ACA Implementation—Monitoring and Tracking

Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us About How to Reach Them?

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

INTRODUCTION

2016 is the third year of full implementation of Affordable Care Act (ACA) reforms designed to expand health insurance coverage. Among other policy changes, these reforms include an expansion of Medicaid eligibility for all those with incomes up to 138 percent of the federal poverty level (FPL) residing in states that chose to expand, new health insurance marketplaces providing subsidized insurance coverage for low- and moderate-income individuals without access to affordable employer-sponsored insurance (ESI), significant changes to nongroup and small-group insurance regulations that increase the sharing of health care risk for enrollees, and an individual responsibility requirement for most people to enroll in health insurance coverage or pay a penalty. Although substantial evidence indicates that the ACA has significantly reduced the number of uninsured in the United States since 2013,[1] analysis of the characteristics of those remaining uninsured has been limited.[2] Although the ACA was not designed to eliminate uninsurance, a detailed assessment of those remaining uninsured after reform can provide insight into the potential to increase coverage further.

Data collected from the 2015 Current Population Survey—Annual Social and Economic Supplement (CPS-ASEC) provides information on those with and without insurance coverage from a large, federal, nationally representative survey (most of the data are collected in March, although there are some interviews in February and April;[3] hereafter we refer to the data as having been collected in March 2015). Although the CPS-ASEC questionnaire changed in significant ways in 2014 such that it should not be used to compare 2015 coverage to 2013, the data allow analysts to assess the characteristics of those remaining uninsured following the first year of implementation of the ACA's main coverage provisions and after two marketplace open enrollment periods.[4] We use reports of current coverage status in 2015 to expand upon previous work, studying the remaining uninsured on a wider array of socioeconomic and demographic characteristics, identifying their insurance program eligibility, separating children and adults where appropriate, and using the characteristics of the uninsured to provide insights into strategies for further reducing their numbers and to set realistic goals regarding the extent to which current reforms could expand coverage further. The Current Population Survey (CPS) has several advantages over the National Health Interview Survey for these purposes, described in the Data and Methods section.

MAIN FINDINGS

- **According to the CPS-ASEC, 32.9 million nonelderly residents of the United States remained uninsured as of March 2015, constituting 12.2 percent of the total non-elderly, civilian, non-institutionalized population of the country.**

- Roughly half of the uninsured reside in states that have expanded Medicaid eligibility as of March 2015 (expansion states) and roughly half live in those that have not (nonexpansion states). However, this relatively even split disguises the fact that **the rate of uninsurance is significantly higher in nonexpansion states, where 15.4 percent of the nonelderly are uninsured compared with only 10.1 percent in expansion states, a relative difference of over 50 percent.**[5]

- **About 28 percent of the uninsured are eligible for Medicaid or the Children's Health Insurance Program (Medicaid/CHIP), and 21 percent are eligible for marketplace tax credits.** About 12 percent fall in the assistance gap (those with very low incomes but who are ineligible for Medicaid or marketplace assistance because their states have not expanded Medicaid eligibility; figure 1). About 16 percent are undocumented persons who do not qualify for any assistance under the ACA, and another 24 percent do not qualify for assistance because their incomes are too high or they have an affordable offer of coverage from an employer.[6]

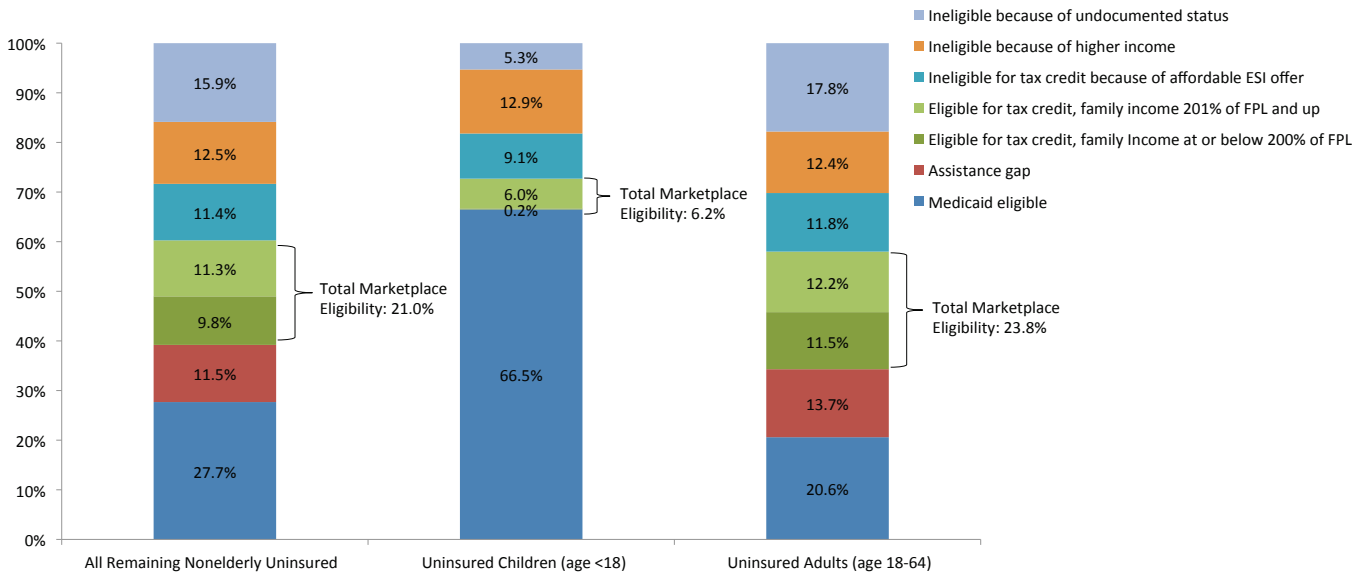
- **Fully 66.5 percent of uninsured children are eligible for Medicaid/CHIP compared with only 20.6 percent of uninsured adults.**

- **We posit that the uninsured who are eligible for the greatest amount of financial assistance under the ACA—12.4 million uninsured in total—are those for whom additional outreach and enrollment efforts are likely to be most successful.** These include 9.1 million people who are eligible for Medicaid/CHIP but not enrolled (those for whom coverage is extremely low cost) and the estimated 3.2 million people who both are eligible for marketplace tax credits and have incomes below 200 percent of FPL, which makes them eligible for more generous premium assistance and for significant cost-sharing reductions relative to tax-credit eligibles with incomes above 200 percent of FPL.

- **Absent further policy changes (e.g., more states expanding Medicaid, increased financial assistance, and expanded eligibility for assistance), we do not expect that a substantial share of the other uninsured—who constitute 20.6 million of the total—will gain coverage.** Some of the higher-income uninsured surely will become insured as the penalties for remaining uninsured increase and information on new insurance options spread further, but the potential for increased coverage among those with higher incomes is much lower than among the 12.4 million uninsured eligible for the most substantial financial assistance.

- **Targeting of resources to those 12.4 million uninsured with the greatest potential to enroll in either Medicaid/CHIP or marketplace coverage can be improved by understanding their characteristics.** For example, within both the Medicaid/CHIP and marketplace populations of most interest, over 80 percent of the uninsured live in metropolitan statistical areas. In addition, majorities (67 percent of those eligible for Medicaid/CHIP and 53 percent of those eligible for tax credits) live in families in which at least one member is already receiving the earned income tax credit (EITC) or at least one other public benefit, such as the Supplemental Nutritional Assistance Program (SNAP) or a free or reduced-price school lunch.[7,8] Nearly half of those uninsured eligible for Medicaid/CHIP have at least one school-aged child in the family; the same is true for 24 percent of the uninsured eligible for the most generous marketplace assistance. Almost half of the tax credit–eligible uninsured but about one-third of the Medicaid/CHIP eligible uninsured are between the ages of 18 and 34; the Medicaid/CHIP eligible uninsured are significantly more likely to be children than are the low-income, tax credit–eligible uninsured.

Figure 1. Program Eligibility of Remaining Nonelderly Uninsured, March 2015



Source: 2015 Current Population Survey – Annual Social and Economic Supplement.

Notes: Percentages are based on a total of 32.9 million non-elderly residents (5.1 million children age 17 and below; 27.8 million adults age 18 through 64) that remain uninsured as of March 2015, or 12.2% of the total nonelderly, civilian, noninstitutionalized population of the United States.

DATA AND METHODS

Data. Our analysis of the characteristics of the remaining uninsured focuses exclusively on the nonelderly (those below age 65) because the coverage status of those age 65 and older was not affected by the ACA. We rely upon 2015 CPS-ASEC data that reflect respondents' current insurance coverage status at the time of the interview (as noted, interviews largely occurred in March, but some interviews occurred in February and April) rather than reported coverage over the past year (the 2015 CPS-ASEC collects data on both from respondents, and the past year coverage variables have been the focus of others' analyses using the survey).[9] Currently, these data allow us to assess whether an individual was insured or uninsured, but they do not permit analysis of the type of coverage held if insured; additional coverage breakouts have not yet been released. We rely upon these data because they provide the most recent snapshot of coverage information using the CPS-ASEC and because point-in-time reports of coverage are more likely to be accurate than are reports of previous-year coverage; the questions are more straightforward and require far less recall from respondents. The overall sample size is 199,024 individuals, the sample size for the nonelderly is 174,198, and the sample size for the uninsured nonelderly is 20,308.

The 2015 CPS-ASEC provides detailed information on health insurance coverage; income; household composition; and demographic, socioeconomic, and geographic characteristics for a nationally representative sample of U.S. households. The CPS surveys the civilian noninstitutionalized population, and as such it includes noninstitutional group quarters, such as college dormitories (a very small portion of the sample) and workers' group living quarters, but it excludes such locations as jails, prisons, psychiatric hospitals, and group homes for juveniles.[10] The 2015 CPS-ASEC supplement is the first in which the full sample received redesigned income and health insurance questions, including questions focused on insurance coverage at the time of the survey.[11] For this analysis, we focus on nonelderly individuals (children age 17 or younger and adults ages 18 to 64) who report having no health insurance coverage at the time of the survey. Although previous studies have shown that survey respondents tend to underreport enrollment in Medicaid/CHIP, which may affect estimates of point-in-time coverage status, we do not make adjustments to the data to correct for potential underreporting.[12,13]

The CPS has several advantages over the National Health Interview Survey for these purposes. First, the CPS has more-detailed information about family income that is useful for estimating Medicaid/CHIP and tax credit eligibility. The National Health Interview Survey only collects data on total combined family income; the CPS collects data on the amount of each type of income from each family member. Second, the CPS has a larger sample size that is more useful for analyzing subgroups, such as Medicaid-eligible uninsured adults and children and the low-income, tax credit–eligible nonelderly uninsured. Third, the CPS has somewhat more-detailed information about family employment status, such as firm size for all workers, whereas the National Health Interview Survey only collects firm size data in its sample adult file. Fourth, the CPS has more-detailed information about receipt of public benefits, such as the EITC and free or reduced-price school lunches.

Program Eligibility. We explore the characteristics of the nonelderly uninsured and their eligibility either for Medicaid/CHIP or for premium tax credits to purchase coverage through the health insurance marketplaces. We approximate tax units and calculate the modified adjusted gross income (MAGI) of each unit to determine income eligibility for Medicaid/CHIP and marketplace tax credits. Our unit measure is similar to the U.S. Census Bureau's definition of a subfamily, which may include "a married couple with or without children, or a single parent with one or more own never-married children under 18 years old."[14] We define the units to include members of a subfamily who may be covered under one health insurance policy (i.e., policyholders, spouses, own children under age 19, and own children under age 23 who are full-time students). Sources of reported income used to calculate MAGI include wage, salary, and self-employment earnings; unemployment compensation; retirement, interest, dividend, and rental income; other income not deducted from adjusted gross income (e.g., alimony); and taxable and nontaxable Social Security benefits.

Because undocumented immigrants are not eligible for Medicaid or for coverage through the marketplace with or without tax credits, we impute documentation status for noncitizens using a methodology that replicates estimates from the Pew Hispanic Center, the Department of Homeland Security, and the Center for Migration Studies.[15] We also impute offers of affordable ESI such that offer rates by firm size match those in the 2013 Medical Expenditure Panel Survey Insurance Component summary tables. To impute employer offer status, we begin by using regression models based on employment status, wage and salary earnings, firm size, industry, occupation, coverage type, and an indicator for whether the individual is a full-time student; the models are estimated from the Contingent Worker Supplement to the February CPS collected in 2005, the last year available from the CPS supplement that includes information on ESI offers. This allows us to compute a probability of offer based on detailed firm characteristics. We then adjust the model to match the probabilities of offer by firm size to the 2013 Medical Expenditure Panel Survey Insurance Component data.

MAGI-based Medicaid/CHIP income eligibility limits for children, parents, and other nondisabled adults as of March 2015 are produced by the Centers for Medicare and Medicaid Services and made available in a concise format by the Kaiser Family Foundation.[16,17] We assign eligibility to immigrant children lawfully residing in the United States for less than five years if they are below the income eligibility threshold and live in states that have opted not to impose a five-year waiting period for Medicaid/CHIP eligibility.[18] In Texas, lawfully residing immigrants are not eligible for Medicaid even if they have been in the United States for more than five years.[19] Non-MAGI-based Medicaid/CHIP eligibility is assigned to individuals who are foster children; report receiving SSI; or report a disability and have income and assets below state-defined thresholds and are eligible based on immigration status under pre-ACA state rules. We also assign eligibility to children with incomes below the tax filing threshold who have parents or others in the household who (1) could claim that child as a dependent and (2) could themselves be claimed by someone else in the household as a dependent (e.g., a child living with both a parent and a grandparent who could claim that parent as a dependent).

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

In states not expanding Medicaid, many adults, including adults with incomes below 100 percent of FPL who are not eligible for Medicaid, fall into a financial assistance gap. That gap also includes those with incomes between 100 percent and 138 percent of FPL who are not eligible for tax credits because of an affordable ESI offer, but who would be eligible for assistance if their state expanded Medicaid.[20]

Rationale for Focused Analyses. In addition to analyzing the remaining uninsured in total, we separately analyze two groups, composing 38 percent of the nonelderly uninsured population, that would most likely benefit from targeted outreach and enrollment assistance: (1) those who are eligible for Medicaid and (2) those who are eligible for the most generous marketplace tax credits and cost-sharing reductions because they have incomes below 200 percent of FPL. Evidence suggests that substantially increasing coverage among the other groups of uninsured will require changes in policy and investment of additional government funds to improve financial assistance; we therefore do not focus on their specific characteristics here (discussed further in the results section).

Individual and Household Characteristics. All estimates are reported as percentages and numbers of uninsured individuals using the CPS-ASEC population weights. Variables are defined in table 1.

Limitations. Efforts to simulate eligibility for public coverage based on survey data are inherently challenging because income, insurance coverage, and other information used to model eligibility is often misreported and because specific information needed to simulate some of the pathways to eligibility is unavailable. The CPS, like many other surveys, does not contain information on such factors as pregnancy status, legal disability status, whether custodial parents meet child support cooperation requirements, and duration of Medicaid enrollment or income history to determine Medicaid Transitional Medical Assistance and related eligibility. Further, some have found evidence of underreporting of enrollment in public programs such as Medicaid, SNAP, and the EITC.[21]

RESULTS

All Nonelderly Uninsured

The first column of table 2 shows the number of uninsured with each of the characteristics studied. The second column provides information on how the nonelderly uninsured population is distributed across particular socioeconomic characteristics, and the third column shows the share of individuals with each characteristic who are uninsured. As of the end of the ACA's second open enrollment period, 32.9 million nonelderly adults and children, or 12.2 percent of the nonelderly population, were uninsured according to the CPS.

Age. As was true before the implementation of the ACA, the vast majority of the uninsured are adults (84.5 percent); only 15.5 percent are children age 17 and under. Young adults age 18 to 34 constitute the largest portion of the uninsured (38.6 percent of the total uninsured and 45.7 percent of uninsured adults). Almost 20 percent are ages 50 to 64. About one-third of the uninsured have at least one school-age child (age 5 to 17) in their family. Approximately 43 percent of uninsured children (2.2 million of 5.1 million) live in households in which at least one parent is absent. In most of these cases (34.7 percent of uninsured children) the child lives with one parent, but roughly 9 percent of uninsured children live in households with only nonparents.

In addition to being the largest age group of uninsured persons, young adults are the most likely to be uninsured. Over 17 percent of them are uninsured compared with 10.4 percent of their counterparts ages 50 to 64 and only 6.9 percent of children. Individuals in families in which at least one school-age child is present are less likely to be uninsured (9.4 percent uninsured) than those in families without a school-age child present (14.4 percent uninsured). In addition, children not living with either parent are almost twice as likely to be uninsured as all children, with 13.1 percent uninsured compared with 6.9 percent of all children.

Race/Ethnicity and Citizenship Status. White non-Hispanics make up 45.8 percent of the total uninsured, 13.7 percent are black non-Hispanics, and 32.8 percent are Hispanic. About 80 percent of the uninsured are U.S. citizens, another 4.6 percent are legal noncitizen residents, and 15.9 percent are undocumented immigrants. Roughly 11 percent of the uninsured live in households of mixed immigration status (households with at least one undocumented resident and one legal resident). This is a more prominent situation for uninsured children, 16.1 percent of whom live in households of mixed immigration status (data not shown).

Although white non-Hispanics are the racial/ethnic group composing the largest share of the uninsured, they have one of the lowest uninsurance rates of any racial/ethnic group: 9.4 percent are uninsured compared with 13.1 percent of black non-Hispanics and over 20 percent of both Hispanics and Native peoples. Asian/Pacific Islanders and those reporting more than one race have comparable uninsurance rates to white non-Hispanics. Over 49 percent of undocumented immigrants are uninsured compared with 10.5 percent of U.S. citizens and 14.7 percent of legal noncitizen residents. Approximately 30 percent of

Table 1. Variable Definitions

Age	Reported as of March 2015
School-age child in family	Children 5 through 17 years old
Children (age 17 or younger) not living with both parents	
Children living with one parent	Defined as children living with only one biological or adoptive parent
Children living with only nonparents	Children living with no biological or adoptive parents and who are living with grandparents, other relatives, nonrelatives, stepparents, or foster parents
Race/ethnicity	Racial and Hispanic origin categories as defined by the U.S. census
Citizenship status	
Citizen	Native born or naturalized
Legal noncitizen resident	This category includes lawful permanent residents and other lawfully present noncitizens. A lawful permanent resident is a noncitizen who is legally permitted to live and work in the United States permanently. Other legal noncitizens include refugees and persons granted aslyum in the United States. We impute legal status for all those reporting they are noncitizens (see details below).
Undocumented immigrant	Because all civilian noninstitutionalized residents of the United States are represented in the sample of households interviewed by the CPS, undocumented immigrants are likely included in CPS data. However, the CPS makes no attempt to ascertain the legal status of any person interviewed. As such, we impute documentation status for noncitizens using a methodology that replicates estimates from the Pew Hispanic Center, the Department of Homeland Security, and the Center for Migration Studies.
Mixed immigration status	Families with at least one undocumented resident and at least one legal resident
Family income of citizens, other legal residents and undocumented residents	Family income is the reported MAGI for the past year (2014) and is adjusted to 2015 dollars based on the Consumer Price Index for All Urban Consumers. Sources of reported income included in MAGI are wage, salary, and self-employment earnings; unemployment compensation; retirement, interest, dividend, and rental income; other income not deducted from adjusted gross income (e.g., alimony), and taxable and nontaxable Social Security benefits. Respondents are then classified into FPL categories based on the family's income relative to the 2015 FPL guidelines (at or below 200% FPL, 201–399% FPL, and 400% FPL and greater)
Educational attainment (age 18 or older)	Reported as of March 2015
Region	
Northeast	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
Midwest	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
South	Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
West	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

Table 1, continued. Variable Definitions

Urban/rural	
MSA	An MSA contains a core urban area of at least 50,000 or more population based on the White House Office of Management and Budget's definition.
Non-MSA	Areas that are not MSAs.
Family employment status in 2014	
At least one working adult in large firm	Large firms are those with 50 or more employees.
No working adult in large firm, at least one in small firm	Small firms are those with fewer than 50 employees.
All working adults self-employed	Working adults in family were self-employed, either incorporated or not incorporated.
All adults nonworking	Adults in family were not self-employed and did not work for a firm.
Family employment status/usual weekly hours worked in March 2015, adults	
At least one full-time (30 hours per week or more) working adult in family	Based on usual weekly hours at main current job. Excludes children age 17 and under and adults serving in the armed forces.
Only part-time (less than 30 hours per week) working adults in family	Based on usual weekly hours at main current job. Excludes children age 17 and under and adults serving in the armed forces.
No working adults, at least one unemployed adult	People are classified as unemployed if they do not have a job, have actively looked for work in the past four weeks, and are currently available for work.
No adults in labor force	Those who have no job and are not looking for one are counted as not in the labor force. Many who are not in the labor force are going to school or are retired, or have other responsibilities that prevent them from working.
Receipt of public benefits	
Family claimed earned income tax credit in 2014	Positive value reported for earned income tax credit claimed by someone in family.
Family received Supplemental Nutrition Assistance Program benefits in 2014	Positive estimated market value of Supplemental Nutrition Assistance Program benefits reported for family in 2014.
Child in household received free or reduced price lunch in 2014	Reported on behalf of any child in the household, where a household includes unrelated individuals who reside in the same home.
Other reported benefits	Includes Supplemental Security Income, subsidized housing, public housing, unemployment compensation, Temporary Assistance for Needy Families, other public assistance, or energy assistance reported by individuals in the family.
Medicaid expansion status	
Resides in state that had expanded Medicaid as of March 2015	These states are: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.
Resides in state that did not expand Medicaid as of March 2015	These states are: Alabama, Alaska, Florida, Georgia, Idaho, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

Table 1, continued. Variable Definitions

Program eligibility	
Medicaid/CHIP eligible	Non-MAGI-based eligibility is assigned to foster children; Supplemental Security Income recipients; and those with a disability who have income and assets below state-defined thresholds and are eligible based on immigration status under pre-ACA state rules. MAGI-based eligibility is based on state thresholds for children, parents, and other nondisabled adults as of March 2015. Immigrant children lawfully residing in the U.S. for less than five years and who meet income eligibility criteria are considered eligible if states do not impose a waiting period. We also assign eligibility to children with incomes below the tax filing threshold with parents who could claim them as a dependent and be claimed by someone else in the household as a dependent.
Assistance gap	The assistance gap includes adults with incomes below 100% of FPL who are not eligible for Medicaid, and those with incomes between 100 and 138% of FPL who are not eligible for tax credits because of an affordable ESI offer, but who would be eligible for assistance if their state expanded Medicaid.
Marketplace tax credit eligible	Individuals are eligible for tax credits if they are not undocumented, not eligible for Medicaid or Medicare, do not live in a family with an affordable offer of ESI, and have incomes between 138% and 400% of FPL if they live in states that expanded Medicaid as of March 2015 or between 100% and 400% of FPL if they live in states that did not. Immigrants lawfully residing in the U.S. for less than five years with incomes below these thresholds are assigned eligibility if they are not eligible for Medicaid and do not have an affordable ESI offer.
Ineligible for tax credit due to affordable ESI offer	Includes those who would otherwise be eligible for tax credits if they did not have an affordable ESI offer, which is imputed based on employment status, wage and salary earnings, firm size, industry, occupation, coverage type, and whether the individual is a full-time student, and estimates are adjusted to match offer rates by firm size in the Medical Expenditure Panel Survey Insurance/Employer Component summary tables.
Ineligible due to being undocumented person	Undocumented status is imputed as described above.
Ineligible due to higher income	Citizens and lawfully residing noncitizens with incomes above 400% of FPL.
Children in mixed eligibility families[a]	
Uninsured child (age 17 and under) who is eligible for Medicaid/CHIP with uninsured parent who is eligible for marketplace tax credit	See eligibility criteria described above.
Uninsured child (age 17 and under) who is eligible for Medicaid/CHIP with parents who are undocumented	
Uninsured child (age 17 and under) who is eligible for marketplace tax credit with parents who are undocumented	

Notes: ACA = the Affordable Care Act; CHIP = the Children's Health Insurance Program; CPS = Current Population Survey; ESI = employer-sponsored insurance; FPL = the federal poverty level; MAGI = modified adjusted gross income; MSA = metropolitan statistical area.

[a] Category also includes uninsured children with tax-credit eligible incomes who had nongroup coverage in the past year while a parent had ESI in the past year, and undocumented children with an undocumented parent and a Medicaid/CHIP eligible child in the family.

those living in households of mixed immigration status are uninsured, more than twice the uninsurance rate for the nonelderly population as a whole.

Health Insurance Unit Income. The uninsured are dominated by the low-income population: fully 60.1 percent of uninsured legal residents (those potentially eligible for health care–related financial assistance and who can enroll in marketplaces without financial assistance if they choose) have family income at or below 200 percent of FPL,[22] whereas 25.1 percent have incomes from 201 to 399 percent of FPL, and 14.8 percent have incomes at or above 400 percent of FPL. The uninsured who are undocumented residents of the United States are even more predominantly low-income: 75.5 percent of the undocumented uninsured have incomes at or below 200 percent of FPL.

Among all nonelderly citizens and legal residents, 10.7 percent are uninsured compared with 49.3 percent of the undocumented population. Those below 200 percent of FPL are the most likely to be uninsured in both groups, with 16.2 percent of low-income citizens and legal residents uninsured and 64.8 percent of low-income undocumented persons uninsured.

Educational Attainment. Just over 22 percent of uninsured adults have less than a high school education, and 36.1 percent have a high school degree alone. Twenty-six percent have some college education but do not have a college degree, and 15.3 percent have at least a bachelor's degree.

The lower an adult's level of education, the more likely he or she is to be uninsured. About 28 percent of those without a high school degree are uninsured compared with only 8.0 percent of those with a college degree.

Geographic Residence. Close to half (46.5 percent) of the uninsured live in the South, almost a quarter (23.2 percent) live in the West, and the rest are more evenly split between the Midwest and the Northeast. Across the United States, 84.2 percent of the uninsured live in metropolitan statistical areas. The uninsured are about evenly divided across Medicaid expansion states, and nonexpansion states.

Although some of the regional composition differences in the uninsured relate to population size across regions, residents of the South are noticeably more likely to be uninsured (15.1 percent) than residents of other regions (9.1 percent of Northeastern residents, 10.0 percent of Midwestern residents, and 11.8 percent of Western residents). The rate of uninsurance is roughly the same for those living in metropolitan statistical areas and those not living in metropolitan statistical areas (12.0 percent and 13.1 percent, respectively). The roughly even split of the uninsured across expansion and nonexpansion states disguises that residents of nonexpansion states are substantially more likely to be uninsured than residents of expansion states. More than 15 percent of residents of nonexpansion states are uninsured compared with 10.1 percent of residents of expansion states, a 53 percent difference (table 2).

Employment Status. The 2015 CPS-ASEC measures employment status by firm size in 2014. Individuals in families with at least one working adult in a large firm (a firm with 50 or more workers) make up over 40 percent of the uninsured. Individuals in families with no large-firm workers and at least one small-firm worker (firm with fewer than 50 workers) constitute 30.1 percent of the nonelderly uninsured. About 19 percent of the uninsured are in families with no workers, and 8.8 percent are in families in which the only workers are self-employed.

Although the largest share of the uninsured are in families with at least one large-firm worker (because many more families include at least one large-firm worker), individuals in such families are much less likely to be uninsured than their counterparts in families with small-firm workers alone (7.9 percent compared with 20.8 percent uninsured). Family members in which all workers are self-employed or in which there are no workers have similarly high rates of being uninsured: 22.4 percent and 17.5 percent, respectively.

Fully 61.2 percent of the uninsured are in families with at least one full-time working adult (one who works 30 hours a week or more) as of March 2015, and 12.9 percent are in families in which the only working adults are employed part-time. Almost 18 percent of the uninsured are in families with no adult in the labor force, and 6.8 percent are in families with no working adults but at least one who is unemployed (looking for work).

Individuals in families with no working adults and in which at least one adult is unemployed are, among all individuals grouped by family employment status, the most likely to be uninsured (24.2 percent). Individuals in families with at least one adult working full-time are the least likely to be uninsured (10.3 percent).

Receipt of Public Benefits. Substantial percentages of the uninsured (48.5 percent) are in families that receive public benefits not related to health. These contacts with other public programs provide potential avenues for health insurance program outreach to the uninsured. As Blavin and colleagues found, using government data already

Table 2. Characteristics of All Remaining Nonelderly Uninsured

	Number of Uninsured	Share of uninsured in the category who have the characteristic	Rate of uninsurance for those with the characteristic
Total	32,945,000	100.0%	12.2%
Age			
0-17	5,121,000	15.5%	6.9%
18-34	12,718,000	38.6%	17.4%
35-49	8,606,000	26.1%	14.2%
50-64	6,500,000	19.7%	10.4%
School-age child in family			
Child ages 5–17 in family	11,090,000	33.7%	9.4%
No school age child in family	21,855,000	66.3%	14.4%
Presence/absence of a parent (children age 17 or under only)			
Children living with both parents	2,898,000	56.6%	6.2%
Children not living with both parents	2,223,000	43.4%	8.3%
Children living with one parent	1,777,000	34.7%	7.6%
Children living with only nonparents	446,000	8.7%	13.1%
Race/ethnicity			
White, single race, non-Hispanic	15,080,000	45.8%	9.4%
Black, single race, non-Hispanic	4,527,000	13.7%	13.1%
Asian/Pacific Islander, single race, non-Hispanic	1,547,000	4.7%	9.5%
American Indian/Alaska Native, single race, non-Hispanic	472,000	1.4%	21.3%
More than one race, non-Hispanic	506,000	1.5%	9.2%
Hispanic	10,813,000	32.8%	20.8%
Citizenship status			
Citizen	26,205,000	79.5%	10.5%
Legal noncitizen resident	1,507,000	4.6%	14.7%
Undocumented immigrant	5,233,000	15.9%	49.3%
Mixed immigration status (i.e., at least one undocumented resident and at least one legal resident in family)	3,455,000	10.5%	29.4%
Family income of citizens and other legal residents			
At or below 200% of FPL	16,646,000	60.1%	16.2%
201–399% of FPL	6,956,000	25.1%	10.2%
400% of FPL and up	4,109,000	14.8%	4.6%
Total citizens and legal residents	27,712,000	100.0%	10.7%
Family income of undocumented persons			
At or below 200% of FPL	3,954,000	75.5%	64.8%
201–399% of FPL	975,000	18.6%	36.9%
400% of FPL and up	304,000	5.8%	16.2%
Total undocumented persons	5,233,000	100.0%	49.3%

Table 2, continued. Characteristics of All Remaining Nonelderly Uninsured

	Number of Uninsured	Share of uninsured in the category who have the characteristic	Rate of uninsurance for those with the characteristic
Educational attainment (age 18 and older only)			
Less than high school	6,274,000	22.5%	27.9%
High school degree	10,048,000	36.1%	18.0%
Some college	7,257,000	26.1%	12.5%
Bachelor's degree	3,145,000	11.3%	8.0%
Master's degree and above	1,101,000	4.0%	5.4%
Region			
Northeast	4,297,000	13.0%	9.1%
Midwest	5,689,000	17.3%	10.0%
South	15,321,000	46.5%	15.1%
West	7,637,000	23.2%	11.8%
Urban/rural			
MSA	27,740,000	84.2%	12.0%
Non-MSA	4,831,000	14.7%	13.1%
Not identified	373,000	1.1%	17.2%
Medicaid expansion status in state of residence			
Resides in state that had expanded Medicaid as of March 2015	16,200,000	49.2%	10.1%
Resides in state that had not expanded Medicaid as of March 2015	16,745,000	50.8%	15.4%
Family employment status, firm size in 2014			
At least one working adult in large firm (50+ workers)	13,482,000	40.9%	7.9%
No working adults in large firm, at least one in small firm	9,911,000	30.1%	20.8%
All working adults self-employed	2,903,000	8.8%	22.4%
All adults nonworking	6,222,000	18.9%	17.5%
No adults in family or only adult armed forces members in family	427,000	1.3%	12.2%
Family employment status, usual weekly hours worked at main job in March 2015			
At least one full-time working adult in family	20,159,000	61.2%	10.3%
Only part-time working adults in family	4,234,000	12.9%	17.4%
No working adults, at least one unemployed adult	2,249,000	6.8%	24.2%
No adults in labor force	5,877,000	17.8%	16.1%
No adults in family or only adult armed forces members in family	427,000	1.3%	12.2%

Table 2, continued. Characteristics of All Remaining Nonelderly Uninsured

	Number of Uninsured	Share of uninsured in the category who have the characteristic	Rate of uninsurance for those with the characteristic
Receipt of public benefits			
Family claimed EITC in 2014	9,916,000	30.1%	17.9%
Family received SNAP in 2014	4,837,000	14.7%	14.1%
Child in household received free or reduced price lunch in 2014	7,476,000	22.7%	15.7%
Other[a]	3,217,000	9.8%	9.6%
At least one person in family reported any of the above benefits for self or family	15,986,000	48.5%	16.4%

Source: Urban Institute analysis of the 2015 Current Population Survey-Annual Social and Economic Supplement.

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

[a] Other public benefit categories include receipt of SSI in 2014; subsidized housing, public housing, or energy assistance; or unemployment compensation, TANF or other public assistance in family in 2014. Free and reduced-price school lunches are reported on behalf of children in the household.

acquired by other agencies to determine program eligibility can increase Medicaid/CHIP enrollment[23] and may provide similar opportunities for marketplace enrollment. The most common public benefit reported by the uninsured is the EITC: 30.1 percent of the uninsured are in families that claimed the EITC in 2014. The next most commonly reported benefit is free and reduced-price school lunches; 22.7 percent of the uninsured live in households in which at least one child received subsidized lunches in 2014. The third most commonly reported benefit is through SNAP; almost 15 percent of the uninsured are in families receiving SNAP benefits.

Program Eligibility. The remaining uninsured are quite diverse in their eligibility for health insurance programs and financial assistance, and the situation of uninsured children differs markedly from that of uninsured adults (table 3 and figure 1). Almost 28 percent of all nonelderly uninsured are eligible for Medicaid/CHIP (including those eligible under pre-ACA rules and those eligible because of their states' decisions to take-up the ACA's Medicaid expansion), but fully 66.5 percent of uninsured children are eligible for these programs compared with only 20.6 percent of uninsured adults.[24]

Approximately 21 percent of the uninsured are eligible for marketplace financial assistance. A greater share of the adult uninsured are eligible for marketplace tax credits than are children (23.8 percent compared with 6.2 percent), largely because of the higher Medicaid/CHIP eligibility levels for children (individuals eligible for Medicaid/CHIP are not eligible for tax credits). Altogether, 46.5 percent of uninsured children and adults (3.2 million people) who are eligible for marketplace financial assistance have family incomes at or below 200 percent of FPL, making them eligible for the largest premium tax credits and for substantial cost-sharing reductions. As research shows,[25] this eligibility category is the one most likely to enroll in marketplace-based nongroup insurance coverage. Higher-income individuals are substantially less likely to enroll, most likely because the financial assistance provided is considerably lower.

Almost 12 percent of the uninsured, an estimated 3.8 million people as of March 2015, are ineligible for any financial assistance to obtain health insurance because of their states' decisions not to expand Medicaid. Those individuals have incomes below 100 percent of FPL or have incomes between 100 and 138 percent of FPL and are ineligible for marketplace tax credits because of an affordable offer of ESI. More than 5 million uninsured people are ineligible for financial assistance because they are undocumented immigrants; the vast majority are adults. These individuals are not eligible for any financial assistance and are barred from purchasing coverage through the marketplaces with their own funds. The remaining 23.8 percent of the uninsured are ineligible for Medicaid or marketplace-based financial assistance either because their incomes exceed 400 percent of FPL (4.1 million people) or because they are in households in which at least one adult has access to an offer of worker-only ESI that the ACA deems affordable (i.e., the worker's contribution to single coverage was less than 9.56 percent of family income; 3.7 million people).

The high enrollment rate of Medicaid/CHIP among children may also provide an opportunity to identify and enroll their siblings and parents in insurance coverage with financial assistance. More than 4.6 million uninsured parents had a child enrolled in Medicaid/CHIP in 2014, constituting 14.1 percent of the remaining uninsured. However, only 1.5 million of these uninsured parents, 4.4 percent of the uninsured, were eligible for Medicaid or marketplace tax credits (62 percent of these 1.5 million were eligible for Medicaid; data not shown). Approximately 400,000 uninsured individuals in 2015 lived in households in which a sibling was enrolled in Medicaid/CHIP in 2014, but just about half of those individuals themselves were eligible for Medicaid or tax credits (94 percent of those eligible for Medicaid/CHIP or tax credits were eligible for Medicaid).

Members of a family may also be divided in their eligibility for particular programs, complicating enrollment and leading to lower participation rates. For example, some children are eligible for Medicaid/CHIP while their parents are eligible for marketplace tax credits (because many states have higher Medicaid/CHIP income eligibility thresholds for children than for adults). Also, some children are eligible for Medicaid or tax credits while their parents are not eligible for any program because those parents are undocumented. Following the work done by McMorrow, Kenney, and Coyer, we create three mixed-eligibility categories for uninsured children: children eligible for Medicaid/CHIP with an uninsured parent eligible for marketplace tax credits; children eligible for Medicaid/CHIP with an undocumented parent; and children eligible for marketplace tax credits with an undocumented parent.[26] Slightly more than one-fifth of uninsured children (20.8 percent) are in mixed-eligibility families, and almost all of these children are eligible for Medicaid/CHIP while their parents are either eligible for marketplace-based tax credits (10.7 percent of uninsured children) or are undocumented (7.9 percent of uninsured children).

Table 3. Program Eligibility of the Remaining Nonelderly Uninsured

	All Nonelderly (under age 65)		Children (under age 18)		Adults (ages 18–64)	
	Number of Uninsured	Share of uninsured in the category who have the characteristic	Number of Uninsured	Share of uninsured in the category who have the characteristic	Number of Uninsured	Share of uninsured in the category who have the characteristic
Total	32,945,000	100.0%	5,121,000	100.0%	27,824,000	100.0%
Program eligibility						
Medicaid/CHIP eligible	9,132,000	27.7%	3,404,000	66.5%	5,728,000	20.6%
Assistance gap	3,799,000	11.5%	0	0.0%	3,799,000	13.7%
Marketplace tax credit eligible	6,932,000	21.0%	316,000	6.2%	6,616,000	23.8%
Family income at or below 200% of FPL	3,224,000	9.8%	11,000	0.2%	3,213,000	11.5%
Family income 201% of FPL and up	3,708,000	11.3%	305,000	6.0%	3,403,000	12.2%
Ineligible for tax credit due to affordable ESI offer	3,740,000	11.4%	468,000	9.1%	3,271,000	11.8%
Ineligible due to being undocumented person	5,233,000	15.9%	274,000	5.3%	4,959,000	17.8%
Ineligible due to higher income	4,109,000	12.5%	658,000	12.9%	3,451,000	12.4%
Family members of children enrolled in Medicaid/CHIP in 2014						
Uninsured parent	4,637,000	14.1%	1,000	<0.1%	4,636,000	16.7%
Uninsured parent eligible for Medicaid or Marketplace tax credits	1,455,000	4.4%	1,000	<0.1%	1,453,000	5.2%
Uninsured sibling	412,000	1.3%	268,000	5.2%	144,000	0.5%
Uninsured sibling eligible for Medicaid or Marketplace tax credits	219,000	0.7%	168,000	3.3%	51,000	0.2%
Children in mixed-eligibility families[a]						
Total	-	-	1,065,000	20.8%	-	-
Uninsured child (under age 18) who is eligible for Medicaid/CHIP with uninsured parent who is eligible for Marketplace tax credit	-	-	550,000	10.7%	-	-
Uninsured child (under age 18) who is eligible for Medicaid/CHIP with parents who are undocumented	-	-	407,000	7.9%	-	-
Uninsured child (under age 18) who is eligible for Marketplace tax credit with parents who are undocumented	-	-	72,000	1.4%	-	-

Source: Urban Institute analysis of the 2015 Current Population Survey-Annual Social and Economic Supplement.

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

[a] Uninsured children in mixed eligibility families include uninsured children eligible for Medicaid/CHIP with uninsured parents who are eligible for marketplace tax credits, as well as uninsured children eligible for Medicaid/CHIP or marketplace tax credits with parents who are undocumented. The following subgroups of uninsured children are in mixed eligibility families but are not shown in the table: uninsured children with subsidy-eligible incomes who had nongroup coverage in the past year while a parent had ESI in the past year; and undocumented children with an undocumented parent and a Medicaid/CHIP–eligible child in the family.

The Most Promising Target Populations for Additional Outreach and Enrollment Efforts

The 27.7 percent of the uninsured (9.1 million people) eligible for Medicaid have access to very low cost or no-cost comprehensive insurance coverage.[27] The 9.8 percent of the uninsured (3.2 million people) who are eligible for the largest premium tax credits and substantial cost-sharing reductions have also been shown to be the most likely to enroll in marketplace-based insurance coverage.[28,29] Combined, these populations constitute 37.5 percent of the remaining uninsured (12.4 million people), and they represent the target population that we believe to be most amenable to additional outreach and enrollment efforts.

As the ACA's individual mandate penalties increase and information on new coverage options is disseminated, we can expect some additional coverage among the individuals eligible for smaller marketplace tax credits and among higher-income individuals ineligible for any financial assistance. Increases beyond those already achieved, however, are likely to be modest for these groups because their lower participation rates and survey findings suggest many find the subsidized coverage still unaffordable.[30] Approximately 16 percent of the uninsured are undocumented, most of whom are very low income, and because they are not eligible for financial assistance, significant gains in coverage for them are extremely unlikely absent further policy changes. Another 11.5 percent of the uninsured are currently ineligible for any financial assistance because of their states' decisions not to expand Medicaid. This population also has very low incomes (nearly all have incomes below 100 percent of the federal poverty level) and little or no ability to contribute to their medical costs. Accordingly, coverage progress for this population is extremely unlikely unless their state governments expand Medicaid. Expansion is likely to occur in at least some states over time, but until then this group will remain among the persistently uninsured.

Those who have an affordable offer of ESI and who remain uninsured are very likely aware of their employer's offer, and being ineligible for financial assistance through the marketplace, they are unlikely to change their current coverage decisions in large numbers. Some are likely caught in the "family glitch," wherein all family members are denied access to financial assistance in the marketplaces because one of the adult workers has an offer of affordable single coverage but family coverage is still very costly relative to income. Those with incomes above the tax credit eligibility threshold who are also ineligible for any financial assistance under the ACA are also unlikely to experience substantially higher enrollment rates without additional policy changes.

Without policy changes, future coverage expansions will largely be limited to those eligible for Medicaid and those eligible for tax credits and cost-sharing reductions with incomes below 200 percent of FPL, and detailed analysis of their characteristics can help identify the most promising avenues for outreach and enrollment efforts. The following sections focus on the characteristics of these two groups; we then discuss strategies to increase coverage that directly relate to their characteristics.

Characteristics of the Medicaid/CHIP–Eligible Uninsured. Table 4 shows the characteristics of the uninsured nonelderly who are eligible for Medicaid/CHIP coverage under current law (accounting for state Medicaid expansion decisions), in total and for children and adults separately. About 37 percent of the Medicaid/CHIP–eligible uninsured are children, and more than half of the uninsured adults are ages 18 to 34. Fully 45.8 percent of the uninsured eligible for Medicaid/CHIP are in families with at least one school-age child; this is true for 85.1 percent of eligible children and 22.4 percent of eligible adults. Over half of eligible children live in households in which at least one parent is absent, and nearly 60 percent of uninsured children in such households are living only with their mother (data not shown). The racial and ethnic composition of the Medicaid/CHIP–eligibles is very similar to that of the total uninsured population.

As would be expected, the Medicaid/CHIP–eligible uninsured are more heavily concentrated in the lowest-income group than are the rest of the uninsured. Almost all of the eligible adults have family incomes at or below 138 percent of FPL, as do two-thirds of eligible children. Almost 55 percent of the uninsured Medicaid/CHIP-eligibles are in families in which at least one adult worked for a firm in the previous calendar year (i.e., they were not self-employed or nonworkers).

Fourteen percent of Medicaid eligible uninsured adults, over 805,000 people, report having a disability. Further, over two-thirds of the eligible uninsured report that someone in their family received at least one public benefit not related to health during the year. Most frequently, the reported benefit was EITC (45.4 percent of eligible uninsured), free and reduced-price school lunch (30.3 percent of eligible uninsured), and SNAP (20.5 percent of eligible uninsured).

Table 4. Characteristics of Remaining Uninsured Among Medicaid/CHIP-eligible Nonelderly

	All Nonelderly (under age 65)		Children (under age 18)		Adults (ages 18–64)	
	Number of Uninsured	Share of uninsured in the category who have the characteristic	Number of Uninsured	Share of uninsured in the category who have the characteristic	Number of Uninsured	Share of uninsured in the category who have the characteristic
Total	9,132,000	100.0%	3,404,000	100.0%	5,728,000	100.0%
Age						
0–17	3,404,000	37.3%	3,404,000	100.0%	-	0.0%
18–34	3,047,000	33.4%	-	0.0%	3,047,000	53.2%
35–49	1,415,000	15.5%	-	0.0%	1,415,000	24.7%
50–64	1,265,000	13.9%	-	0.0%	1,265,000	22.1%
School-age child in family	4,178,000	45.8%	2,895,000	85.1%	1,283,000	22.4%
Children (under age 18) not living with both parents	-	-	1,751,000	51.4%	-	-
Children living with one parent	-	-	1,334,000	39.2%	-	-
Children living with only non-parents	-	-	417,000	12.3%	-	-
Race/ethnicity						
White, single race, non-Hispanic	4,120,000	45.1%	1,294,000	38.0%	2,826,000	49.3%
Black, single race, non-Hispanic	1,461,000	16.0%	490,000	14.4%	970,000	16.9%
Asian/Pacific Islander, single race, non-Hispanic	456,000	5.0%	149,000	4.4%	307,000	5.4%
American Indian/Alaska Native, single race, non-Hispanic	227,000	2.5%	88,000	2.6%	139,000	2.4%
More than one race, non-Hispanic	224,000	2.5%	104,000	3.1%	120,000	2.1%
Hispanic	2,645,000	29.0%	1,279,000	37.6%	1,366,000	23.9%
Citizenship status						
Citizen	8,712,000	95.4%	3,328,000	97.8%	5,384,000	94.0%
Legal noncitizen resident	419,000	4.6%	76,000	2.2%	344,000	6.0%
Undocumented immigrant	-	-	-	-	-	-
Mixed immigration status (i.e., at least one undocumented resident and at least one legal resident in family)	667,000	7.3%	563,000	16.6%	104,000	1.8%
Family income						
At or below 138% of FPL	7,890,000	86.4%	2,255,000	66.2%	5,635,000	98.4%
139–399% of FPL	1,241,000	13.6%	1,149,000	33.8%	93,000	1.6%
400% FPL and up	0	0.0%	0	0.0%	0	0.0%
Educational attainment (age 18 and older only)						
Less than high school	-	-	-	-	1,305,000	22.8%
High school degree	-	-	-	-	2,287,000	39.9%
Some college	-	-	-	-	1,544,000	27.0%
Bachelor's degree	-	-	-	-	474,000	8.3%
Master's degree and above	-	-	-	-	118,000	2.1%

Table 4, continued. Characteristics of Remaining Uninsured Among Medicaid/CHIP-eligible Nonelderly

	All Nonelderly (under age 65)		Children (under age 18)		Adults (ages 18–64)	
	Number of Uninsured	Share of uninsured in the category who have the characteristic	Number of Uninsured	Share of uninsured in the category who have the characteristic	Number of Uninsured	Share of uninsured in the category who have the characteristic
Region						
Northeast	1,614,000	17.7%	439,000	12.9%	1,175,000	20.5%
Midwest	2,030,000	22.2%	614,000	18.0%	1,415,000	24.7%
South	2,678,000	29.3%	1,462,000	43.0%	1,216,000	21.2%
West	2,810,000	30.8%	888,000	26.1%	1,922,000	33.5%
Urban/rural						
MSA	7,527,000	82.4%	2,771,000	81.4%	4,757,000	83.0%
Non-MSA	1,512,000	16.6%	583,000	17.1%	929,000	16.2%
Not identified	92,000	1.0%	50,000	1.5%	42,000	0.7%
Family employment status in 2014						
At least one working adult in large firm (50+ workers)	2,957,000	32.4%	1,412,000	41.5%	1,545,000	27.0%
No working adults in large firm, at least one in small firm	2,020,000	22.1%	881,000	25.9%	1,139,000	19.9%
All working adults self-employed	675,000	7.4%	291,000	8.5%	384,000	6.7%
All adults non-working	3,074,000	33.7%	414,000	12.2%	2,660,000	46.4%
No adults in family or only adult armed forces members in family	406,000	4.5%	406,000	11.9%	0	0.0%
Family employment status, usual weekly hours worked at main job in March 2015						
At least one full-time working adult in family	3,777,000	41.4%	2,052,000	60.3%	1,724,000	30.1%
Only part-time working adults in family	1,380,000	15.1%	361,000	10.6%	1,018,000	17.8%
No working adults, at least one unemployed adult	818,000	9.0%	137,000	4.0%	681,000	11.9%
No adults in labor force	2,751,000	30.1%	446,000	13.1%	2,304,000	40.2%
No adults in family or only adult armed forces members in family	406,000	4.5%	406,000	11.9%	0	0.0%
Receipt of public benefits						
Family claimed EITC in 2014	4,149,000	45.4%	2,034,000	59.8%	2,115,000	36.9%
Family received SNAP in 2014	1,868,000	20.5%	626,000	18.4%	1,242,000	21.7%
Child in household received free or reduced price lunch in 2014	2,771,000	30.3%	1,506,000	44.3%	1,265,000	22.1%
Other[a]	1,176,000	12.9%	328,000	9.6%	848,000	14.8%
At least one person in family reported any of the above benefits for self or family	6,149,000	67.3%	2,686,000	78.9%	3,462,000	60.4%

Table 4, continued. Characteristics of Remaining Uninsured Among Medicaid/CHIP-eligible Nonelderly

	All Nonelderly (under age 65)		Children (under age 18)		Adults (ages 18–64)	
	Number of Uninsured	Share of uninsured in the category who have the characteristic	Number of Uninsured	Share of uninsured in the category who have the characteristic	Number of Uninsured	Share of uninsured in the category who have the characteristic
Medicaid expansion status						
Resides in state that expanded Medicaid as of March 2015	6,433,000	70.4%	1,746,000	51.3%	4,687,000	81.8%
Resides in state that did not expand Medicaid as of March 2015	2,699,000	29.6%	1,658,000	48.7%	1,040,000	18.2%
Disability status						
Has a disability	825,000	9.0%	20,000	0.6%	805,000	14.1%
Does not have a disability	8,307,000	91.0%	3,384,000	99.4%	4,922,000	85.9%
Children in mixed eligibility families						
Total	-	-	957,000	28.1%	-	-
Uninsured child (under age 18) who is eligible for Medicaid/CHIP with uninsured parent who is eligible for Marketplace tax credit	-	-	550,000	16.2%	-	-
Uninsured child (under age 18) who is eligible for Medicaid/CHIP with parents who are undocumented	-	-	407,000	11.9%	-	-

Source: Urban Institute analysis of the 2015 Current Population Survey-Annual Social and Economic Supplement.

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

[a] Other public benefit categories include receipt of SSI in 2014; subsidized housing, public housing, or energy assistance; or unemployment compensation, TANF or other public assistance in family in 2014.

Table 5. Characteristics of the Remaining Uninsured Among Tax Credit-Eligible Nonelderly with Incomes at or below 200% of FPL

	Number of Uninsured	Share of uninsured in the category who have the characteristic
Total	3,224,000	100.0%
Age		
0–17	11,000	0.3%
18–34	1,462,000	45.3%
35–49	920,000	28.5%
50–64	832,000	25.8%
School-age child in family	759,000	23.5%
Race/ethnicity		
White, single race, non-Hispanic	1,647,000	51.1%
Black, single race, non-Hispanic	539,000	16.7%
Asian/Pacific Islander, single race, non-Hispanic	161,000	5.0%
American Indian/Alaska Native, single race, non-Hispanic	31,000	1.0%
More than one race, non-Hispanic	43,000	1.3%
Hispanic	804,000	24.9%
Citizenship status		
Citizen	2,806,000	87.0%
Legal noncitizen resident	418,000	13.0%
Undocumented immigrant	n/a	n/a
Mixed immigration status (i.e., at least one undocumented resident and at least one legal resident in family)	104,000	3.2%
Family income		
At or below 138% of FPL	1,081,000	33.5%
139–200% of FPL	2,143,000	66.5%
Educational attainment (age 18 and older only)		
Less than high school	612,000	19.0%
High school degree	1,220,000	38.0%
Some college	963,000	30.0%
Bachelor's degree	340,000	10.6%
Master's degree and above	78,000	2.4%
Region		
Northeast	352,000	10.9%
Midwest	497,000	15.4%
South	1,788,000	55.5%
West	587,000	18.2%
Urban/rural		
MSA	2,678,000	83.1%
Non-MSA	510,000	15.8%
Not identified	37,000	1.1%

Table 5, continued. Characteristics of the Remaining Uninsured Among Tax Credit-Eligible Nonelderly with Incomes at or below 200% of FPL

	Number of Uninsured	Share of uninsured in the category who have the characteristic
Family employment status in 2014		
At least one working adult in large firm (50+ workers)	1,107,000	34.3%
No working adults in large firm, at least one in small firm	1,323,000	41.0%
All working adults self-employed	419,000	13.0%
All adults non-working	371,000	11.5%
No adults in family or only adult armed forces members in family	4,000	0.1%
Family employment status, usual weekly hours worked at main job in March 2015		
At least one full-time working adult in family	1,987,000	61.6%
Only part-time working adults in family	488,000	15.1%
No working adults, at least one unemployed adult	230,000	7.1%
No adults in labor force	516,000	16.0%
No adults in family or only adult armed forces members in family	4,000	0.1%
Receipt of public benefits		
Family claimed EITC in 2014	1,109,000	34.4%
Family received SNAP in 2014	498,000	15.4%
Child in household received free or reduced-price lunch in 2014	643,000	20.0%
Other[a]	338,000	10.5%
At least one person in family reported any of the above benefits for self or family	1,691,000	52.5%
Medicaid expansion status		
Resides in state that had expanded Medicaid as of March 2015	1,205,000	37.4%
Resides in state that had not expanded Medicaid as of March 2015	2,020,000	62.6%
Disability status		
Has a disability	215,000	6.7%
Does not have a disability	3,009,000	93.3%
Mixed eligibility family		
Uninsured parent who is eligible for Marketplace tax credit, child is eligible for Medicaid/CHIP	319,000	9.9%

Source: Urban Institute analysis of the 2015 Current Population Survey-Annual Social and Economic Supplement.

Notes: CHIP = the Children's Health Insurance Program; EITC = the earned income tax credit; FPL = the federal poverty level; MSA = metropolitan statistical area; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

[a] Other public benefit categories include receipt of SSI in 2014; subsidized housing, public housing, or energy assistance; or unemployment compensation, TANF or other public assistance in family in 2014. Free and reduced price school lunches are reported on behalf of children in the household.

Characteristics of the Low-Income Uninsured Eligible for Marketplace Tax Credits and Cost-Sharing Reductions. Table 5 provides the distribution of characteristics of those uninsured with family income at or below 200 percent of FPL who are eligible for premium tax credits and cost-sharing reductions through the marketplaces. We do not differentiate between the characteristics of children and adults, because of sample size constraints.

Virtually all members of this potential target group are adults; 45.3 percent are young adults ages 18 to 34. Over 23 percent of the low-income tax credit eligible uninsured have a school-age child living in the family. One-third of these tax credit eligibles have incomes at or below 138 percent of FPL, and two-thirds have incomes between 138 percent and 200 percent of FPL. As is the case with the uninsured Medicaid eligible adults, two-thirds either have a high school degree or a high school degree coupled with some college. More than half of the individuals in this group live in the South.

Over three-quarters of this tax credit–eligible group are in families with at least one worker in a small or large firm. The remainder are fairly evenly split between families in which the only work is self-employment and those in which the adults do not work. As with all uninsured, a large share of this target group reports that someone in their family received a public benefit not related to health, most commonly the EITC, free and reduced-price school lunch, or SNAP.

Policy Options Targeted to Uninsured with Greatest Enrollment Potential

Focusing on these two target populations likely most amenable to expanding coverage, several of the populations' predominant characteristics provide indicators of potentially effective outreach and enrollment strategies. These strategies do not require policy changes but instead require an allocation of outreach and enrollment resources to strategies most likely to reach these populations. Evidence suggests a significant share of the remaining uninsured are still unaware of the financial assistance available to them.[31] Although some are aware of marketplace assistance but still find it too costly, this is much less likely to be true for those eligible for Medicaid/CHIP, the programs for which beneficiaries have the lowest required contributions. Affordability is also less likely to be the barrier to enrollment for those eligible for the largest marketplace tax credits and cost-sharing reductions (those with incomes below 200 percent of FPL) compared with those eligible for less assistance.

Public School-Based Strategies. Over 45 percent of uninsured eligible for Medicaid/CHIP and 24 percent of low-income uninsured eligible for tax credits live in families with at least one school-age child. In addition, significant shares of the remaining uninsured live in a household with a child receiving free or reduced-price lunches through the public schools. This makes public school–based strategies to educate the uninsured and assist them in enrolling in coverage an attractive approach, although such strategies face significant challenges. Some schools already collect information on the health insurance coverage of children at the beginning of each school year, allowing them to quickly identify uninsured students.[32] And as noted, a child's eligibility for free and reduced-price lunches is significantly correlated with eligibility. Enrollment assisters could work directly with schools, extracurricular programs, and parent-teacher associations to boost enrollment. Enrollment assisters could be colocated in schools for certain periods, and school communications with parents could provide information on the benefits of insurance, the availability of low-cost options, and the availability of enrollment assistance.

Challenges in relying upon schools' involvement include the fact that school districts are administered in a decentralized manner, so there is no single state agency to approve involvement. In addition, children who are undocumented can qualify for the subsidized lunches, whereas those children are not eligible for Medicaid. Plus, income misreporting means that not all families with children receiving subsidized school lunches will be eligible for these programs. In addition, school staff themselves tend to be under-resourced, so relying on the schools' own staff for enrollment assistance is more than can likely be expected. However, schools are viewed by many as a trusted setting, and providing information to parents through schools, giving parents an easy option to have assisters contact them directly, and placing enrollment assisters at schools and school-related functions may be effective at boosting participation.

Further, middle school and high school health classes could incorporate information on the importance of having insurance coverage and the programs available to provide financial assistance to those without it and provide focused teaching to improve health insurance literacy. Activities for high school seniors could remind them of the need for insurance coverage and how to obtain assistance.

We also see that roughly 30 percent of uninsured adults in these target populations have some college education without receiving a bachelor's degree. Many of these low-income individuals likely obtain their college coursework

through community colleges, making these public entities another potential focus for education and outreach. Although this approach most directly benefits active students, new individuals would be affected each year, and they may talk about the enrollment efforts with others in their communities.

Outreach Through Non-Health-Related Public Benefit Programs. Two-thirds of the uninsured eligible for Medicaid and just over half of the low–income uninsured eligible for tax credits live in families in which at least one person is reported to receive a public benefit not related to health. Collaborating with government entities providing these benefits (most often the EITC, free and reduced-price school lunches, and SNAP) could therefore reach large percentages of these uninsured target populations. Some states have already had significant success using information on beneficiaries of SNAP to enroll individuals into insurance coverage, and agencies in those states are encouraged to use information on children's enrollment in CHIP to identify parents potentially eligible for Medicaid under the ACA's expansion.[33] Schools could offer parents of children qualifying for free and reduced-priced lunches the option to have an outside (non-school staff) navigator or in-person assister contact them directly, as suggested above, to explore eligibility for insurance coverage for family members.

The US Treasury could explore notifying all individuals receiving the EITC in the past year that they may be eligible for substantial financial assistance for coverage; the Treasury could also provide an easy mechanism (such as text messaging) that allows individuals to request a navigator to contact them directly to provide additional information and application assistance. Although privacy rules prevent others from using tax data this way, the Internal Revenue Service does send notices to tax filers it believes are eligible for the EITC but have not claimed it on their return. In recent years the Internal Revenue Service mailed individual notices to inform tax filers and Social Security and Veterans Administration benefit recipients about economic stimulus payments. Similarly, EITC claimants could be sent information about potential eligibility for Medicaid or advanced premium tax credits. Mere notices of potential eligibility are likely to produce low response rates; providing an easy mechanism to request a direct contact with an assister may prove more effective. Mailed notices can be costly, and that presents a barrier for the IRS as well.

Other public benefit programs, such as TANF; home energy assistance programs; unemployment benefits; public housing agencies; and maternal and infant health programs, such as WIC or MOMS, could also be more actively engaged in outreach activities. As we have shown, however, smaller percentages of the remaining uninsured are associated with those programs than with EITC, SNAP, and free and reduced-price school lunches.

Outreach Through Place of Employment. Three-quarters of the low-income uninsured eligible for tax credits and over half of the uninsured eligible for Medicaid/CHIP live in households in which at least one family member works for either a large or small firm. In other words, the adults are not all self-employed or outside of the workforce. This makes employers, particularly those in low-wage industries, potentially effective partners in increasing the number of individuals with insurance. Trade associations for low-wage industries, small-business associations, brokers, local consumer advocates, navigator organizations, and others could collaborate to reach out to workers and their family members through employers. Employers can be educated that encouraging and facilitating their employees to enroll in Medicaid would have no bearing on employer mandate penalties and could improve workers' health and productivity while reducing absenteeism. Benestream, which terms itself a Medicaid migration service, is a firm that works with brokers and large employers to enroll eligible workers into Medicaid; this is a private sector example of an employer-focused outreach and enrollment approach.

Although some of these strategies could encourage some Medicaid-eligible individuals to enroll in public insurance instead of private ESI, the share of workers with incomes below 138 percent of FPL who are offered insurance coverage is relatively low, and for many of those who do have offers, the premium contributions and out-of-pocket requirements associated with ESI make it unaffordable. Thus, although some displacement of private coverage could be inherent in the types of employer focused outreach efforts suggested here, the increased coverage and healthcare affordability gains should outweigh that displacement.

Small employers (those with fewer than 50 full-time equivalent employees) in particular may misunderstand the employer penalty rules and consequently may erroneously fear that facilitating marketplace enrollment for their workers could lead to financial penalties. Small-business associations and brokers could allay those concerns and develop strategies to provide low-income workers outreach and enrollment assistance. Brokers selling coverage through the marketplaces can work directly with small employers not offering health insurance to their workers, benefiting both the workers and the brokers themselves.

Outreach Through Family Courts and Support Programs for Single Parents. Roughly half of Medicaid-eligible uninsured children live in households in which at least one parent is absent. In about 60 percent of those

situations, the child is living with his or her mother only, and most of the remaining children in this situation live in homes with neither parent (i.e., with other relatives or with non-relatives). As such, public agencies and programs in contact with single parents and nonparent custodians have the potential to reach large segments of the uninsured children eligible for Medicaid/CHIP. These may include family courts, domestic legal aid programs, community support networks, state agencies responsible for child support and custody matters, and others. Placing navigators or other enrollment assisters in family courts is one potential strategy, although judges may differ in their willingness to permit this. State agencies involved with child support and custody matters can be trained to ask parents for permission to have navigators or assisters contact them directly. As is the case with public schools, legal aid programs and others involved with providing legal assistance to low-income families are not resourced to do enrollment assistance themselves, but they could potentially be used as a conduit to connect those with whom they come in contact with professional assisters.

Reaching Beyond the Uninsured with the Greatest Enrollment Potential

Substantially increasing coverage outside of the uninsured eligible for Medicaid and the low-income uninsured eligible for tax credits will likely require changes in policy and increased resources for financial assistance to particular populations.

Two very low income populations who are not eligible for financial assistance for health insurance under current law account for 27.4 percent of the uninsured: those falling into the Medicaid assistance gap (3.8 million uninsured) and undocumented immigrants (5.2 million uninsured). Those in the Medicaid gap are either adults with family incomes below 100 percent of FPL or adults with incomes between 100 and 138 percent of FPL who are ineligible for marketplace tax credits because of an ESI offer. Accordingly, those uninsured have little or no resources to devote to coverage purchase, and few can be expected to obtain coverage without significant financial support. A few states that have yet to expand Medicaid are considering expanding eligibility, but the outcomes of those processes are still highly uncertain; most of the 20 nonexpansion states are not considering changing their current policy decisions. The financial case for expanding is strong,[34] however, and it is possible that more states may expand in the future.

At least three federal policy changes have been outlined that could address the Medicaid gap. The first option would allow states to choose to expand Medicaid eligibility up to 100 percent of FPL instead of 138 percent of FPL.[35] States having the choice to constrain the size of the expansion population to those in poverty would reduce the financial risk of the Medicaid expansion these states seem to fear. Keeping the public program smaller also carries political appeal in nonexpansion states. A second option would federalize the costs of the Medicaid expansion population.[36] Such an approach would eliminate the state financial contribution for the expansion population entirely (currently, state contributions phase up over time to a maximum of 10 percent of costs). A third option was proposed by the Obama administration in its fiscal year 2017 budget proposal. This approach would provide 100 percent federal funding for the first three years after a state expands Medicaid eligibility to 138 percent of FPL, extending financial support to states beyond the 2014 to 2016 period included in the ACA. Such an additional incentive may encourage some state governments to expand eligibility.[37]

As research has shown,[38] even with financial assistance made available under the ACA, health care financial burdens continue to be high for many purchasing coverage outside of ESI who have incomes above 200 percent of FPL. Such burdens are likely an important source of the much lower marketplace participation rates among this income group.[39] Increasing financial assistance through expanded eligibility for cost-sharing reductions and improved premium tax credits could reduce financial burdens sufficiently to increase enrollment in nongroup insurance. Again, such an approach would require additional federal or state investment.[40]

Affordability can also be a barrier to obtaining coverage for low-income workers who have access to offers of health insurance deemed affordable under the law but for whom those employer policies carry large out-of-pocket requirements (e.g., large deductibles or high out-of-pocket maximums). These low-income workers are not eligible for financial assistance through the marketplaces because of their ESI offers, but the high out-of-pocket costs associated with the plans may dissuade them from enrolling. Although anecdotal evidence of this problem exists,[41] more data on the specifics of the ESI available to low-income workers would be helpful to analyze both the extent of this problem and potential costs to providing these workers with subsidies to reduce the direct costs of their care.[42]

CONCLUSION

As evidenced by several household surveys,[43] the ACA has significantly reduced the number of uninsured persons in the United States, but many remain uninsured. Now, as the third open enrollment period has passed, is an appropriate time to assess who the remaining uninsured are, discern how many more of them could likely be enrolled under current law, and identify the strategies most likely to reach them. The data presented here reflect the characteristics of the uninsured as of March 2015; further (although more modest) decreases in the number of uninsured have likely occurred since that time. However, the distribution of the characteristics of those currently remaining uninsured are likely very similar to those presented here. Although different surveys will inevitably differ in their estimates of the number of uninsured because of variations in questionnaires, sample size, and sampling design, the CPS-ASEC is an important resource for understanding the distribution of characteristics of the uninsured because it is a large, nationally representative data set.

Understanding the characteristics of the uninsured is important for several reasons. First, such analysis allows us to identify uninsured subgroups that hold promise for large coverage gains. Second, it allows us both to target outreach and enrollment resources to those populations based upon public and private entities with which they interact and to identify marketing approaches to which those populations might be amenable. And third, analyzing the uninsured highlights the size of uninsured subpopulations for whom current policies provide less assistance or no assistance in obtaining coverage, allowing an informed discussion of the potential for and merits of additional assistance.

Our analysis of the CPS-ASEC combined with past work on program participation rates and case studies on insurance enrollment behavior under the ACA suggests that two subpopulations of the uninsured have the most promise in further expanding coverage: the Medicaid eligible and the low-income marketplace tax credit eligible. These are the uninsured eligible for the most comprehensive coverage at the lowest direct cost under current law, and those eligible for this level of assistance have relatively high rates of participation in health insurance programs. Together, these subgroups account for 37.5 percent of the remaining uninsured, or approximately 12.4 million people. Focusing on the characteristics of these individuals, we find high rates of school age children in the household, household receipt of other non-health public benefits, firm-based employment, and single parent households. These characteristics suggest promising avenues for targeted outreach and enrollment efforts through public schools, EITC, SNAP, school lunch programs, employers, and those associated with child custody and support systems. Such investments could have substantial payoffs in the reduction of the uninsured under current law.[44]

Under current law, however, expectations of increasing coverage substantially among the other 62.5 percent of the remaining uninsured should be tempered. Although some additional coverage within these groups is likely as the individual mandate penalties increase and information on available coverage alternatives spread further, gains are likely to be quite modest unless further financial assistance is provided.

ENDNOTES

1. Marken, Stephanie. U.S. uninsured rate 11.9% in fourth quarter of 2015. *Gallup.* January 7, 2016. www.gallup.com/poll/188045/uninsured-rate-fourth-quarter-2015.aspx; Karpman M, Long SK. *QuickTake: Taking Stock: Gains in Health Insurance Coverage under the ACA Continue as of September 2015, but Many Remain Uninsured.* Washington: Urban Institute; 2015. http://hrms.urban.org/quicktakes/Gains-in-Health-Insurance-Coverage-under-the-ACA-Continue-as-of-September-2015-but-Many-Remain-Uninsured.html; National Center for Health Statistics. *National Health Interview Survey Early Release Program.* Hyattsville, MD: National Center for Health Statistics; 2016. www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2010_2015_q123.pdf.

2. Garfield R, Damico A, Cox C, Claxton G, and Levitt L. *New Estimates of Eligibility for ACA Coverage among the Uninsured.* Washington: Kaiser Family Foundation; 2016. http://kff.org/health-reform/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/; Shartzer A, Kenney GM, Long SK, Odu Y. *A Look at Remaining Uninsured Adults as of March 2015.* Washington: Urban Institute; 2015. http://hrms.urban.org/briefs/A-Look-at-Remaining-Uninsured-Adults-as-of-March-2015.html.

3. U.S. Bureau of Labor Statistics and U.S. Census Bureau. *Design and Methodology: Current Population Survey.* Technical Paper 66. Washington: U.S. Census Bureau; 2006: 11–5. www.census.gov/prod/2006pubs/tp-66.pdf.

4. The second marketplace open enrollment period began November 15, 2014, and ended February 15, 2015. Therefore, a small percentage of the 2015 CPS-ASEC respondents were likely interviewed in the last two weeks of the open enrollment period, though most interviews happened following the end of it. A special open enrollment period was offered that year between February 15, 2015, and February 22, 2015, for people who started applications in the federal marketplace but experienced technical issues or waited in line at the call center. Most state-based marketplaces offered similar special enrollment periods, with most ending in February (See Office of the Assistant Secretary for Planning and Evaluation. *Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report.* Washington: U.S. Department of Health and Human Services; 2015. https://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf). In addition, the Centers for Medicare and Medicaid Services extended a special open enrollment period for the federally facilitated marketplace from March 15, 2015, to April 30, 2015, to individuals who were subject to the tax penalty for not having coverage in 2014 and who became aware of the tax penalty after the end of the second open enrollment period while preparing their taxes (see Centers for Medicare and Medicaid Services. CMS announces special enrollment period for tax season. Press release. February 20, 2015. www.cms.gov/newsroom/mediareleasedatabase/press-releases/2015-press-releases-items/2015-02-20.html). Eight state-based Marketplaces also extended special enrollment periods to these individuals (see Manatt Health Solutions. *Tax Season Special Enrollment Periods.* Los Angeles: Manatt Health Solutions; 2015).

5. Data from the Urban Institute's Health Reform Monitoring Survey show that between September 2013 and March 2015, the population of uninsured nonelderly adults became more concentrated in states that did not expand Medicaid by March 2015 (see Urban Institute. *QuickTake: Uninsured Nonelderly Adults Were More Concentrated in Medicaid Nonexpansion States and in the South in March 2015 than in September 2015.* Washington: Urban Institute; 2015. http://hrms.urban.org/quicktakes/Uninsured-Nonelderly-Adults-Were-More-Concentrated-in-Medicaid-Nonexpansion-States.html).

6. These estimates are consistent with the Kaiser Family Foundation's analysis of the remaining uninsured, which uses data from the CPS on respondents' coverage over the past year as opposed to the current coverage data used in our analysis. Kaiser Family Foundation found that of the remaining nonelderly uninsured, 27 percent were eligible for Medicaid/CHIP, 12 percent were ineligible for financial assistance because their incomes were too high, and 15 percent were ineligible for financial assistance because of an ESI offer. Twenty-two percent were eligible for tax credits, 15 percent were ineligible for coverage because of immigration status, and 10 percent of the uninsured remained in the assistance gap. See Garfield et al., 2016.

7. Receipt of free and reduced-price school lunch is reported on behalf of children in the household.

8. For two reports on efforts to integrate health and other human service program eligibility determinations and enrollment, see Dorn S. *Integrating Health and Human Services Programs and Reaching Eligible Individuals Under the Affordable Care Act.* Washington: Urban Institute; 2015. http://www.urban.org/research/publication/integrating-health-and-human-services-programs-and-reaching-eligible-individuals-under-affordable-care-act. And see Dorn S, Benatar S. *CHIPRA Express Lane Eligibility Evaluation: Case Study of Louisiana's Express Lane Eligibility.* Washington: Urban Institute; 2014. http://www.urban.org/research/publication/chipra-express-lane-eligibility-evaluation-case-study-louisianas-express-lane-eligibility.

9. Garfield et al., 2016.

10. Can you tell me more about group quarters (GQ) or group housing facilities in the American Community Survey (ACS)? U.S. Census Bureau website. https://ask.census.gov/faq.php?id=5000&faqId=1681. Accessed March 10, 2016.

11. Before March 2014, the CPS only ascertained coverage in the previous calendar year, and these estimates were often closer to point-in-time estimates from other federal surveys than to the full-year coverage estimates from those surveys. In the March 2014 survey, all respondents received the new health insurance coverage question but only about 38 percent of the sample received the redesigned income questions.

12. The direction of any potential bias introduced by underreporting is unclear because individuals could be reporting that they have private insurance or are uninsured, and we do not know the proportions or the characteristics of those most likely to underreport. However, some earlier research suggests that the underreporters most commonly respond to health insurance surveys as if they had employer-based coverage, thereby inflating those estimates. See Call KT, Davidson G, Sommers AS, Feldman R, Farseth P, Rockwood T. Uncovering the missing Medicaid cases and assessing their bias for estimates of the uninsured. *Inquiry*. 2001;38(4): 396–408; Davern M, Klerman JA, Baugh DK, Call KT, Greenberg GD. An examination of the Medicaid undercount in the Current Population Survey: Preliminary results from record linking. *Health Services Research.* 44(3): 965–987.

13. Different household surveys also differ on estimates of the uninsured. For example, according to the 2015 CPS-ASEC, 6.9 percent of children under age 18 were uninsured at the time of the survey. In contrast, National Health Interview Survey data show an uninsurance rate of 4.6 percent in January through March 2015 for this age group (see National Center for Health Statistics. *Comparison of the Prevalence of Uninsured Persons from the National Health Interview Survey and the Current Population Survey, 2014 and 2015.* Hyattsville, MD: National Center for Health Statistics; 2015. www.cdc.gov/nchs/data/nhis/health_insurance/NCHS_CPS_Comparison092015.pdf). Differences can be caused by many variables, such as the structure of health insurance questions or positioning of the questions in the survey.

14. Current Population Survey: Subject definitions. U.S. Census Bureau website. www.census.gov/programs-surveys/cps/technical-documentation/subject-definitions.html. Updated August 25, 2015. Accessed March 10, 2016.

15. We start with a regression model built from wave 2 of the 2008 Survey of Income and Program Participation and calibrate the resulting probabilities to replicate widely accepted estimates of the undocumented population. We replicated the number of undocumented immigrants in 15 states and nationwide estimated by the Pew Hispanic Center (See chapter 1 of Passel JS, Cohn D. *Unauthorized Immigrant Totals Rise in 7 States, Fall in 14: Decline in Those From Mexico Fuels Most State Decreases.* Washington: Pew Research Center; 2014. www.pewhispanic.org/2014/11/18/chapter-1-state-unauthorized-immigrant-populations), which we have always used in our imputations. This source does not provide estimates of other characteristics, so we also replicated the age distribution of undocumented immigrants estimated by the Department of Homeland Security (See Hoefer M, Rytina N, Baker B. Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2011. Washington: Department of Homeland Security, Office of Immigration Statistics; 2012. www.dhs.gov/xlibrary/assets/statistics/publications/ois_ill_pe_2011.pdf) and the share of undocumented immigrants lacking insurance from the Center for Migration Studies (See Estimates of the unauthorized population for states. Center for Migration Studies. http://data.cmsny.org. Accessed March 10, 2016).

16. Medicaid/CHIP Eligibility Limits. Kaiser Family Foundation website. http://kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/. Accessed March 10, 2016.

17. As of March 2015 the states that had expanded Medicaid eligibility under the ACA were Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. Since then, Alaska and Montana have also expanded Medicaid eligibility.

18. Medicaid and CHIP coverage of lawfully residing children and pregnant women. Centers for Medicare and Medicaid Services website. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/lawfully-residing.html. Updated March 24, 2014. Accessed March 10, 2016.

19. "Table: Medical Assistance Programs for Immigrants in Various States." National Immigration Law Center website. https://www.nilc.org/wp-content/uploads/2015/11/med-services-for-imms-in-states-2015-09.pdf. Last updated September 2015. Wyoming denies Medicaid to lawful permanent residents who are not pregnant and who do not have at least 40 quarters of work history in the United States; however, because the CPS-ASEC does not include data on pregnancy or work history, here we treat Medicaid eligibility in Wyoming in the same manner as we do for the bulk of other states. Our analytic file contains only five unweighted observations of immigrants residing in Wyoming, so their treatment will not noticeably affect our estimates.

20. Buettgens M. Medicaid expansion could make health insurance affordable for 5.6 Million. *Urban Wire.* October 2, 2015. www.urban.org/urban-wire/medicaid-expansion-could-make-health-insurance-affordable-56-million.

21. In addition to the previously cited papers on the underreporting of Medicaid, see for example Meyer B, Nikolas M. *Using Linked Survey and Administrative Data to Better Measure Income: Implications for Poverty, Program Effectiveness, and Holes in the Safety Net.* NBER Working Paper 21676. Cambridge, MA: National Bureau of Economic Research; 2015. www.nber.org/papers/w21676.pdf; and Wheaton L. *Underreporting of Means-Tested Transfer Programs in the CPS and SIPP.* Washington: Urban Institute; 2008. www.urban.org/research/publication/underreporting-means-tested-transfer-programs-cps-and-sipp/view/full_report.

22. In 2015, the annual income for a single adult at 200 percent of FPL was $23,540. The annual income for a family of four at 200 percent of FPL was $48,500.

23. Blavin F, Kenney GM, Huntress M. The Effects of Express Lane Eligibility on Medicaid and CHIP Enrollment among Children. *Health Services Research.* 2014;49(4): 1268–1289. www.urban.org/research/publication/effects-express-lane-eligibility-medicaid-and-chip-enrollment-among-children-0.

24. This estimate is quite close to the previous estimate of 68 percent of uninsured children eligible for Medicaid or CHIP found by Kenney GM, Haley JM, Anderson N, Lynch V. Children eligible for Medicaid or CHIP: Who remains uninsured, and why?" *Academic Pediatrics.* 2015;15(3S): S36–S43.

25. Buettgens M, Kenney GM, Pan C. *Variation in Marketplace Enrollment Rates in 2015 by State and Income.* Washington: Urban Institute; 2015. www.urban.org/research/publication/variation-marketplace-enrollment-rates-2015-state-and-income.

26. McMorrow S. Kenney GM, Coyer C. *Addressing Barriers to Health Insurance Coverage Among Children: New Estimates for the Nation, California, New York, and Texas.* Washington: Urban Institute; 2012. www.urban.org/research/publication/addressing-barriers-health-insurance-coverage-among-children-new-estimates; and McMorrow S, Kenney GM, Coyer C. *Addressing Coverage Challenges for Children Under the Affordable Care Act.* Washington: Urban Institute; 2011. http://www.urban.org/research/publication/addressing-coverage-challenges-children-under-affordable-care-act. Smaller subgroups of uninsured individuals in our measure of mixed eligibility families include uninsured children with tax-credit eligible incomes who had nongroup coverage in the past year while a parent had ESI in the past year, and undocumented children with an undocumented parent and a Medicaid/CHIP eligible child in the family.

27. Most individuals with Medicaid do not have premiums and for those that do, premiums are low. However, some states have begun experimenting with higher premiums for adults who are newly eligible for Medicaid under the ACA. For instance, as part of its Medicaid expansion, the state of Indiana received a waiver to charge newly eligible beneficiaries with incomes between 101 and 138 percent of income a premium of up to two percent of income. See The Kaiser Commission on Medicaid and the Uninsured. "Medicaid Expansion in Indiana." Washington DC: The Kaiser Family Foundation. February 2015. http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/.

28. Buettgens et al., 2015.

29. Pearson CF. *Exchanges Struggle to Enroll Consumers as Income Increases.* Washington, DC: Avalere Health; 2015. http://avalere.com/expertise/managed-care/insights/exchanges-struggle-to-enroll-consumers-as-income-increases.

30. Karpman M, Gates J, Kenney GM. *QuickTake: Further Reducing Uninsurance Among Parents Will Require Tackling Affordability Concerns.* Washington: Urban Institute; 2016. http://hrms.urban.org/quicktakes/Further-Reducing-Uninsurance-among-Parents-Will-Require-Tackling-Affordability-Concerns.html.

31. Shartzer et al., 2015.

32. Shalala DE, Riley RW. Letter to state officials: School-based CHIP and Medicaid Outreach Strategies. October 18, 1999. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/sho101899.pdf; Medicaid enrollment—Albuquerque public schools. Albuquerque Public Schools website. http://www.aps.edu/student-family-and-community-supports/accountability-medicaid-operations/medicaid-enrollment. Accessed March 10, 2016; Hagan L. School-based outreach for health coverage: Which policies make it successful? *Enroll America* blog. January 28, 2014. https://www.enrollamerica.org/blog/2014/01/school-based-outreach-for-health-coverage-which-policies-make-it-successful/. Accessed March 10, 2016; InsureKidsNow.gov. Connecting kids to coverage national campaign: Campaign notes eNewsletter–July 23, 2015. http://www.insurekidsnow.gov/downloads/2015-07-23-campaignnotesenewsletter.pdf. Accessed March 10, 2016.

33. Dorn, 2015; Dorn and Benatar 2014; and Kaiser Commission on Medicaid and the Uninsured. *Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion.* Washington: Kaiser Family Foundation; 2013. https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8517-fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion1.pdf.

34. Buettgens, 2015.

35. Blumberg LJ, Holahan J. *After King v. Burwell: Next Steps for the Affordable Care Act.* Washington: Urban Institute; 2015. www.urban.org/research/publication/after-king-v-burwell-next-steps-affordable-care-act.

36. Jost TS, Pollack H. *Key Proposals to Strengthen the Affordable Care Act.* Washington: The Century Foundation; 2015. http://apps.tcf.org/key-proposals-to-strengthen-the-aca.

37. Galewitz P. Obama seeks to offer new incentive for states to expand Medicaid. *Kaiser Health News.* January 14, 2016. http://khn.org/news/obama-seeks-to-offer-new-incentive-for-states-to-expand-medicaid/.

38. Blumberg LJ, Holahan J, Buettgens M. *How Much Do Marketplace and Other Nongroup Enrollees Spend on Health Care Relative to Their Incomes?* Washington: Urban Institute; 2015. http://www.urban.org/research/publication/how-much-do-marketplace-and-other-nongroup-enrollees-spend-health-care-relative-their-incomes; Blumberg and Holahan, 2015.

39. Buettgens et al., 2015.

40. For one possible approach to expanding marketplace financial assistance, see Blumberg and Holahan, 2015.

41. Cowley S. Many low-income workers say 'no' to health insurance." *New York Times.* October 19, 2015. http://www.nytimes.com/2015/10/20/business/many-low-income-workers-say-no-to-health-insurance.html.

42. Collins SR, Rasmussen PW, Doty MM, Beutel S. Too High a Price: Out-of-Pocket Health Care Costs in the United States. New York: Commonwealth Fund; 2014. http://www.commonwealthfund.org/~/media/files/publications/issuebrief/2014/nov/1784_collins_too_high_a_price_out_of_pocket_tb_v2.pdf; Potheir M. Out-of-pocket costs put health care out of reach. *Boston Globe*. June 25, 2015. www.bostonglobe.com/opinion/2015/06/25/out-pocket-costs-put-health-care-out-reach/KnOembdhz8vCghJY6BPHXJ/story.html; Leonard K. Employees paying more for premiums, deductibles. *U.S. News & World Report*. January 8, 2015. http://www.usnews.com/news/blogs/data-mine/2015/01/08/employees-paying-more-for-premiums-deductibles.

43. Karpman M, Long SK. *QuickTake: HRMS Benchmarks Well against Gallup-Healthways and NHIS on Changes in Health Insurance Coverage between 2013 and 2015.* Washington: Urban Institute; 2015. http://hrms.urban.org/quicktakes/HRMS-Benchmarks-Well-against-Gallup-Healthways-and-NHIS-on-Changes-in-Health-Insurance-Coverage-between-2013-and-2015.html.

44. In addition, Massachusetts and Vermont provide additional state-funded financial assistance to reduce financial burdens and increase enrollment in marketplace coverage. Two other states, New York and Minnesota, are implementing basic health program options under the ACA, providing coverage at lower costs to those eligible for marketplace tax credits with income at or below 200 percent of FPL.

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