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

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

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

**SURVEY HIGHLIGHTS**

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

People who are underinsured or spend any time uninsured report cost-related problems getting care and difficulty paying medical bills at higher rates than those with continuous, adequate coverage.

Federal and state governments could enact policies to extend the ACA’s health coverage gains and improve the cost protection provided by individual-market and employer plans.

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

WHO IS UNDERINSURED?

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

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

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

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

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

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

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

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

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

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

There Has Been Some Improvement in Long-Term Uninsured Rates

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


Percent of adults ages 19–64 who are uninsured now

- Uninsured for 6 months or less
- Uninsured for more than 2 years

Survey Brief, February 2019
More Adults Are Underinsured, with the Greatest Growth Occurring Among Those with Employer Coverage

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

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

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

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

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

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

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

4. Growth in Americans’ incomes has not kept pace with growth in health care costs. Even when health costs rise more slowly, they can take an increasingly larger bite out of incomes.
Fewer Adults Report Not Getting Needed Care Because of Costs, but Gains Have Stalled in Recent Years

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

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


It is well documented that people who gained coverage under the ACA’s expansions have better access to health care as a result. This has led to overall improvement in health care access, as indicated by multiple surveys. In 2014, the year the ACA’s major coverage expansions went into effect, the share of adults in our survey who said that cost prevented them from getting health care that they needed, such as prescription medication, dropped significantly (Table 4). But there has been no significant improvement since then.
Inadequate Coverage Is Associated with More Cost-Related Problems Getting Needed Care

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

<table>
<thead>
<tr>
<th>Did not fill prescription</th>
<th>Skipped recommended test, treatment, or follow-up</th>
<th>Had a medical problem, did not visit doctor or clinic</th>
<th>Did not get needed specialist care</th>
<th>At least one of four access problems because of cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured all year, not underinsured</td>
<td>11</td>
<td>25</td>
<td>32</td>
<td>11</td>
</tr>
<tr>
<td>Insured all year, underinsured</td>
<td>25</td>
<td>34</td>
<td>36</td>
<td>49</td>
</tr>
<tr>
<td>Insured now, had a coverage gap</td>
<td>32</td>
<td>23</td>
<td>24</td>
<td>35</td>
</tr>
<tr>
<td>Uninsured now</td>
<td>56</td>
<td>59</td>
<td>56</td>
<td>59</td>
</tr>
</tbody>
</table>

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

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).
Fewer Adults Have Difficulty Paying Their Medical Bills, but the Improvement Has Stalled

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

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

There was modest but significant improvement following the ACA’s coverage expansions in the proportion of all U.S. adults who reported having difficulty paying their medical bills or said they were paying off medical debt over time (Table 4). Federal surveys have found similar improvements. However, those gains have stalled.
Inadequate Coverage Is Associated with More Problems Paying Medical Bills

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Insured all year, not underinsured</th>
<th>Insured all year, underinsured</th>
<th>Insured now, had a coverage gap</th>
<th>Uninsured now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had problems paying or unable to pay medical bills</td>
<td>13%</td>
<td>30%</td>
<td>47%</td>
<td>40%</td>
</tr>
<tr>
<td>Contacted by collection agency for unpaid medical bills</td>
<td>9%</td>
<td>19%</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Had to change way of life to pay bills</td>
<td>6%</td>
<td>19%</td>
<td>22%</td>
<td>26%</td>
</tr>
<tr>
<td>Medical bills/debt being paid over time</td>
<td>16%</td>
<td>33%</td>
<td>33%</td>
<td>26%</td>
</tr>
<tr>
<td>Any bill problem or medical debt</td>
<td>25%</td>
<td>47%</td>
<td>56%</td>
<td>52%</td>
</tr>
</tbody>
</table>

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

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).
Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured

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

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

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).
Continuously Insured Adults, Including Those Underinsured, Are More Likely to Get Cancer Screenings

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

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).
CONCLUSION AND POLICY IMPLICATIONS

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

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

Increase Coverage

- **Expand Medicaid without restrictions.** The 2018 midterm elections moved as many as five states closer to joining the 32 states that, along with the District of Columbia, have expanded eligibility for Medicaid under the ACA. As many as 300,000 people may ultimately gain coverage as a result. But, encouraged by the Trump administration, several states are imposing work requirements on people eligible for Medicaid — a move that could reverse these coverage gains. So far, the U.S. Department of Health and Human Services (HHS) has approved similar work-requirement waivers in seven states and is considering applications from at least seven more. Arkansas imposed a work requirement last June, and, to date, more than 18,000 adults have lost their insurance coverage as a result.

- **Ban or place limits on short-term health plans and other insurance that doesn’t comply with the ACA.** The Trump administration loosened regulations on short-term plans that don’t comply with the ACA, potentially leaving people who enroll in them exposed to high costs and insurance fraud. These plans also will draw healthier people out of the marketplaces, increasing premiums for those who remain and federal costs of premium subsidies. Twenty-three states have banned or placed limits on short-term insurance policies. Some lawmakers have proposed a federal ban.

- **Reinsurance, either state or federal.** The ACA’s reinsurance program was effective in lowering marketplace premiums. After it expired in 2017, several states implemented their own reinsurance programs. Alaska’s program reduced premiums by 20 percent in 2018. These lower costs particularly help people whose incomes are too high to qualify for ACA premium tax credits. More states are seeking federal approval to run programs in their states. Several congressional bills have proposed a federal reinsurance program.

- **Reinstate outreach and navigator funding for the 2020 open-enrollment period.** The administration has nearly eliminated funding for advertising and assistance to help people enroll in marketplace plans. Research has found that both activities are effective in increasing enrollment. Some lawmakers have proposed reinstating this funding.

- **Lift the 400-percent-of-poverty cap on eligibility for marketplace tax credits.** This action would help people with income exceeding $100,000 (for a family of four) better afford marketplace plans. The tax credits work by capping the amount people pay toward their premiums at 9.86 percent. Lifting the cap has a built in phase out: as income rises, fewer people qualify, since premiums consume an increasingly smaller share of incomes. RAND researchers estimate that this policy change would increase enrollment by 2 million and lower marketplace premiums by as much as 4 percent as healthier people enroll. It would cost the federal government an estimated $10 billion annually. Legislation has been introduced to lift the cap.
• **Make premium contributions for individual market plans fully tax deductible.** People who are self-employed are already allowed to do this.16

• **Fix the so-called family coverage glitch.** People with employer premium expenses that exceed 9.86 percent of their income are eligible for marketplace subsidies, which trigger a federal tax penalty for their employers. There’s a catch: this provision applies only to single-person policies, leaving many middle-income families caught in the “family coverage glitch.” Congress could lower many families’ premiums by pegging unaffordable coverage in employer plans to family policies instead of single policies.17

### Reduce Coverage Gaps

• **Inform the public about their options.** People who lose coverage during the year are eligible for special enrollment periods for ACA marketplace coverage. Those eligible for Medicaid can sign up at any time. But research indicates that many people who lose employer coverage do not use these options.18 The federal government, the states, and employers could increase awareness of insurance options outside the open-enrollment periods through advertising and education.

• **Reduce churn in Medicaid.** Research shows that over a two-year period, one-quarter of Medicaid beneficiaries leave the program and become uninsured.19 Many do so because of administrative barriers.20 By imposing work requirements, as some states are doing, this involuntary disenrollment is likely to get worse. To help people stay continuously covered, the federal government and the states could consider simplifying and streamlining the enrollment and reenrollment processes.

• **Extend the marketplace open-enrollment period.** The current open-enrollment period lasts just 45 days. Six states that run their own marketplaces have longer periods, some by as much as an additional 45 days. Other states, as well as the federal marketplace, could extend their enrollment periods as well.

### Improve Individual-Market Plans’ Cost Protections

• **Fund and extend the cost-sharing reduction subsidies.** The Trump administration eliminated payments to insurers for offering plans with lower deductibles and copayments. Insurers, which by law must still offer reduced-cost plans, are making up the lost revenue by raising premiums. But this fix, while benefiting enrollees who are eligible for premium tax credits, has distorted both insurer pricing and consumer choice.21 In addition, it is unknown whether the administration’s support for the fix will continue in the future, creating uncertainty for insurers.22 Congress could reinstate the payments to insurers and consider making the plans available to people with higher earnings.

• **Increase the number of services excluded from the deductible.** Most plans sold in the individual market exclude certain services from the deductible, such as primary care visits and certain prescriptions.23 As the survey data suggest, these types of exclusions appear to be important in ensuring access to preventive care among people who have coverage but are underinsured. In 2016, HHS provided a standardized plan option for insurers that excluded eight health services — including mental health and substance-use disorder outpatient visits and most prescription drugs — from the deductible at the silver and gold level.24 The Trump administration eliminated the option in 2018. Congress could make these exceptions mandatory for all plans.
Improve Employer Plans’ Cost Protections

- **Increase the ACA’s minimum level of coverage.** Under the ACA, people in employer plans may become eligible for marketplace tax credits if the actuarial value of their plan is less than 60 percent, meaning that under 60 percent of health care costs, on average, are covered. Congress could increase this to the 70 percent standard of silver-level marketplace plans, or even higher.

- **Require deductible exclusions.** Congress could require employers to increase the number of services that are covered before someone meets their deductible. Most employer plans exclude at least some services from their deductibles. Congress could specify a minimum set of exclusions for employer plans that might resemble the standardized-choice options that once existed for ACA plans.

- **Refundable tax credits for high out-of-pocket costs.** Congress could make refundable tax credits available to help insured Americans pay for qualifying out-of-pocket costs that exceed a certain percentage of their income.

- **Protect consumers from surprise medical bills.** Several states have passed laws that protect patients and their families from unexpected medical bills, generally from out-of-network providers. A bipartisan group of U.S. senators has proposed federal legislation to protect consumers, including people enrolled in employer and individual-market plans.

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

The Commonwealth Fund Biennial Health Insurance Survey, 2018, was conducted by SSRS from June 27 to November 11, 2018. The survey consisted of telephone interviews in English and Spanish and was conducted among a random, nationally representative sample of 4,225 adults ages 19 to 64 living in the continental United States. A combination of landline and cellular phone random-digit dial samples was used to reach people. In all, 725 interviews were conducted with respondents on landline telephones and 3,500 interviews were conducted on cellular phones. The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. Statistical results are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau’s 2017 Annual Social and Economic Supplement.

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

We also report estimates from the 2001, 2003, 2005, 2010, 2012, 2014, and 2016 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy that was used in 2018, except the 2001, 2003, and 2005 surveys did not include a cellular phone random-digit dial sample. In 2001, the survey was conducted from April 27 through July 29, 2001, and included 2,829 adults ages 19 to 64; in 2003, the survey was conducted from September 3, 2003, through January 4, 2004, and included 3,293 adults ages 19 to 64; in 2005, the survey was conducted from August 18, 2005, to January 5, 2006, among 3,352 adults ages 19 to 64; in 2010, the survey was conducted from July 14 to November 30, 2010, among 3,033 adults ages 19 to 64; in 2012, the survey was conducted from April 26 to August 19, 2012, among 3,393 adults ages 19 to 64; in 2014, the survey was conducted from July 22 to December 14, 2014, among 4,251 adults ages 19 to 64; and in 2016, the survey was conducted from July 12 to November 20, 2016, among 4,186 adults ages 19 to 64.
# Changes in U.S. Uninsured Rates Since 2013

Uninsured Rate for Adults Compared to Other Surveys Since 2013

<table>
<thead>
<tr>
<th>Survey</th>
<th>Preimplementation uninsured rate (%) [95% CI]</th>
<th>Lowest uninsured rate (%) [95% CI]</th>
<th>Current uninsured rate (%) [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonwealth Fund Biennial Health Insurance Survey*</td>
<td>19.3% [17.5%–21.3%]</td>
<td>12.0% [10.7%–13.52%] (July–Nov. 2016)</td>
<td>12.4% [11.2%–13.7%]</td>
</tr>
<tr>
<td>Commonwealth Fund Affordable Care Act Tracking Surveyb</td>
<td>19.9% [18.5%–21.4%]</td>
<td>12.7% [11.5%–14.0%] (Feb.–Apr. 2016)</td>
<td>15.5% [13.7%–17.5%]</td>
</tr>
<tr>
<td>Current Population Survey (CPS)d</td>
<td>18.3%</td>
<td>11.9% (2016)</td>
<td>12.1%</td>
</tr>
<tr>
<td>Gallup Healthways Well-Being Indexe,f</td>
<td>20.8%</td>
<td>13.1% (Q4 2016)</td>
<td>16.3%</td>
</tr>
<tr>
<td>Urban Institute Health Reform Monitoring Surveyg</td>
<td>17.4%</td>
<td>9.8% (Q1 2016)</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

Methodological Differences Between Surveys

<table>
<thead>
<tr>
<th>Survey</th>
<th>Population</th>
<th>Time Frame</th>
<th>Sample Frame</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Interview Survey (NHIS) (2016)c</td>
<td>U.S. adults ages 18–64</td>
<td>2013 to Jan.–June 2018</td>
<td>Multistage area probability design</td>
<td>70%</td>
</tr>
</tbody>
</table>


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

<table>
<thead>
<tr>
<th>Total (millions)</th>
<th>Insured all year</th>
<th>Insured all year, not underinsured</th>
<th>Insured all year, underinsured</th>
<th>Insured now, had a coverage gap</th>
<th>Uninsured now</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total (19–64)</strong></td>
<td>193.9</td>
<td>150.6</td>
<td>106.8</td>
<td>43.8</td>
<td>19.3</td>
</tr>
<tr>
<td>Percent distribution</td>
<td>100.0%</td>
<td>77.7%</td>
<td>55.1%</td>
<td>22.6%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Unweighted n</td>
<td>4225</td>
<td>3254</td>
<td>2272</td>
<td>982</td>
<td>416</td>
</tr>
</tbody>
</table>

#### Gender

- **Female**:
  - Total (19–64): 52
  - Insured all year: 78
  - Insured all year, not underinsured: 56
  - Insured all year, underinsured: 22
  - Insured now, had a coverage gap: 11
  - Uninsured now: 11

- **Male**:
  - Total (19–64): 48
  - Insured all year: 77
  - Insured all year, not underinsured: 54
  - Insured all year, underinsured: 23
  - Insured now, had a coverage gap: 9
  - Uninsured now: 14

#### Age

- **19–34**:
  - Total (19–64): 32
  - Insured all year: 69
  - Insured all year, not underinsured: 48
  - Insured all year, underinsured: 21
  - Insured now, had a coverage gap: 14
  - Uninsured now: 17

- **35–49**:
  - Total (19–64): 30
  - Insured all year: 79
  - Insured all year, not underinsured: 58
  - Insured all year, underinsured: 21
  - Insured now, had a coverage gap: 9
  - Uninsured now: 12

- **50–64**:
  - Total (19–64): 35
  - Insured all year: 84
  - Insured all year, not underinsured: 59
  - Insured all year, underinsured: 26
  - Insured now, had a coverage gap: 7
  - Uninsured now: 8

#### Race/Ethnicity

- **Non-Hispanic White**: Total (19–64): 59
  - Insured all year: 83
  - Insured all year, not underinsured: 58
  - Insured all year, underinsured: 25
  - Insured now, had a coverage gap: 8
  - Uninsured now: 9

- **Black**: Total (19–64): 12
  - Insured all year: 73
  - Insured all year, not underinsured: 56
  - Insured all year, underinsured: 18
  - Insured now, had a coverage gap: 16
  - Uninsured now: 11

- **Latino**: Total (19–64): 18
  - Insured all year: 62
  - Insured all year, not underinsured: 45
  - Insured all year, underinsured: 17
  - Insured now, had a coverage gap: 14
  - Uninsured now: 24

- **Asian/Pacific Islander**: Total (19–64): 4
  - Insured all year: 81
  - Insured all year, not underinsured: 61
  - Insured all year, underinsured: 21
  - Insured now, had a coverage gap: 8
  - Uninsured now: 10

- **Other/Mixed**: Total (19–64): 5
  - Insured all year: 77
  - Insured all year, not underinsured: 51
  - Insured all year, underinsured: 26
  - Insured now, had a coverage gap: 9
  - Uninsured now: 14

#### Poverty status

- **Below 133% poverty**: Total (19–64): 25
  - Insured all year: 68
  - Insured all year, not underinsured: 37
  - Insured all year, underinsured: 31
  - Insured now, had a coverage gap: 14
  - Uninsured now: 18

- **133%–249% poverty**: Total (19–64): 19
  - Insured all year: 69
  - Insured all year, not underinsured: 45
  - Insured all year, underinsured: 24
  - Insured now, had a coverage gap: 14
  - Uninsured now: 17

- **250%–399% poverty**: Total (19–64): 19
  - Insured all year: 80
  - Insured all year, not underinsured: 57
  - Insured all year, underinsured: 23
  - Insured now, had a coverage gap: 10
  - Uninsured now: 10

- **400% poverty or more**: Total (19–64): 29
  - Insured all year: 91
  - Insured all year, not underinsured: 75
  - Insured all year, underinsured: 16
  - Insured now, had a coverage gap: 5
  - Uninsured now: 3

- **Below 200% poverty**: Total (19–64): 39
  - Insured all year: 67
  - Insured all year, not underinsured: 39
  - Insured all year, underinsured: 28
  - Insured now, had a coverage gap: 15
  - Uninsured now: 18

- **200% poverty or more**: Total (19–64): 53
  - Insured all year: 86
  - Insured all year, not underinsured: 67
  - Insured all year, underinsured: 19
  - Insured now, had a coverage gap: 7
  - Uninsured now: 7

#### Fair/Poor health status, or any chronic condition*

- Total (19–64): 50
  - Insured all year: 78
  - Insured all year, not underinsured: 54
  - Insured all year, underinsured: 24
  - Insured now, had a coverage gap: 10
  - Uninsured now: 12

#### Adult work status

- **Full-time**: Total (19–64): 53
  - Insured all year: 81
  - Insured all year, not underinsured: 59
  - Insured all year, underinsured: 22
  - Insured now, had a coverage gap: 9
  - Uninsured now: 10

- **Part-time**: Total (19–64): 14
  - Insured all year: 67
  - Insured all year, not underinsured: 47
  - Insured all year, underinsured: 20
  - Insured now, had a coverage gap: 16
  - Uninsured now: 17

- **Not currently employed**: Total (19–64): 33
  - Insured all year: 77
  - Insured all year, not underinsured: 52
  - Insured all year, underinsured: 25
  - Insured now, had a coverage gap: 9
  - Uninsured now: 14

#### Employer size**

- **1–19 employees**: Total (19–64): 23
  - Insured all year: 66
  - Insured all year, not underinsured: 44
  - Insured all year, underinsured: 21
  - Insured now, had a coverage gap: 10
  - Uninsured now: 24

- **20–49 employees**: Total (19–64): 11
  - Insured all year: 79
  - Insured all year, not underinsured: 59
  - Insured all year, underinsured: 20
  - Insured now, had a coverage gap: 9
  - Uninsured now: 13

- **50–99 employees**: Total (19–64): 8
  - Insured all year: 74
  - Insured all year, not underinsured: 57
  - Insured all year, underinsured: 17
  - Insured now, had a coverage gap: 14
  - Uninsured now: 13

- **100 or more employees**: Total (19–64): 56
  - Insured all year: 85
  - Insured all year, not underinsured: 62
  - Insured all year, underinsured: 22
  - Insured now, had a coverage gap: 10
  - Uninsured now: 6

---

**NOTES**

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

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

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

** Commonwealth Fund Biennial Health Insurance Survey (2018).
Table 2. Insurance Status, 2003–2018 (base: adults ages 19–64)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (millions)</td>
<td>172.0</td>
<td>172.5</td>
<td>183.6</td>
<td>183.9</td>
<td>182.8</td>
<td>187.4</td>
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<tr>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Unweighted n</td>
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<td>3352</td>
<td>3033</td>
<td>3393</td>
<td>4251</td>
<td>4186</td>
<td>4225</td>
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<td>72</td>
<td>70</td>
<td>72</td>
<td>78</td>
<td>78</td>
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<tr>
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<td>56</td>
<td>54</td>
<td>55</td>
<td>56</td>
<td>55</td>
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<td>16</td>
<td>16</td>
<td>17</td>
<td>22</td>
<td>23</td>
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<td>Insured now, had a coverage gap</td>
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<td>8</td>
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<td>10</td>
<td>10</td>
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<tr>
<td>Uninsured now</td>
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<td>18</td>
<td>20</td>
<td>19</td>
<td>16</td>
<td>12</td>
<td>12</td>
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</tbody>
</table>

NOTES

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

DATA

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

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<tr>
<td>Total (millions uninsured)</td>
<td>29.8</td>
<td>31.6</td>
<td>37.1</td>
<td>35.5</td>
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<td>Percent distribution</td>
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<td>590</td>
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<td>685</td>
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<td>Race/Ethnicity</td>
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<td>Non-Hispanic White</td>
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<td>15</td>
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<td>10</td>
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<td>9</td>
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<td>Black</td>
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<td>19</td>
<td>24</td>
<td>20</td>
<td>18</td>
<td>12</td>
<td>11</td>
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<tr>
<td>Latino</td>
<td>37</td>
<td>48</td>
<td>39</td>
<td>40</td>
<td>34</td>
<td>28</td>
<td>24</td>
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<td>Asian/Pacific Islander</td>
<td>14</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>4</td>
<td>10</td>
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<tr>
<td>Other/Mixed</td>
<td>17</td>
<td>18</td>
<td>29</td>
<td>29</td>
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<td>Poverty status</td>
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<tr>
<td>Below 133% poverty</td>
<td>—</td>
<td>—</td>
<td>38</td>
<td>35</td>
<td>26</td>
<td>21</td>
<td>18</td>
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<tr>
<td>133%–249% poverty</td>
<td>—</td>
<td>—</td>
<td>26</td>
<td>22</td>
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<td>14</td>
<td>17</td>
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<tr>
<td>250%–399% poverty</td>
<td>—</td>
<td>—</td>
<td>8</td>
<td>11</td>
<td>11</td>
<td>6</td>
<td>10</td>
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<tr>
<td>400% poverty or more</td>
<td>—</td>
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<td>4</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Below 200% poverty</td>
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<td>32</td>
<td>24</td>
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<td>200% poverty or more</td>
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<td>7</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Fair/Poor health status, or</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>any chronic condition*</td>
<td>17</td>
<td>22</td>
<td>22</td>
<td>20</td>
<td>15</td>
<td>13</td>
<td>12</td>
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<tr>
<td>Adult work status</td>
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<tr>
<td>Full-time</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>12</td>
<td>11</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Part-time</td>
<td>26</td>
<td>22</td>
<td>32</td>
<td>26</td>
<td>23</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Not currently employed</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>27</td>
<td>19</td>
<td>15</td>
<td>14</td>
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<tr>
<td>Employer size**</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–19 employees</td>
<td>28</td>
<td>27</td>
<td>—</td>
<td>25</td>
<td>28</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>20–49 employees</td>
<td>17</td>
<td>26</td>
<td>—</td>
<td>30</td>
<td>22</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>50–99 employees</td>
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<td>19</td>
<td>13</td>
<td>12</td>
<td>15</td>
<td>12</td>
<td>13</td>
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<tr>
<td>100 or more employees</td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

NOTES

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

— Data not collected or collected differently for that year.

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

DATA

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

<table>
<thead>
<tr>
<th>Total (adults ages 19–64)</th>
<th>Percent</th>
<th>Estimated millions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access problems in past year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Went without needed care in past year because of cost:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not fill prescription</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Skipped recommended test, treatment, or follow-up</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Had a medical problem, did not visit doctor or clinic</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Did not get needed specialist care</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>At least one of four access problems because of cost</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Delayed or did not get dental care</td>
<td>27</td>
<td>—</td>
</tr>
<tr>
<td><strong>Medical bill problems in past year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had problems paying or unable to pay medical bills</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Contacted by collection agency</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Contacted by collection agency for unpaid medical bills</td>
<td>—</td>
<td>13</td>
</tr>
<tr>
<td>Contacted by collection agency because of billing mistake</td>
<td>—</td>
<td>7</td>
</tr>
<tr>
<td>Had to change way of life to pay bills</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Any bill problem*</td>
<td>—</td>
<td>28</td>
</tr>
<tr>
<td>Medical bills/debt being paid off over time</td>
<td>—</td>
<td>21</td>
</tr>
<tr>
<td>Any bill problem or medical debt*</td>
<td>—</td>
<td>34</td>
</tr>
</tbody>
</table>

**NOTES**

— Data not collected for that year.

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

**DATA**

Table 5. Cost-Related Access Problems and Preventive Care by Insurance Continuity, Insurance Status, and Poverty
(base: adults ages 19–64)

<table>
<thead>
<tr>
<th>Access problems in past year</th>
<th>Insurance status</th>
<th>Insurance type**</th>
<th>Federal poverty level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total 19–64</td>
<td>Insured all year</td>
<td>Uninsured now</td>
</tr>
<tr>
<td></td>
<td>Total (millions)</td>
<td>Percent distribution</td>
<td>Unweighted n</td>
</tr>
<tr>
<td></td>
<td>193.9</td>
<td>150.6</td>
<td>106.8</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>78%</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td>4225</td>
<td>3254</td>
<td>2272</td>
</tr>
<tr>
<td>Preventive care</td>
<td></td>
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<td></td>
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<tr>
<td>Regular source of care</td>
<td>89</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>Blood pressure checked in past two years*</td>
<td>91</td>
<td>94</td>
<td>94</td>
</tr>
<tr>
<td>Dental exam in past year</td>
<td>60</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>Received mammogram in past two years (females age 40+)</td>
<td>65</td>
<td>71</td>
<td>71</td>
</tr>
<tr>
<td>Received Pap test in past three years (females ages 21–64)</td>
<td>70</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>Received colon cancer screening in past five years (age 50+)</td>
<td>58</td>
<td>62</td>
<td>63</td>
</tr>
<tr>
<td>Cholesterol checked in past five years**</td>
<td>72</td>
<td>78</td>
<td>79</td>
</tr>
<tr>
<td>Seasonal flu shot in past year</td>
<td>42</td>
<td>47</td>
<td>48</td>
</tr>
<tr>
<td>Access problems for people with health conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unweighted n</td>
<td>474</td>
<td>276</td>
<td>118</td>
</tr>
<tr>
<td>Skipped doses or did not fill a prescription for medications for the health condition(s) because of the cost of the medicines*</td>
<td>19</td>
<td>14</td>
<td>10</td>
</tr>
</tbody>
</table>

NOTES

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

** Insurance type at time of survey.

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

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

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

** Insufficient sample.

DATA

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

<table>
<thead>
<tr>
<th>Medical bill problems in past year</th>
<th>Total (millions)</th>
<th>Percent distribution</th>
<th>Unweighted n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 19–64</td>
<td>193.9</td>
<td>100%</td>
<td>4225</td>
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<tr>
<td>Insured all year</td>
<td>150.6</td>
<td>78%</td>
<td>3254</td>
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<tr>
<td>Insured all year, not uninsured</td>
<td>106.8</td>
<td>55%</td>
<td>2272</td>
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<tr>
<td>Insured all year, had a coverage gap</td>
<td>43.8</td>
<td>23%</td>
<td>982</td>
</tr>
<tr>
<td>Insured now, had a coverage gap</td>
<td>19.3</td>
<td>10%</td>
<td>416</td>
</tr>
<tr>
<td>Uninsured now</td>
<td>24.0</td>
<td>12%</td>
<td>555</td>
</tr>
<tr>
<td><strong>Insurance status</strong></td>
<td><strong>193.9</strong></td>
<td><strong>100%</strong></td>
<td><strong>4225</strong></td>
</tr>
<tr>
<td><strong>Total 19–64</strong></td>
<td><strong>150.6</strong></td>
<td><strong>78%</strong></td>
<td><strong>3254</strong></td>
</tr>
<tr>
<td><strong>Insured all year</strong></td>
<td><strong>106.8</strong></td>
<td><strong>55%</strong></td>
<td><strong>2272</strong></td>
</tr>
<tr>
<td><strong>Insured all year, not uninsured</strong></td>
<td><strong>43.8</strong></td>
<td><strong>23%</strong></td>
<td><strong>982</strong></td>
</tr>
<tr>
<td><strong>Insured all year, had a coverage gap</strong></td>
<td><strong>19.3</strong></td>
<td><strong>10%</strong></td>
<td><strong>416</strong></td>
</tr>
<tr>
<td><strong>Uninsured now</strong></td>
<td><strong>24.0</strong></td>
<td><strong>12%</strong></td>
<td><strong>555</strong></td>
</tr>
</tbody>
</table>

#### Medical bills in past year

- **Went without needed care in past year because of cost:**
  - Had problems paying or unable to pay medical bills: 24 18 13 30 47 40
  - Contacted by collection agency for unpaid medical bills: 15 12 9 19 29 26
  - Had to change way of life to pay bills: 13 10 6 19 26 22
  - Any bill problem: 29 24 18 38 52 47
  - Medical bills/debt being paid off over time: 23 21 16 33 33 26
  - Medical bills/debt being paid off over time: 23 21 16 33 33 26
  - Any bill problem or medical debt: 37 32 25 47 56 52

**Base: Any medical debt**

- **How much are the medical bills that are being paid off over time?**
  - Less than $2,000: 43 46 51 40 35 36
  - $2,000 to less than $4,000: 22 23 21 26 18 17
  - $4,000 to less than $8,000: 17 14 9 21 23 22
  - $8,000 to less than $10,000: 4 4 3 4 5 7
  - $10,000 or more: 12 10 11 8 16 18

- **Was this for care received in past year or earlier?**
  - Past year: 47 50 53 48 38 35
  - Earlier year: 46 43 42 43 49 58

- **Were these bills for someone who was insured at the time the care was provided or was the person uninsured then?**
  - Insured at time care was provided: 65 77 77 79 42 30
  - Uninsured at time care was provided: 28 16 15 17 46 64

**Notes**

- “Underinsured” refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. “Insured now, had a coverage gap” refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date.
- “Uninsured now” refers to adults who reported being uninsured at the time of the survey.
- * Individual includes adults who are enrolled in either marketplace plans or purchased directly off the marketplace.
- ** Insurance type at time of survey.
Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured


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

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


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


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


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About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society’s most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.