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# Sustained Gains In Coverage, Access, And Affordability Under The ACA: A 2017 Update

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**ABSTRACT** The significant gains in health insurance coverage and improvements in health care access and affordability that followed the implementation of the key coverage provisions of the Affordable Care Act in 2014 have persisted into 2017. Adults in all parts of the country, of all ages, and across all income groups have benefited from a large and sustained increase in the percentage of the US population that has health insurance. The gains have been particularly striking among low- and moderate-income Americans living in states that expanded Medicaid. Our latest survey data from the Urban Institute's 2017 Health Reform Monitoring Survey shows that only 10.2 percent of nonelderly adults are now uninsured—a decline of almost 41 percent from the period before implementation of the ACA. Nonetheless, repealing and replacing the ACA remained under consideration during the summer of 2017, along with more systematic changes to the financing of the Medicaid program. Many people will be at substantial risk if key components of the law are repealed or otherwise changed without carefully considering the health and financial consequences for those projected to lose coverage. Though the politics of health reform are challenging, opportunities exist to create a more equitable and efficient health care system.

Although the Affordable Care Act (ACA) has its problems,<sup>1,2</sup> there was a sustained decline in uninsurance following the 2014 implementation of its key coverage provisions, benefiting adults across the country.<sup>3–10</sup> These declines have been accompanied by improvements in access to and affordability of health care.<sup>5,6,8,11</sup> Efforts to repeal and replace the ACA, which remained under consideration during the summer of 2017, could roll back these gains. While the details of the different repeal-and-replace proposals vary,<sup>12</sup> many would eliminate the ACA's Medicaid expansion and make significant changes to the Marketplace and to insurance regulations that would likely disadvantage older adults and adults with preexisting health conditions.<sup>13–15</sup> Under many of the repeal-

and-replace scenarios, which often include fundamental changes to the financing of the Medicaid program, millions of Americans would be at risk of losing their health insurance coverage, wiping out the coverage gains made since the ACA was enacted.<sup>14–16</sup> But even if the ACA remains in place, the coverage gains for many low- and moderate-income adults are at risk if the administration pursues strategies that undermine the ACA's Marketplace, such as refusing to pay for cost-sharing reductions for low-income adults, failing to enforce the individual mandate, and eliminating support for outreach efforts.

These potential coverage losses are important, especially when viewed in the broader context of the changes in health care access and affordability that have taken place under the ACA. As shown in this analysis, which uses data from

the Urban Institute's Health Reform Monitoring Survey (HRMS) through the first quarter of 2017, many adults face substantial risks if key components of the law are repealed or otherwise changed without careful consideration of the health and financial consequences for those losing coverage.

## Study Data And Methods

The Health Reform Monitoring Survey has been used to track the ACA since 2013. It is one of several national surveys, including those conducted by federal agencies and other private research organizations,<sup>17</sup> that have found a significant decline in the share of nonelderly adults without health insurance since the implementation of the ACA's key coverage provisions. These surveys include the American Community Survey,<sup>3,4</sup> National Health Interview Survey,<sup>5-7</sup> and Gallup-Sharecare (formerly Healthways).<sup>8-10</sup> While surveys like the Health Reform Monitoring Survey and Gallup-Sharecare have much lower response rates than federal surveys (roughly 5 percent for the HRMS and 7 percent for Gallup-Sharecare<sup>18</sup> versus 67–96 percent for the federal surveys),<sup>19,20</sup> both surveys have tracked well with the federal surveys while providing timely information on the ACA with a rapid turnaround.<sup>21,22</sup> Additional information on the HRMS is in the online Appendix.<sup>23</sup>

In this article we used data from the Health Reform Monitoring Survey to examine changes in uninsurance at the time of the survey,<sup>24</sup> changes in access to health care (measured by the share of adults without a usual source of care and the share without a routine checkup in the past twelve months), and changes in health care affordability (measured by the share with unmet need for medical care<sup>25</sup> because of affordability problems in the past twelve months and the share with problems paying family medical bills in the past twelve months) for adults ages 18–64 overall and by family income, age, and state Medicaid expansion status.<sup>26</sup> We focused on regression-adjusted<sup>27</sup> changes since the third quarter of 2013, which was just before the ACA's major coverage provisions were implemented, that were significantly different from zero at the 5 percent level. As described in the Appendix,<sup>23</sup> the regression model controlled for the characteristics of the survey respondents and their families, as well as the county employment rate, which provided a control for changing economic circumstances over time.

In presenting the regression-adjusted estimates, we used the predicted rate for the outcome in each round of the HRMS for the same nationally representative population. For this

analysis, we based the nationally representative sample on survey respondents for quarter 3 2015 through quarter 1 2017. The size of our analytic sample was 98,855 adults for the study period.

This analysis had several limitations. Though the HRMS estimates capture changes in outcomes from the first ACA open enrollment period, the estimates cannot capture the full effects of the ACA because they do not reflect the effects of some important ACA provisions implemented before 2013 (for example, early state Medicaid expansions in six states and the ability to keep dependents on a parent's health plan until age twenty-six). In addition, these estimates reflect more than the effects of the ACA because, although we included the county employment rate in the regression model, we could not control for long-term trends in health insurance coverage that predate the ACA, changes in the business cycle, and other factors. However, as shown in Appendix Exhibit A1,<sup>23</sup> the drop in uninsurance following the ACA's coverage expansions in 2014 happened more quickly than the drop in the unemployment rate as the economy improved following the Great Recession. Finally, the difference in coverage gains between Medicaid expansion states and nonexpansion states should not be entirely attributed to the Medicaid expansion because other factors, including differences in other ACA policy choices, likely affected coverage as well.

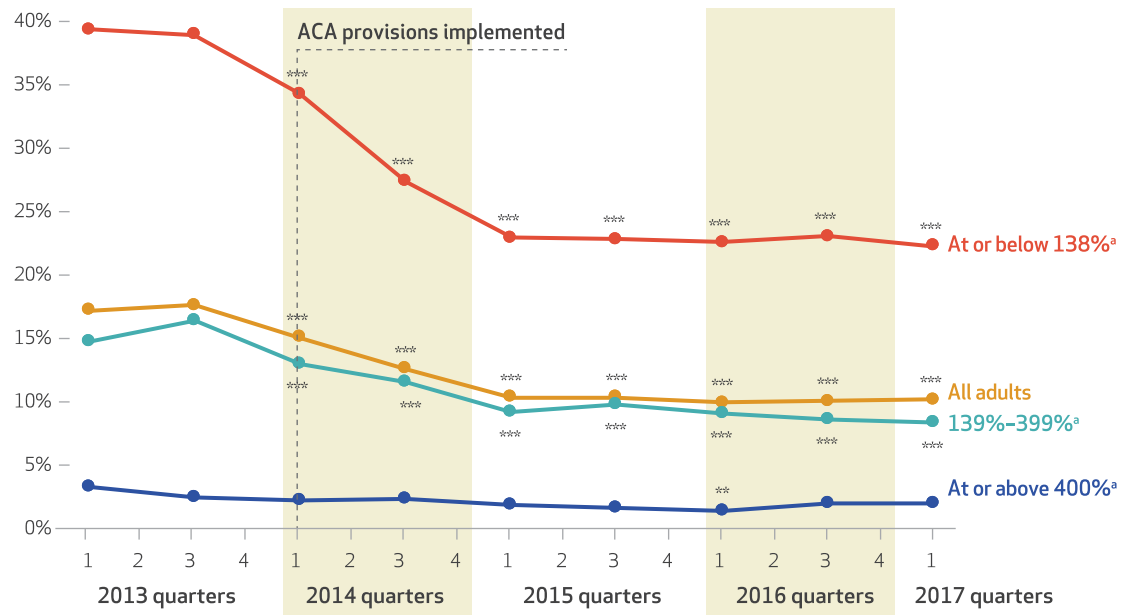
## Study Results

**TRENDS IN UNINSURANCE** Three years after the implementation of the ACA's major insurance coverage provisions in 2014, we found a large and sustained reduction in the level of uninsurance among nonelderly adults, particularly for low- and moderate-income adults (Exhibit 1). Uninsurance dropped steadily in the year following the rollout of the ACA's major coverage provisions, declining from 17.6 percent for adults in quarter 3 2013, just before the major coverage provisions were implemented, to 10.4 percent in quarter 1 2015—a decline of 40.9 percent. Since that time, uninsurance has remained low: In quarter 1 2017, uninsurance was at 10.2 percent.<sup>28</sup>

Adults with low and moderate incomes—the target population for the ACA's Medicaid expansions and Marketplace subsidies—saw the largest reductions in uninsurance under the ACA, while uninsurance among higher-income adults has remained quite low since 2013, at roughly 2 percent. Between quarter 3 2013 and quarter 1 2017, uninsurance among adults with family incomes at or below 138 percent of the federal poverty level decreased by 42.7 percent (from

## EXHIBIT 1

## Trends in uninsurance among adults ages 18–64, overall and by family income, 2013–17



**SOURCE** Authors' analysis of data from the Health Reform Monitoring Survey, quarter 1 2013 through quarter 1 2017. **NOTES** Estimates are regression adjusted. Family is the health insurance unit. Significance denotes estimates that differ from the estimate for quarter 3 2013, using two-tailed tests. <sup>a</sup>Percentage of the federal poverty level. \* $p < 0.10$  \*\* $p < 0.05$  \*\*\* $p < 0.01$

38.9 percent to 22.3 percent), while uninsurance among adults with incomes of 139–399 percent of poverty decreased by 49.4 percent (from 16.4 percent to 8.3 percent). As shown in Appendix Exhibit A2,<sup>23</sup> nearly all of the reduction in uninsurance for low-income adults was due to gains in Medicaid coverage, while the reduction in uninsurance for moderate-income adults was due to roughly equal gains in Medicaid and nongroup coverage.

Uninsurance also dropped under the ACA for adults in all age groups, with the largest percentage reductions among younger adults ages 18–34 (down by 43.2 percent since quarter 3 2013) and older adults ages 50–64 (down by 50.8 percent) (Exhibit 2).<sup>29</sup> For adults at all ages, increased Medicaid coverage was the driving source of much of the reduction in uninsurance (Appendix Exhibit A3).<sup>23</sup> The increase in coverage among younger adults represents an influx of largely healthy people into the overall health insurance risk pool, while the older adults who gained coverage are more likely to have benefited from less expensive nongroup coverage under the ACA, with its limited age rating and preexisting condition exclusions, along with access to Medicaid.

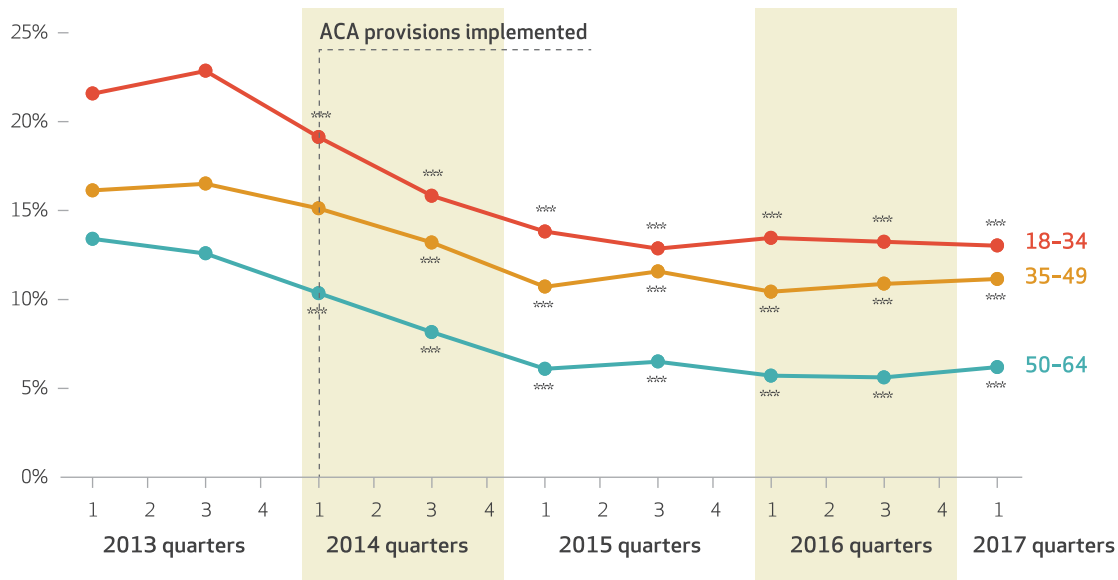
Not surprisingly, given the important role that Medicaid played in reducing uninsurance, the decline in uninsurance under the ACA was strongest among adults in the states that implemented

the ACA's Medicaid expansion, where uninsurance declined by 56.7 percent between quarter 3 2013 and quarter 1 2017, from 15.7 percent to 6.8 percent (Appendix Exhibit A4).<sup>23</sup> In states that did not expand Medicaid, where uninsurance rates started out much higher, uninsurance dropped by 25.0 percent between quarter 3 2013 and quarter 1 2017, from 20.4 percent to 15.3 percent.<sup>30</sup> As would be expected, larger gains in Medicaid coverage in the Medicaid expansion states explain much of the difference in the reduction in uninsurance between expansion and nonexpansion states, although nonexpansion states did have greater gains in nongroup coverage (Appendix Exhibit A5).<sup>23</sup> This likely reflects, at least in part, the availability of nongroup coverage to adults with incomes of 100–138 percent of poverty in nonexpansion states.

**HEALTH CARE ACCESS AND AFFORDABILITY** As uninsurance declined under the ACA, health care access and affordability improved (Exhibit 3). By quarter 1 2017, the share of adults without a usual source of care decreased to 24.7 percent, and the share without a routine checkup in the past twelve months decreased to 34.6 percent. Fewer adults reported unmet need for medical care because of affordability problems, which decreased to 23.3 percent, while the share reporting problems paying family medical bills decreased to 17.9 percent.

**EXHIBIT 2**

**Trends in uninsurance among adults ages 18–64, by age group, 2013–17**



**SOURCE** Authors’ analysis of data from the Health Reform Monitoring Survey, quarter 1 2013 through quarter 1 2017. **NOTES** Estimates are regression adjusted. Significance denotes estimates that differ from the estimate for quarter 3 2013, using two-tailed tests. \* $p < 0.10$  \*\* $p < 0.05$  \*\*\* $p < 0.01$

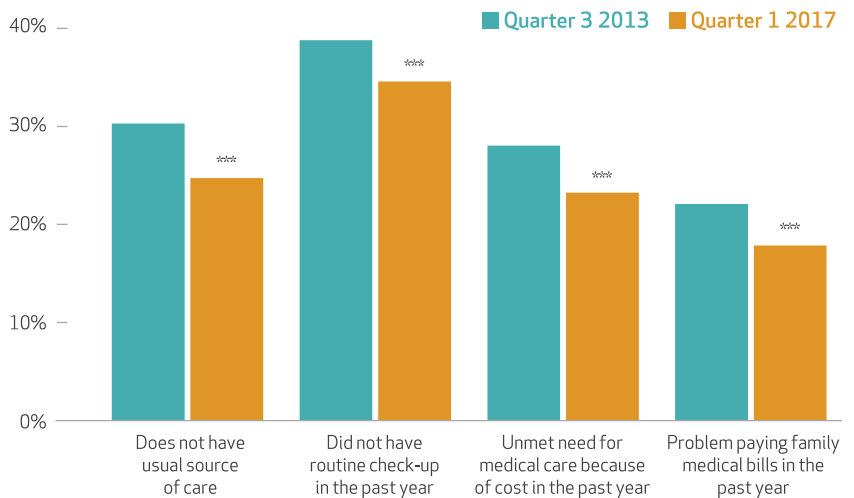
Consistent with the large gains in insurance coverage for low- and moderate-income adults, we also found significant improvement in health care access and affordability for those adults between quarter 3 2013 and quarter 1 2017 (Appendix Exhibit A6).<sup>23</sup> As with the overall population, low- and moderate-income adults saw significant declines in the shares with problems accessing care and with health care affordability. As would be expected, given their larger gains in insurance coverage, the improvements in access and affordability were generally larger for low-income adults than moderate-income adults. There were also some gains in access to care for high-income adults, for whom health insurance coverage has remained fairly stable over time. These gains likely reflect elements of the ACA beyond expanded eligibility for coverage (for example, the establishment of essential benefits and expanded access to preventive care).

**PERSISTENT GAPS** Despite the gains under the ACA among low-income adults, gaps in the levels of health insurance coverage and health care access and affordability between low-income adults in Medicaid expansion and nonexpansion states persisted in quarter 1 2017 (Exhibit 4). These low-income adults are the population targeted for the Medicaid expansion, but many were trapped in a “coverage gap” in the nineteen states that did not expand Medicaid.<sup>31</sup> In quarter 1 2017, the uninsurance rate for this group was

almost 2.5 times higher in nonexpansion states than in expansion states (33.2 percent versus 13.9 percent). Affordability problems were also more pronounced in nonexpansion states, with low-income adults in those states more likely to

**EXHIBIT 3**

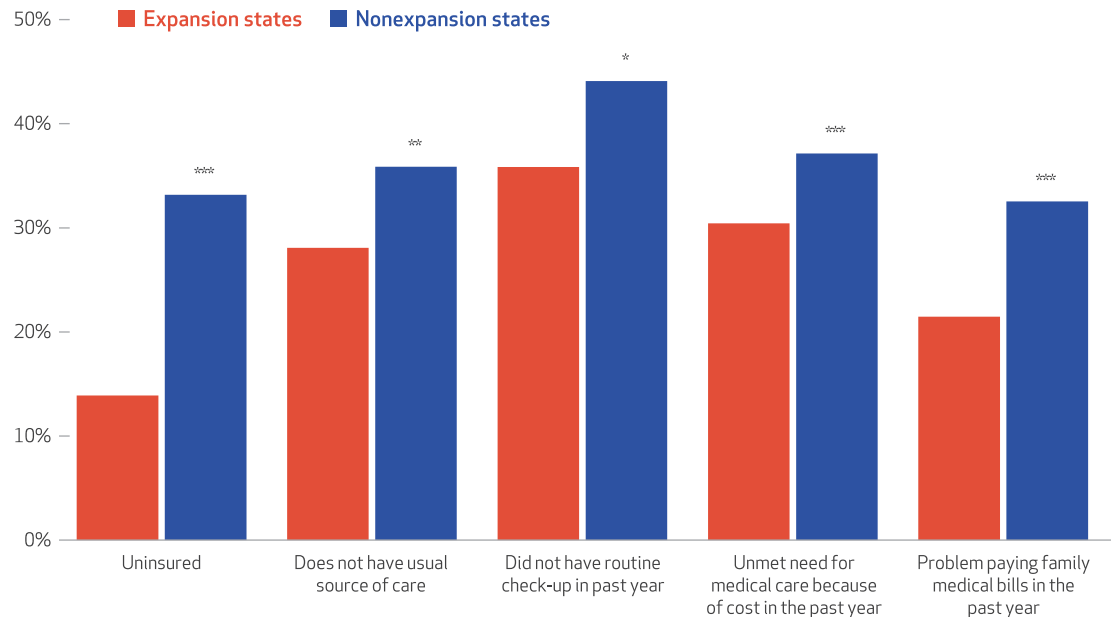
**Changes in health care access and affordability among adults ages 18–64, quarter 3 2013 and quarter 1 2017**



**SOURCE** Authors’ analysis of data from the Health Reform Monitoring Survey, quarter 1 2013 through quarter 1 2017. **NOTES** Estimates are regression adjusted. Significance denotes estimates that differ from the estimate for quarter 3 2013, using two-tailed tests. \* $p < 0.10$  \*\* $p < 0.05$  \*\*\* $p < 0.01$

## EXHIBIT 4

Insurance coverage and health care access and affordability among adults ages 18–64 with family income at or below 138 percent of poverty, by Medicaid expansion status as of quarter 1 2017



**SOURCE** Authors' analysis of data from the Health Reform Monitoring Survey, quarter 1 2013 through quarter 1 2017. **NOTES** Estimates are regression adjusted. Family is the health insurance unit. Expansion states are those that expanded Medicaid by March 2016. Significance denotes estimates that differ from the estimate for expansion states, using two-tailed tests. \* $p < 0.10$  \*\* $p < 0.05$  \*\*\* $p < 0.01$

report unmet need for medical care because they could not afford it (37.1 percent versus 30.4 percent in expansion states) and more likely to report problems paying family medical bills (32.5 percent versus 21.5 percent).

**THE REMAINING UNINSURED** Many of the adults who remained uninsured in quarter 1 2017 were potentially eligible for financial assistance for insurance coverage through the ACA, and most lived in states that did not expand Medicaid (Exhibit 5). Nearly all (92.5 percent) of the remaining uninsured had family incomes below 400 percent of poverty. Even though this population was targeted for financial assistance under the ACA through either the Medicaid expansion or the Marketplace subsidies, nearly two-thirds of the uninsured adults cited cost as their reason for being uninsured in quarter 1 2017. As shown in Appendix Exhibit A7,<sup>23</sup> the cost of coverage was cited more often as the reason for being uninsured among uninsured adults in states that did not expand Medicaid (69.1 percent) than in Medicaid expansion states (58.7 percent). Only 12.0 percent of the uninsured reported that they were uninsured because they did not want coverage (Exhibit 5). Even among younger adults, who make up 46.2 percent of the remaining uninsured, only 13.1 percent were uninsured because they did not want coverage (Appendix

Exhibit A7).<sup>23</sup>

Although only nineteen states have not expanded Medicaid, 60.4 percent of the remaining uninsured adults live in those states. Among these adults, 65.6 percent have incomes at or below 138 percent of poverty and are potentially eligible for coverage if their state expands Medicaid. Thus, despite opportunities to further reduce uninsurance in the states that expanded Medicaid, the potential is much greater in the states that did not. In scoring proposals to repeal and replace the ACA, the Congressional Budget Office (CBO) baseline assumes that several more states would expand Medicaid to take advantage of enhanced federal matching funds.<sup>14–16</sup> However, to do so, those states would need to have confidence in the continuation of federal support for traditional Medicaid and the ACA expansion.

## Discussion

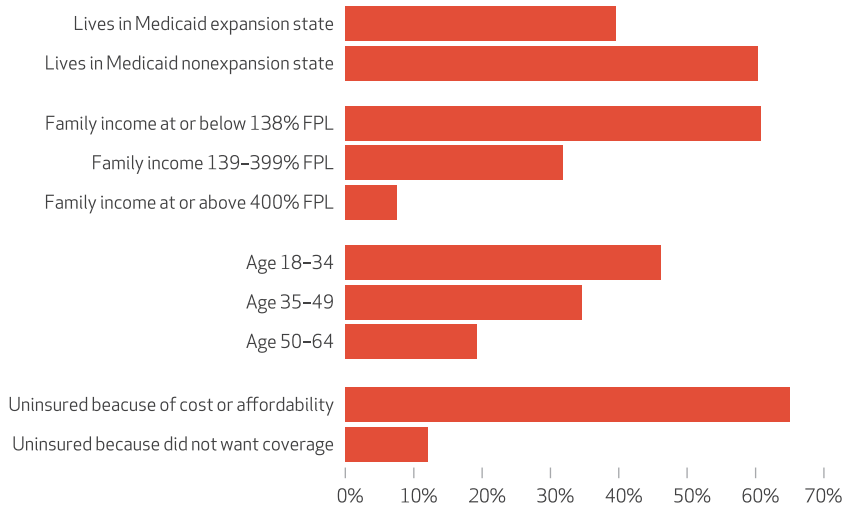
These findings highlight the sustained progress that has been achieved under the ACA in reducing uninsurance and improving health care access and affordability for adults, particularly for those with low and moderate incomes and in states that implemented the ACA's Medicaid expansion. The findings also highlight what is at

stake if key elements of the ACA are repealed without replacing those provisions with policies that would preserve the ACA's coverage gains or if the administration withdraws federal support for the Marketplace by not enforcing the individual mandate or refusing to pay for cost-sharing reductions for low-income adults. Under the alternative scenarios for repealing and replacing the ACA that have been considered, and as a result of actions that undermine the Marketplace in the absence of repeal and replace, low- and moderate-income adults are the most likely to lose their health insurance coverage and experience diminished access to health care.<sup>14-16,32-34</sup> They are also the most likely to face increased financial burdens when they do need health care and, thus, the most likely to go without needed care.

Scaling back the coverage options under the ACA would have serious health and financial consequences for some of the most vulnerable Americans, including older adults and adults with preexisting health conditions.<sup>13-15</sup> Though the politics of health reform are challenging, there are opportunities to create a more equitable and efficient health care system by recognizing the ACA's achievements while addressing its problems. These problems include the inadequacy of financial assistance, the need for greater consumer education about the program, the high level of premiums before subsidies, and insurers' reluctance to participate in sufficient

## EXHIBIT 5

### Characteristics of adults ages 18-64 who remained uninsured in quarter 1 2017



**SOURCE** Authors' analysis of data from the Health Reform Monitoring Survey, quarter 1 2017. **NOTES** Family is the health insurance unit. Expansion states are those that expanded Medicaid by March 2016. Since respondents could report multiple reasons for being uninsured, we relied on a hierarchy in reporting reasons, where costs and affordability issues were first and not wanting coverage was second. FPL is federal poverty level.

numbers in some areas.<sup>1</sup> Policy makers will need to decide whether they want to build on the gains documented in this study or put these gains at risk. ■

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## NOTES

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  - 25 Medical care includes general doctor care, specialist care, medical tests, follow-up care, mental health care, and prescription drugs.
  - 26 For this analysis, Medicaid expansion states are those that expanded by March 2016: AK, AZ, AR, CA, CO, CT, DE, DC, HI, IL, IN, IA, KY, MD, MA, MI, MN, MT, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV. Because our definition of expansion states has changed as more states adopted the expansion, HRMS estimates based on Medicaid expansion status are not necessarily comparable over time.
  - 27 The regression models controlled for differences in the demographic, socioeconomic, and geographic characteristics of respondents and their families across the different rounds of the survey, as well as changes in the county employment rate. This removes changes in our outcomes caused by changes in types of respondents over time rather than by changes in the health care landscape.
  - 28 While the size of the estimated change in uninsurance and the time path of the decline vary across surveys, similar downward trajectories are reported in research based on both federal and nonfederal surveys. See Notes 3–10.
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