unweighted n	4225	3254	2272	982	416	555	2016	360	523	479	1212	796	783	1138
Access problems in past year														
Went without needed care in past year because of cost:														
Did not fill prescription	19	15	11	25	35	32	16	21	22	20	24	22	19	13
Skipped recommended test, treatment, or follow-up	19	14	10	23	34	36	16	25	14	14	18	25	20	14
Had a medical problem, did not visit doctor or clinic	21	15	11	24	35	49	16	24	16	14	24	28	23	13
Did not get needed specialist care	14	10	7	17	27	29	11	17	12	12	16	19	15	8
At least one of four access problems because of cost	35	29	23	41	56	59	31	42	32	32	39	43	38	26
Delayed or did not get dental care	33	28	23	41	49	56	26	38	38	35	39	45	38	21
Preventive care														
Regular source of care	89	93	93	94	84	68	92	86	93	96	88	88	88	93
Blood pressure checked in past two years¥	91	94	94	94	89	72	94	94	89	96	88	89	90	96
Dental exam in past year	60	67	67	67	40	32	72	59	49	40	43	49	61	79
Received mammogram in past two years (females age 40+)	65	71	71	71	48	32	75	60	55	64	56	48	70	75
Received Pap test in past three years (females ages 21–64)	70	72	73	70	72	53	77	64	71	58	67	63	72	78
Received colon cancer screening in past five years (age 50+)	58	62	63	60	38	35	62	52	51	63	50	51	64	63
Cholesterol checked in past five years¥¥	72	78	79	76	63	44	80	70	69	77	63	63	71	87
Seasonal flu shot in past year	42	47	48	44	30	20	48	36	39	55	40	36	38	51
Access problems for people with health conditions														
Unweighted n	*474*	*276*	*118*	*158*	^^	*115*	*143*	^^	^^	^^	*198*	*125*	^^	^^
Skipped doses or did not fill a prescription for medications for the health condition(s) because of the cost of the medicines^	19	14	10	23	^^	45	14	^^	^^	^^	22	30	^^	^^

NOTES

"Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

* Individual includes adults who are enrolled in either marketplace plans or purchased directly off the marketplace.

** Insurance type at time of survey.

¥ In past year if respondent has hypertension or high blood pressure.

¥¥ In past year if respondent has hypertension or high blood pressure, heart disease, or high cholesterol.

^ Base: Respondents with at least one of the following health problems: hypertension or high blood pressure, heart disease, diabetes, asthma, emphysema, lung disease, high cholesterol, depression, kidney disease, cancer, or stroke.

^^ Insufficient sample.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2018).

Table 6. Medical Bill Problems, by Insurance Continuity, Insurance Status, and Poverty (base: adults ages 19–64)

	Insurance status						Insurance type**				Federal poverty level			
			Insured all year											
	Total 19–64	Insured all year	Insured all year, not underinsured	Insured all year, underinsured	Insured now, had a coverage gap	Uninsured now	Employer	Individual*	Medicaid	Medicare (under age 65, disabled)	Below 133% poverty	133%–249% poverty	250%–399% poverty	400% poverty or more
Total (millions)	**193.9**	**150.6**	**106.8**	**43.8**	**19.3**	**24.0**	**102.6**	**15.8**	**22.5**	**15.8**	**47.8**	**37.5**	**37.4**	**57.1**
Percent distribution	**100%**	**78%**	**55%**	**23%**	**10%**	**12%**	**53%**	**8%**	**12%**	**8%**	**25%**	**19%**	**19%**	**29%**
Unweighted n	4225	3254	2272	982	416	555	2016	360	523	479	1212	796	783	1138
Medical bill problems in past year														
Went without needed care in past year because of cost:														
Had problems paying or unable to pay medical bills	24	18	13	30	47	40	19	28	23	35	28	35	28	12
Contacted by collection agency for unpaid medical bills	15	12	9	19	29	26	12	14	15	29	21	27	14	5
Had to change way of life to pay bills	13	10	6	19	26	22	10	16	11	25	16	20	14	7
Any bill problem	29	24	18	38	52	47	23	35	30	46	36	43	32	14
Medical bills/debt being paid off over time	23	21	16	33	33	26	24	22	19	28	21	30	27	19
Any bill problem or medical debt	37	32	25	47	56	52	32	42	35	53	42	48	40	24
Base: Any medical debt														
How much are the medical bills that are being paid off over time?														
Less than $2,000	43	46	51	40	35	36	46	52	36	35	46	40	46	39
$2,000 to less than $4,000	22	23	21	26	18	17	22	24	27	15	20	20	22	27
$4,000 to less than $8,000	17	14	9	21	23	22	18	8	9	18	10	21	16	22
$8,000 to less than $10,000	4	4	3	4	5	7	2	6	9	4	6	5	4	3
$10,000 or more	12	10	11	8	16	18	10	6	17	14	14	11	13	9
Was this for care received in past year or earlier?														
Past year	47	50	53	48	38	35	53	54	34	37	38	41	49	57
Earlier year	46	43	42	43	49	58	39	38	63	55	56	51	39	38
Both	7	6	5	9	11	7	8	5	1	8	5	8	11	5
Were these bills for someone who was insured at the time the care was provided or was the person uninsured then?														
Insured at time care was provided	65	77	77	79	42	30	81	73	45	63	49	55	74	86
Uninsured at time care was provided	28	16	15	17	46	64	13	19	47	29	43	37	21	7

NOTES

"Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. "Insured now, had a coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

* Individual includes adults who are enrolled in either marketplace plans or purchased directly off the marketplace.

** Insurance type at time of survey.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2018).

NOTES

1. Analysis of the 2018 U.S. Current Population Survey by Ougni Chakraborty and Sherry Glied of New York University for the Commonwealth Fund.

2. One of the ACA's most notable provisions aimed at employers was the so-called employer mandate — the requirement that large firms offer affordable coverage to full-time employees or pay penalties.

3. Princeton Survey Research Associates International conducted the prior-year Biennial Surveys analyzed in this brief.

4. Centers for Medicare and Medicaid Services, "Effectuated Enrollment for the First Half of 2018," fact sheet, Nov. 28, 2018.

5. Sara R. Collins and David C. Radley, *The Cost of Employer Insurance Is a Growing Burden for Middle-Income Families* (Commonwealth Fund, Dec. 2018).

6. Benjamin D. Sommers et al.,"Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults," *Health Affairs* Web First, published online May 17, 2017; and Munira Z. Gunja, Sara R. Collins, and Herman K. Bhupal, *Is the Affordable Care Act Helping Consumers Get Health Care? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017* (Commonwealth Fund, Dec. 2017).

7. Tainya C. Clarke, Tina Norris, and Jeannine S. Schiller, *Early Release of Selected Estimates Based on Data From the 2016 National Health Interview Survey* (National Center for Health Statistics, May 2017).

8. Robin A. Cohen and Jeannine S. Schiller, *Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates from the National Health Interview Survey, 2011–June 2016* (National Center for Health Statistics, Dec. 2015).

9. "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," *Federal Register* 75, no. 137 (July 19, 2010): 41726–60.

10. In three states — Idaho, Nebraska, and Utah — voters approved ballot initiatives to expand eligibility for Medicaid; Kansas elected a Democratic governor who has pledged to expand; Maine's newly elected Democratic governor is expanding Medicaid one year after voters approved a ballot initiative to expand. See Donald Moulds et al., "The Midterm Election Results Have Big Implications for Health Care," *To the Point* (blog), Commonwealth Fund, Nov. 7. 2018.

11. Matthew Buettgens, *The Implications of Medicaid Expansion in the Remaining States: 2018 Update* (Urban Institute, May 2018); and Rachel Garfield, Anthony Damico, and Kendal Orgera, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* (Henry J. Kaiser Family Foundation, June 2018).

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13. Sara R. Collins, "Consumers Shopping for Health Plans Are Left in the Dark by Trump Administration," *To the Point* (blog), Commonwealth Fund, July 19, 2018.

14. Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty, *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017* (Commonwealth Fund, Sept. 2017).

15. Jodi Liu and Christine Eibner, *Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market* (Commonwealth Fund, Aug. 2018).

16. Timothy S. Jost, "Fixing Our Most Pressing Health Insurance Problems: A Bipartisan Path Forward," *To the Point* (blog), Commonwealth Fund, July 13, 2017.

17. Christine Eibner, Sarah Nowak, and Jodi Liu, *Hillary Clinton's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit* (Commonwealth Fund, Sept. 2016).

18. Matthew Buettgens, Stan Dorn, and Hannah Recht, *More Than 10 Million Uninsured Could Obtain Marketplace Coverage Through Special Enrollment Periods* (Robert Wood Johnson Foundation and Urban Institute, Nov. 2015).

19. Sara R. Collins, Sherry A. Glied, and Adlan Jackson, *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky* (Commonwealth Fund, Oct. 2018).

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21. Christina Cousart, *How Elimination of Cost-Sharing Reduction Payments Changed Consumer Enrollment in State-Based Marketplaces* (National Academy for State Health Policy, March 20, 2018).

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26. Christine Eibner, Sarah Nowak, and Jodi Liu, *Hillary Clinton's Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit* (Commonwealth Fund, Sept. 2016).

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ABOUT THE AUTHORS

Sara R. Collins, Ph.D., is vice president for Health Care Coverage and Access at the Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, she has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine. Earlier in her career, she was an associate editor at *U.S. News & World Report,* a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. Dr. Collins holds a Ph.D. in economics from George Washington University.

Herman K. Bhupal is program associate in the Health Care Coverage and Access program at the Commonwealth Fund, joining the staff in June 2017. She is responsible for providing daily support for the program, with responsibilities ranging from daily administrative and grants management tasks to writing and research. Prior to joining the Fund, Ms. Bhupal was an associate at PwC Strategy&, where she served several health care clients in a strategy consulting role. She graduated with a B.A. in economics with honors from Harvard University in May 2016.

Michelle McEvoy Doty, Ph.D., is vice president of survey research and evaluation for the Commonwealth Fund. She has authored numerous publications on cross-national comparisons of health system performance, access to quality health care among vulnerable populations, and the extent to which lack of health insurance contributes to inequities in quality of care. Dr. Doty holds an M.P.H. and a Ph.D. in public health from the University of California, Los Angeles.

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For more information about this brief, please contact:
Sara R. Collins, Ph.D.
Vice President, Health Care Coverage and Access
The Commonwealth Fund
src@cmwf.org

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