

U.S. Health Reform—Monitoring and Impact

# Characteristics of the Remaining Uninsured: An Update

July 2018

Linda J. Blumberg, John Holahan, Michael Karpman, and Caroline Elmendorf



Robert Wood Johnson  
Foundation

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.



With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at [www.rwjf.org](http://www.rwjf.org) and [www.healthpolicycenter.org](http://www.healthpolicycenter.org).

## INTRODUCTION

The coverage components of the Affordable Care Act (ACA) were fully implemented in 2014. The law made many changes to Medicaid and private insurance markets. The ACA has made considerable coverage gains, with the number of uninsured people declining by over 19 million between 2010 and 2017, according to the National Health Interview Survey.<sup>1</sup> The first major source of coverage gains is the expansion of Medicaid eligibility to nearly all people with incomes up to 138 percent of the federal poverty level (FPL). Medicaid expansion under the ACA is voluntary for states because of a 2012 Supreme Court ruling.<sup>2</sup> At this writing, 17 states still have not expanded Medicaid eligibility.<sup>3</sup> The second source of coverage gains is the transformation of private nongroup insurance. Reforms to private nongroup insurance market rules were designed to eliminate pricing and benefit discrimination against people with health problems, to set coverage standards, and to provide subsidized insurance for people with low and moderate incomes through new health insurance marketplaces. These changes were also intended to promote competition among insurers through a combination of greater comparability, transparency, and consumer financial incentives. These and other changes to the nongroup and small-group insurance markets increased the sharing of health care risk among enrollees. The ACA also required that most

people have health insurance meeting federal standards or pay a penalty.

Though insurance coverage has expanded considerably, many remain uninsured. In 2015, we used the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) to analyze the characteristics of the 32.9 million nonelderly people who remained uninsured at that time.<sup>4</sup> In this paper, we update the previous analysis and assess the characteristics of people who were uninsured in 2017 as well as how those characteristics changed. According to the CPS ASEC, the number of uninsured people fell by nearly 2.9 million between 2015 and 2017.

This analysis relies upon data from the March 2015 and March 2017 CPS ASEC. The CPS provides information for people with and without health insurance. The data on coverage were collected in March in each year (with some interviews in February and April).<sup>5</sup> For uninsured people in 2015 and 2017, we provide data on a wide array of socioeconomic and demographic characteristics, identify insurance eligibility, separate children and adults where appropriate, and use the characteristics of the uninsured to suggest strategies for further expanding coverage.

---

## MAIN FINDINGS

- The number of uninsured nonelderly people fell from 32.9 million in 2015 to 30.1 million in 2017. The uninsured rate for the nonelderly population fell from 12.2 percent in 2015 to 11.1 percent in 2017.
- The uninsured rate fell for all age groups but most dramatically among young adults ages 18 to 34; this age group accounted for 38.6 percent of the nonelderly uninsured in 2015, but 37.9 percent in 2017.

- Uninsured rates declined significantly among non-Hispanic whites, Asians/Pacific Islanders, and Hispanics between 2015 and 2017. The uninsured rate among non-Hispanic black people did not decline further during this period, so this group grew as a share of the total uninsured population, from 13.7 percent in 2015 to 15.0 percent in 2017.
- The uninsured rate among people with incomes below 200 percent of FPL fell from 18.9 percent to 17.3 percent from 2015 to 2017. This group's share of all uninsured people fell from 62.0 percent in 2015 to 57.0 percent in 2017. Higher income groups grew as a share of the total uninsured.
- Consistent with the findings for income, adults with a high school degree or less decreased as a share of the uninsured, while adults with a college degree increased as a share of the uninsured.
- The largest drop in the uninsured rate was in the Northeast, from 9.1 percent in 2015 to 7.4 percent in 2017. The uninsured rate fell in each of the other regions as well, but the reduction was smallest in the South. Roughly 49.2 percent of the uninsured lived in the South in 2017, up from 46.5 percent in 2015.
- In 2017, 25.0 percent of the uninsured were eligible for Medicaid. Another 10.4 percent had incomes below 200 percent of FPL and were eligible for the most generous financial assistance for purchasing private nongroup insurance. Thus, 35.4 percent of the uninsured in 2017 were part of the target population for outreach and enrollment assistance, down from 38.0 percent in 2015 (when 27.2 percent were eligible for Medicaid and 10.8 percent were eligible for the most generous marketplace subsidies).
- Since 2015, the hardest-to-reach populations have grown as a share of the uninsured total. People who are eligible for tax credits but have incomes above 200 percent of FPL increased from 13.4 percent of the uninsured to 14.7 percent in 2017. The share of the uninsured ineligible for tax credits because of an affordable offer of employer-sponsored insurance stayed relatively constant. People ineligible for tax credits because their incomes exceeded 400 percent of FPL increased from 12.8 percent of the uninsured in 2015 to 15.5 percent in 2017. With lower or no financial assistance available, uninsured people are significantly less likely to enroll even with increased outreach and enrollment assistance efforts.
- In 2017, the uninsured rate declined among Medicaid-eligible people in the Northeast, Midwest, and West. In contrast, the uninsured rate among Medicaid-eligible people in the South stayed essentially constant. Roughly 34.2 percent of the Medicaid-eligible uninsured lived in the South in 2017, up from 29.4 percent in 2015.
- The uninsured rate among people who were eligible for tax credits and had incomes below 200 percent of FPL did not change significantly. Within this group, uninsured rates declined for people with a school-age child in the household and for people in households where a child was receiving free or reduced-price school lunches.
- Between 2015 and 2017, uninsured rates declined significantly among low-income, tax credit-eligible people in the Northeast and in states that had expanded Medicaid eligibility. Residents of the South increased as a share of all uninsured people who were eligible for tax credits and had incomes below 200 percent of FPL, from 54.9 to 58.6 percent.

## DATA AND METHODS

**Data.** Our analysis of the characteristics of the remaining uninsured focuses exclusively on the nonelderly (people younger than 65) because the coverage status of people ages 65 and older was not affected by the ACA. We rely upon 2015 and 2017 data from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) that reflect respondents' insurance coverage status at the time of the interview (most interviews occurred in March, some in February and April) rather than reported coverage over the past year (the CPS ASEC collects data on both, and the past-year coverage variables have been the focus of others' analyses using the survey<sup>6</sup>). These data allow us to assess whether an individual was insured or uninsured, but they do

not permit analysis of the type of coverage held if insured; additional coverage breakouts have not yet been released. We rely upon these data because they provide the most recent snapshot of coverage information using the CPS ASEC and because point-in-time reports of coverage are more likely to be accurate than reports of previous-year coverage; the questions are more straightforward and require far less recall from respondents. The total sample size for the March 2017 CPS ASEC is 185,914 individuals, the sample size for the nonelderly is 160,986, and the sample size for the uninsured nonelderly is 17,200.

The 2015 and 2017 CPS ASEC provide detailed information on health insurance coverage; income; household composition;

and demographic, socioeconomic, and geographic characteristics for a nationally representative sample of U.S. households. The CPS sampling frame covers the entire civilian noninstitutional population and members of the Armed Forces in civilian housing units, so it includes noninstitutional group quarters, such as college dormitories (a very small portion of the sample) and workers' group living quarters, but it excludes locations such as jails, prisons, psychiatric hospitals, and group homes for juvenile offenders.<sup>5</sup> The 2015 CPS ASEC is the first in which the full sample received redesigned income and health insurance questions, including questions focused on insurance coverage at the time of the survey. For this analysis, we focus on nonelderly individuals (children ages 17 or younger and adults ages 18 to 64) who report having no health insurance coverage at the time of the survey. Although previous studies have shown that survey respondents tend to underreport enrollment in Medicaid/CHIP, which may affect estimates of point-in-time coverage status, we do not make adjustments to the data to correct for potential underreporting.<sup>7</sup>

Different surveys yield different estimates of the number of uninsured because of variations in questionnaires, sample size, and sampling design. The CPS ASEC is an important resource for understanding the distribution of characteristics of the uninsured because it is a large, nationally representative data set and has several advantages over the National Health Interview Survey (NHIS) for these purposes. First, the CPS has more detailed information about family income, which is useful for estimating Medicaid and tax credit eligibility more accurately. Second, the CPS has a larger sample size, which is more useful for analyzing subgroups, such as Medicaid-eligible uninsured adults and children and low-income, tax credit-eligible nonelderly uninsured people. Third, the CPS has somewhat more detailed information about family employment status, such as firm size for all workers, but the NHIS only collects firm size data in its sample adult file. Fourth, the CPS has more detailed information about receipt of public benefits, such as the earned income tax credit (EITC) and free or reduced-price school lunches. And unlike NHIS data, the CPS data with state identifiers (which we need for our program eligibility determination) are publicly available. The largest difference between the two surveys' estimates of the uninsured is in children. The National Health Interview Survey estimated 3.7 million uninsured children in 2017, and the CPS estimated 4.6 million. As a result, the CPS estimated 30.1 million nonelderly uninsured adults and children, compared with 28.9 million in the NHIS.

**Program eligibility.** We explore the characteristics of the nonelderly uninsured and their eligibility for Medicaid/CHIP or for premium tax credits to purchase coverage through the

health insurance marketplaces. We approximate tax units and calculate the modified adjusted gross income (MAGI) of each unit to determine income eligibility for Medicaid/CHIP and marketplace tax credits. Our unit measure is similar to the U.S. Census Bureau's definition of a subfamily, which may include "a married couple with or without children, or a single parent with one or more own never-married children under 18 years old."<sup>8</sup> We define the units to include members of a subfamily who may be covered under one health insurance policy (e.g., policyholders, spouses, own children younger than 19, and own children younger than 23 who are full-time students). Sources of reported income used to calculate MAGI include wage, salary, and self-employment earnings; unemployment compensation; retirement, interest, dividend, and rental income; other income not deducted from adjusted gross income (e.g., alimony); and taxable and nontaxable Social Security benefits.

Because undocumented immigrants are not eligible for Medicaid or for coverage through the marketplace with or without tax credits, we impute documentation status for noncitizens using a methodology that replicates estimates from the Pew Hispanic Center, the Department of Homeland Security, and the Center for Migration Studies.<sup>9</sup> Our estimates of the undocumented share of the uninsured are slightly higher than estimates reported in our previous analysis because of a change in our imputation procedure. A few states use their own funds to provide Medicaid-type coverage to some undocumented people,<sup>10</sup> but our analysis does not separate this group out.

We also impute single out-of-pocket (OOP) premiums for workers with an offer of employer-sponsored insurance (ESI) who are eligible to participate in the plan. This imputation is designed to identify families in which at least one individual has an ESI offer with a premium that would be considered affordable under the ACA (i.e., a single OOP premium for the employee that is 9.69 percent or less of the employee's family income as of 2017) and thus would make the family ineligible for premium tax credits to purchase marketplace coverage. Our approach for identifying whether families have an affordable ESI offer differs from the approach used in a previous report because we now rely on CPS variables for ESI offer, eligibility, and take-up that were first released in June 2016, rather than imputing ESI offer and eligibility. To impute single OOP premiums in the CPS, we use a hot-deck match based on an American Community Survey donor file with premium data imputed using the Urban Institute's Health Insurance Policy Simulation Model. Although CPS respondents are somewhat more likely to report eligibility for an ESI offer than data from the Medical Expenditure Panel Survey Insurance Component tables would suggest, the estimated

share of workers with an affordable ESI offer is lower than the estimated share under our previous approach, resulting in a smaller share of the uninsured estimated to be ineligible for premium tax credits because of an affordable ESI offer.

MAGI-based Medicaid/CHIP income eligibility limits for children, parents, and other nondisabled adults as of March 2015 and March 2017 are produced by the Centers for Medicare & Medicaid Services (CMS) and made available in a concise format by the Kaiser Family Foundation.<sup>11</sup> We assign eligibility to immigrant children lawfully residing in the United States for fewer than five years if their family income is below the eligibility threshold and they live in states that have opted not to impose a five-year waiting period for Medicaid/CHIP eligibility.<sup>12</sup> In Texas, lawfully residing immigrants are not eligible for Medicaid even if they have been in the United States for more than five years.<sup>13</sup> Non-MAGI-based Medicaid/CHIP eligibility is assigned to foster children; people who report receiving SSI; and people who report a disability, have income and assets below state-defined thresholds, and are eligible based on immigration status under pre-ACA state rules. We also assign eligibility to children with incomes below the tax filing threshold who have parents or others in the household who (1) could claim that child as a dependent and (2) could themselves be claimed by someone else in the household as a dependent (e.g., a child living with both a parent and a grandparent who could claim that parent as a dependent).

Individuals are eligible for marketplace premium tax credits if they are not undocumented; not eligible for Medicaid; do not live in a family with an affordable offer of ESI; and have incomes between 138 and 400 percent of FPL if they live in expansion states, or between 100 and 400 percent of FPL if they live in nonexpansion states. Immigrants lawfully residing in the United States for fewer than five years with incomes below those thresholds are also eligible for tax credits if they are not eligible for Medicaid and do not have an affordable ESI offer.

In nonexpansion states, many adults, including adults with incomes below 100 percent of FPL who are not eligible for

Medicaid, fall into a financial assistance gap. That gap also includes people with incomes between 100 and 138 percent of FPL who are not eligible for tax credits because of an affordable ESI offer, but who would be eligible for assistance if their state expanded Medicaid.<sup>14</sup>

**Rationale for focused analyses.** In addition to analyzing the remaining uninsured in total, we separately analyze two groups, composing 35 percent of the nonelderly uninsured population in 2017, that would most likely benefit from targeted outreach and enrollment assistance: (1) people eligible for Medicaid and (2) people eligible for the most generous marketplace tax credits and cost-sharing reductions because they have incomes below 200 percent of FPL. Evidence suggests that substantially increasing coverage among the other groups of uninsured people will require changes in policy and investment of additional government funds to improve financial assistance; thus, we do not focus on their characteristics here (discussed further in the Results section).

**Individual and household characteristics.** All estimates are reported as percentages and numbers of uninsured individuals using the CPS ASEC population weights. Variables are defined in Appendix Table 1.

**Limitations.** Simulating eligibility for public coverage based on survey data is challenging because income, insurance coverage, and other information used to model eligibility is often misreported and because specific information needed to simulate some of the pathways to eligibility is unavailable. For example, it is possible that in some instances we have erroneously imputed premium tax credit eligibility to a person based on their misreported income, while that person is actually enrolled in Medicaid. The CPS, like many other surveys, does not contain information on factors such as pregnancy status, legal disability status, custodial parents' compliance with child support cooperation requirements, and duration of Medicaid enrollment or income history to determine Medicaid Transitional Medical Assistance and related eligibility. And some studies have found evidence of underreporting of enrollment in public programs such as Medicaid, SNAP, and the EITC.<sup>15</sup>

---

## RESULTS

**Characteristics of the remaining uninsured.** The number of uninsured people fell from 32.9 million in 2015 to 30.1 million in 2017, with the uninsured rate falling from 12.2 percent to 11.1 percent (Table 1). People with lower incomes, people with less education, young adults, and Hispanic people saw disproportionate gains in coverage.

The number of uninsured young adults (ages 18 to 34) fell from 12.7 million in 2015 to 11.4 million in 2017. The uninsured rate for this age group fell from 17.4 percent to 15.5 percent. As of 2017, young adults accounted for 37.9 percent of the nonelderly uninsured. People ages 35 to 49 and 50 to 64 accounted for 26.6 percent and 20.1 percent,

**Table 1. Characteristics of the Remaining Nonelderly Uninsured, 2015 and 2017**

	Number of uninsured people, 2015	Number of uninsured people, 2017	Share of all uninsured in category, 2015	Share of all uninsured in category, 2017	Uninsured rate, 2015	Uninsured rate, 2017
<b>Total</b>	<b>32,945,000</b>	<b>30,089,000</b>	<b>100.0%</b>	<b>100.0%</b>	<b>12.2%</b>	<b>11.1%***</b>
<b>Age</b>						
0–17	5,121,000	4,602,000	15.5%	15.3%	6.9%	6.2%***
18–34	12,718,000	11,413,000	38.6%	37.9%	17.4%	15.5%***
35–49	8,606,000	8,012,000	26.1%	26.6%	14.2%	13.2%***
50–64	6,500,000	6,062,000	19.7%	20.1%	10.4%	9.7%**
<b>School-age child in family</b>						
Child age 5–17 in family	11,090,000	10,049,000	33.7%	33.4%	9.4%	8.6%***
No school-age child in family	21,855,000	20,040,000	66.3%	66.6%	14.4%	13.0%***
<b>Race/Ethnicity</b>						
White, single race, non-Hispanic	15,080,000	13,637,000	45.8%	45.3%	9.4%	8.7%***
Black, single race, non-Hispanic	4,527,000	4,507,000	13.7%	15.0%***	13.1%	12.9%
Asian/Pacific Islander, single race, non-Hispanic	1,547,000	1,435,000	4.7%	4.8%	9.5%	8.4%*
American Indian/Alaska Native, single race, non-Hispanic	472,000	432,000	1.4%	1.4%	21.3%	20.2%
More than one race, non-Hispanic	506,000	477,000	1.5%	1.6%	9.2%	8.2%
Hispanic	10,813,000	9,601,000	32.8%	31.9%	20.8%	17.9%***
<b>Self-reported health status</b>						
Excellent or very good	20,195,000	18,779,000	61.3%	62.4%	10.9%	10.1%***
Good	9,733,000	8,541,000	29.5%	28.4%	15.9%	13.8%***
Fair or poor	3,017,000	2,769,000	9.2%	9.2%	13.2%	12.4%
<b>Citizenship status</b>						
Citizen	26,205,000	24,004,000	79.5%	79.8%	10.5%	9.6%***
Legal noncitizen resident	1,229,000	1,222,000	3.7%	4.1%	13.2%	11.9%
Undocumented immigrant	5,511,000	4,863,000	16.7%	16.2%	47.7%	42.4%***
<b>Family income relative to FPL</b>						
At or below 200% of FPL	20,413,000	17,143,000	62.0%	57.0%***	18.9%	17.3%***
Greater than 200% but less than 400% of FPL	8,002,000	7,950,000	24.3%	26.4%***	11.4%	11.0%
At or above 400% of FPL	4,530,000	4,996,000	13.7%	16.6%***	4.9%	5.0%
<b>Educational attainment (ages 18 and older only)</b>						
Less than high school	6,274,000	5,183,000	22.5%	20.3%***	27.9%	25.5%***
High school degree	10,048,000	9,143,000	36.1%	35.9%	18.0%	16.5%***
Some college	7,257,000	6,785,000	26.1%	26.6%	12.5%	11.6%***
College degree or more	4,245,000	3,173,000	15.3%	17.2%***	7.1%	7.0%
<b>Region</b>						
Northeast	4,297,000	3,435,000	13.0%	11.4%***	9.1%	7.4%***
Midwest	5,689,000	4,998,000	17.3%	16.6%	10.0%	8.9%***
South	15,321,000	14,812,000	46.5%	49.2%***	15.1%	14.4%**
West	7,637,000	6,844,000	23.2%	22.7%	11.8%	10.5%***
<b>Urban/Rural</b>						
MSA	27,740,000	25,479,000	84.2%	84.7%	12.0%	10.8%***
Non-MSA	4,831,000	4,282,000	14.7%	14.2%	13.1%	12.7%

**Table 1. Characteristics of the Remaining Nonelderly Uninsured, 2015 and 2017 (continued)**

	Number of uninsured people, 2015	Number of uninsured people, 2017	Share of all uninsured in category, 2015	Share of all uninsured in category, 2017	Uninsured rate, 2015	Uninsured rate, 2017
<b>State Medicaid expansion status by 2017</b>						
<i>Resides in state that had expanded Medicaid by March 2017</i>	17,074,000	14,802,000	51.8%	49.2%***	10.2%	8.9%***
<i>Resides in state that had not expanded Medicaid by March 2017</i>	15,871,000	15,287,000	48.2%	50.8%***	15.3%	14.5%**
<b>Family employment status, firm size in previous year</b>						
<i>At least one working adult in large firm (50+ workers)</i>	13,482,000	12,712,000	40.9%	42.2%*	7.9%	7.2%***
<i>No adults working in large firm, at least one in small firm</i>	9,911,000	9,061,000	30.1%	30.1%	20.8%	19.4%**
<i>All working adults self-employed</i>	2,903,000	2,654,000	8.8%	8.8%	22.4%	20.8%
<i>All adults nonworking</i>	6,222,000	5,285,000	18.9%	17.6%**	17.5%	16.1%**
<i>No civilian adults in family</i>	427,000	377,000	1.3%	1.3%	13.2%	11.4%
<b>Employment status/Usual weekly hours worked at main job at time of survey</b>						
<i>Full-time (30 hrs/week or more)</i>	13,517,000	13,323,000	41.0%	44.3%***	12.0%	11.3%***
<i>Part-time (less than 30 hrs/week) or hours vary</i>	4,217,000	3,607,000	12.8%	12.0%*	16.2%	14.1%***
<i>Unemployed</i>	2,375,000	1,754,000	7.2%	5.8%***	27.6%	25.1%**
<i>Not in labor force</i>	8,655,000	7,660,000	26.3%	25.5%	14.3%	13.0%***
<i>Armed forces member or younger than 15</i>	4,181,000	3,746,000	12.7%	12.4%	6.8%	6.1%**
<b>Receipt of public benefits</b>						
<i>Family claimed EITC in previous year</i>	9,916,000	8,851,000	30.1%	29.4%	17.9%	16.4%***
<i>Family received SNAP in previous year</i>	4,837,000	3,946,000	14.7%	13.1%***	14.1%	12.9%**
<i>Child in household received free or reduced-price lunch in previous year</i>	7,476,000	6,504,000	22.7%	21.6%	15.7%	14.1%***
<i>Other public benefits received in previous year<sup>a</sup></i>	3,217,000	2,570,000	9.8%	8.5%***	9.6%	8.4%***
<i>At least one person in family reported a nonhealth public benefit for self or family in previous year</i>	15,986,000	13,718,000	48.5%	45.6%***	16.4%	14.5%***

SOURCE: Authors' analysis of data from the Current Population Survey Annual Social and Economic Supplement, 2015 and 2017.

NOTES: EITC = earned income tax credit; FPL = federal poverty level; MSA = metropolitan statistical area; SNAP = Supplemental Nutrition Assistance Program.

Estimates not shown for areas for which metropolitan status is not identified.

<sup>a</sup> Other public-benefit categories include Supplemental Security Income, subsidized housing, public housing, energy assistance, unemployment compensation, Temporary Assistance for Needy Families, and other public assistance. Free and reduced-price school lunches are reported on behalf of children in the household.

\*\*\* 2017 estimate differs significantly from 2015 estimate at the 0.10/0.05/0.01 level, using two-tailed tests. Standard errors are estimated using successive difference replication methods and Current Population Survey replicate weights.

respectively. Although uninsured rates fell for each age group, the reductions were greatest among people ages 18 to 34.

Among race/ethnicity groups, the Hispanic uninsured rate fell the most, from 20.8 percent in 2015 to 17.9 percent in 2017. Hispanic people accounted for 31.9 percent of the uninsured in 2017. The uninsured rate for non-Hispanic black people did not fall significantly (13.1 percent in 2015 to 12.9 percent in 2017), so they accounted for a larger share of the uninsured in 2017, 15.0 percent compared with 13.7 percent in 2015. Other groups were largely unchanged; for example, non-Hispanic white people remained the largest group of the uninsured (45.3 percent in 2017), with an uninsurance rate of only 8.7 percent, a drop from 9.4 percent in 2015.

Uninsured rates fell among people who reported being in excellent or very good health and among those who reported good health, but the declines were largest among those in good health. In 2017, 13.8 percent of people who reported good health were uninsured, compared with 15.9 percent in 2015.

Surprisingly, the number of uninsured undocumented immigrants decreased from 5.5 million in 2015 to 4.9 million in 2017. The uninsured rate for undocumented immigrants fell from 47.7 percent in 2015 to 42.4 percent in 2017. This appears to be the result of increased access to employer-sponsored insurance among this population over this period (data not shown). The uninsured rate for citizens fell nearly one percentage point (from 10.5 percent to 9.6 percent).

We found that people with incomes at or below 200 percent of FPL accounted for a smaller segment of the uninsured in 2017 than in 2015. The uninsured rate for this group fell from 18.9 percent in 2015 to 17.3 percent in 2017. Those with incomes at or below 200 percent of FPL accounted for 57.0 percent of all uninsured in 2017, down from 62.0 percent. Higher income groups increased as a share of the total number uninsured. For example, those with incomes at or above 400 percent of FPL accounted for 16.6 percent of the uninsured in 2017, compared with 13.7 percent in 2015, largely because their uninsured rate was essentially unchanged while the uninsured rate for the lowest income group fell.

Looking at educational attainment, adults with less than a high school education and adults with only a high school degree had the largest reductions in their uninsured rates over the two years. This is consistent with the findings for coverage changes by income. The uninsured rate for adults with less than a high school education fell from 27.9 percent in 2015 to 25.5 percent in 2017. The uninsured rate for adults with a high school degree fell from 18.0 percent in 2015 to

16.5 percent in 2017. Adults with less than a high school education decreased as a share of all uninsured adults, to 20.3 percent in 2017. Those with at least a college degree now account for more of the uninsured than in 2015.

Reductions in uninsurance from 2015 to 2017 were particularly large in the Northeast. The uninsured rate in this region fell from 9.1 percent to 7.4 percent. The uninsured rate in the Midwest fell from 10.0 percent to 8.9 percent, and the uninsured rate in the West fell from 11.8 percent to 10.5 percent. The uninsured rate fell in the South too, but by less than a percentage point. As a result, the number of uninsured people in the South increased as a share of the total uninsured population, while the share of the total uninsured living in the Northeast decreased. As of 2017, the South accounted for 49.2 percent of all nonelderly uninsured people, up from 46.5 percent in 2015. The distribution of the uninsured between metropolitan statistical areas (MSAs) and non-MSAs was largely unchanged over the two years.

Between 2015 and 2017, the uninsured rate continued to fall among people living in states that had expanded Medicaid relative to those living in states that did not. The uninsured rate in the expansion states fell from 10.2 percent to 8.9 percent over this period. The uninsured rate also fell in nonexpansion states but by less, from 15.3 percent to 14.5 percent. Nonexpansion states accounted for 50.8 percent of the uninsured in 2017, up from 48.2 percent in 2015.

Looking at employment, full-time workers accounted for 44.3 percent of the uninsured in 2017, largely because their uninsured rate fell the least over the two years. Part-time workers and unemployed people decreased as a share of the total uninsured population in 2017. Uninsured rates fell for people in families with at least one worker in a large firm, people in families with at least one worker in a small firm, and members of nonworking families. However, members of families with at least one working adult employed in a large firm became a larger share of the total number of uninsured people because the uninsured rate for nonworking family members fell more over this period.

Like the low-income group, people who reported receiving at least one non-health care public benefit decreased as a share of the total uninsured population (48.5 percent in 2015 to 45.6 percent in 2017). Families who claimed the EITC represented 29.4 percent of all uninsured in 2017, those receiving SNAP benefits represented 13.1 percent, and those in households with a child who received free or reduced-price lunch represented 21.6 percent.

**Most promising target populations for additional outreach and enrollment efforts.** In 2017, 7.5 million people

or 25.0 percent of the uninsured were eligible for Medicaid/CHIP and had access to no- or very low-cost insurance coverage, and another 3.1 million people or 10.4 percent of the uninsured were eligible for large premium tax credits as well as substantial cost-sharing reductions to make private nongroup health insurance coverage more affordable (Table 2). These populations account for 35.4 percent of the remaining uninsured, or 10.6 million people, down from 38.0 percent or 12.5 million people in 2015. This group is most likely to respond to additional outreach and enrollment efforts because the coverage available to them is subsidized the most.

Other groups among the uninsured are less likely to enroll because they are more likely to consider coverage unaffordable. Affordability will be further compromised by policy changes since early 2017 that have affected nongroup premiums for 2018 (i.e., no federal reimbursement for cost-sharing reductions paid by insurers, a shortened open enrollment period, reduced federal funding for outreach and enrollment assistance, uncertainty over the future of the ACA), by the increase in premiums caused by elimination of the individual mandate penalties in 2019, and by the increase in premiums caused by the administration’s expansion of short-term limited-duration policies.<sup>16</sup> These premium increases will have the largest impact on people ineligible for premium tax credits because they have incomes above 400 percent of FPL—4.7 million people, or 15.5 percent of the remaining uninsured in 2017. Those with incomes between 200 and

400 percent of FPL without access to affordable employer-sponsored insurance—4.4 million people, or 14.7 percent of the remaining uninsured—are eligible for smaller tax credits but only small (for people with incomes between 200 and 250 percent of FPL) or no cost-sharing reductions. For people with incomes below 400 percent of FPL, premium subsidies will increase with higher premiums because the premium tax credits are structured as percent-of-income caps for the purchase of the second-lowest-priced silver plan.

Approximately 2.7 million people, or 8.9 percent of the uninsured population, were ineligible for tax credits in 2017 because they had an affordable ESI offer in the family. As the economy improves, affordable offers may become more available, causing an increase in this population. Some of these people are caught in the “family glitch,” where all family members are denied access to marketplace financial assistance because one adult worker has an offer of affordable single coverage, even though family coverage is very costly relative to income.<sup>17</sup>

Another 9.4 percent of the uninsured, or 2.8 million people, are in the assistance gap. These are people ineligible for any financial assistance because their state did not expand Medicaid eligibility. Most of the people in this group have family incomes below the federal poverty level and have little or no ability to contribute to their own health insurance costs. Some states may decide to expand Medicaid eligibility in the future, but if not, expansion of coverage for this low-income population is unlikely. Another 4.9 million people, or 16.2

**Table 2. Program Eligibility among the Remaining Nonelderly Uninsured, 2015 and 2017**

	Number of uninsured people, 2015	Number of uninsured people, 2017	Share of all uninsured, 2015	Share of all uninsured, 2017	Uninsured rate, 2015	Uninsured rate, 2017
<b>Total</b>	<b>32,945,000</b>	<b>30,089,000</b>	<b>100.0%</b>	<b>100.0%</b>	<b>12.2%</b>	<b>11.1%***</b>
<b>Program eligibility</b>						
Medicaid/CHIP-eligible	8,948,000	7,522,000	27.2%	25.0%***	11.6%	10.5%***
Assistance gap	3,607,000	2,822,000	10.9%	9.4%***	33.7%	30.9%**
Marketplace tax credit-eligible	7,963,000	7,556,000	24.2%	25.1%	24.2%	22.9%**
Family income at or below 200% of FPL	3,555,000	3,122,000	10.8%	10.4%	25.5%	24.2%
Family income above 200% of FPL	4,408,000	4,434,000	13.4%	14.7%***	23.3%	22.2%
Ineligible for tax credit because of affordable ESI offer	2,709,000	2,677,000	8.2%	8.9%	5.6%	5.5%
Ineligible because of undocumented immigration status	5,511,000	4,863,000	16.7%	16.2%	47.7%	42.4%***
Ineligible because of higher income	4,207,000	4,650,000	12.8%	15.5%***	4.7%	4.8%

SOURCE: Authors’ analysis of data from the Current Population Survey Annual Social and Economic Supplement, 2015 and 2017.

NOTES: FPL = federal poverty level; ESI = employer-sponsored insurance.

\*\*\* 2017 estimate differs significantly from 2015 estimate at the 0.10/0.05/0.01 level, using two-tailed tests. Standard errors are estimated using successive difference replication methods and Current Population Survey replicate weights.

percent of the uninsured, are undocumented immigrants and thus not eligible for any financial assistance with coverage.

Without significant policy changes, future coverage expansions likely will be limited to people eligible for Medicaid and to people with incomes below 200 percent of FPL eligible for substantial tax credits and cost-sharing reductions.

**Medicaid/CHIP-eligible nonelderly.** The number of uninsured people eligible for Medicaid/CHIP fell from 8.9 million in 2015 to 7.5 million in 2017 (Table 3), a decrease of 15.9 percent. The uninsured rate among people eligible for Medicaid or CHIP fell from 11.6 percent to 10.5 percent over the two years. The uninsured rate fell for all age subgroups except people ages 35 to 49; as a result, this age group increased as a share of the Medicaid/CHIP-eligible uninsured, to 17.3 percent.

Non-Hispanic black people were the only racial/ethnic group of Medicaid/CHIP-eligible people whose uninsured rate increased between 2015 and 2017, from 10.3 percent to 11.8 percent. As a result, non-Hispanic black people accounted for a larger percentage of uninsured Medicaid/CHIP-eligible people in 2017—21.1 percent, up from 16.2 percent in 2015. The uninsured rate for Medicaid/CHIP-eligible Hispanic people declined from 12.0 percent to 10.0 percent, and the uninsured rate declined substantially among Asians/Pacific Islanders.

By definition, almost all uninsured Medicaid/CHIP-eligible people have incomes below 200 percent of FPL. The uninsured rate for Medicaid/CHIP-eligible adults with less than a high school education fell from 15.4 percent to 12.7 percent, and that for adults with a high school degree but no college education fell from 17.2 percent to 15.1 percent between 2015 and 2017. The uninsured rates for eligible adults with at least some college education stayed roughly constant, so people with less than a high school education decreased as a share of the Medicaid/CHIP-eligible uninsured.

The uninsured rate of Medicaid/CHIP-eligible people declined the most in the Northeast, from 10.3 percent to 7.8 percent in 2017. The uninsured rate also fell in the Midwest and West but stayed about the same in the South. As a result, the share of the Medicaid/CHIP-eligible uninsured living in the South increased from 29.4 percent in 2015 to 34.2 percent in 2017. The uninsured rate fell among Medicaid/CHIP-eligible residents of non-MSAs and MSAs over the period.

The uninsured rate among Medicaid/CHIP-eligible residents of expansion states continued to fall, from 11.6 percent in 2015 to 10.0 percent in 2017. The uninsured rate among eligible people in nonexpansion states was roughly unchanged. Thus,

the share of Medicaid/CHIP-eligible uninsured increased in nonexpansion states, from 28.2 percent in 2015 to 31.2 percent in 2017.

In the Medicaid/CHIP-eligible population, the uninsured rate fell for people in families with at least one large-firm worker and for people in families with only self-employed workers. The largest uninsured rate declines were among members of families where all adult workers were self-employed (19.1 percent to 15.9 percent uninsured) and among adults working part-time (18.4 percent to 15.1 percent uninsured). Unemployed Medicaid-eligible adults decreased as a share of all Medicaid/CHIP-eligible uninsured, from 8.0 percent to 6.7 percent.

The uninsured rate for Medicaid-eligible people in families claiming the EITC fell between 2015 and 2017, as did the uninsured rate among those in families receiving any non-health public benefit.

**Medicaid/CHIP-eligible children and adults.** Table 4 shows important differences in the characteristics of uninsured Medicaid/CHIP-eligible children and adults. In 2017, 42.4 of uninsured Medicaid/CHIP-eligible children lived with both parents; 57.6 percent did not. Of the 57.6 percent uninsured eligible children not living with both parents, 45.7 percent lived with one parent; the remaining 11.9 percent lived with nonparents. Importantly, Medicaid/CHIP-eligible children not living with either parent were more likely to be uninsured (10.4 percent) than children living with one parent (7.2 percent).

In 2017, the non-Hispanic white share of uninsured Medicaid/CHIP-eligible children was 35.0 percent, the Hispanic share was 35.0 percent, and the non-Hispanic black share was 20.7 percent. Uninsured rates for the largest racial/ethnic subgroups of Medicaid/CHIP-eligible children were quite similar, ranging from 6.4 percent of non-Hispanic white children to 7.9 percent of non-Hispanic black children. The uninsured rate for native populations was considerably higher, 16.9 percent, perhaps reflecting that group's exemption from the individual mandate and access to care through the Indian Health Service. But it might also reflect differential outreach and enrollment assistance or other factors.

In 2017, 46.0 percent of uninsured Medicaid/CHIP-eligible children lived in the South. Medicaid/CHIP-eligible children living in the South were twice as likely to be uninsured as children living in the Northeast, 8.8 percent compared with 4.4 percent uninsured, respectively.

The share of uninsured Medicaid/CHIP-eligible children living with an adult worker employed in a large firm (50 employees or more) or a small firm accounted for 64.3

**Table 3. Characteristics of the Remaining Nonelderly Uninsured Eligible for Medicaid/CHIP, 2015 and 2017**

	Number of eligible uninsured people, 2015	Number of eligible uninsured people, 2017	Share of all eligible uninsured, 2015	Share of all eligible uninsured, 2017	Uninsured rate, 2015	Uninsured rate, 2017
<b>Total</b>	<b>8,948,000</b>	<b>7,522,000</b>	100.0%	100.0%	11.6%	10.5%***
<b>Age</b>						
0–17	3,338,000	2,800,000	37.3%	37.2%	8.1%	7.2%**
18–34	2,970,000	2,426,000	33.2%	32.2%	16.6%	14.8%**
35–49	1,394,000	1,302,000	15.6%	17.3%*	16.7%	16.8%
50–64	1,246,000	993,000	13.9%	13.2%	13.4%	11.2%**
<b>School-age child in family</b>						
Child age 5–17 in family	4,077,000	3,503,000	45.6%	46.6%	9.2%	8.5%*
No school-age child in family	4,872,000	4,019,000	54.4%	53.4%	15.0%	13.2%***
<b>Race/Ethnicity</b>						
White, single race, non-Hispanic	4,076,000	3,247,000	45.5%	43.2%*	11.7%	10.2%***
Black, single race, non-Hispanic	1,448,000	1,590,000	16.2%	21.1%***	10.3%	11.8%*
Asian/Pacific Islander, single race, non-Hispanic	450,000	297,000	5.0%	4.0%	12.3%	9.2%**
American Indian/Alaska Native, single race, non-Hispanic	227,000	178,000	2.5%	2.4%	22.0%	19.2%
More than one race, non-Hispanic	222,000	202,000	2.5%	2.7%	9.6%	8.8%
Hispanic	2,527,000	2,008,000	28.2%	26.7%	12.0%	10.0%***
<b>Self-reported health status</b>						
Excellent or very good	5,454,000	4,744,000	60.9%	63.1%	11.1%	10.3%*
Good	2,569,000	1,997,000	28.7%	26.6%*	14.2%	12.0%***
Fair or poor	926,000	780,000	10.4%	10.4%	9.6%	8.5%
<b>Family income relative to FPL</b>						
At or below 200% of FPL	8,470,000	7,195,000	94.7%	95.7%	12.2%	11.1%***
Greater than 200% but less than 400% of FPL	478,000	327,000	5.3%	4.3%	6.6%	4.7%**
At or above 400% of FPL	0	0	0.0%	0.0%	N/A	N/A
<b>Educational attainment (ages 18 and older only)</b>						
Less than high school	1,266,000	904,000	22.6%	19.1%***	15.4%	12.7%***
High school degree	2,235,000	1,889,000	39.8%	40.0%	17.2%	15.1%**
Some college	1,524,000	1,378,000	27.2%	29.2%	14.7%	14.1%
College degree or more	585,000	550,000	10.4%	11.7%	14.8%	15.1%
<b>Region</b>						
Northeast	1,572,000	1,108,000	17.6%	14.7%**	10.3%	7.8%***
Midwest	2,016,000	1,581,000	22.5%	21.0%	11.9%	10.3%**
South	2,630,000	2,576,000	29.4%	34.2%***	11.4%	11.6%
West	2,730,000	2,257,000	30.5%	30.0%	12.6%	11.3%**
<b>Urban/Rural</b>						
MSA	7,376,000	6,311,000	82.4%	83.9%	11.4%	10.5%***
Non-MSA	1,482,000	1,153,000	16.6%	15.3%	12.4%	10.6%**

**Table 3. Characteristics of the Remaining Nonelderly Uninsured Eligible for Medicaid/CHIP, 2015 and 2017 (continued)**

	Number of eligible uninsured people, 2015	Number of eligible uninsured people, 2017	Share of all eligible uninsured, 2015	Share of all eligible uninsured, 2017	Uninsured rate, 2015	Uninsured rate, 2017
<b>State Medicaid expansion status by 2017</b>						
<i>Resides in state that had expanded Medicaid by March 2017</i>	6,422,000	5,178,000	71.8%	68.8%**	11.6%	10.0%***
<i>Resides in state that had not expanded Medicaid by March 2017</i>	2,526,000	2,344,000	28.2%	31.2%**	11.8%	11.6%
<b>Family employment status, firm size in previous year</b>						
<i>At least one working adult in large firm (50+ workers)</i>	2,881,000	2,310,000	32.2%	30.7%	9.2%	7.8%***
<i>No adults working in large firm, at least one in small firm</i>	1,957,000	1,724,000	21.9%	22.9%	12.9%	12.4%
<i>All working adults self-employed</i>	668,000	529,000	7.5%	7.0%	19.1%	15.9%*
<i>All adults nonworking</i>	3,044,000	2,616,000	34.0%	34.8%	12.7%	12.0%
<i>No civilian adults in family</i>	397,000	343,000	4.4%	4.6%	12.6%	10.7%
<b>Employment status/Usual weekly hours worked at main job at time of survey</b>						
<i>Full-time (30 hrs/week or more)</i>	1,367,000	1,231,000	15.3%	16.4%	17.2%	16.4%
<i>Part-time (less than 30 hrs/week) or hours vary</i>	1,041,000	818,000	11.6%	10.9%	18.4%	15.1%***
<i>Unemployed</i>	718,000	503,000	8.0%	6.7%**	22.2%	20.4%
<i>Not in labor force</i>	3,027,000	2,673,000	33.8%	35.5%	12.1%	11.3%*
<i>Armed forces member or younger than 15</i>	2,795,000	2,297,000	31.2%	30.5%	7.9%	7.0%**
<b>Receipt of public benefits</b>						
<i>Family claimed EITC in previous year</i>	4,073,000	3,539,000	45.5%	47.0%	11.3%	10.2%**
<i>Family received SNAP in previous year</i>	1,842,000	1,588,000	20.6%	21.1%	7.4%	7.3%
<i>Child in household received free or reduced-price lunch in previous year</i>	2,691,000	2,314,000	30.1%	30.8%	8.9%	8.3%
<i>Other public benefits received in previous year<sup>a</sup></i>	1,158,000	1,040,000	12.9%	13.8%	5.4%	5.3%
<i>At least one person in family reported a nonhealth public benefit for self or family in previous year</i>	6,031,000	5,124,000	67.4%	68.1%	10.5%	9.5%***

SOURCE: Authors' analysis of data from the Current Population Survey Annual Social and Economic Supplement, 2015 and 2017.

NOTES: CHIP = Children's Health Insurance Program; EITC = earned income tax credit; FPL = federal poverty level; MSA = metropolitan statistical area; SNAP = Supplemental Nutrition Assistance Program.

Estimates not shown for areas for which metropolitan status is not identified.

<sup>a</sup> Other public-benefit categories include Supplemental Security Income, subsidized housing, public housing, energy assistance, unemployment compensation, Temporary Assistance for Needy Families, and other public assistance. Free and reduced-price school lunches are reported on behalf of children in the household.

\*\*\* 2017 estimate differs significantly from 2015 estimate at the 0.10/0.05/0.01 level, using two-tailed tests. Standard errors are estimated using successive difference replication methods and Current Population Survey replicate weights.

**Table 4. Characteristics of the Remaining Uninsured Children and Nonelderly Adults Eligible for Medicaid/CHIP, 2017**

	Medicaid/CHIP-eligible child population			Medicaid/CHIP-eligible adult population		
	Number of eligible uninsured children	Share of all eligible uninsured children	Uninsured rate	Number of eligible uninsured adults	Share of all eligible uninsured adults	Uninsured rate
<b>Total</b>	<b>2,800,000</b>	<b>100.0%</b>	<b>7.2%</b>	<b>4,721,000</b>	<b>100.0%</b>	<b>14.3%</b>
<b>Age</b>						
0–17	2,800,000	100.0%	7.2%	N/A	N/A	N/A
18–34	N/A	N/A	N/A	2,426,000	51.4%	14.8%
35–49	N/A	N/A	N/A	1,302,000	27.6%	16.8%
50–64	N/A	N/A	N/A	993,000	21.0%	11.2%
<b>School-age child in family</b>						
Child age 5–17 in family	2,431,000	86.8%	7.3%	1,072,000	22.7%	13.2%
No school-age child in family	369,000	13.2%	6.7%	3,649,000	77.3%	14.7%
<b>Presence/Absence of a parent (children ages 17 and younger only)</b>						
Children living with both parents	1,188,000	42.4%	6.7%	N/A	N/A	N/A
Children not living with both parents	1,612,000	57.6%	7.7%	N/A	N/A	N/A
Children living with one parent	1,281,000	45.7%	7.2%	N/A	N/A	N/A
Children living with only nonparents	332,000	11.9%	10.4%	N/A	N/A	N/A
<b>Race/Ethnicity</b>						
White, single race, non-Hispanic	981,000	35.0%	6.4%	2,267,000	48.0%	13.7%
Black, single race, non-Hispanic	579,000	20.7%	7.9%	1,011,000	21.4%	16.3%
Asian/Pacific Islander, single race, non-Hispanic	90,000	3.2%	6.3%	207,000	4.4%	11.5%
American Indian/Alaska Native, single race, non-Hispanic	73,000	2.6%	16.9%	105,000	2.2%	21.1%
More than one race, non-Hispanic	97,000	3.5%	6.0%	104,000	2.2%	15.6%
Hispanic	980,000	35.0%	7.7%	1,027,000	21.8%	14.0%
<b>Self-reported health status</b>						
Excellent or very good	2,269,000	81.0%	7.4%	2,475,000	52.4%	16.2%
Good, fair, or poor <sup>a</sup>	531,000	19.0%	6.6%	2,246,000	47.6%	12.6%
<b>Family income relative to FPL</b>						
At or below 200% of FPL	2,495,000	89.1%	7.7%	4,700,000	99.6%	14.6%
Greater than 200% but less than 400% of FPL <sup>b</sup>	306,000	10.9%	4.8%	21,000	0.4%	-
At or above 400% of FPL	0	0.0%	N/A	0	0.0%	N/A
<b>Educational attainment (ages 18 and older only)</b>						
Less than high school	N/A	N/A	N/A	904,000	19.1%	12.7%
High school degree	N/A	N/A	N/A	1,889,000	40.0%	15.1%
Some college	N/A	N/A	N/A	1,378,000	29.2%	14.1%
College degree or more	N/A	N/A	N/A	550,000	11.7%	15.1%
<b>Region</b>						
Northeast	300,000	10.7%	4.4%	808,000	17.1%	11.1%
Midwest	463,000	16.5%	5.9%	1,118,000	23.7%	14.8%
South	1,287,000	46.0%	8.8%	1,288,000	27.3%	17.0%
West	750,000	26.8%	8.0%	1,506,000	31.9%	14.2%

**Table 4. Characteristics of the Remaining Uninsured Children and Nonelderly Adults Eligible for Medicaid/CHIP, 2017** (continued)

	Medicaid/CHIP-eligible child population			Medicaid/CHIP-eligible adult population		
	Number of eligible uninsured children	Share of all eligible uninsured children	Uninsured rate	Number of eligible uninsured adults	Share of all eligible uninsured adults	Uninsured rate
<b>Urban/Rural</b>						
MSA	2,350,000	83.9%	7.3%	3,961,000	83.9%	14.1%
Non-MSA	420,000	15.0%	7.0%	733,000	15.5%	15.2%
<b>State Medicaid expansion status by 2017</b>						
Resides in state that had expanded Medicaid by March 2017	1,431,000	51.1%	6.0%	3,747,000	79.4%	13.5%
Resides in state that had not expanded Medicaid by March 2017	1,369,000	48.9%	9.2%	975,000	20.6%	18.4%
<b>Family employment status, firm size in previous year</b>						
At least one working adult in large firm (50+ workers)	1,047,000	37.4%	5.4%	1,262,000	26.7%	12.5%
No adults working in large firm, at least one in small firm	753,000	26.9%	8.8%	971,000	20.6%	18.4%
All working adults self-employed	265,000	9.5%	13.2%	264,000	5.6%	19.8%
All adults nonworking	393,000	14.0%	7.1%	2,224,000	47.1%	13.6%
No civilian adults in family	343,000	12.2%	10.7%	0	0.0%	N/A
<b>Employment status/Usual weekly hours worked at main job at time of survey</b>						
Full-time (30 hrs/week or more)	N/A	N/A	N/A	1,219,000	25.8%	16.5%
Part-time (less than 30 hrs/week) or hours vary	N/A	N/A	N/A	753,000	15.9%	15.6%
Unemployed	N/A	N/A	N/A	481,000	10.2%	21.1%
Not in labor force	N/A	N/A	N/A	2,269,000	48.0%	12.3%
Armed forces member or younger than 15	N/A	N/A	N/A	0	0.0%	0.0%
<b>Receipt of public benefits</b>						
Family claimed EITC in previous year	1,730,000	61.8%	7.4%	1,809,000	38.3%	16.2%
Family received SNAP in previous year	453,000	16.2%	3.9%	1,135,000	24.0%	11.1%
Child in household received free or reduced-price lunch in previous year	1,243,000	44.4%	6.2%	1,072,000	22.7%	13.3%
Other public benefits received in previous year <sup>c</sup>	267,000	9.5%	3.1%	773,000	16.4%	7.0%
At least one person in family reported a nonhealth public benefit for self or family in previous year	2,186,000	78.1%	6.9%	2,938,000	62.2%	13.0%

SOURCE: Authors' analysis of data from the Current Population Survey Annual Social and Economic Supplement, 2017.

NOTES: CHIP = Children's Health Insurance Program; EITC = earned income tax credit; FPL = federal poverty level; MSA = metropolitan statistical area; SNAP = Supplemental Nutrition Assistance Program.

Estimates not shown for areas for which metropolitan status is not identified.

<sup>a</sup> Categories combined because of low sample size.

<sup>b</sup> Estimated uninsured rate suppressed because of low sample size.

<sup>c</sup> Other public-benefit categories include Supplemental Security Income, subsidized housing, public housing, energy assistance, unemployment compensation, Temporary Assistance for Needy Families, and other public assistance. Free and reduced-price school lunches are reported on behalf of children in the household.

percent of uninsured Medicaid-eligible children, about 1.8 million children in total. Medicaid/CHIP-eligible children in families where the only workers were self-employed were the most likely to be uninsured, 13.2 percent compared with 5.4 percent with at least one adult employed in a large firm.

In 2017, 48.0 percent of uninsured Medicaid-eligible adults were non-Hispanic white, 21.4 percent were non-Hispanic black, and 21.8 percent were Hispanic. Uninsurance rates varied by race/ethnicity group, ranging from 11.5 percent of Asians/Pacific Islanders to 21.1 percent of American Indians/Alaska Natives. The share of uninsured Medicaid-eligible adults with less than a high school education was 19.1 percent, and the share with only a high school education was 40.0 percent in 2017. The uninsured rate was lowest among those with less than a high school education (12.7 percent, compared with 15.1 percent for those with only a high school diploma and those with a college degree or more).

Like Medicaid/CHIP-eligible children, eligible adults living in the South were more likely to be uninsured than their counterparts in the Northeast, 17.0 percent versus 11.1 percent, respectively. Most low-income adults are eligible for Medicaid in expansion states, and 79.4 percent of uninsured Medicaid-eligible adults lived in Medicaid expansion states in 2017. Eligible adults living in nonexpansion states were more likely to be uninsured than those living in expansion states (18.4 percent compared with 13.5 percent).

In 2017, 21.1 percent of unemployed Medicaid-eligible adults were uninsured, the highest rate across the different employment statuses. However, almost half (48.0 percent) of uninsured Medicaid-eligible adults reported not being in the labor force. More than one-third claimed the EITC in the previous year, and almost a quarter received SNAP benefits.

**Characteristics of tax credit-eligible uninsured people with incomes below 200 percent of FPL.** Like the uninsured Medicaid/CHIP-eligible population, this group is eligible for substantial subsidies and could be targeted for additional outreach and enrollment assistance. The number of uninsured people in this group fell from 3.6 million to 3.1 million between 2015 and 2017, a decline of 12.2 percent (Table 5). The uninsured rate for the tax credit-eligible population with low incomes fell from 25.5 percent in 2015 to 24.2 percent in 2017, but this difference was not statistically significant. In fact, the distribution of the uninsured and the uninsured rates by characteristic stayed quite stable between 2015 and 2017. But because of the smaller sample sizes for this eligibility and income group, our ability to detect meaningful changes is limited.

Uninsured rates fell from 27.1 to 25.2 percent among premium tax credit-eligible people who reported being in excellent or very good health. Uninsured rates for the tax credit-eligible, low-income group declined significantly in the Northeast, falling from 20.5 percent in 2015 to 13.9 percent in 2017. There were no significant changes in the other regions. As a result, the share of this uninsured group living in the Northeast declined to 7.3 percent from 10.6 percent. In 2017, 17.4 percent of the tax credit-eligible, low-income uninsured lived in the Midwest, 58.6 percent lived in the South, and 16.7 percent lived in the West.

The low-income tax credit-eligible uninsured rate fell in MSAs and in states that had expanded Medicaid eligibility. The uninsured rate for residents of expansion states fell from 21.2 percent to 18.0 percent. The share of the uninsured, low-income, tax credit-eligible group living in nonexpansion states was 64.4 percent in 2017, up from 58.8 percent in 2015.

Uninsured tax credit-eligible people were more likely to have claimed the EITC in the previous year in 2017 than in 2015. They were also less likely to receive other types of public benefits besides the EITC, SNAP, and free or reduced-price school lunches.

**Policies with the greatest enrollment potential.**<sup>18</sup> As we have documented, the number of uninsured people fell from 32.9 million in 2015 to 30.1 million in 2017, according to the CPS ASEC. The lowest-income group—those most heavily subsidized under the ACA—saw disproportionate coverage gains, either through Medicaid or through marketplace premium tax credits and cost-sharing reductions. The remaining uninsured were more likely to have incomes above 200 percent of FPL in 2017 than in 2015; affordability remains a problem for this group. However, low-income people were still more likely to be uninsured than higher-income people.

The remaining uninsured were also more likely to live in the South in 2017 than in 2015, and this region tends to have lower political support for expanding coverage. People were significantly more likely to be uninsured in the South than in any other region.

Significant coverage gains are still possible for two groups: people eligible for Medicaid/CHIP and people eligible for marketplace tax credits. Affordability likely is not a problem for people eligible for Medicaid and/or CHIP, which require little or no enrollee contributions. Affordability is also less likely to be the enrollment barrier for people eligible for the largest marketplace tax credits and cost-sharing reductions (those with incomes below 200 percent of FPL), compared with those eligible for less assistance. Together, these two populations accounted for 35.4 percent of the uninsured in

**Table 5. Characteristics of the Remaining Nonelderly Uninsured Eligible for Premium Tax Credits with Incomes at or Below 200% of FPL, 2015 and 2017**

	Number of eligible uninsured people, 2015	Number of eligible uninsured people, 2017	Share of all eligible uninsured, 2015	Share of all eligible uninsured, 2017	Uninsured rate, 2015	Uninsured rate, 2017
<b>Total</b>	<b>3,555,000</b>	<b>3,122,000</b>	<b>100.0%</b>	<b>100.0%</b>	<b>25.5%</b>	<b>24.2%</b>
<b>Age</b>						
0–17 <sup>a</sup>	8,000	4,000	0.2%	0.1%	-	-
18–34	1,633,000	1,457,000	45.9%	46.7%	27.1%	25.3%
35–49	979,000	872,000	27.5%	27.9%	28.1%	27.1%
50–64	934,000	790,000	26.3%	25.3%	21.2%	20.5%
<b>School-age child in family</b>						
Child age 5–17 in family	835,000	747,000	23.5%	23.9%	25.7%	22.6%**
No school-age child in family	2,721,000	2,374,000	76.5%	76.1%	25.4%	24.7%
<b>Race/Ethnicity</b>						
White, single race, non-Hispanic	1,883,000	1,558,000	53.0%	49.9%	24.1%	23.2%
Black, single race, non-Hispanic	575,000	525,000	16.2%	16.8%	28.4%	26.1%
Other race or more than one race, non-Hispanic <sup>b</sup>	265,000	264,000	7.5%	8.5%	21.0%	20.2%
Hispanic	833,000	774,000	23.4%	24.8%	29.2%	26.7%
<b>Self-reported health status</b>						
Excellent or very good	2,112,000	1,827,000	59.4%	58.5%	27.1%	25.2%*
Good	1,038,000	961,000	29.2%	30.8%	26.5%	26.5%
Fair or poor	405,000	334,000	11.4%	10.7%	18.1%	16.4%
<b>Citizenship status</b>						
Citizen	3,170,000	2,754,000	89.2%	88.2%	26.0%	24.9%
Legal noncitizen resident	385,000	368,000	10.8%	11.8%	22.2%	19.8%
Undocumented immigrant	N/A	N/A	N/A	N/A	N/A	N/A
<b>Family income relative to FPL</b>						
At or below 200% of FPL	3,555,000	3,122,000	100.0%	100.0%	25.5%	24.2%
Greater than 200% but less than 400% of FPL	N/A	N/A	N/A	N/A	N/A	N/A
At or above 400% of FPL	N/A	N/A	N/A	N/A	N/A	N/A
<b>Educational attainment (ages 18 and older only)</b>						
Less than high school	649,000	575,000	18.3%	18.4%	31.9%	31.2%
High school degree	1,381,000	1,236,000	38.9%	39.6%	27.9%	26.5%
Some college	1,056,000	899,000	29.8%	28.8%	23.0%	21.0%
College degree or more	461,000	408,000	13.0%	13.1%	19.8%	20.1%
<b>Region</b>						
Northeast	376,000	229,000	10.6%	7.3%**	20.5%	13.9%***
Midwest	594,000	544,000	16.7%	17.4%	23.3%	22.8%
South	1,952,000	1,828,000	54.9%	58.6%*	29.4%	29.6%
West	633,000	520,000	17.8%	16.7%	21.7%	19.1%
<b>Urban/Rural</b>						
MSA	2,964,000	2,553,000	83.4%	81.8%	25.5%	23.7%*
Non-MSA	544,000	524,000	15.3%	16.8%	25.2%	26.7%

**Table 5. Characteristics of the Remaining Nonelderly Uninsured Eligible for Premium Tax Credits with Incomes at or Below 200% of FPL, 2015 and 2017 (continued)**

	Number of eligible uninsured people, 2015	Number of eligible uninsured people, 2017	Share of all eligible uninsured, 2015	Share of all eligible uninsured, 2017	Uninsured rate, 2015	Uninsured rate, 2017
<b>State Medicaid expansion status by 2017</b>						
<i>Resides in state that had expanded Medicaid by March 2017</i>	1,464,000	1,112,000	41.2%	35.6%***	21.2%	18.0%***
<i>Resides in state that had not expanded Medicaid by March 2017</i>	2,091,000	2,010,000	58.8%	64.4%***	29.7%	29.8%
<b>Family employment status, firm size in previous year</b>						
<i>At least one working adult in large firm (50+ workers)</i>	1,392,000	1,221,000	39.2%	39.1%	25.8%	23.8%
<i>No adults working in large firm, at least one in small firm</i>	1,388,000	1,220,000	39.0%	39.1%	30.6%	30.4%
<i>All working adults self-employed</i>	420,000	382,000	11.8%	12.2%	31.0%	30.9%
<i>All adults nonworking</i>	352,000	296,000	9.9%	9.5%	13.3%	11.6%
<i>No civilian adults in family<sup>a</sup></i>	3,000	2,000	0.1%	0.1%	-	24.9%
<b>Employment status/Usual weekly hours worked at main job at time of survey</b>						
<i>Full-time (30 hrs/week or more)</i>	1,828,000	1,595,000	51.4%	51.1%	30.7%	29.6%
<i>Part-time (less than 30 hrs/week) or hours vary</i>	575,000	578,000	16.2%	18.5%*	25.6%	26.5%
<i>Unemployed</i>	299,000	276,000	8.4%	8.8%	32.7%	34.7%
<i>Not in labor force</i>	851,000	669,000	23.9%	21.4%*	18.3%	15.3%***
<i>Armed forces member or younger than 15<sup>a</sup></i>	3,000	3,000	0.1%	0.1%	-	-
<b>Receipt of public benefits</b>						
<i>Family claimed EITC in previous year</i>	1,311,000	1,346,000	36.9%	43.1%***	26.6%	27.1%
<i>Family received SNAP in previous year</i>	569,000	438,000	16.0%	14.0%	26.6%	23.0%*
<i>Child in household received free or reduced-price lunch in previous year</i>	667,000	579,000	18.8%	18.5%	28.7%	24.3%**
<i>Other public benefits received in previous year<sup>c</sup></i>	429,000	294,000	12.1%	9.4%**	22.5%	19.4%
<i>At least one person in family reported a nonhealth public benefit for self or family in previous year</i>	1,939,000	1,735,000	54.5%	55.6%	27.0%	25.8%

SOURCE: Authors' analysis of data from the Current Population Survey Annual Social and Economic Supplement, 2015 and 2017.

Notes: EITC = earned income tax credit; FPL = federal poverty level; MSA = metropolitan statistical area; SNAP = Supplemental Nutrition Assistance Program.

Estimates not shown for areas for which metropolitan status is not identified.

<sup>a</sup> Estimated uninsured rate suppressed because of low sample size.

<sup>b</sup> Categories combined because of low sample size.

<sup>c</sup> Other public-benefit categories include Supplemental Security Income, subsidized housing, public housing, energy assistance, unemployment compensation, Temporary Assistance for Needy Families, and other public assistance. Free and reduced-price school lunches are reported on behalf of children in the household.

\*\*\* 2017 estimate differs significantly from 2015 estimate at the 0.10/0.05/0.01 level, using two-tailed tests. Standard errors are estimated using successive difference replication methods and Current Population Survey replicate weights.

2017, or 10.6 million people. Their characteristics can inform strategies for better targeting of outreach and enrollment assistance efforts to increase insurance coverage. Below, we refer to this combined group of 10.6 million uninsured people as the enrollment target population.

**Public school–based strategies.** Over 46 percent of uninsured people eligible for Medicaid/CHIP and 24 percent of low-income uninsured people eligible for tax credits live in families with at least one school-age child as of March 2017. In addition, significant shares of the enrollment target population live in a household with a child receiving free or reduced-price lunches through public schools. Using public schools to educate uninsured people and assist them in enrolling in coverage could help raise enrollment. Some schools already collect information on the health insurance coverage of children at the beginning of each school year, allowing them to quickly identify uninsured students.<sup>19,20</sup> And, as noted, a child’s eligibility for free and reduced-price lunches is significantly correlated with eligibility. Enrollment assisters could work directly with schools, extracurricular programs, and parent-teacher associations to boost enrollment. School communications with parents could provide information on the benefits of insurance, the availability of low-cost options, and the availability of enrollment assistance.

But school-based enrollment efforts also face challenges. School districts are administered in a decentralized manner, so there is no single state agency to approve their involvement in outreach and enrollment assistance. In addition, children who are undocumented can qualify for the subsidized lunches, but most are not eligible for Medicaid. Many schools’ staff already lack resources and would not be able to participate in enrollment assistance. But this strategy is attractive because many people trust schools and the information they provide and because it would give parents an easy way to contact assisters directly. Placing enrollment assisters at schools and school-related functions may help boost participation.

Middle school and high school health classes could incorporate information on the importance of having insurance coverage and the financial assistance available to people who enroll. Roughly 30 percent of uninsured adults in these target populations have some college education without receiving a bachelor’s degree. Many of these low-income people attend community colleges, which could also become hubs for education and outreach. Although this approach most directly benefits active students, new students would be affected each year.

**Outreach through non-health-related public benefit programs.** Over two-thirds of uninsured people eligible for Medicaid and over half of the low-income uninsured

people eligible for tax credits live in families in which at least one person receives a public benefit not related to health. Collaborating with government entities providing these benefits (most often the EITC, free and reduced-price school lunches, and SNAP) could therefore reach large percentages of these uninsured target populations. Some states have already had significant success using information on SNAP beneficiaries to enroll people in insurance coverage, and agencies in those states are encouraged to use information on children’s enrollment in CHIP to identify parents potentially eligible for Medicaid under the ACA’s expansion.<sup>21–23</sup> Schools could offer parents of children qualifying for free and reduced-priced lunches the option to have an outside navigator or in-person assister contact them directly, as suggested above, to explore eligibility for insurance coverage for family members.

The US Treasury could notify all those who received the EITC in the past year that they may be eligible for substantial financial assistance for health coverage. The Treasury could also provide an easy mechanism (such as text messaging) that would allow people to request a navigator to contact them directly to provide additional information and application assistance. The Internal Revenue Service (IRS) sends notices to tax filers it believes are eligible for the EITC but have not claimed it on their return (privacy rules prevent others from using tax data this way). In recent years, the IRS mailed individual notices to inform tax filers and Social Security and Veterans Administration benefit recipients about economic stimulus payments. During the 2016–2017 open enrollment period, in an effort to increase marketplace enrollment particularly among young adults, the IRS partnered with CMS to send targeted messages about financial assistance for coverage to uninsured tax filers who paid a penalty for not having coverage in 2015 or claimed an exemption from the penalty.<sup>24</sup> Similarly, EITC claimants could be sent information about potential eligibility for Medicaid or advanced premium tax credits. Such mail notices are costly and not likely to produce high response rates on their own; providing an easy mechanism to request direct contact with an assister may prove more effective.

**Outreach through workplaces.** Almost 80 percent of low-income uninsured people eligible for tax credits and over half of uninsured people eligible for Medicaid/CHIP live in households in which at least one family member works for either a large or small firm; in other words, the adults are not all self-employed or outside of the workforce.

This makes employers, particularly those in low-wage industries, potential partners in increasing coverage. Trade associations for low-wage industries, small-business associations, brokers, local consumer advocates, navigator organizations, and others could collaborate to reach out

to workers and their family members through employers. Employers would be informed that encouraging and helping their employees enroll in Medicaid would have no bearing on employer mandate penalties and could improve workers' health and productivity while reducing absenteeism. The enrollment platform BeneStream is a private-sector example of an employer-focused outreach and enrollment approach: It works with brokers and large employers to enroll eligible workers into Medicaid.

These strategies could encourage some Medicaid-eligible people to enroll in public insurance instead of private ESI. But the share of workers with incomes below 138 percent of FPL who are offered ESI is relatively low, and many of those who do have offers still find the premium contributions and out-of-pocket requirements associated with ESI unaffordable. Thus, although some displacement of private coverage may result from these outreach efforts, the increased coverage and health care affordability gains should outweigh that displacement. Small employers (those with fewer than 50 full-time equivalent employees) in particular may misunderstand the employer penalty rules and erroneously fear that facilitating marketplace enrollment for their workers could lead to financial penalties. Small-business associations and brokers could allay those concerns and develop strategies to provide outreach and enrollment assistance to low-income workers. Brokers selling coverage through the marketplaces can work directly with small employers that do not offer health insurance to their workers, benefiting the workers and the brokers themselves.

**Outreach through family courts and support programs for single parents.** About 58 percent of Medicaid/CHIP-eligible uninsured children live in households in which at least one parent is absent. In about 80 percent of those households, the child lives with one parent only; in the other 20 percent, the child lives with other relatives or nonrelatives. Thus, public agencies and programs in contact with single parents and nonparent custodians could reach many uninsured children eligible for Medicaid/CHIP. These agencies and programs include family courts, domestic legal aid programs, and community support networks. State agencies involved in child support and custody matters could be trained to ask parents for permission to have navigators or assisters contact them directly. Like public schools, legal aid programs and other organizations that provide legal assistance to low-income families do not have the resources to do enrollment assistance on their own, but they could be used as a conduit to connect families with professional assisters.

**Reaching beyond the target population.** Substantially increasing coverage beyond the uninsured population eligible for Medicaid or substantial marketplace tax credits likely

would require changes in policy and increased resources for financial assistance. Two very low-income populations ineligible for financial assistance for health insurance under current law account for 25.5 percent of the uninsured: people who fall into the Medicaid assistance gap (2.8 million uninsured) and undocumented immigrants (4.9 million uninsured). People in the Medicaid gap live in nonexpansion states and are either adults with family incomes below 100 percent of FPL or adults with incomes between 100 and 138 percent of FPL who are ineligible for marketplace tax credits because of an ESI offer. These uninsured people have little or no resources to spend on coverage, and few can be expected to obtain coverage without significant financial support. A few nonexpansion states are now considering expanding eligibility, but this is still highly uncertain, and most nonexpansion states have no plans to change their current policies. Still, the financial case for expanding is strong, and more states may expand in the future.<sup>25</sup>

At least three federal policy changes could address the Medicaid gap. The first option would allow states to expand Medicaid eligibility up to 100 percent of FPL instead of 138 percent of FPL.<sup>26</sup> Constraining the size of the expansion population in this way would reduce the perceived financial risk of the expansion, and keeping the public program smaller would have political appeal in nonexpansion states. A second option would federalize the costs of the Medicaid expansion population.<sup>27</sup> Such an approach would eliminate the state financial contribution for the expansion population entirely (currently, state contributions phase up over time to a maximum of 10 percent of costs). A third option, proposed by the Obama administration in its fiscal year 2017 budget proposal,<sup>28</sup> would provide 100 percent federal funding for the first three years after a state expands Medicaid eligibility to 138 percent of FPL, extending financial support to states beyond the 2014–2016 period included in the ACA. This additional incentive may encourage some state governments to expand eligibility.

Even with the financial assistance made available under the ACA, health care financial burdens remain high for many people purchasing coverage outside of ESI who have incomes above 200 percent of FPL. Such burdens likely contribute to this income group's much lower marketplace participation rate.<sup>29</sup> Increasing financial assistance through expanded eligibility for cost-sharing reductions and improved premium tax credits could reduce financial burdens enough to increase enrollment in nongroup insurance, but it would require additional federal or state investment.<sup>30,31</sup>

Affordability can be a coverage barrier for low-income workers who have access to offers of health insurance deemed affordable under the law if those employer policies have large

out-of-pocket requirements (e.g., large deductibles or high out-of-pocket maximums). These low-income workers are not eligible for financial assistance through the marketplaces because of their ESI offers, but the high out-of-pocket costs associated with the plans may dissuade them from enrolling.

Although there is anecdotal evidence of this problem,<sup>32</sup> more data on the specifics of the ESI available to low-income workers would be helpful to analyze both the extent of this problem and the potential costs of giving these workers subsidies to reduce the direct costs of their care.<sup>33-35</sup>

---

## CONCLUSION

The ACA has significantly reduced the number of uninsured people in the United States, but 30.1 million nonelderly remained uninsured in 2017. In this paper, we have provided detailed data on who the remaining uninsured are, estimated how many more of them likely could be enrolled under current law, and identified strategies most likely to reach them. The data presented here reflect the characteristics of the uninsured as of March 2017; the number of uninsured people may have grown since then, particularly in response to recent policy changes.

Yet a disproportionate share of coverage gains between 2015 and 2017 occurred among people with the lowest incomes, least education, and most limited attachment to the workforce. Thus, those who remain uninsured likely will be harder to reach.

Understanding the characteristics of the uninsured is important for several reasons. First, it allows us to identify uninsured subgroups that stand to make large coverage gains. Second, it allows us to target outreach and enrollment resources to those populations and to identify marketing approaches for them. Third, analyzing the uninsured highlights the size of uninsured subpopulations for whom current policies provide little or no assistance in obtaining coverage, fostering an informed discussion of the potential for and merits of additional assistance.

Our analysis of the CPS ASEC, combined with past work on program participation rates and case studies on insurance

enrollment behavior under the ACA, suggests that two subpopulations of the uninsured stand to make the largest coverage gains: people eligible for Medicaid and low-income people eligible for marketplace tax credits. These are the uninsured people eligible for the most comprehensive coverage at the lowest direct cost under current law, and those eligible for this level of assistance have relatively high rates of participation in health insurance programs. Together, these subgroups account for 35.4 percent of the remaining uninsured, or approximately 10.6 million people. Focusing on the characteristics of this group, we find high rates of school-age children in the household, household receipt of non-health public benefits, firm-based employment, and single-parent households. These characteristics suggest promising avenues for targeted outreach and enrollment efforts through public schools, EITC, SNAP, school lunch programs, employers, and child custody and support systems. Such investments could substantially reduce the number of people uninsured under current law.

But increasing coverage among the other 64.6 percent of the uninsured will be a formidable challenge—even more so with the pending elimination of individual mandate penalties and expansion of short-term policies and the failure of the federal government to directly reimburse insurers for cost-sharing reductions. All these policies will lead to higher marketplace premiums. Significant changes in federal policy are needed to make more progress in reducing uninsurance.

## Appendix Table 1. Definitions of Variables

<b>Age</b>	Reported at the time of the survey
<b>School-age child in family</b>	Children ages 5 through 17
<b>Race/Ethnicity</b>	Racial and Hispanic origin categories as defined by the U.S. Census
<b>Self-reported health status</b>	Reported in March of survey year
<b>CITIZENSHIP STATUS</b>	
Citizen	Native-born or naturalized
Legal noncitizen resident	This category includes lawful permanent residents and other lawfully present noncitizens. A lawful permanent resident is a noncitizen who is legally permitted to live and work in the United States permanently. Other legal noncitizens include refugees and people granted asylum in the United States. We impute legal status for all those reporting they are noncitizens.
Undocumented immigrant	Because all civilian noninstitutional residents of the United States are represented in the sample of households interviewed by the CPS, undocumented immigrants are likely included in CPS data. However, the CPS makes no attempt to ascertain the legal status of any person interviewed. Thus, we impute documentation status for noncitizens using a methodology that replicates estimates from the Pew Hispanic Center, the Department of Homeland Security, and the Center for Migration Studies.
<b>Family income relative to FPL</b>	Family income is the reported MAGI for the calendar year before the survey. Sources of reported income included in MAGI are wage, salary, and self-employment earnings; unemployment compensation; retirement, interest, dividend, and rental income; other income not deducted from adjusted gross income (e.g., alimony); and taxable and nontaxable Social Security benefits. Respondents are classified into FPL categories based on the family's income relative to the FPL guidelines for the corresponding calendar year (at or below 200% of FPL, greater than 200% but less than 400% of FPL, and at or above 400% of FPL).
<b>Educational attainment (ages 18 or older)</b>	Reported at the time of the survey
<b>REGION</b>	
Northeast	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
Midwest	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
South	Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
West	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming
<b>URBAN/RURAL</b>	
MSA	A metropolitan statistical area contains a core urban area of at least 50,000 people, based on the White House Office of Management and Budget's definition.
Non-MSA	Areas that are not MSAs.

<b>MEDICAID EXPANSION STATUS</b>	
Resides in state that had expanded Medicaid as of March 2017	Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia
Resides in state that did not expand Medicaid as of March 2017	Alabama, Florida, Georgia, Idaho, Kansas, Maine, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming
<b>FAMILY EMPLOYMENT STATUS/FIRM SIZE IN PREVIOUS YEAR</b>	
At least one working adult in large firm	Large firms are those with 50 or more employees.
No adults working in large firm, at least one in small firm	Small firms are those with fewer than 50 employees.
All working adults self-employed	Working adults in family were self-employed, either incorporated or not incorporated.
All adults nonworking	Adults in family were not self-employed and did not work for a firm.
No civilian adults in family	Families with all adults in the armed forces or with no adults.
<b>EMPLOYMENT STATUS/USUAL WEEKLY HOURS WORKED AT TIME OF SURVEY</b>	
Full-time (30 hours per week or more)	Based on usual weekly hours at main current job.
Part-time (less than 30 hours per week) or hours vary	Based on usual weekly hours at main current job.
Unemployed	People are classified as unemployed if they do not have a job, have actively looked for work in the past four weeks, and are currently available for work.
Not in labor force	People who have no job and are not looking for one are counted as not in the labor force. Many who are not in the labor force are going to school or are retired, or have other responsibilities that prevent them from working.
<b>RECEIPT OF PUBLIC BENEFITS</b>	
Family claimed earned income tax credit in previous year	Positive value reported for earned income tax credit claimed by someone in family.
Family received Supplemental Nutrition Assistance Program benefits in previous year	Positive estimated market value of Supplemental Nutrition Assistance Program benefits reported for family in previous year.
Child in household received free or reduced-price lunch in previous year	Reported on behalf of any child in the household, where a household includes unrelated individuals who reside in the same home.
Other reported benefits	Includes Supplemental Security Income, subsidized housing, public housing, unemployment compensation, Temporary Assistance for Needy Families, other public assistance, and energy assistance reported by individuals in the family.

<b>PROGRAM ELIGIBILITY</b>	
Medicaid/CHIP-eligible	Non-MAGI-based eligibility is assigned to foster children, Supplemental Security Income recipients, and people with a disability who have income and assets below state-defined thresholds and are eligible based on immigration status under pre-ACA state rules. MAGI-based eligibility is based on state thresholds for children, parents, and other nondisabled adults. Immigrant children who have lawfully resided in the U.S. for fewer than five years and meet income eligibility criteria are considered eligible if states do not impose a waiting period. We also assign eligibility to children with family incomes below the tax filing threshold who have parents who could claim them as a dependent and be claimed by someone else in the household as a dependent.
Assistance gap	The assistance gap includes adults with incomes below 100% of FPL who are not eligible for Medicaid and adults with incomes between 100% and 138% of FPL who are not eligible for tax credits because of an affordable ESI offer but who would be eligible for assistance if their state expanded Medicaid.
Marketplace tax credit-eligible	Individuals are eligible for tax credits if they are not undocumented, not eligible for Medicaid or Medicare, do not live in a family with an affordable offer of ESI, and have incomes between 138% and 400% of FPL if they live in states that expanded Medicaid or between 100% and 400% of FPL if they live in states that did not. Immigrants lawfully residing in the U.S. for fewer than five years with incomes below these thresholds are assigned eligibility if they are not eligible for Medicaid and do not have an affordable ESI offer.
Ineligible for tax credit because of affordable ESI offer	Includes people who would otherwise be eligible for tax credits if they did not have an affordable ESI offer, which is imputed as described above.
Ineligible for financial assistance because of undocumented immigration status	Undocumented status is imputed as described above.
Ineligible for assistance because of higher income	Citizens and lawfully residing noncitizens with incomes above 400% of FPL.
<b>PRESENCE/ABSENCE OF A PARENT (CHILDREN AGES 17 OR YOUNGER ONLY)</b>	
Children living with both parents	Children living with both parents (biological or adoptive) present.
Children living with one parent	Children living with only one biological or adoptive parent.
Children living with only nonparents	Children living with grandparents, other relatives, nonrelatives, stepparents, or foster parents (no biological or adoptive parents in household).

# ENDNOTES

1. Cohen RA, Zammitti EP, Martinez ME. *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017*. Hyattsville, MD: National Center for Health Statistics; 2018. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf>. Although the analysis presented in this paper relies on the Current Population Survey, here we provide decreases in the number of uninsured people over time from the National Health Interview Survey because changes in the CPS insurance questions between 2010 and 2017 do not permit comparisons of estimates over the period starting before the Affordable Care Act and ending after it was fully implemented.
2. *National Federation of Independent Business v Sebelius*, 567 US 519 (2012).
3. Here we count Virginia and Maine as Medicaid expansion states, even though neither has yet begun to enroll people eligible through the expansions. Virginia passed a Medicaid expansion into law in May 2018. Maine voters passed a ballot referendum for a Medicaid expansion in 2017, but Governor LePage has thus far refused to implement it. In June 2018, a judge ordered the governor to begin implementing it.
4. Blumberg LJ, Karpman M, Buettgens M, Solleveld P. *Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us About How to Reach Them?* Washington: Urban Institute; March 2016. <https://www.urban.org/sites/default/files/publication/79051/2000691-Who-Are-The-Remaining-Uninsured-And-What-Do-Their-Characteristics-Tell-Us-About-How-To-Reach-Them.pdf>.
5. US Census Bureau. *Current Population Survey: Design and Methodology, Technical Paper 66*. Washington: US Census Bureau; 2006, 11–15. <http://www.census.gov/prod/2006pubs/tp-66.pdf>.
6. Garfield R, Damico A, Foutz J, Claxton G, Levitt L. Estimates of eligibility for ACA coverage among the uninsured in 2016. Menlo Park, CA: Kaiser Family Foundation; 2017. <https://www.kff.org/uninsured/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016-october-2017-update/>.
7. The direction of any potential bias introduced by underreporting is unclear because people could be reporting that they have private insurance or that they are uninsured, and we do not know the proportions or the characteristics of those most likely to underreport. However, some earlier research suggests that underreporters most commonly respond to health insurance surveys as if they had employer-based coverage, thereby inflating those estimates: Call KT, Davidson G, Sommers AS, Feldman R, Farseth P, Rockwood T. Uncovering the missing Medicaid cases and assessing their bias for estimates of the uninsured. *Inquiry*. 2001;38(4):396–408. Davern M, Klerman JA, Baugh DK, Call KT, Greenberg GD. An examination of the Medicaid undercount in the Current Population Survey: preliminary results from record linking. *Health Serv Res*. 2009;44(3):965–987.
8. Current Population Survey: subject definitions. US Census Bureau website. <http://www.census.gov/programs-surveys/cps/technical-documentation/subject-definitions.html>. Updated August 25, 2015. Accessed May 7, 2018.
9. We start with a regression model built from wave 2 of the 2008 Survey of Income and Program Participation and calibrate the resulting probabilities to replicate widely accepted estimates of the undocumented population. We replicated the number of undocumented immigrants in 15 states and nationwide estimated by the Pew Hispanic Center, the gender by age distribution of undocumented immigrants estimated by the Department of Homeland Security, and the place of origin of undocumented immigrants estimated by the Center for Migration Studies.
10. Information on states providing health benefits to some undocumented immigrants can be found at: National Immigration Law Center. Medical assistance programs for immigrants in various states. Los Angeles: National Immigration Law Center; January 2018. <https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-immigrants-in-states.pdf>.
11. Trends in Medicaid income eligibility limits. Kaiser Family Foundation website. <https://www.kff.org/data-collection/trends-in-medicaid-income-eligibility-limits/>. Accessed May 7, 2018.
12. Medicaid and CHIP coverage of lawfully residing children and pregnant women. Centers for Medicare & Medicaid Services website. <https://www.medicaid.gov/medicaid/outreach-and-enrollment/lawfully-residing/index.html>. Updated September 9, 2016. Accessed May 7, 2018.
13. See note 10. Wyoming denies Medicaid to lawful permanent residents who are not pregnant and who do not have at least 40 quarters of work history in the United States; however, because the CPS ASEC does not include data on pregnancy or work history, here we treat Medicaid eligibility in Wyoming the same as we do for most other states.
14. Buettgens M. Medicaid expansion could make health insurance affordable for 5.6 million. Urban Wire blog. Posted October 2, 2015. <https://www.urban.org/urban-wire/medicaid-expansion-could-make-health-insurance-affordable-56-million>.
15. In addition to the previously cited papers on the underreporting of Medicaid, see, for example: Meyer BD, Mittag N. *Using Linked Survey and Administrative Data to Better Measure Income: Implications for Poverty, Program Effectiveness and Holes in the Safety Net*. NBER Working Paper 21676. Cambridge, MA: National Bureau of Economic Research; 2015. <http://www.nber.org/papers/w21676.pdf>. Wheaton L. *Underreporting of Means-Tested Transfer Programs in the CPS and SIPP*. Washington: Urban Institute; 2008. <https://www.urban.org/research/publication/underreporting-means-tested-transfer-programs-cps-and-sipp>.
16. Blumberg LJ, Buettgens M, Wang R. Updated: the potential impact of short-term limited-duration policies on insurance coverage, premiums, and federal spending. Washington: Urban Institute; March 2018. [https://www.urban.org/sites/default/files/publication/96781/2001727\\_updated\\_finalized.pdf](https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf).
17. Buettgens M, Dubay L, Kenney GM. Marketplace subsidies: changing the ‘family glitch’ reduces family health spending but increases government costs. *Health Aff*. 2016;35(7):1167–1175.
18. The policy options we delineate in the following sections are largely consistent with those presented in our previous paper on this topic, *Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us About How to Reach Them?* See note 4.
19. US Department of Health and Human Services, US Department of Education. Letter to state officials on CHIP and Medicaid outreach in schools. October 18, 1999. <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/sho101899.pdf>.
20. Medicaid enrollment. Albuquerque Public Schools website. <http://www.aps.edu/student-family-and-community-supports/accountability-medicaid-operations/medicaid-enrollment>. Accessed May 7, 2018.
21. Dorn S. *Integrating Health and Human Services Programs and Reaching Eligible Individuals Under the Affordable Care Act*. Washington: Urban Institute; 2015. <http://www.urban.org/research/publication/integrating-health-and-human-services-programs-and-reaching-eligible-individuals-under-affordable-care-act>.
22. Dorn S, Benatar S. *CHIPRA Express Lane Eligibility Evaluation: Case Study of Louisiana’s Express Lane Eligibility*. Washington: Urban Institute; 2014. <http://www.urban.org/research/publication/chipra-express-lane-eligibility-evaluation-case-study-louisianas-express-lane-eligibility>.
23. Guyer J, Schwartz T, Artiga S. Fast track to coverage: facilitating enrollment of eligible people into the Medicaid expansion. Menlo Park, CA: Kaiser Family Foundation; 2013. <https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8517-fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion1.pdf>.
24. Strengthening the marketplace by covering young adults [news release]. Baltimore, MD: Centers for Medicare & Medicaid Services; June 21, 2016. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-21.html>. Accessed May 24, 2018.
25. Buettgens M. The implications of Medicaid expansion in the remaining states: 2018 update. Washington: Urban Institute; 2018. <https://www.urban.org/research/publication/implications-medicaid-expansion-remaining-states-2018-update>.
26. The authors note, however, that doing so would best be done coupled with improved premium tax credits and cost-sharing reductions for people with incomes of 100 to 138 percent of FPL. Holahan J, Blumberg LJ. Instead of ACA repeal and replace, fix it. Washington: Urban Institute; 2017. <https://www.urban.org/research/publication/instead-aca-repeal-and-replace-fix-it>.
27. Jost TS, Pollack H. *Key Proposals to Strengthen the Affordable Care Act*. Washington: The Century Foundation; 2015. <https://tcf.org/content/report/key-proposals-to-strengthen-the-aca/>.
28. Galewitz P. Obama seeks to offer new incentive for states to expand Medicaid. *Kaiser Health News*. January 14, 2016. <http://khn.org/news/obama-seeks-to-offer-new-incentive-for-states-to-expand-medicaid/>.
29. Buettgens M, Kenney GM, Pan C. *Variation in Marketplace Enrollment Rates in 2015 by State and Income*. Washington: Urban Institute; 2015. <https://www.urban.org/research/publication/variation-marketplace-enrollment-rates-2015-state-and-income>.
30. Blumberg LJ, Holahan J. *After King v. Burwell: Next Steps for the Affordable Care Act*. Washington: Urban Institute; 2015. <http://www.urban.org/research/publication/after-king-v-burwell-next-steps-affordable-care-act>.
31. Blumberg LJ, Holahan J, Zuckerman S. *The Healthy America Program: Building on the Best of Medicare and the Affordable Care Act*. Washington: Urban Institute; 2018. <https://www.urban.org/research/publication/healthy-america-program>.
32. Cowley S. Many low-income workers say ‘no’ to health insurance. *New York Times*. October 19, 2015. <http://www.nytimes.com/2015/10/20/business/many-low-income-workers-say-no-to-health-insurance.html>.
33. Collins SR, Rasmussen PW, Doty MM, Beutel S. Too high a price: out-of-pocket health care costs in the United States. New York: Commonwealth Fund; 2014. <http://www.commonwealthfund.org/publications/issue-briefs/2014/nov/out-of-pocket-health-care-costs>.
34. Pothier M. Out-of-pocket costs put health care out of reach. *Boston Globe*. June 25, 2015. <https://www.bostonglobe.com/opinion/2015/06/25/out-pocket-costs-put-health-care-out-reach/KnOembdzh8vCghJY6BPHXJ/story.html>.
35. Leonard K. Employees paying more for premiums, deductibles. Data Mine blog. Posted January 8, 2015. <https://www.usnews.com/news/blogs/data-mine/2015/01/08/employees-paying-more-for-premiums-deductibles>.

Copyright© July 2018. The Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

### **About the Authors and Acknowledgments**

Linda J. Blumberg and John Holahan are Institute Fellows, Michael Karpman is a research associate, and Caroline Elmendorf is a research assistant in the Urban Institute's Health Policy Center.

The authors are grateful for assistance from Matthew Buettgens and Robin Wang in using analytic variables from the Health Insurance Policy Simulation Model, for helpful comments and suggestions from Stacey McMorrow, and for copyediting by Vicky Gan. The authors also acknowledge Matthew Buettgens, Dean Resnick, and Victoria Lynch for their roles in developing the procedure to impute undocumented status.

### **About the Robert Wood Johnson Foundation**

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit [www.rwjf.org](http://www.rwjf.org). Follow the Foundation on Twitter at [www.rwjf.org/twitter](https://www.rwjf.org/twitter) or on Facebook at [www.rwjf.org/facebook](https://www.rwjf.org/facebook).

### **About the Urban Institute**

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information, visit [www.urban.org](http://www.urban.org). Follow the Urban Institute on [Twitter](#) or [Facebook](#). More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at [www.healthpolicycenter.org](http://www.healthpolicycenter.org).