THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON

Medicaid and the Uninsured

REPORT

The Uninsured: A Primer

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KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED IN THE ERA OF HEALTH REFORM

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Executive Summary

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance, and the number of uninsured Americans grew over time, particularly during economic downturns. By 2013, the year before the major coverage provisions of the Affordable Care Act (ACA) went into effect, more than 43 million people lacked coverage.[1] Poor and low-income adults were particularly likely to lack coverage, and the main reason that most people said they lacked coverage was inability to afford the cost.[2]

Under the ACA, as of 2014, Medicaid coverage has been expanded to nearly all adults with incomes at or below 138% of poverty in states that have adopted the expansion, and tax credits are available for people with incomes up to 400% of poverty who purchase coverage through a health insurance marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate has dropped to a historic low. Coverage gains were particularly large among low-income people living in states that expanded Medicaid.

Still, millions of people—28 million nonelderly people as of the end of 2015— remain without coverage.[3] Groups with historically high uninsured rates continue to be at highest risk of being uninsured, including low-income individuals, adults, and people of color. Cost continues to pose a major barrier to coverage with nearly half (46%) of the uninsured in 2015 saying that the main reason they lacked coverage was because it was too expensive.[4]

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected. While the safety net of public hospitals, community clinics and health centers, and local providers provide a crucial health care safety net for uninsured people, it does not close the access gap for the uninsured.

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs, like housing, food, and transportation to work, and many uninsured adults report difficulty paying basic monthly expenses such as rent, food, and utilities.[5] When uninsured people use health care, they may be charged for the full cost of that care (versus insurers, who negotiate discounts) and often face difficulty paying medical bills and potential medical debt. Providers absorb some of the cost of care for the uninsured, and while uncompensated care funds cover some of those costs, these funds do not fully offset the cost of care for the uninsured.

Even with the ACA, the nation's system of health insurance continues to have many gaps that currently leave millions of people without coverage. Over half (57%) of the remaining uninsured are outside the reach of the ACA either because their state did not expand Medicaid, they are subject to immigrant eligibility restrictions, or their income makes them ineligible for financial assistance. The remainder are eligible for assistance under the law but may still struggle with affordability and knowledge of options and require targeted outreach to help them gain coverage. For both eligible and ineligible remaining uninsured people, health care needs persist regardless of insurance status, underscoring the importance of safety net providers and community health clinics to serve this population.[6]

Introduction

Despite record coverage gains under the 2010 Affordable Care Act (ACA), millions of people in the United States still lack health insurance. The ACA builds on the foundation of employer-based coverage and fills in historic gaps in insurance availability and affordability by expanding Medicaid for adults with incomes at or below 138% of the federal poverty level (about $16,394 per year for an individual in 2016)[7] and providing premium tax credits to make private insurance in the individual market more affordable for many with incomes between 100-400% of poverty (between $11,770 and $47,080 per year for an individual in 2015). Most of the ACA's major coverage provisions went into effect in 2014, and millions of people have gained coverage under the law. However, many people continue to lack coverage for a variety of reasons. For example, Medicaid eligibility for adults remains limited in states that have not adopted the expansion, some people remain ineligible for financial assistance for private coverage, and some still find coverage unaffordable even with financial assistance.

The gaps in our health insurance system affect people of all ages, races and ethnicities; however, those with the lowest incomes face the greatest risk of being uninsured. Being uninsured affects people's ability to access needed medical care and their financial security. As a result, uninsured people are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact can also be severe. Uninsured families struggle financially to meet basic needs, and medical bills can quickly lead to medical debt.

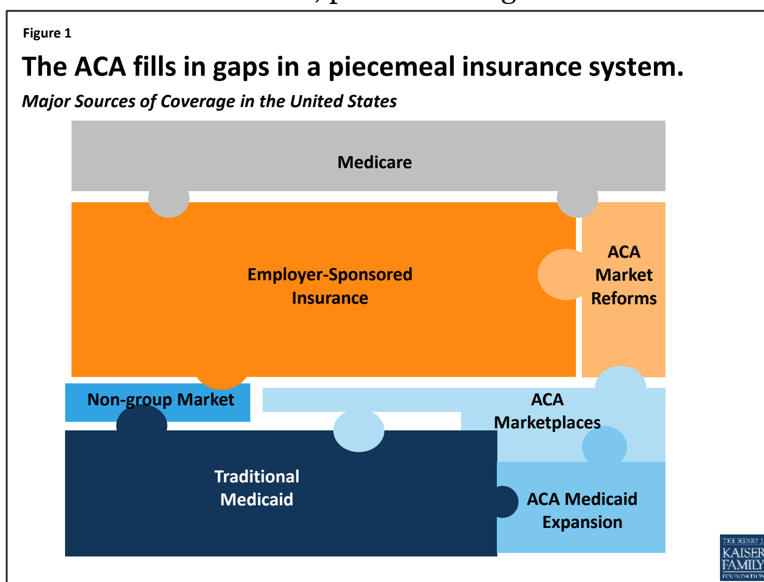
The Uninsured: A Primer provides information on how insurance has changed under the ACA, how many people remain uninsured, who they are, and why they lack health coverage. It also summarizes what we know about the impact that a lack of insurance can have on health outcomes and personal finances and the difference health insurance can make in people's lives.

How has health insurance coverage changed under the ACA?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance, and the number of uninsured Americans grew over time, particularly during economic downturns. By 2013, the year before the major coverage provisions of the ACA went into effect, more than 43 million people lacked coverage.[8] Under the ACA, as of 2014, Medicaid coverage has been expanded to nearly all adults with incomes at or below 138% of poverty in states that have adopted the expansion, and tax credits are available for people with incomes up to 400% of poverty who purchase coverage through a health insurance marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate has dropped to a historic low. Coverage gains were particularly large among low-income people living in states that expanded Medicaid. Still, millions of people—more than 27 million in 2016[9]—remain without coverage.

Health Insurance Coverage before the ACA

The ACA's coverage provisions built on and attempted to fill gaps in a piecemeal insurance system that left many without affordable coverage. This system had built up over time and included employer-based coverage for many—but not all—workers and their families, public coverage for some low-income people, and directly-purchased coverage for a small number of people who bought policies on the non-group market (Figure 1). (Medicare covers most people over age 65 as well as some younger people with disabilities.) Under this system, many were ineligible for coverage or could only access coverage that was too costly for them to afford. In 2013, 44.3 million nonelderly people in the U.S. lacked health insurance.[10] Poor and low-income adults were particularly likely to lack coverage, and the main reason that most people said they lacked coverage was inability to afford the cost.[11]



Historically, the majority of employers offered group health insurance policies to their employees and to their employees' families, but not all workers had access to or could afford such coverage. In 2013, 57% of firms offered employee coverage, with workers in low-wage and small firms less likely than other workers to be offered coverage.[12] Many low- and moderate-income workers who were offered employer coverage found their share of the premium unaffordable, especially if they needed more expensive family coverage.[13]

The availability of employer-sponsored coverage and the share of the population with this type of coverage declined over time. From 1999 to 2013, the share of firms that offered workers health benefits declined from 66% to 57%, primarily due to fewer small firms offering coverage.[14] Also during this period, health insurance premiums and the employee's share of those premiums nearly doubled, outpacing growth in workers' earnings and overall inflation.[15] The share of the nonelderly population with employer-sponsored coverage declined between 2000 and 2007,[16] even during years when the economy was strong and growth in health insurance premiums was slow. The Great Recession caused an even steeper drop in employer coverage

from 2008 to 2010 due to rising unemployment. As the economy began to stabilize from 2010 to 2013, the decline in employer coverage slowed, but rates of employer coverage remained below pre-recession levels.[17]

Very few people were covered by non-group health insurance policies prior to the ACA. Private policies directly purchased in the non-group, or individual, market (i.e., outside of employer-sponsored benefits) covered only 5% of people under age 65 in 2013.[18] Though, on average, non-group insurance premiums were lower than those for employer-sponsored coverage, enrollees paid 100% of the cost because they could not share that premium expense with an employer. Further, premiums in the non-group market could vary by age or health status, and people with health problems or at risk for health problems could be charged high rates, offered only limited coverage, or denied coverage altogether.

Medicaid and CHIP have been important sources of coverage for low-income children and people with disabilities, but in the past, coverage for adults without disabilities was limited. In 2013, Medicaid and CHIP covered just under a fifth (19%) of the nonelderly population[19] by primarily covering four categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities.[20] Prior to the ACA, federal law required state Medicaid programs to cover school age children up to 100% of the poverty level (133% for infants and preschool children), and states took up options to expand coverage to children in families with higher incomes through both Medicaid and CHIP. In contrast, the role of Medicaid for nonelderly, nondisabled adults remained very limited. In most states, parent eligibility remained very limited, often below 50% of the poverty level, and adults without dependent children—regardless of how poor—were ineligible for Medicaid.

Insurance coverage varied by state depending on the income distribution in the state, the nature of employment in the state, and the reach of state Medicaid programs. Insurance market regulations and the availability of jobs with employer-sponsored coverage also influenced the insurance rate in each state.[21] Massachusetts had the lowest uninsured rate in the country in 2013 (4%), due in part to health reform legislation enacted in 2006, while four states (Nevada, Texas, Arizona and Florida) had uninsured rates above 20%.[22]

ACA Coverage Provisions

The ACA expanded Medicaid eligibility to adults with incomes at or below 138% of poverty, but the 2012 Supreme Court ruling effectively made the expansion a state option. In addition to Medicaid's traditional role of covering low-income children, parents, pregnant women, and people with disabilities (as well as some low-income elderly), the ACA expanded Medicaid to nearly all adults with incomes at or below 138% of the poverty level (including low-income adults without dependent children who had historically had no path to coverage). Under the law, the federal government provided 100 percent of the cost of expansion from calendar years 2014-2016, and the federal share of costs gradually phases down to (and remains at) 90 percent by 2020. As of October 2016, 32 states, including DC, had adopted the Medicaid expansion.[23] Among states that have implemented the expansion, median income eligibility levels for parents and childless adults are now 138% of poverty.[24] Eligibility for children is higher, with 48 states covering children at or above 200% of poverty and 19 states covering children at or above 300% of poverty as of January 2016.[25] There is no deadline for states to expand Medicaid under the ACA, and discussion about the Medicaid expansion continues in other states.

The ACA established health insurance marketplaces where individuals and small employers can purchase insurance. Health insurance marketplaces operate in each state, but only some states run their own marketplace.[26] These marketplaces are designed to ensure a more level competitive environment for insurers and to provide consumers with information on cost and quality to help them choose among plans. To help make coverage purchased in these new marketplaces more affordable, the federal government provides tax credits for people with incomes between 100% and 400% of poverty ($20,090 to $80,360 for a family of three in 2015).[27,28] These tax credits are available on a sliding scale based on income and limit premium costs to a share of income. In addition, the federal government also provides cost-sharing subsidies to reduce what people with incomes between 100% and 250% of poverty have to pay out-of-pocket to access health services.

Coverage for immigrants remains limited under the ACA. Lawfully-present immigrants can receive coverage through the ACA coverage expansions, although they continue to face eligibility restrictions in Medicaid that have been in place since prior to the ACA. Specifically, many lawfully present non-citizens who would otherwise be eligible for Medicaid remain subject to a five-year waiting period before they may enroll.[29] Lawfully present immigrants are eligible for tax credits for coverage purchased through a marketplace, regardless of the number of years they have been in the U.S.[30] In addition, lawfully present immigrants who would be eligible for Medicaid but are in a five-year waiting period are also eligible for tax credits for marketplace coverage. Undocumented immigrants are ineligible for Medicaid and are prohibited from purchasing coverage through a marketplace or receiving tax credits.

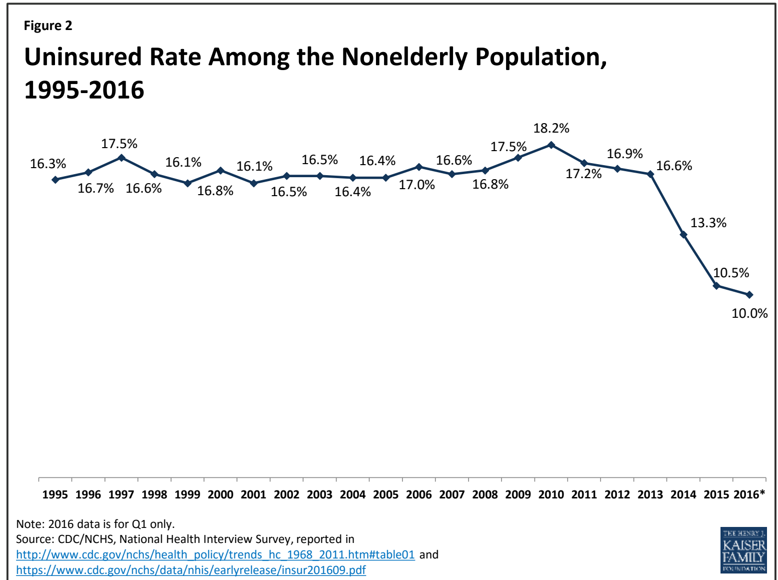
The ACA includes provisions to promote coverage in small firms. Recognizing the challenges that small employers, especially those with low-wage workers, face in providing coverage to their employees, the ACA established the Small Business Health Options Program (SHOP) marketplace, where employers with no more than 50 full-time equivalent (FTE) employees can purchase coverage. Beginning in January 2016, states had the option to expand the SHOP to include employers with 100 or fewer FTEs.[31] Small employers with no more than 25 FTE employees and annual wages of less than $50,000 that purchase coverage through the SHOP may be eligible for tax credits to reduce the cost of that coverage.[32] Eligible employers may take the tax credits for a maximum of two years.[33]

The ACA also extends dependent coverage in the private market. As of 2010, young adults may remain on their parents' private plans (including non-group and employer-based plans) until age 26. This provision led to significant declines in the number and rate of uninsured young adults beginning in 2010.[34]

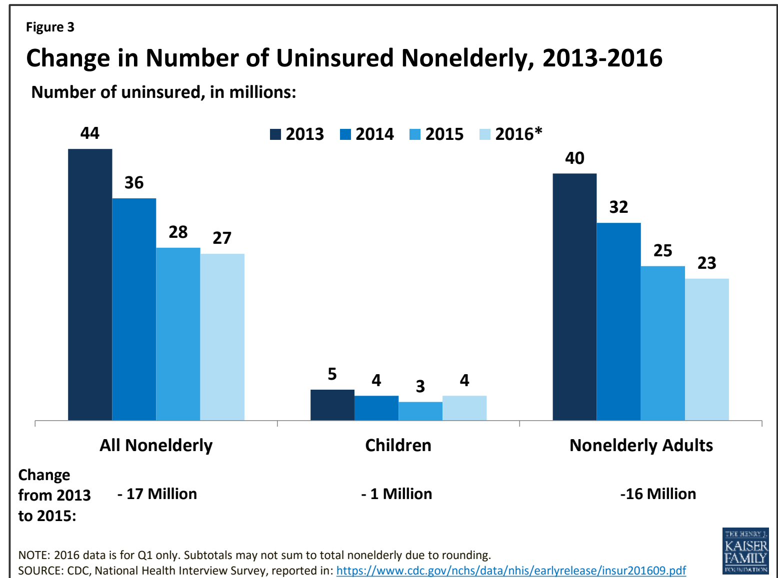
Large and medium-size employers now face penalties for not offering affordable coverage to full-time employees. As of January 2015, employers with 100 or more employees are assessed a fee up to $2,000 per full-time employee (in excess of 30 employees) if they do not offer affordable coverage and have at least one employee who receives a marketplace premium tax credit. As of January 2016, this provision also applies to employers with 50 to 99 full-time or full-time equivalent employees (FTEs). To avoid penalties, employers must offer insurance that pays for at least 60% of covered health care expenses, and the employee's share of the individual premium must not exceed 9.5% of family income.[35]

Changes in the Number of Uninsured Under the ACA

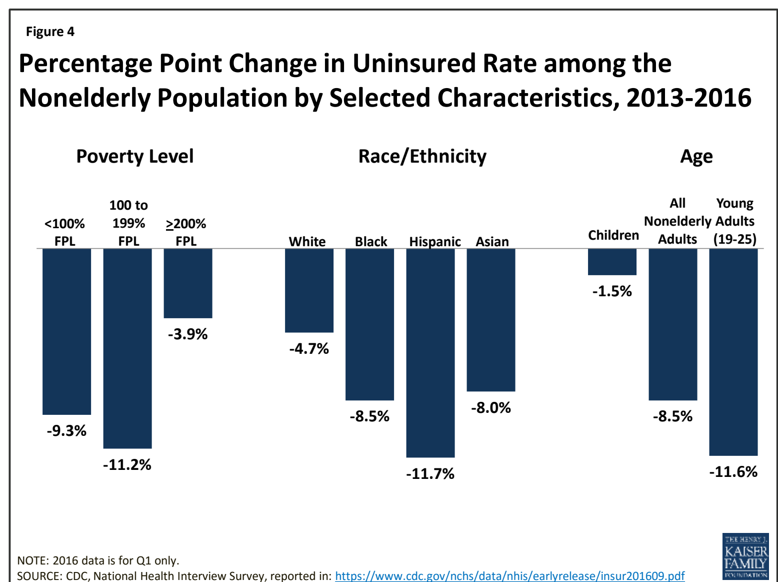
Under the ACA, the uninsured rate has declined to a historic low. The share of the nonelderly population that lacked insurance coverage hovered around 16% between 1995 and 2007, then peaked during the ensuing economic recession (Figure 2). As early provisions of the ACA went into effect in 2010, and as the economy improved, the uninsured rate began to drop. With the implementation of the major ACA coverage provisions in 2014, the uninsured rate dropped dramatically and continued to fall in 2015 and early 2016. In 2016, the nonelderly uninsured rate was 10.0%, the lowest rate ever recorded.



Over 17 million more people have health coverage in 2016 compared to 2013. Corresponding with implementation of the ACA's coverage provisions, the total number of nonelderly uninsured individuals nationally dropped from 44 million in 2013 to 27 million in 2016, with the biggest decline in the first two years of ACA implementation.[36] Because the expansions are largely targeted to adults, who have historically had higher uninsured rates than children, nearly the entire decline in the number of uninsured people under the ACA has occurred among adults (Figure 3).

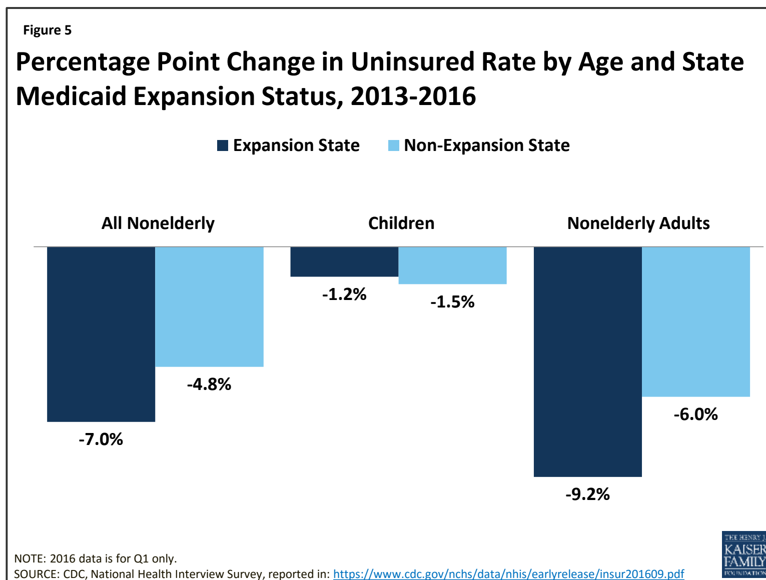


Coverage gains have been largest among low-income people, people of color, and young adults—groups that had high uninsured rates prior to 2014. While uninsured rates decreased across all income groups from 2013 to 2016, they declined most sharply for poor and near-poor people, dropping by 9.3 percentage points and 11.2 percentage points, respectively. Also during this period, the uninsured rate declined by 11.6 percentage points for adults age 19-25. Among racial and ethnic groups, Hispanics, Blacks, and Asian Americans had particularly large declines in uninsured rates, with each group seeing a drop of over 8 percentage points from 2013 to 2016 (Figure 4).[37]



Growth in Medicaid and directly-purchased coverage accounted for much of the decline in the uninsured rate. As of June 2016, national enrollment in Medicaid and CHIP had grown by over 15 million people since October 2013 (before the ACA Medicaid expansion), a 27% increase in monthly Medicaid enrollment.[38] In addition, as of March 2016, over 11 million individuals were enrolled in a marketplace plan, the vast majority of whom (85%) received premium subsidies.[39]

States that expanded Medicaid had larger gains in coverage than states that did not. Uninsured rates dropped nearly immediately in expansion states following implementation of the ACA's coverage provisions, with sharp declines among the low-income population widely attributed to gains in Medicaid coverage. Uninsured rates among the low-income population dropped somewhat in non-expansion states as well, in part as a result of the availability of ACA subsidies for private insurance to those with incomes above poverty, increased participation among those eligible but not enrolled in Medicaid, and increased outreach and enrollment efforts surrounding the ACA in all states; however, reductions in non-expansion states were far more limited than the substantial declines observed in expansion states.[40] Among nonelderly adults, Medicaid expansion states had a 9.2 percentage point drop in uninsured rates between 2013 and 2016, versus a 6.0 point drop in non-expansion states (Figure 5).

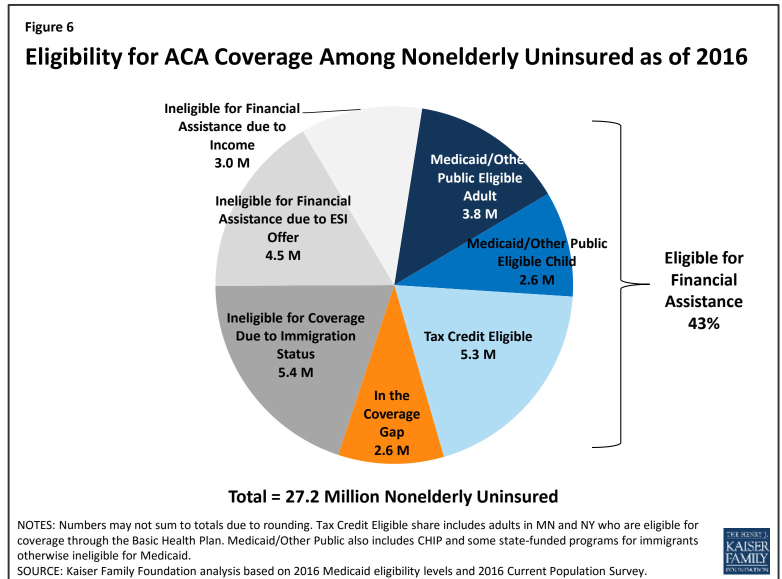


Some people continue to purchase non-group coverage outside the marketplace. Among the entire non-group market in winter 2016, nearly two-thirds of individuals (64%) reported having coverage obtained from a state or federal marketplace, 19% have ACA-compliant coverage purchased outside of the marketplace, and 12% have non-ACA-compliant plans (those that have been in effect since before January 1, 2014). People purchasing coverage outside the marketplace are not eligible for ACA premium tax credits.

Offer, eligibility, and take-up rates of employer sponsored insurance are largely unchanged since 2013. Over half (56%) of all firms offered health benefits in 2016, a rate similar to that in 2013 (57%).[41] Similarly, the percentage of workers eligible for health benefits at offering firms in 2016 (79%) is similar to 2013 (77%), and take-up rates have also remained steady, with 79% of eligible workers taking up offered coverage in 2016 compared to 80% in 2013.[42]

Even with the ACA, many remain uninsured. Of those estimated to be uninsured at the start of 2016, over one in four (11.7 million, or 43%) are eligible for financial assistance through either Medicaid or subsidized marketplace coverage. However, a majority of uninsured people remain outside the reach of the ACA. Some (5.4 million, or 20%) are ineligible due to their immigration status, and others (2.6 million, or 10%) are ineligible due to their state's decision not to expand Medicaid. The remainder of the uninsured either has an offer of coverage through an employer or has income above the limit for marketplace tax credits (Figure 6). These patterns of eligibility vary by state.[43]

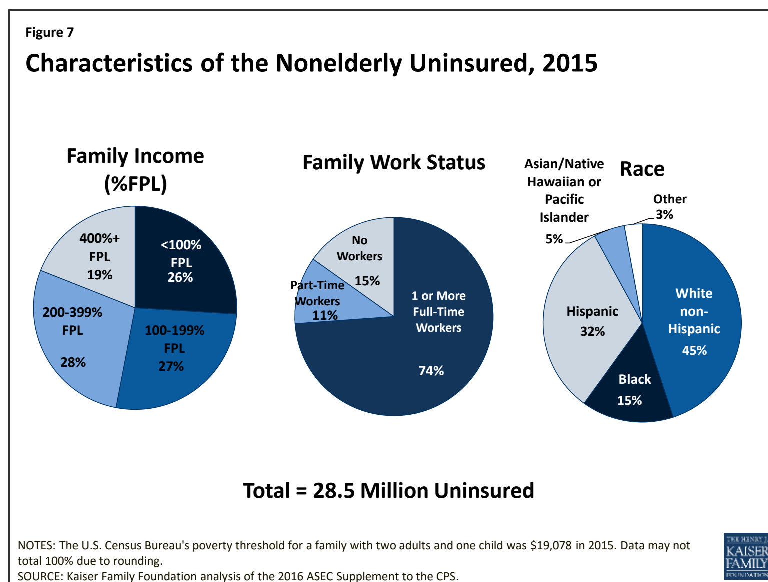
In the nineteen states that had not expanded Medicaid as of October 2016, 2.6 million poor adults fall into a "coverage gap."[44] These adults have incomes above Medicaid eligibility limits in their state but below the lower limit for marketplace premium tax credits, which begin at 100% of poverty. In non-expansion states, the median income eligibility level for parents is 44% of poverty and 0% for childless adults.[45] People in the coverage gap are concentrated in Southern states, with the largest number of people in the coverage gap in Texas (676,000 people, or 26%) followed by Florida (468,000, or 18%), Georgia (312,000, or 12%), and North Carolina (208,000, or 8%).[46]



Who remains uninsured after the ACA and why do they lack coverage?

Even after the ACA, over 28 million nonelderly people in the United States were uninsured as of the end of 2015.[47] Despite coverage gains, groups with historically high uninsured rates continue to be at highest risk of being uninsured, including low-income individuals, adults, and people of color. Cost continues to pose a major barrier to coverage with nearly half (46%) of the uninsured in 2015 saying that the main reason they lacked coverage was because it was too expensive.[48]

Though provisions in the ACA aim to make coverage more affordable for low and moderate-income families, these income groups still make up the vast majority of the uninsured. More than half of the remaining uninsured population (53%) has family income at or below 200% of poverty ($19,078 for a family with two adults and one child in 2015)[49] and another 28% has family income between 200 and 399% of poverty (Figure 7). Low-income individuals are at the highest risk of being uninsured.[50]



A majority of the remaining uninsured population is in a family with at least one worker, and many uninsured workers continue to lack access to coverage through their job. As of the end of 2015, over seven in ten (74%) of the uninsured have at least one full time worker in their family, and an additional 11% have a part-time worker in their family (Figure 7).[51] As in the past, low-income workers and those who work in blue-collar jobs (versus white-collar jobs) are more likely than other workers to be uninsured.[52] Uninsured adults report that access to coverage through a job remains limited or unaffordable.[53] While the ACA's employer offer requirements may help many uninsured individuals with a worker in their family, nearly half (49%) of uninsured workers in 2015 worked in firms with fewer than 50 employees, which are not required to offer affordable insurance coverage.[54]

People of color are at higher risk of being uninsured than Whites. While a plurality (45%) of the uninsured are non-Hispanic Whites, people of color are disproportionately likely to be uninsured: they make up 41% of the overall U.S. population but account for over half of the total uninsured population (Figure 7). Hispanics account for nearly a third (32%) of the uninsured, and non-Hispanic Blacks account for 15%.[55] Differences in coverage by race/ethnicity likely reflect a combination of factors, including language and immigration barriers, income and work status, and state of residence.

Adults are still more likely than children to be uninsured. Nonelderly adults were more than twice as likely as children (13% vs. 5%) to be uninsured in 2015.[56] This disparity reflects ongoing differences in eligibility for public coverage. While the ACA has increased Medicaid eligibility levels for adults, states have expanded coverage for children even higher through CHIP, while adults without children are excluded from Medicaid in all but one non-expansion state.[57]

Uninsured rates for children are low, and most uninsured children are eligible for Medicaid or CHIP. Largely due to expanded eligibility for public coverage under Medicaid and CHIP, the uninsured rate for children is relatively low: in 2015, 5% of children nationwide were uninsured.[58] Two-thirds (66%) of uninsured children are eligible for Medicaid, CHIP, or other public programs.[59] Some of these children may be reached by covering their parents, as research has found that parent coverage in public programs is associated with higher enrollment of eligible children.[60,61]

Insurance coverage continues to vary by state and region, with individuals living in the South and West the most likely to be uninsured (Figure 8). In 2014, the 16 states with the highest uninsured rates were all in the South and West,[62] reflecting state Medicaid expansion status, demographic characteristics, economic conditions, availability of employer-based coverage, and state outreach efforts under the ACA.

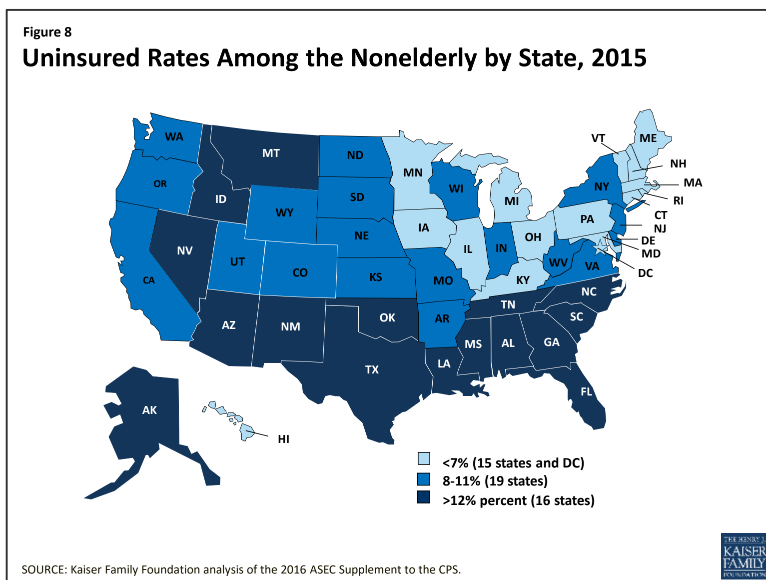


Figure 8
Uninsured Rates Among the Nonelderly by State, 2015

SOURCE: Kaiser Family Foundation analysis of the 2016 ASEC Supplement to the CPS.

While most of the uninsured are U.S. citizens, non-citizens continue to be at much higher risk of being uninsured. In 2015, nearly three out of four (73%) uninsured nonelderly individuals were citizens. However, non-citizens (including those who are lawfully present and those who are undocumented) are more likely than citizens to be uninsured in 2015. Among citizens, 9% were uninsured in 2015, compared to 28% of non-citizens.[63]

Cost still poses a major barrier to coverage for the uninsured. Nearly half (46%) of uninsured adults in 2015 said that the main reason they lacked coverage was because it was too expensive.[64] Though financial assistance is available to many of the remaining uninsured under the ACA,[65] not everyone who is uninsured is eligible for free or subsidized coverage. In addition, affordability of ACA Marketplace coverage remains a concern for some people. In 2016, 40% of people with Marketplace coverage said they were dissatisfied with their monthly premium and nearly half (46%) were dissatisfied with their deductible.

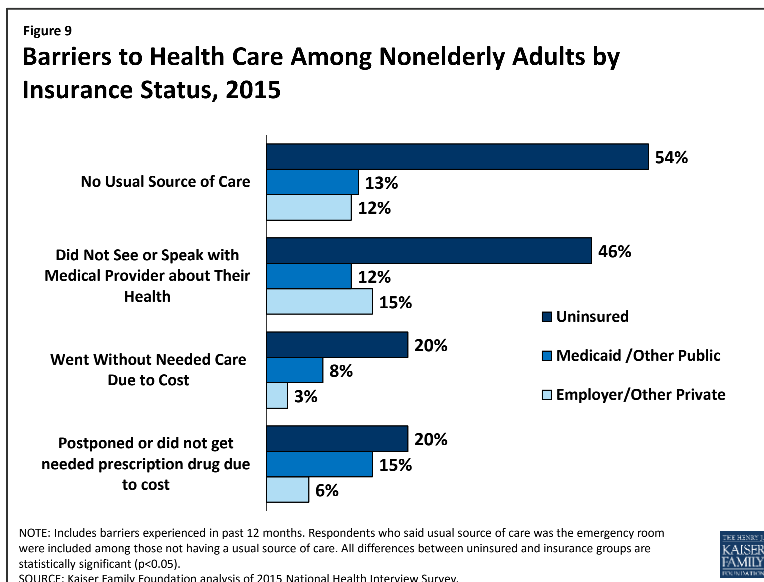
Some individuals may remain uninsured because they are not aware of coverage options or face barriers to enrollment, even though they may be eligible for financial assistance under the ACA. In 2015, about one in five uninsured nonelderly adults said they remained uninsured because they didn't know about the requirement to have health insurance (7%) or didn't think the requirement applied to them (13%) (some in fact may be exempt under specific provisions of the law). About one in ten said they tried to get coverage but were unable (11%),[66] though many enrollment barriers encountered in the first year of ACA coverage have been addressed.

Most people who remained uninsured in 2015 were uninsured for more than a year. Though the share of uninsured who lacked coverage for more than a year decreased from 81% in 2013 to 76% in 2015,[67] the vast majority of uninsured people were still long-term uninsured. People who have been without coverage for long periods may be particularly hard to reach through outreach and enrollment efforts.

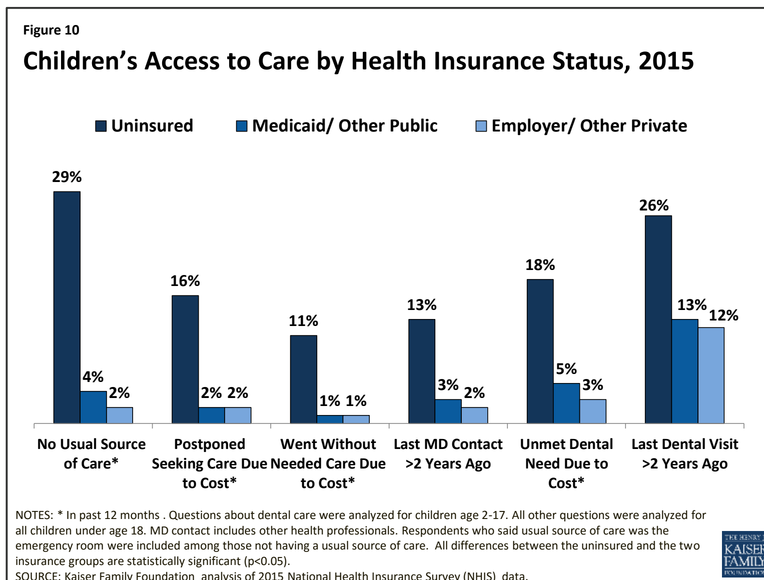
How does lack of insurance affect access to health care?

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Compared to those who have health coverage, people without health insurance are more likely to skip preventive services and report that they do not have a regular source of health care. Adults who are uninsured are three times more likely than insured adults to say they have not seen or spoken with a medical provider about their health in the past year (Figure 9). They are also less likely to receive recommended screening tests such as blood pressure checks, cholesterol checks, blood sugar screening, pap smear or mammogram (among women), and colon cancer screening.[68] Part of the reason for poor access among the uninsured is that most (54%) do not have a regular place to go when they are sick or need medical advice, while most insured people do have a regular source of care (Figure 9).[69]



Uninsured people are more likely than those with insurance to report problems getting needed medical care. One in five (20%) uninsured adults say that they went without care in the past year because of cost compared to 3% of adults with private coverage and 8% of adults with public coverage. Many uninsured people do not obtain the treatments their health care providers recommend for them. In 2015, 20% of uninsured adults said they delayed or did not get a needed prescription drug due to cost, compared to 15% with public coverage and 6% with private coverage.[70] And while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care from their doctors, people without health coverage are less likely than those with coverage to obtain all the recommended services.[71,72]



Because uninsured people are less likely than those with insurance to have regular outpatient care, they are more likely to have negative health consequences. Because uninsured patients are less likely than those with insurance to receive necessary follow-up screenings,[73] they have an increased risk of being diagnosed at later stages of diseases, including cancer, and have higher mortality rates than those with insurance.[74,75,76] In addition, when

uninsured people are hospitalized, they receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.[77,78,79,80]

Uninsured children also face problems getting needed care. Uninsured children are more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance (Figure 10).[81] Further, uninsured children with common childhood illnesses and injuries do not receive the same level of care as others and are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.[82,83] Among children with special health care needs, those without health insurance have worse access to care, including specialist care, than those with insurance.[84]

Lack of health coverage, even for short periods of time, results in decreased access to care. Research has shown that adults who experience gaps in their health insurance coverage are less likely to have a regular source of care or to be up to date with blood pressure or cholesterol checks than those with continuous coverage.[85] Research also indicates that children who are uninsured for part of the year have more access problems than those with full-year coverage.[86,87] Similarly, adults who lack insurance for an entire year have poorer access to care than those who have coverage for at least part of the year, suggesting that even a short period of coverage can improve access to care.[88]

Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care than their counterparts who did not gain coverage.[89] Gaining Medicaid increased the likelihood of having an outpatient visit by approximately 35%, increased the likelihood of prescription drug utilization by 15%, and decreased the likelihood of depression and stress. Findings two years out from the expansion showed significant improvements in access, utilization, and self-reported health, and virtual elimination of catastrophic out-of-pocket medical spending among the adults who gained coverage.[90] In addition, a large body of research on the impact of Medicaid expansion under the ACA demonstrates that gains in Medicaid coverage positively impact access to care and utilization of health care services.[91] Research also shows that individuals who gained marketplace coverage in 2014 were far more likely than those who remained uninsured to obtain a usual source of care and receive preventive care services.[92]

Public hospitals, community clinics and health centers, and local providers provide a crucial health care safety net for uninsured people; however, the safety net does not close the access gap for the uninsured. Safety net providers, including public and community hospitals, community health centers, rural health centers, and local health departments, provide care to many people without health coverage. In addition, nearly all other hospitals and some private, office-based physicians provide some charity care. However, safety net providers have limited resources and service capacity, and not all uninsured people have geographic access to a safety net provider.[93,94] The ACA has led to significant growth in the number of health centers and their service capacity through both a large financial investment in community health centers to help meet the increasing demand for primary care as coverage expands and new patient revenues due to expanded coverage.[95] However, this impact has been more limited in states not expanding Medicaid, where a much larger share of health center patients remains uninsured than in states that did expand.[96] In addition, regardless of their state's Medicaid expansion decision, health centers report that securing needed specialty care for their uninsured patients is a major challenge.[97]

What are the financial implications of lacking insurance?

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs, like housing, food, and transportation to work, and many uninsured adults report difficulty paying basic monthly expenses such as rent, food, and utilities.[98] When uninsured people use health care, they may be charged for the full cost of that care (versus insurers, who negotiate discounts) and often face difficulty paying medical bills. Providers absorb some of the cost of care for the uninsured, and while uncompensated care funds cover some of those costs, these funds do not fully offset the cost of care for the uninsured.

Most uninsured people do not receive health services for free or at reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.[99, 100] In 2014, only 40% of uninsured adults who received health care services reported receiving free or reduced cost care.[101]

Uninsured people often must pay "up front" before services will be rendered. When people without health coverage are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or be turned away.[102] Among uninsured adults who received health care in 2013, nearly a third (31%) were asked to pay for the full cost of medical care before they could see a doctor.[103]

People without health insurance have lower medical expenditures than those with insurance, but they pay a much larger portion of their medical costs out-of-pocket. Compared to insured nonelderly people with full-year coverage, whose average per capita medical expenditures were $4,876 in 2013, nonelderly people who were full-year uninsured used health care services valued at about half that amount, or just $2,443 per capita in 2013.[104] Despite lower overall medical spending, people without insurance pay nearly as much out-of-pocket as insured people.[105]

The uncompensated costs of care for the uninsured amounted to about $84.9 billion in 2013. Funding from a number of sources, totaling $53.3 billion in 2013, helps providers defray the costs associated with uncompensated care. Most of these funds (62%) came from the federal government through a variety of programs including Medicaid and Medicare, the Veterans Health Administration, the Indian Health Service, the Community Health Centers block grant, and the Ryan White CARE Act. States and localities provided $19.8 billion, and the private sector provided $0.7 billion. While substantial, these payments to providers for uncompensated care amount to a small slice of total health care spending in the U.S.[106]

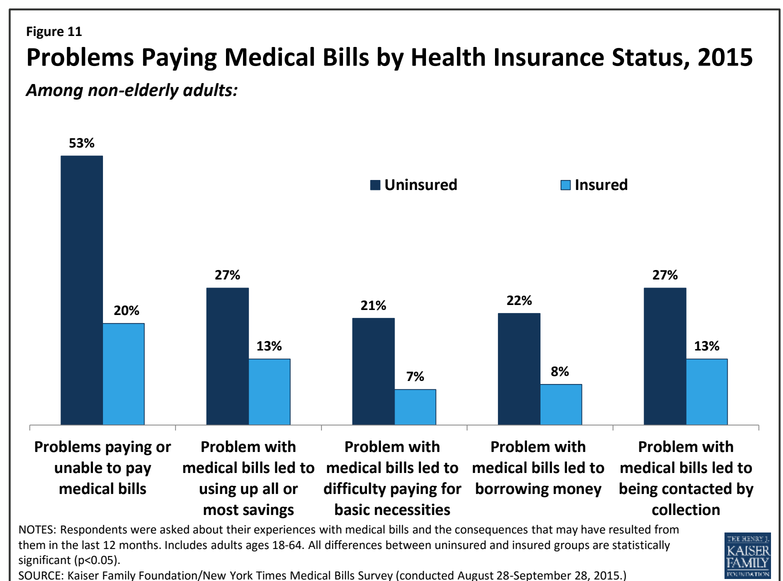
The burden of uncompensated care varies across providers. Hospitals, community providers (such as clinics and health centers), and office-based physicians all provide care to the uninsured. Given the high cost of hospital-based care, the majority (60%) of the cost of uncompensated care is incurred in hospitals. Community-based providers that receive public funds provide a little over a quarter (26%) of total uncompensated care, and the remainder of uncompensated care, 14%, is provided by office-based physicians.[107]

With the expansion of coverage under the ACA, providers in states that expanded Medicaid are seeing reductions in uncompensated care costs. For example, between 2013 and 2014, total uncompensated care costs for hospitals (including charity care costs and bad debt) dropped from $34.9 billion to $28.9 billion, a $6 billion or 17% drop, with nearly all of the decrease occurring in expansion states. In non-

expansion states, the change in uncompensated care was nearly flat between 2013 and 2014, dropping just 1% in 2014.[108]

Many safety net hospitals that serve a large number of Medicaid and low-income uninsured individuals receive Medicaid disproportionate share hospital payments (DSH); however, federal DSH payments are scheduled to be cut beginning in FY 2018.[109] Federal law requires that state Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Unlike other Medicaid payments, federal DSH funds are capped and each state receives a capped allotment. DSH allotments vary across states and totaled about $11.9 billion in FY 2015.[110] Anticipating fewer uninsured and lower levels of uncompensated care, the ACA called for a reduction in federal Medicaid DSH payments. Cuts were originally scheduled to begin in 2014 but were delayed to FY 2018. These reductions will amount to $43 billion between 2018 and 2025.[111] The HHS Secretary is required to develop a methodology to allocate the reductions that must take into account factors outlined in the law.[112] While safety-net hospitals across the country will be affected, hospitals in states that do not expand Medicaid may face cuts without additional revenues from new coverage.

Being uninsured leaves individuals at an increased risk of financial strain due to medical bills. Uninsured people are more likely than those with insurance (53% vs. 20%) to report having trouble paying or being unable to pay medical bills in the past year. Medical bills may also lead to serious financial strain. In 2015, 27% of uninsured adults reported that medical bills caused them to use up all or most of their savings, 21% said they led to difficulties paying for basic necessities, 22% said it led them to borrow money, and 27% said it led to being contacted by a collection agency. These rates were significantly higher than those among individuals with insurance (Figure 11).



Most uninsured people have few, if any, savings or assets they can easily use to pay health care costs. The average uninsured household has no net assets,[113] and half of uninsured families living below 200% of poverty have no savings.[114,115] The uninsured are much more likely than those with insurance to say they are worried or very worried about paying medical bills if they get sick or get into an accident (79% vs. 45%).[116]

Uninsured people are at risk of medical debt. Like any bill, when medical bills are not paid or are paid off too slowly, they are turned over to a collection agency. In 2015, uninsured adults were three times as likely as insured adults to say they owed money on at least one medical bill (45% vs. 16%).[117] Medical debts contribute to over half (52%) of debt collections actions that appear on consumer credit reports in the United States,[118] and uninsured people are at higher risk of falling into medical bankruptcy than people with insurance.[119]

Conclusion

The ACA led to historic drops in the uninsured rate, with millions of previously uninsured Americans now insured and gaining access to health services and protection from catastrophic health costs. Prior to the ACA, the options for the uninsured population were limited in the individual market, as coverage was often expensive and insurers could deny coverage based on health status. Medicaid and CHIP have provided coverage to many families, but pre-2014 eligibility levels were low for parents and few states provided coverage to adults without dependent children. The ACA fills in many of these gaps by expanding Medicaid to low-income adults and providing subsidized coverage to people with incomes from 100 to 400% of poverty in the marketplaces.

Nonetheless, even with the ACA, the nation's system of health insurance continues to have many gaps that currently leave millions of people without coverage. Over half (57%) of the remaining uninsured are outside the reach of the ACA either because their state did not expand Medicaid, they are subject to immigrant eligibility restrictions, or their income makes them ineligible for financial assistance. The remainder are eligible for assistance under the law but may still struggle with affordability and knowledge of options and require targeted outreach to help them gain coverage. For both eligible and ineligible remaining uninsured people, health care needs persist regardless of insurance status, underscoring the importance of safety net providers and community health clinics to serve this population.[120]

The ACA has provided coverage to millions of people in the United States in its first three years and has the potential to reach many more, ensuring that fewer individuals and families will face the health and financial consequences of not having health insurance.

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