Getting America Covered: Tracking Gains in Health Insurance Coverage, 2013-2016

By Molly Warren | **January 2017**

Three years ago to the month, the major coverage expansions under the Patient Protection and Affordable Care Act (ACA) went into effect. Since then, the uninsured rate in the United States has been nearly halved, and the percent of Americans without health insurance is at a historic low. Furthermore, the coverage gains have benefited Americans across virtually all demographic groups and geographies.

This issue brief describes the increases in health insurance coverage rates, including the magnitude and breadth of the coverage gains between 2013 and 2016 using Enroll America/Civis Analytics' uninsured estimates, as well as providing background on the policies underlying the coverage expansions and the impact of coverage on enrollees. Highlights include:

- **The uninsured rate for non-elderly adults declined nationally by nearly half, from 16.4 to 8.3 percent between 2013 and 2016.**
- **Uninsured rates in all 50 states and the District of Columbia have declined since 2013, and about 90 percent of counties saw their rate drop by a quarter or more.**
- **The uninsured rate declined across every demographic group accounted for in our methodology, including for all racial/ethnic groups, all ages and age groups, men and women, and for residents of metro as well as non-metro areas.**

Policies Driving the Coverage Expansions

On March 23, 2010, President Barack Obama signed the ACA into law. The ACA includes reforms on a wide range of subjects in the health coverage and delivery system, with different parts phasing in over several years. One of the ACA's major goals was to expand coverage to uninsured Americans and add consumer protections and financial help to ensure access to comprehensive coverage no matter an individual's health, income, sex, or location.

The ACA's coverage expansions were designed to build upon the existing patchwork of private and public health coverage, providing targeted help to Americans with disproportionally high uninsured rates. One of the first permanent expansions of coverage, starting at the end of 2010, focused on young adults and required private health insurance plans (both employer-sponsored and via the individual market) to allow

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Best Practices in Outreach and Enrollment

Heading into 2014, uninsured Americans and those with health insurance from the individual market had new coverage options available to them and the possibility of getting financial help for the first time. Many of the individuals eligible for new coverage, however, were not aware of these changes and what they may qualify for.[1] Enroll America, created after the ACA became law with the sole mission of maximizing enrollment, launched the Get Covered America national grassroots campaign in 2013 to tackle this issue, aiming to educate consumers about these options and connect them with the information and resources they needed to enroll in health coverage.

Mathematica Policy Research has done several evaluations of Enroll America's efforts and found evidence that a robust data-driven outreach campaign can meaningfully boost enrollment. Specifically, they found that states where Enroll America focused its efforts had 20 percent higher enrollment relative to enrollment estimates during the first open enrollment period (2013-2014) and 15 percent higher enrollment during the second open enrollment period (2014-2015) compared to other states.[2]

Over the years, Enroll America has tested and refined its outreach strategies, finding several core components to success:

1. **Financial help messaging**: Most consumers want health insurance but have found it unaffordable in the past, and assumptions about insurance being unaffordable are persistent. Continuing a regular drumbeat promoting the availability of financial help is key to gaining consumers' interest in investigating their options and ultimately enrolling.

2. **Personalized information**: When possible, quickly providing consumers with personalized information about their specific situation and what they may qualify for is very helpful in moving them to take the next step and apply for coverage (even more so than providing broad "financial help is here" or "people like you saved $X" messages). Enroll America created the consumer-facing online "Get Covered Calculator", which estimates program eligibility, financial help, and premium on a large scale efficiently and found that one in four consumers immediately moved to enrollment after seeing their personalized estimates.[3]

3. **List-building and repeated follow-up**: A critical component of successful outreach efforts has been collecting consumer information and engaging in repeated follow-up to urge consumers to take action. Enrollees interested in getting coverage who were reminded to sign up during open enrollment are more likely to enroll.[4]

4. **In-person application assistance**: Many uninsured individuals, particularly those less likely to enroll, have little experience with health insurance and want help applying for coverage. In fact, Enroll America found that in the first year of marketplace enrollment, consumers who reported having in-person assistance were roughly twice as likely to successfully enroll in a health plan as those who attempted to enroll online without any help. Connecting consumers to local, in-person, culturally appropriate assistance has been critical to helping the most vulnerable enroll in and retain coverage.[5]

5. **Empowering trusted messengers at the local level**: Partnering with community organizations and businesses that serve or employ potential enrollees is the most effective way to reach these individuals, and is particularly effective when the organization/business is a trusted messenger. Coordinating work with community organizations and enrollment assisters by developing and leading city or statewide coalitions, proved to be critical to have continued investment in year-long outreach activities and education.

6. **Culturally competent outreach**: Communities of color and LGBT individuals have historically had unique barriers to enrollment. In order to increase access to enrollment in these communities integrating culturally specific resources and strategies to mobilize and engage leaders, partners, and trusted messengers within various constituency groups proved most successful.

adult children to remain on their parents' plans until the age of 26.

The more sweeping coverage expansions took effect in January 2014, and focused on making coverage affordable for low and middle income consumers and opening up the health insurance market to all Americans, even if they were previously unable to get coverage due to pre-existing conditions or other disqualifying characteristics. The main coverage initiatives were:

- Expanded Medicaid coverage for low-income adults.[6]
- Financial help for middle income Americans to help them purchase private health coverage on the new health insurance marketplaces.
- Guaranteed access to health insurance for all Americans regardless of health status or sex.

Important to these coverage expansions are several underlying reforms to the individual health insurance market nationwide that also went into effect in 2014. Health insurance is primarily regulated at the state level, but the ACA set minimum national standards for coverage, added consumer protections, and instituted policies to encourage healthy Americans to get and maintain coverage, including:

- Creating uniform standards for covered benefits and cost-sharing.
- Setting a nationwide annual enrollment period for the individual market and establishing a requirement for all Americans to have health insurance.

Coverage Gains Since 2013

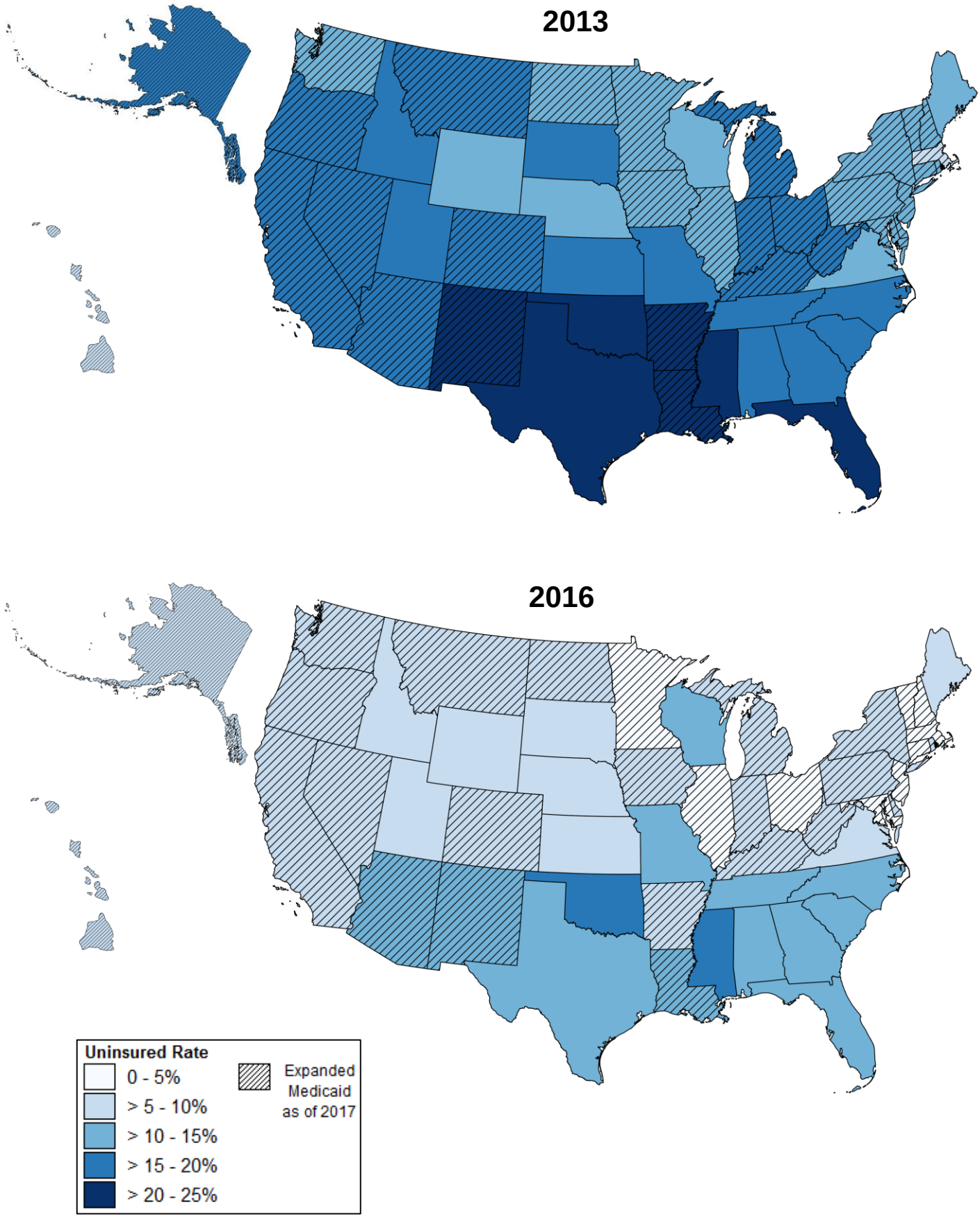
In 2013, before the health insurance marketplaces opened and Medicaid expansion fully went into effect, Enroll America/Civis Analytics' uninsured model estimated that 16.4 percent of non-elderly adult Americans lacked health insurance.[7] When the model was last updated in the summer of 2016, the non-elderly uninsured rate was 8.3 percent uninsured, a historic low for the United States. This decline of 8.1 percentage points means that the uninsured rate was nearly halved in just four years. In contrast, the uninsured rates for non-elderly adults remained stagnant in the years prior to 2014.[8]

Enroll America/Civis Analytics' uninsured model estimates uninsured rates only; it does not estimate the number of people who are uninsured nor factor in eligibility to enroll in coverage. According to the latest estimates from the U.S. Census Bureau, which does estimate raw numbers, 25.8 million non-elderly adults were uninsured in 2015. The states with the largest number of uninsured are those with large populations, led by Texas with 3.9 million uninsured, California with 2.9 million uninsured, and Florida with 2.3 million uninsured.[9]

The uninsured model does produce uninsured rates for specific demographic groups and geographic areas. Beyond the magnitude of the drop in the uninsured rate, the universality of the gains is notable. Between 2013 and 2016, the uninsured rate declined across all geographies (regardless of states' policy decisions) and for all demographic groups. Generally, areas and demographic groups with higher uninsured rates in 2013 saw higher percentage-point declines in uninsured rates, with the exception of states (and counties within states) without Medicaid expansion.

The rest of this section describes the changes in the uninsured landscape between the summers of 2013 and 2016 for various geographic areas and demographic groups using Enroll America/Civis' uninsured model. For additional data, see Appendix I for national uninsured estimates and demographic and geographic breakdowns for 2013-2016, Appendix II for state-level uninsured estimates for 2013-2016, , and Appendix III for selected county-level uninsured estimates for 2013 and 2016.

Figure 1. Estimated Uninsured Rates for Non-Elderly Adults by State in 2013 and 2016



Geography

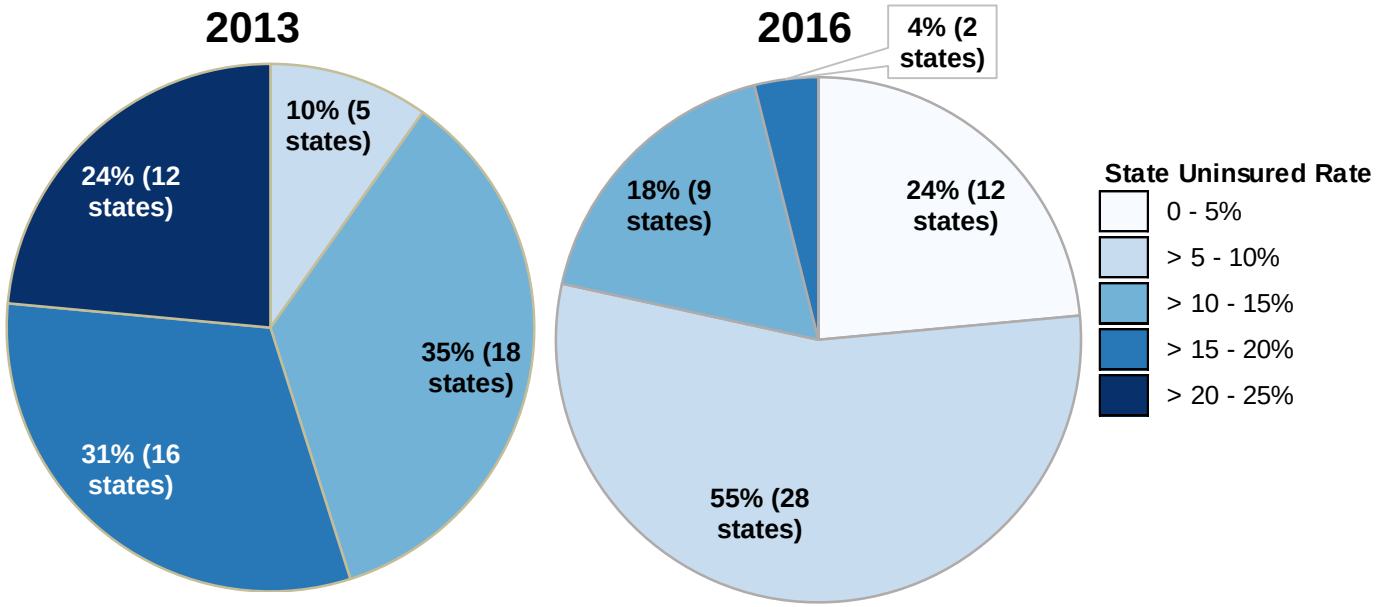
Across the nation, uninsured rates fell between 2013 and 2016 in every region and state, and nearly all counties. Key findings:

- *Region*: The uninsured rate declined substantially in every region. The West saw the greatest percentage point (10.1 percentage points) and proportional declines (59 percent) with its uninsured rate dropping from 17.1 to 7.0 percent. The Midwest and Northeast had nearly as high proportional declines (47 and 55 percent, respectively). The South saw a sizable percentage point decline (7.9 percentage points) but lags in its proportional declines (41 percent).[10]

"In 2013, 2,506 counties had uninsured rates of 15 percent or higher, while in 2016, that was true in just 665 counties. The number of counties with uninsured rates of 10 percent and under grew from a mere 145 counties in 2013 to 1,834 counties in 2016."

- *State*: All 50 states and the District of Columbia saw declines in uninsured rates between 2013 and 2016, ranging from a 1.8 percentage point decline in Wisconsin to 13.1 percentage point declines in Kentucky and West Virginia. (See Figure 1.) In fact, in 2013, 28 states had uninsured rates at 15 percent or higher, while in 2016, just two states still had uninsured rates that high (Mississippi and Oklahoma). Conversely, the number of states with uninsured rates of 10 percent and under went from five to 37 states between 2013 and 2016. (See Figure 2.)
- *County:* The uninsured rate dropped in 98 percent of the more than 3,000 counties in the United States between 2013 and 2016, including 90 percent of counties that had a decline of more than one-quarter. More than one-third of counties saw 10 percentage point or greater declines in uninsured rates and more than half saw between 5 and 10 percentage point declines. Looking at this in another way, in 2013, 2,506 counties had uninsured rates of 15 percent or higher, while in 2016, that was true in just 665 counties. The number of counties with uninsured rates of 10 percent and under grew from a mere 145 counties in 2013 to 1,834 counties in 2016.

Figure 2. Distribution of State Non-Elderly Adult Uninsured Rates in 2013 and 2016

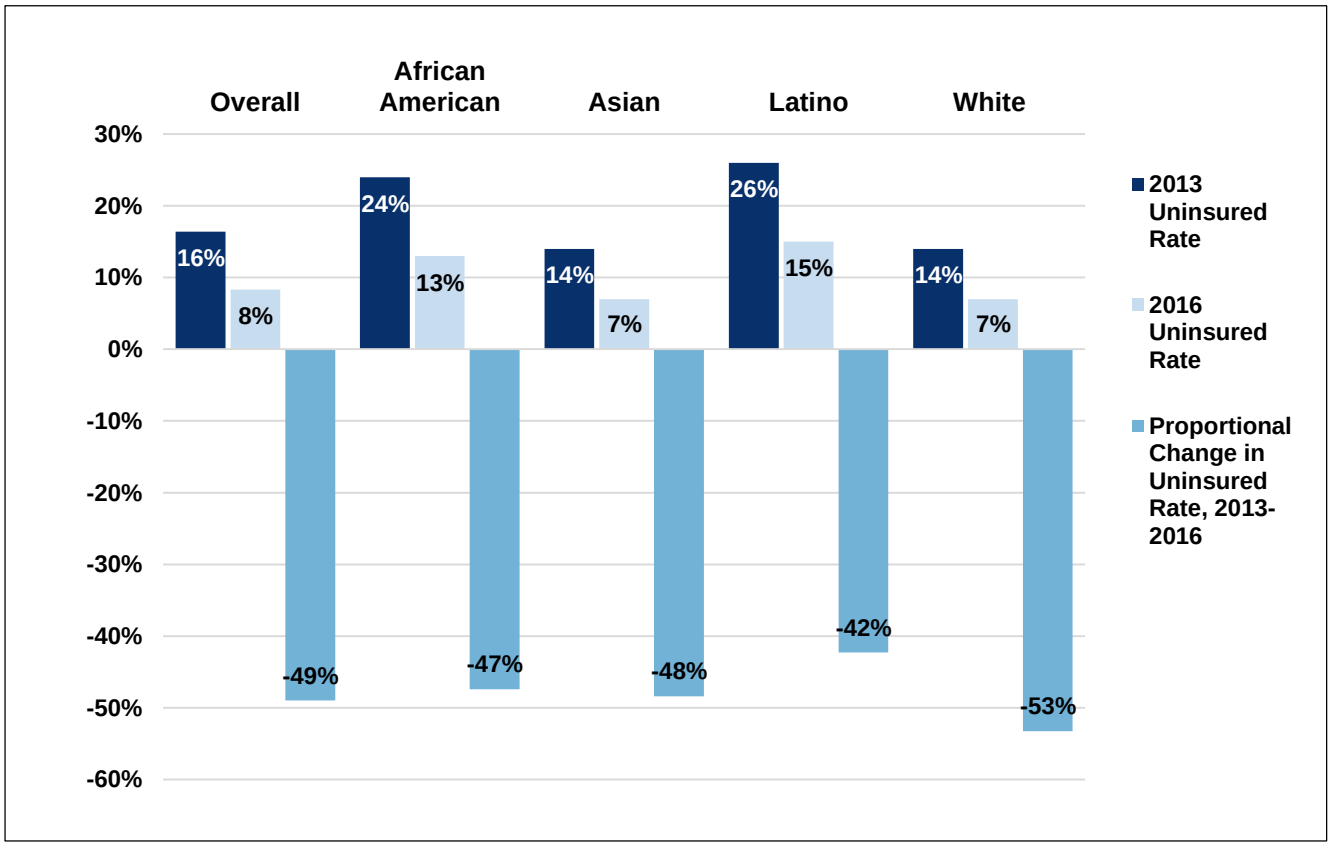


Demographic groups

Uninsured rates declined between 2013 and 2016 for all racial/ethnic groups that are accounted for by the model (White, African American, Latino, and Asian), all ages from 18 to 64 and age groups (18-34, 35-44, 45-54, 55-64), both men and women, and for metro and non-metro residents. (See Figure 3.) Key findings:

- *Race/ethnicity:* The uninsured rate declined across all racial/ethnic groups. The largest percentage point decline in uninsured rate from 2013 to 2016 was among African Americans, with a reduction of 11.4 percentage points (from 24.0 to 12.6 percent), followed closely by Latinos with a reduction of 11.1 percentage points (from 26.2 to 15.1 percent). When looking at proportional declines, Whites saw the largest decline in their uninsured rate with a 53 percent reduction (from 14.1 to 6.6 percent).
- *Age*: The uninsured rate declined among every age and age group. Young adults age 18-34 years had by far the largest percentage point and proportional declines among all age groups. Young adults' uninsured rate dropped from 21.6 to 7.1 percent, a decline of 12.6 percentage points and a 58 percent reduction in their rate.
- *Metro/non-metro:* Uninsured rates declined across both metro and non-metro regions. Non-metro residents saw slightly larger percentage point declines in their uninsured rate between 2013 and 2016 compared with metro residents (8.7 and 8.3 percentage point declines, respectively), while metro residents had higher proportional declines (44 vs. 52 percent declines).[11]

Figure 3. Estimated Uninsured Rate by Race/Ethnicity in 2013 and 2016, and the Proportional Change in Uninsured Rate from 2013 to 2016



State Policy Decisions

States' policy decisions affect enrollment, including the decisions surrounding Medicaid eligibility and degree of involvement in the marketplace, as well as numerous other, often unseen decisions. Generally, states that embraced coverage expansion, through the Medicaid expansion and election of a state or partnership marketplace, saw greater declines in uninsured rates. Key findings:

- *Medicaid expansion:* While all states saw declines, states that expanded Medicaid saw significantly higher percentage point and proportional declines in uninsured rates on average compared with non-expansion states, although non-expansion states (which tended to have higher uninsured rates to begin with) still made substantial gains.[12]
- *Type of marketplace:* States with marketplaces of all types saw declines in uninsured rates. Partnership marketplaces had the largest percentage point and proportional declines, followed very closely by state-based marketplaces.[13]

The Impact of Coverage

Health insurance provides more affordable access to health care as well as financial security in case of serious illness or injury and the intangible peace of mind that comes from these protections. Already there is mounting evidence that those who have gained coverage in recent years are benefiting from expanded coverage in all of these ways. Studies consistently show significant positive changes in a variety of measures related to access to care, affordability, and reduction in bankruptcy, including specifically:

- A Journal of the American Medical Association (JAMA) study found that in 2015 non-elderly adults experienced improvements in the share of individuals who have a personal physician and easy access to medicine, as well as decreases in the share who are unable to afford care and report fair or poor health relative to before the coverage expansions.[14]
- The Centers for Disease Control and Prevention's National Health Interview Survey found that the number of non-elderly Americans having difficulty paying medical bills declined by more than 20 percent between 2011 and 2015.[15]
- The Commonwealth Fund found decreases between 2012 and 2014 in the percentage of adults who reported that costs stopped them from visiting a doctor or clinic when they had a medical issue, filling a prescription, seeing a specialist, or skipping a recommended medical test, treatment, or follow-up visit between.[16]

Other research has looked at the effects of coverage from Medicaid expansion specifically. These studies found that Medicaid expansion was associated with increased access to primary care and prescriptions, as well as higher rates of diagnosis of chronic conditions.[17] Another study found that Medicaid expansion likely improved the financial situation of those who gained Medicaid coverage due the ACA, including reducing unpaid bills and debt.[18]

Conclusion

For decades prior to the enactment of the ACA, federal health reform eluded lawmakers, and the national uninsured rate was stagnant. The ACA has imperfections and has experienced its shares of bumps during implementation, including being dogged by extreme politicization. However, as decisions about the future of the law play out, it is critical not to lose sight of the very real benefits it has brought to the millions of Americans who have been able to enroll in high quality, affordable health coverage because of it. Between 2013 and 2016, the uninsured rate in the United States fell significantly across geographies and demographics leading to improved access to care, affordability, and financial security for millions of Americans. Preserving these gains and institutionalizing the best practices in outreach and enrollment that have been identified is a core part of the work the lies ahead for enrollment stakeholders.

Acknowledgments

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Appendix I

Enroll America/Civis Analytics' National Uninsured Rates for Non-Elderly Adults, 2013-2016

Group	2013	2014	2015	2016	Percentage point change 2013 to 2016	Proportional change 2013 to 2016
United States	16.4%	11.3%	10.7%	8.3%	-8.1	-49%
Region						
Northeast	11.6%	9.1%	6.5%	5.2%	-6.4	-55%
Midwest	15.2%	10.4%	8.9%	6.6%	-8.6	-57%
South	19.1%	13.7%	13.8%	11.2%	-7.9	-41%
West	17.1%	10.1%	10.6%	7.0%	-10.1	-59%
Race/ethnicity						
African American	24.0%	16.1%	15.0%	12.6%	-11.4	-47%
White	14.1%	10.0%	9.3%	6.6%	-7.5	-53%
Latino	26.2%	16.5%	16.5%	15.1%	-11.1	-42%
Asian	13.7%	9.7%	9.2%	7.1%	-6.6	-48%
Age						
18-34	21.6%	14.2%	15.5%	9.01%	-12.6	-58%
35-44	16.4%	11.1%	9.6%	7.58%	-8.8	-54%
45-54	15.0%	10.6%	9.5%	8.36%	-6.6	-44%
55-64	12.7%	9.1%	8.2%	7.60%	-5.1%	-40%
Sex						
Male	17.7%	13.0%	11.4%	8.7%	-9.0	-51%
Female	15.3%	9.8%	10.0%	7.7%	-7.6	-49%
Metro v. Non-Metro						
Metro	16.0%	11.0%	10.3%	7.7%	-8.3	-52%
Non-Metro	19.6%	12.8%	12.9%	10.9%	-8.7	-44%
Medicaid Expansion Status						
Medicaid Expansion	14.7%	9.1%	8.5%	5.9%	-8.8	-60%
No Expansion	18.7%	14.0%	14.0%	11.6%	-7.1%	-38%
Late Expansion	16.5%	12.1%	9.2%	6.7%	-9.8	-59%
Marketplace Type						
Federally facilitated	17.7%	13.0%	12.6%	10.1%	-7.6	-43%
Partnership	16.1%	9.7%	8.2%	5.5%	-10.6	-66%
State-based	14.2%	9.0%	8.2%	5.7%	-8.5	-60%
Supported state-based	18.2%	10.1%	11.0%	7.8%	-10.4	-57%

Appendix II

Enroll America/Civis Analytics' Uninsured Rates for Non-Elderly Adults By State, 2013-2016

State	2013	2014	2015	2016	Percentage point change 2013 to 2016	Proportional change 2013 to 2016
United States	16.4%	11.3%	10.7%	8.3%	-8.1	-49%
Alaska	15.8%	10.6%	13.4%	9.9%	-5.9	-37%
Alabama	19.9%	14.8%	13.8%	10.9%	-9.0	-45%
Arkansas	20.9%	10.9%	11.2%	8.9%	-12.0	-57%
Arizona	16.3%	9.6%	13.7%	11.1%	-5.2	-32%
California	17.9%	10.5%	10.6%	6.2%	-11.7	-65%
Colorado	15.8%	8.6%	9.4%	6.3%	-9.5	-60%
Connecticut	10.2%	7.4%	5.3%	4.6%	-5.6	-55%
District of Columbia	8.0%	7.0%	5.0%	5.7%	-2.3	-29%
Delaware	13.2%	8.6%	7.6%	5.9%	-7.3	-55%
Florida	21.5%	15.2%	16.9%	13.2%	-8.3	-39%
Georgia	19.7%	14.5%	13.0%	10.4%	-9.3	-47%
Hawaii	9.2%	6.6%	4.5%	5.6%	-3.6	-39%
Iowa	13.6%	8.7%	6.2%	5.1%	-8.5	-62%
Idaho	17.9%	12.8%	11.8%	8.8%	-9.1	-51%
Illinois	14.8%	9.1%	7.7%	4.7%	-10.1	-68%
Indiana	17.3%	13.5%	10.3%	7.2%	-10.1	-58%
Kansas	16.0%	12.7%	12.0%	8.2%	-7.8	-49%
Kentucky	19.2%	10.9%	9.8%	6.1%	-13.1	-68%
Louisiana	21.3%	15.0%	13.3%	12.3%	-9.0	-42%
Massachusetts	6.7%	6.1%	4.9%	3.6%	-3.1	-46%
Maryland	11.3%	7.8%	6.6%	4.0%	-7.3	-65%
Maine	13.1%	11.8%	10.1%	7.3%	-5.8	-45%
Michigan	17.3%	10.4%	8.5%	5.6%	-11.7	-67%
Minnesota	10.3%	7.2%	6.0%	4.5%	-5.8	-56%
Missouri	17.1%	13.1%	13.1%	10.8%	-6.3	-37%
Mississippi	22.3%	15.6%	17.3%	16.8%	-5.5	-25%
Montana	19.4%	12.9%	14.1%	8.7%	-10.7	-55%
North Carolina	18.2%	14.6%	14.6%	11.2%	-7.0	-39%
North Dakota	13.0%	7.5%	6.9%	7.9%	-5.1	-39%
Nebraska	14.3%	11.5%	9.2%	7.3%	-7.0	-49%
New Hampshire	11.6%	7.1%	5.8%	4.2%	-7.4	-64%
New Jersey	12.3%	7.9%	6.3%	4.3%	-8.0	-65%
New Mexico	22.4%	11.5%	13.4%	10.1%	-12.3	-55%
Nevada	19.8%	10.7%	14.1%	9.6%	-10.2	-51%

New York	11.7%	8.7%	6.3%	6.2%	-5.5	-47%
Ohio	15.4%	9.4%	8.9%	5.0%	-10.4	-68%
Oklahoma	20.5%	13.9%	15.4%	16.8%	-3.7	-18%
Oregon	17.8%	10.1%	9.5%	6.1%	-11.7	-66%
Pennsylvania	13.8%	12.4%	7.6%	5.2%	-8.6	-63%
Rhode Island	13.5%	8.6%	7.2%	5.1%	-8.4	-63%
South Carolina	19.7%	15.0%	13.9%	11.9%	-7.8	-40%
South Dakota	16.4%	12.0%	11.2%	9.9%	-6.5	-39%
Tennessee	16.4%	13.8%	13.7%	10.6%	-5.8	-35%
Texas	21.3%	14.8%	16.0%	14.1%	-7.2	-34%
Utah	16.4%	12.6%	11.1%	7.6%	-8.8	-54%
Virginia	12.1%	11.0%	8.5%	6.1%	-6.0	-49%
Vermont	10.9%	7.4%	5.4%	4.4%	-6.5	-59%
Washington	14.0%	8.6%	7.8%	5.7%	-8.3	-59%
Wisconsin	12.2%	10.7%	8.6%	10.4%	-1.8	-15%
West Virginia	19.9%	10.8%	11.5%	6.8%	-13.1	-66%
Wyoming	13.3%	10.1%	11.1%	9.7%	-3.6	-27%

Appendix III

Enroll America/Civis Analytics' Uninsured Rates for Non-Elderly Adults for Selected Counties, 2013 and 2016

County	State	2013	2016	Percentage point change 2013 to 2016	Proportional change 2013 to 2016
Top 50 Counties with the Highest Percentage Point Change in Uninsured Rate					
San Miguel County	NM	31%	9%	-22	-71%
Guadalupe County	NM	29%	8%	-21	-72%
Mora County	NM	27%	7%	-21	-78%
Hidalgo County	NM	31%	11%	-20	-65%
Owsley County	KY	26%	6%	-20	-77%
Robertson County	KY	25%	5%	-20	-80%
Willacy County	TX	43%	24%	-19	-44%
Dimmit County	TX	37%	18%	-19	-51%
McCreary County	KY	26%	7%	-19	-73%
Gilmer County	WV	26%	7%	-19	-73%
Breathitt County	KY	25%	6%	-19	-76%
Wolfe County	KY	25%	6%	-19	-76%
Knott County	KY	24%	5%	-19	-79%
Jim Hogg County	TX	36%	18%	-18	-50%
Cibola County	NM	33%	15%	-18	-55%
Taos County	NM	28%	10%	-18	-64%
Conejos County	CO	26%	8%	-18	-69%
Fulton County	KY	26%	8%	-18	-69%
Knox County	KY	26%	8%	-18	-69%
Carter County	KY	24%	7%	-18	-75%
Magoffin County	KY	24%	7%	-18	-75%
Pike County	KY	24%	7%	-18	-75%
Floyd County	KY	25%	7%	-18	-72%
Letcher County	KY	24%	6%	-18	-75%
Martin County	KY	24%	6%	-18	-75%
Clay County	GA	32%	15%	-17	-53%
Lee County	AR	31%	14%	-17	-55%
Chicot County	AR	29%	13%	-17	-59%
Rio Arriba County	NM	28%	11%	-17	-61%
Socorro County	NM	28%	11%	-17	-61%
Nevada County	AR	27%	10%	-17	-63%
Otero County	CO	27%	10%	-17	-63%
Clay County	KY	27%	10%	-17	-63%

Chattahoochee County	GA	26%	9%	-17	-65%
Grant County	NM	26%	9%	-17	-65%
Clinton County	KY	25%	8%	-17	-68%
Harlan County	KY	25%	8%	-17	-68%
Jackson County	KY	25%	8%	-17	-68%
Adair County	KY	24%	7%	-17	-71%
Bath County	KY	24%	7%	-17	-71%
Cumberland County	KY	24%	7%	-17	-71%
Lee County	KY	24%	7%	-17	-71%
Perry County	KY	24%	7%	-17	-71%
Johnson County	KY	23%	6%	-17	-74%
Menifee County	KY	23%	6%	-17	-74%
Morgan County	KY	23%	6%	-17	-74%
Rowan County	KY	23%	6%	-17	-74%
Hopkins County	KY	22%	5%	-17	-77%
Elliott County	KY	21%	4%	-17	-81%
Brooks County	TX	38%	22%	-16	-42%
Top 50 Counties with the Highest Proportional Change in Uninsured Rate					
Elliott County	KY	21%	4%	-17	-81%
Robertson County	KY	25%	5%	-20	-80%
Oldham County	KY	10%	2%	-8	-80%
Knott County	KY	24%	5%	-19	-79%
Putnam County	IL	14%	3%	-11	-79%
Mora County	NM	27%	7%	-21	-78%
Jessamine County	KY	18%	4%	-14	-78%
Medina County	OH	9%	3%	-7	-78%
DuPage County	IL	9%	2%	-7	-78%
McHenry County	IL	9%	2%	-7	-78%
Hopkins County	KY	22%	5%	-17	-77%
Owsley County	KY	26%	6%	-20	-77%
Oakland County	MI	13%	4%	-10	-77%
Marion County	KY	21%	5%	-16	-76%
Breathitt County	KY	25%	6%	-19	-76%
Wolfe County	KY	25%	6%	-19	-76%
Carter County	KY	24%	7%	-18	-75%
Magoffin County	KY	24%	7%	-18	-75%
Pike County	KY	24%	7%	-18	-75%
Letcher County	KY	24%	6%	-18	-75%
Martin County	KY	24%	6%	-18	-75%
Madison County	KY	20%	6%	-15	-75%
Nelson County	KY	20%	5%	-15	-75%

Huron County	OH	16%	5%	-12	-75%
Cambria County	PA	16%	5%	-12	-75%
De Witt County	IL	16%	4%	-12	-75%
Bullitt County	KY	16%	4%	-12	-75%
Kenton County	KY	16%	4%	-12	-75%
Grand Traverse County	MI	16%	4%	-12	-75%
Baltimore County	MD	12%	4%	-9	-75%
Grundy County	IL	12%	3%	-9	-75%
Boone County	KY	12%	3%	-9	-75%
Clermont County	OH	12%	3%	-9	-75%
Fairfield County	OH	12%	3%	-9	-75%
Somerset County	NJ	8%	3%	-6	-75%
Kendall County	IL	8%	2%	-6	-75%
Sussex County	NJ	8%	2%	-6	-75%
Bucks County	PA	8%	2%	-6	-75%
Johnson County	KY	23%	6%	-17	-74%
Menifee County	KY	23%	6%	-17	-74%
Morgan County	KY	23%	6%	-17	-74%
Rowan County	KY	23%	6%	-17	-74%
Otsego County	MI	19%	6%	-14	-74%
Hamilton County	IL	19%	5%	-14	-74%
Gratiot County	MI	19%	5%	-14	-74%
Keweenaw County	MI	19%	5%	-14	-74%
Lucas County	OH	19%	5%	-14	-74%
Monongalia County	WV	19%	5%	-14	-74%
Calaveras County	CA	15%	4%	-11	-73%
Nevada County	CA	15%	4%	-11	-73%

End notes

[1] *Informing Enroll America's Campaign: Findings From a National Survey,* Lake Research Partners, January 2013. Available online: https://s3.amazonaws.com/assets.enrollamerica.org/wp-content/uploads/2013/11/EA_Final_Report.pdf.

[2] Sheila Hoag, Cara Orfield, and Sean Orzol, *Evolution of Outreach: Evaluation of Enroll America's Efforts to Support ACA Enrollment*, Mathematica Policy Research, November 2015. Available online: https://www.mathematicampr.com/our-publications-and-findings/publications/evolution-of-outreach-evaluation-of-enroll-americas-efforts-tosupport-aca-enrollment.

[3] *Cost Information More Important Than Fine Language among Calculator Users,* Enroll America, March 2015. Available online: https://www.enrollamerica.org/cost-information-more-important-than-fine-language-among-calculator-users/.

[4] *State of Enrollment: Lessons Learned from Connecting America to Coverage, 2013-2014,* Enroll America, June 2014. Available online: https://s3.amazonaws.com/assets.getcoveredamerica.org/20140613_SOEReportPDFlr.pdf.

[5] In-Person Assistance Maximizes Enrollment Success, Enroll America, March 2014. Available online: https://www.enrollamerica.org/in-person-assistance-maximizes-enrollment-success/.

[6] The ACA as drafted intended for all states to expand their Medicaid coverage to include adults with incomes below 133 percent of the federal poverty level (FPL). In 2012, however, the U.S. Supreme Court ruled that the Medicaid expansion had to be optional with states deciding to opt in or not. As of January 1, 2017, 32 states and the District of Columbia have expanded Medicaid coverage and 19 states have opted out. Individuals with incomes below 100 percent FPL are not eligible for financial help for marketplace plans and often find themselves ineligible for any financial assistance in states that have not expanded Medicaid (often called the "coverage gap").

[7] Each year over the last four years, Enroll America partnered with Civis Analytics create a model to predict the likelihood that an individual is uninsured. This model is then applied to Enroll America's consumer database of 180 million non-elderly adult Americans. Each individual in the database is given an uninsured score between 0 and 100, representing the probability that the individual is uninsured. This score can be used to rank individuals in order of who is most likely to be uninsured, enabling prioritization of outreach efforts. This scoring procedure also allows us to estimate uninsured rates by demographic and geographic subgroups. Our model estimates the uninsured rate; it does not estimate the number of people who are uninsured nor factor in eligibility to enroll in coverage. For more information: https://www.enrollamerica.org/research-maps/maps/changes-in-uninsured-rates-by-county/detailed-background/.

[8] The American Community Survey 1-Year Estimates put the uninsured rate for 18-64 year old at 20.6 percent in 2009, 21.4 percent in 2010, 21.0 percent 2011, 20.6 percent in 2012, and 20.3 percent in 2013. Available online: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_S2701&prodType=table.

[9] *Health Insurance Coverage Status and Type of Coverage by State and Age for All People*, 2015 American Community Survey, U.S. Census Bureau, September 2016. Available online: https://www2.census.gov/programs-surveys/demo/tables/health-insurance/2016/acs-hi/hi05_acs.xls.

[10] We used the U.S. Census' definition for regions: Northeast includes CT, ME, MA, NH, NJ, NY, PA, RI, VT; Midwest includes IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI; South includes AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV; and West includes AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY. Online at http://www2.census.gov/geo/docs/maps-data/maps/reg_div.txt.

[11] In defining metro/non-metro area, we used the U.S. Department of Agriculture's (USDA) Rural-Urban Continuum Codes, which categorizes counties as metro or non-metro as defined by the Office of Management and Budget based on population and commuting criteria. For more information on these measures, see: http://www.ers.usda.gov/data-products/ruralurban-continuum-codes/documentation.aspx.

[12] States that adopted the Medicaid expansion as of January 1, 2014 include: AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MN, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, WV; states that have adopted Medicaid expansion late (after January 2014) include: MI, NH, PA, IN, AK, MT, LA; states that have not adopted Medicaid expansion as of January 1, 2017 include: AL, FL, GA, ID, KS, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, VA, WI, WY.

[13] Every state has a health insurance marketplace where residents can purchase health insurance and qualified individuals can get financial help. Some states choose to operate their own marketplaces (called state-based marketplaces), some operate their own marketplace but use the federal Healthcare.gov platform, (supported state-based marketplaces), some operate certain aspects of the marketplace in partnership with the federal government (partnership marketplaces), and some are operated by the federal government (federally facilitated marketplaces). As of 2017, state-based marketplaces include: CA, CO, CT, DC, ID, MD, MA, MN, NY, RI, VT, WA; supported state-based marketplaces include: HI, KY, NV, NM, OR; partnership marketplaces are: AR, DE, IA, IL,

MI, NH, WV; and federally facilitated marketplaces include: AL, AK, AZ, FL, GA, IN, KS, LA, ME, MS, MO, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WY.

[14] Benjamin Sommers, Munira Gunja, Kenneth Finegold, et al, *Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act***,** Journal of the American Medical Association, July 2015. Available online: http://jamanetwork.com/journals/jama/fullarticle/2411283.

[15] Robin Cohen and Jeannine Schiller, *Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates From the National Health Interview Survey, 2011–June 2015*, National Health Interview Survey, December 2015. Available online: http://www.cdc.gov/nchs/data/nhis/earlyrelease/probs_paying_medical_bills_jan_2011_jun_2015.pdf.

[16] Sara Collins, Petra Rasmussen, Michelle M. Doty, Sophie Beutel*, The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect,* Commonwealth Fund, January 2015. Available online: http://www.commonwealthfund.org/publications/issue-briefs/2015/jan/biennial-health-insurance-survey.

[17] *Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care*, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, June 2016. Available online: https://aspe.hhs.gov/sites/default/files/pdf/205141/medicaidexpansion.pdf.

[18] Luojia Hu, Robert Kaestner, Bhashkar Mazumder, Sarah Miller, Ashley Wong, *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being*, National Bureau of Economic Research (Working Paper No. 22170), April 2016. Available online: http://www.nber.org/papers/w22170.