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Health Care Cost Trends

“Uninsured Rate” Measurements and Health Policy Considerations

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"Uninsured Rate" Measurements and Health Policy Considerations

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CONTENTS

"Uninsured Rate" Measurements and Health Policy Considerations

Executive Summary

The Patient Protection and Affordable Care Act (ACA) was signed into law March 23, 2010. The transformative health care legislation was multi-faceted, but its primary purpose was to reduce the number of uninsured Americans. Like other federal and state policies proposed in the 21st Century, the ACA's primary devices include government funding, prescriptive rating rules, and insurance mechanisms (e.g. risk adjustment) to mitigate risk and encourage insurer participation. While numerous challenges have been recognized in the law's first decade, the ACA has resulted in more people being enrolled in newly expanded Medicaid markets. The private individual market also has somewhat higher enrollment, but significantly less than original expectations; recent changes in labor economics, market mechanics, and the regulatory environment signal potential renewed growth in this market which may impact health insurance enrollment results.

The individual market has remained at the center of regulatory activity and in the foreground of public discussion due to market challenges and changes in political leadership. Market observers are quick to report on its statistical results and connect outcomes to the success or failure of specific policies and/or administrative program management. Success measurement can take many forms,[1] but the "uninsured rate" is the most common metric cited to measure overall ACA performance; while lacking a reliable population standard and measurement technique, the "uninsured rate" refers to the percentage of Americans who do not have health insurance.

The suboptimal precision of the "uninsured rate" determination stems from various established organizations and survey respondents having different standards of what specifically qualifies as "health insurance coverage". The recent expansion of short-term limited duration plans (generally with more limited benefits) and reductions in enrollment of ACA-compliant coverage is a notable example of potential differentiation in uninsured rate trends. The Census Bureau reports that many individuals have difficultly reporting whether their coverage is "direct purchase" or procured through their employer; distinguishing between qualifying and unqualified types of individual coverage is certainly a more significant and error-prone challenge.[2] Also, time horizon is a distinguishing consideration; a periodic gap between losing group coverage and procuring individual coverage may or may not be reasonably construed as counting toward a population measure of uninsured status. Additionally, changes in the measured uninsured rate may not align with changes in personal risk exposure as some individuals may have access to coverage when needed but are currently uninsured; for example, Medicaid benefits are often retroactively accessible.

[1] Fann, Greg. July 2019. Annual Ranking of The ACA's First Decade. *In the Public Interest*. Annual Ranking Of The ACA's First Decade (soa.org)
[2] State Health Access Data Assistance Center. October 22, 2020. September 23rd Webinar - An Annual Conversation with the U.S. Census Bureau: 2019 Health Insurance Coverage Data from the American Community Survey (ACS) & Current Population Survey (CPS). September 23rd Webinar - An Annual Conversation with the U.S. Census Bureau: 2019 Health Insurance Coverage Data from the American Community Survey (ACS) & Current Population Survey (CPS) | SHADAC

While different measurement techniques are applied, directional changes in uninsured rate calculations are often used as a primary source to gauge the impact of ACA policy, the administrative management of the program, and the impact of subsequent regulations. Consequently, appropriate comprehension of the uninsured rate is an important measure as it shapes the direction of future policy.

Various public and private sources attempt to assess the uninsured rate, usually on an annual reporting cycle. Results between publications vary, but there is consensus agreement that the uninsured rate significantly declined during the ACA implementation and transition period (2014-2016) but has slowly and modestly increased since 2016. It is generally acknowledged that the economic downturn and reductions in employer-sponsored insurance coverage associated with the COVID-19 pandemic have accelerated the increase in the uninsured rate, albeit not as significant as originally anticipated. As reporting is lagged, the precise impact of COVID-19 is not known, but it is evident that enrollment in Medicaid programs has increased while coverage in employer-sponsored insurance has declined. The pandemic has also necessitated logistical changes in survey collection methods, resulting in reduced response rates and potential declines in measurement accuracy.

Looking ahead, 2021 premium subsidy enhancements in the individual market- often the "insurer of last resort"- are expected to commence a return to a declining uninsured rate environment. Transparent parameter changes in the American Rescue Plan Act (APRA)[3] have been widely acknowledged in the public sphere and complement the less-understood and still-developing[4] favorable mechanical market changes[5] which have increased subsidy-determining benchmark plan premiums relative to other benefit plans that consumers purchase in the marketplace. The impact of enhanced subsidies on federal spending and the uninsured rate will be of significant interest to stakeholders in assessing policy impact and will likely serve as a basis for the efficacy of the current framework versus long-promoted public considerations and other private market configurations. Accuracy of reporting estimates and appropriate understanding of results are critical requirements.

In alignment with the SOA's Strategic Plan objective to "inform the public's understanding of key societal issues", this report examines the various publications reporting on the uninsured rate which stakeholders frequently access to measure policy efficacy and inform future policy considerations. A key aim of this research is to highlight the diverse sources and methods used in various reports and guide stakeholders to properly interpret reported results. This research also explores regulatory and market dynamics in recent years and a focus expansion from measurements of the uninsured rate to the rationale of Americans remaining uninsured and likely pathways to broader insurance coverage.

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[3] McDermott, Daniel, Cox, Cynthia, and Amin, Krukita. March 15, 2021. Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums. *KFF Health Reform*. Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums | KFF

[4] Dorn, Stan, Fann, Greg, and Markus, Hannah. April 12, 2021. Misalignment Between Premiums and Coverage Generosity Imposes Heavy Cost Burdens on Consumers in Health Insurance Exchanges. *Axene Health Partners, LLC and Families USA*. Misalignment Between Premiums and Coverage Generosity Imposes Heavy Cost Burdens on Consumers in Health Insurance Exchanges – Axene Health Partners, LLC (axenehp.com) Misalignment between Premiums and Coverage Generosity Imposes Heavy Cost Burdens on Consumers in Health Insurance Exchanges - Families Usa

[5] Fann, Greg. October 21, 2020. Cheaper by the Dozen: 12 Years of the Affordable Care Act. *LinkedIn Pulse*. (1) Cheaper by the Dozen: 12 Years of the Affordable Care Act | LinkedIn

Section 1: Uninsured Rate Reporting

Throughout each year, various published reports are released which contain estimates of the number of people without health insurance. News articles usually follow and often contain the high-level results of the published reports and a comparison to prior year results; such articles often mention the reported statistics in relation to other recent reports. The summarized stories rarely include the methodology and caveats embedded in the research reports. This can lead to an incomplete understanding of results.

As an understanding of health insurance coverage trends is paramount to policy considerations, an appropriate understanding of the uninsured rate is obligatory. Improper comprehension of the uninsured rate is a real danger which may misinform stakeholders of the implications of current policy and potentially lead to the development of misguided policy. Misinterpretation of results may be due to confirmation bias and selective reporting, recency bias,[6] or time constraints prohibiting a complete review of reporting of the uninsured rate. This section describes the various uninsured reports which may influence health policy considerations.

1.1 CURRENT POPULATION SURVEY ANNUAL SOCIAL AND ECONOMIC SUPPLEMENT (CPS ASEC)

The CPS ASEC is an annual survey report that the U.S. Census Bureau has produced since 1987. It is one of the most widely used sources of U.S. health coverage statistics. The survey questions are rich in detail and cover social and economic characteristics of each person. Detailed income data is collected, enabling the relation of economic status to changes in health insurance coverage.

The CPC ASEC is conducted in February through April each year, with questions asked about health coverage at any time during the previous calendar year. Effectively, a respondent insured for only a few days during the year would be counted as "covered" and not uninsured. Beginning in 2013, the CPS ASEC also asks about coverage at the time of interview.

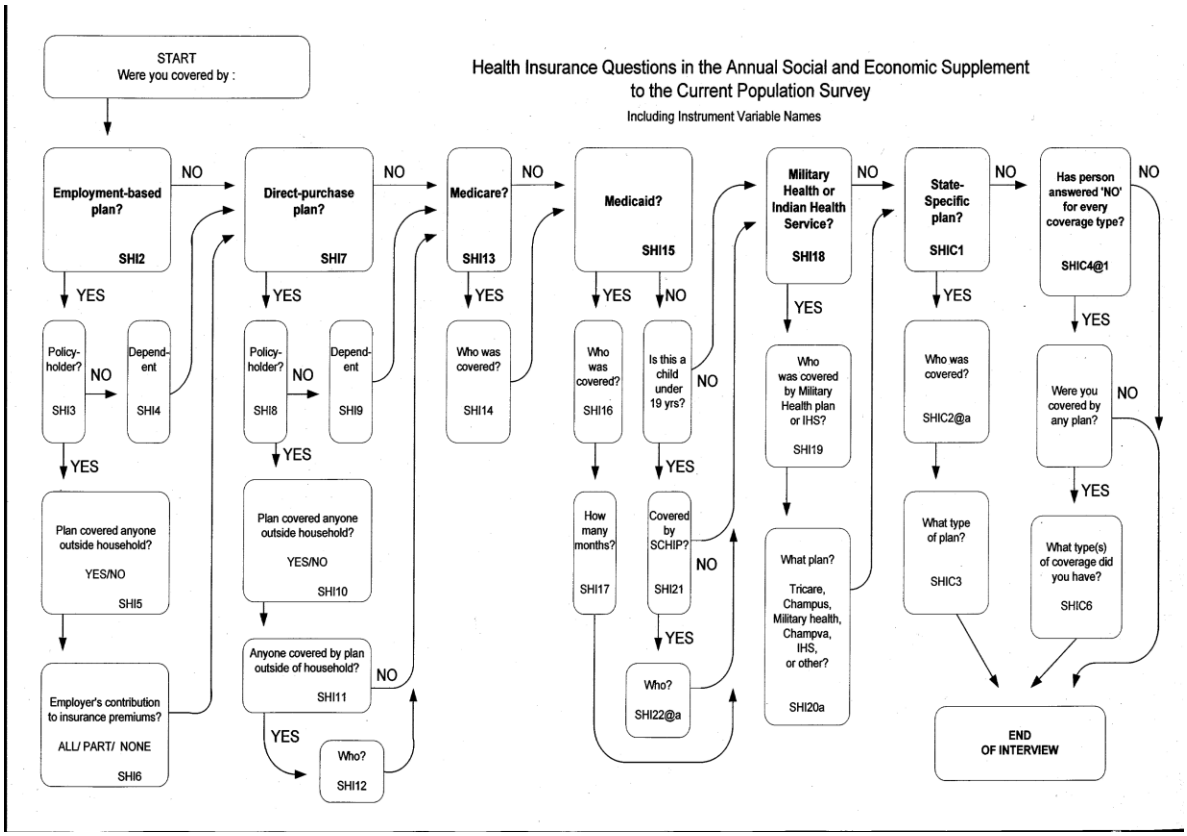
Due to its relatively small sample size of about 60,000, the CPS ASEC is better suited for national measurements rather than analysis of selected local markets or comparisons between states. The CPS ASEC has undergone methodology changes which complicate the analysis of longitudinal studies. In 2014, the questionnaire was redesigned to improve measurements; it 2019, the processing system and underlying algorithms were updated.

Due to the COVID-19 pandemic, data collection methods for the 2019 CPS were modified.[7] For safety reasons, in-person interviews were suspended and shifted to telephone interviews. The response rate declined about 10 percentage points in March and respondents were skewed toward being older, having a higher education level, and more likely to have a disability. Based on limited response mechanisms, respondents are also believed to have higher incomes. Technical adjustments were applied, but the 2019 report (published September 2020) should be utilized with greater caution given the unique circumstances, and data users should bear in mind the context of the pandemic when interpreting these changes.

[6] More recent reports are often regarded in the news cycle as more recent and valuable, regardless of accuracy and measurement period.
[7] Berchick, Edward R., Mykata, Laryssa, and Stern, Sharon M. September 15, 2020. The Influence of COVID-19-related Data Collection Changes on Measuring Health Insurance Coverage in the 2020 CPS ASEC. *United States Census Bureau*. COVID-19 and Measuring Health Insurance Coverage in the 2020 CPS ASEC (census.gov)

The robust survey questionnaire defines "Direct-purchase" as "coverage purchased directly from an insurance company or through a federal or state marketplace".[8] Respondents have personal liberty to determine whether limited coverage benefits (e.g. short-term limited duration plans) qualify as Direct-purchase coverage. Figure 1 displays a flow chart[9] illustrating the series of questions asked to survey respondents.

Figure 1
CPS ASEC QUESTIONAIRE FLOW CHART



1.2 AMERICAN COMMUNITY SURVEY (ACS)

Since 2008, the ACS has served as a second annual health insurance survey from the U.S. Census Bureau. The CPS ASEC and the ACS are released in September and provide prior year results. The ACS has a significantly larger sample size which allows coverage estimates at a regional level; the CPS ASEC is primarily used for national results, and most granularly applied at the state level.[10] This ACS provides a larger sample size than other surveys and is the best source for local level measurements. Consistent ACS reporting allows historical comparisons from 2008 through 2019.

[8]Keisler-Starke, Katherine and Bunch, Lisa N. September 2020. Health Insurance Coverage in the United States: 2019. *United States Census Bureau.* Health Insurance Coverage in the United States: 2019 (census.gov)
[9] Current Population Survey Annual Social and Economic Supplement (CPS-ASEC). September 10, 2019. *United States Census Bureau.* https://www.census.gov/topics/health/health-insurance/guidance/cps-asec.html
[10] Due to sample size, state-level estimates using the CPS ASEC are computed using a three-year average.

ACS survey data is collected throughout the year. Health coverage at the time of interview is assessed; naturally, the ACS reported uninsured rate is higher than the CPS ASEC at any time during the previous calendar year measure. While each CPS ASEC respondent is personally contacted by visitation or telephone, many ACS respondents reply via the Internet or through completion of a paper form. Less detailed information is gathered through the ACS. With a notable exception of the most recent reports, the CPS ASEC and the ACS have generally produced directionally consistent and similar changes in the uninsured rate each year. CPS ASEC showed the uninsured rate declining while the ACS showed an increase in 2019; as mentioned, the recent CPS ASEC results should be interpreted with greater caution because of the data collection interruptions due to COVID-19.

Like the CPS ASEC, the ACS questionnaire defines "Direct-purchase" without coverage specificity as "insurance purchased".[11] Respondents may decide whether non-ACA compliant insurance coverage qualifies. The ACS may underreport Medicaid coverage as other surveys (CPS, NHIS, MEPS) use more familiar state-specific names. Figure 2 displays the health coverage questions asked of survey respondents.

Figure 2
ACS QUESTIONAIRRE

16. Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans? Mark "Yes" or "No" for EACH type of coverage in items a – h.

a. Insurance through a current or former employer or union (of this person or another family member)

b. Insurance purchased directly from an insurance company (by this person or another family member)

c. Medicare, for people 65 and older, or people with certain disabilities d. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability

e. TRICARE or other military health care

f. VA (enrolled for VA health care)

g. Indian Health Service

h. Any other type of health insurance or health coverage plan – Specify.

1.3 NATIONAL HEALTH INTERVIEW SURVEY (NHIS)

The NHIS is an annual report developed by the Center for Disease Control's National Center for Health Statistics. The survey is intended to provide estimates on a wide range of health measures for the civilian noninstitutionalized population. The NHIS estimates are national. The NHIS produced partial state-level estimates of the uninsured rates until 2019 but stopped doing so in conjunction with a reduced sample size.

The NHIS questionnaire was redesigned in 2019. Accordingly, data users are cautioned to apply direct comparisons between estimates for 2019 and earlier years. A working paper[12] entitled "Preliminary

[11] The American Community Survey. *United States Census Bureau.* The American Community Survey 2020 Questionnaire (census.gov)
[12] Preliminary Evaluation of the Impact of the 2019 National Health Interview Survey Questionnaire Redesign and Weighting Adjustments on Early Release Program Estimates. May 2020. *National Health Insurance Survey*. Preliminary Evaluation of the Impact of the 2019 National Health Interview Survey Questionnaire Redesign and Weighting Adjustments on Early Release Program Estimates (cdc.gov)

Evaluation of the Impact of the 2019 National Health Interview Survey Questionnaire Redesign and Weighting Adjustments on Early Release Program Estimates" discusses these changes.

Most NHIS reports are branded as "Early Release", signifying the desire to provide timely estimates before the release of final annual microdata files. These reports are published prior to final editing and final weighting to provide timely access to results.

The NHIS Early Release Program also includes quarterly estimates. As most uninsured rate reporting is on an annual cycle, these quarterly reports provide the most frequent updating of changes in the uninsured rate. Data users need to be aware of seasonal changes in the uninsured rate before drawing conclusions.

The common NHIS measure is a point in time estimate, although "uninsured for the Entire Year" information is also collected.

1.4 MEDICAL EXPENDITURE PANEL SURVEY HOUSEHOLD COMPONENT (MEPS-HC)

The MEPS-HC report is produced by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ, like the CDC, is a division of the Department of Health and Human Services. Many stakeholders are familiar with "MEPS" from MEPS-IC, with "IC" referencing "Insurance Component". The MEPS-IC is a report of insurance coverage through private and public-sector employers.

The MEPS-HC includes data from individual and families represented in the prior year's NHIS. The MEPS-HC results are lagged an additional year relative to other reports when published and generally attract less attention.

1.5 HEALTH REFORM MONITORING SURVEY (HRMS)

The HRMS is an Urban Institute research program designed to monitor ACA dynamics before federal government surveys are available. The HRMS utilizes questions from federal government surveys and results are compared to federal data. The Urban Institute highlights that nongovernmental surveys are necessary to supplement federal survey to expedite understanding of emerging results. While recognizing the value of federal surveys, the Urban Institute notes that "the time lag between data collection and release means little information has been available as major provisions of the law have been implemented in 2014 and early 2015, an important window of opportunity to make policy and programmatic changes that could improve the law's effectiveness".[13]

HRMS data is collected quarterly. Unlike the federal surveys, the output is data available to researchers rather than a formal report. Various measures can be gleaned to report on emerging ACA dynamics.[14]

1.6 NATIONAL HEALTH AND WELL-BEING INDEX (GALLUP)

Gallup, Inc. is a private analytics company widely known for public opinion polling. Since 2008, Gallup has produced the National Health and Well-Being Index. The survey "provides an in-depth view of Americans' wellbeing and offers insights into their attitudes and behaviors at the national, state and community

[13] Karpman, Michael, Long, Sharon K., and Michael Huntress. March 2015. Nonfederal Surveys Fill a Gap in Data on ACA. *Urban Institute*. Nonfederal Surveys Fill a Gap in Data on ACA (urban.org)
[14] Long, Sharon K., Bart, Lea, Karpman, Michael, Shartzer, Adele, and Zuckerman, Stephen. September 2017. Sustained Gains In Coverage, Access, And Affordability Under The ACA: A 2017 Update. *Health Affairs*. Sustained Gains In Coverage, Access, And Affordability Under The ACA: A 2017 Update | Health Affairs

levels".[15] Larry Levitt of the Kaiser Family Foundation (KFF), an organization that closely tracks the uninsured rate,[16] characterizes Gallup's survey to the federal surveys as "Gallup generally has the most current data on insurance coverage, and it's a large survey. Government surveys measure insurance coverage more precisely with a long series of questions, but results are lagged."[17] While generally on an annual cycle, Gallup's most recent reporting of the uninsured rate was published in January 2019 and reflected insurance coverage in the fourth quarter of 2018.

1.7 COMMONWEALTH FUND SURVEYS

This Commonwealth Fund ACA Tracking survey tracks ACA implementation. The most recent report was released in May 2018. The Commonwealth Fund Biennial Health Insurance survey assesses the uninsured rate every two years. Additionally, the survey assesses underinsurance, which the Commonwealth Fund believes is a measure of deductibles and out-of-pocket limits relative to income.

1.8 CONGRESSIONAL BUDGET OFFICE (CBO) REPORTS

The CBO is a federal agency that supplies Congress with nonpartisan budget and economic information. The CBO provides independent analyses to support the Congressional budget process and develops reports and cost estimates for proposed legislation, often upon request from Congress. In addition to reporting on the uninsured rate, the CBO projects the future uninsured rate in the process of assessing the implication of various policies. Most CBO reports are ten-year projections with annual results.

In a 2019 report,[18] the CBO explained the agency's view of what constitutes health insurance coverage. The definition of coverage has always been a challenge. Many of the uninsured rate reports ask respondents if they had insurance, sometimes from time periods predating the interview by a year. Survey results are necessarily dependent on respondents' views of what meets the definition of health insurance.

The CBO's definition of private insurance coverage is designed to include what industry stakeholders generally regard as comprehensive major medical coverage. Interestingly and perhaps more challenging for measurements, some short-term, limited-duration policies "are included in CBO's definition of private insur-ance if they provide major medical coverage".[19]

Short-term, limited-duration policies are of particular interest as their popularity grew during the first three years of ACA markets. They were particularly comparatively attractive to relatively healthy individuals who did not qualify for ACA premium subsidies. Aware of their growth, President Obama limited their duration to three months. President Trump later expanded their flexibility. While enrollment reporting of short-term limited-duration policies is very weak unlike ACA markets, it is believed that growth has been significant in recent years. The inclusion or exclusion of short-term limited-duration policies could determine whether the insured rate is increasing or declining.

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[15] How Does the Gallup National Health and Well-Being Index Work?. *Gallup*. How Does the Gallup National Health and Well-Being Index Work?
[16] Uninsured. *KFF*. Uninsured | KFF
[17] Levitt, Larry. January 23, 2019. *Twitter*. https://twitter.com/larry_levitt/status/1088083503604916230?s=20
[18] Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018. April 2019. *Congressional Budget Office*. Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018 (cbo.gov)
[19] Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018. April 2019. *Congressional Budget Office*. Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018 (cbo.gov)

The CBO compiles data from the NHIS, the MEPS-HC; and the CPS to determine the number of people without insurance coverage. The CBO aptly describes the clear challenges with federal survey data:

"The only reliable information about the number of people without health insurance coverage comes from federal surveys, and there is no single, definitive survey for measuring that population. For a variety of reasons, CBO uses data from the NHIS as its primary benchmark for estimates of the number of people who are uninsured. Those data are available more quickly than data from some other surveys, and, because they are generated from a larger sample, they provide more reliable estimates of the uninsured. Also, because the NHIS samples households continuously throughout the year and includes a question about insurance status on the day each household is surveyed, it produces the most accurate measure of the average number of people uninsured over the course of the year. As a result, the data more closely correspond to the concept of average enrollment that underlies CBO's projections.

Although CBO uses the NHIS as its primary benchmark for the uninsured, the agency also compares that benchmark with estimates from the MEPS-HC and the CPS, taking into account the strengths and weaknesses of those surveys, to continually evaluate the accuracy of the NHIS and better understand trends over time in the number of uninsured."[20]

[20] Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018. April 2019. *Congressional Budget Office*. Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018 (cbo.gov)

Section 2: Uninsured Rate Tables

A tabular comparison of the various surveys referenced in Section 1 and longitudinal charts of the uninsured rate measures are presented in this section.

2.1 MEASUREMENT PARAMETERS

The various surveys are listed in Table 1 with general timing, rough sample size, and population measured. As discussed in Section 1, the measurement definition has a differential impact on the uninsured rate calculation. Age is also a determining factor. According to the ACS, the uninsured rate for children under age 19 is 6%. It is higher for adults age 19 to 64 (13%) and lower for adults over age 65 (1%).[21] These results are logical as Medicare covers almost adults over age 65 and government programs are more apt to cover children (e.g. Children's Health Insurance Program) than adults.

Table 1
UNINSURED SURVERY PARAMATERS

	Organization (Department)	Report Title	Timing	Sample Size	Population	Measurement
Government	CDC (HHS)	National Health Interview Survey	May/Sept	40,000	Civilian Non-institutionalized	At time of interview
	AHRQ (HHS)	MEPS-HC	Annually	30,000	Non-institutionalized	Insured any time during year
	Census Bureau (Commerce)	CPS ASEC	Annually	60,000	Non-institutionalized	Insured any time during prior year, detailed information
	Census Bureau (Commerce)	ACS	Annually	2,150,000	Non-institutionalized	At time of interview
Private	Gallup	National Health and Well-Being Index	Annually	28,000	Adults 18-64	At time of interview
	Urban Institute	Health Reform Monitoring Survey	Quarterly	8,000	Adults 18-64	At time of interview
	Commonwealth Fund	ACA Tracking Survey	2 to 4 months early in year	2,403	Adults 19-64	At time of interview
	Commonwealth Fund	Biennial Health Insurance Surveys	August 2019	4,272	Adults 19-64	At time of interview

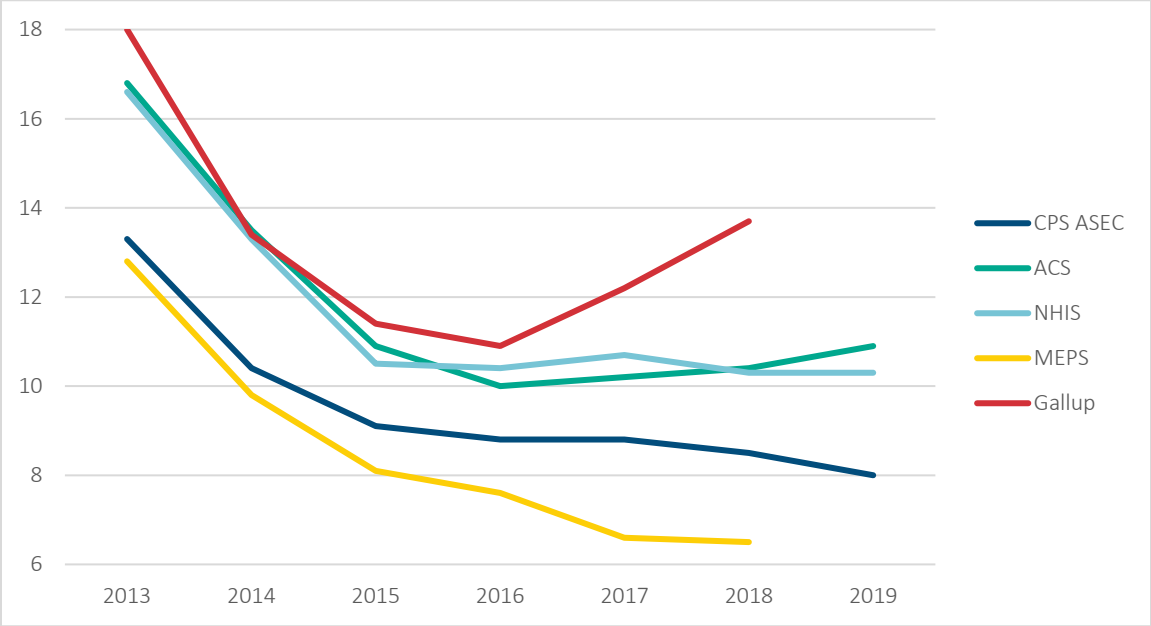
[21] Health Insurance Historical Tables – HHI Series. *United States Census Bureau.* Health Insurance Historical Tables - HHI Series (census.gov)

2.2 MEASUREMENT RESULTS

Figure 3 displays the measured uninsured rate since 2013 of the federal surveys and the private Gallup poll. The ACS and the NHIS results are generally similar. The CPS ASEC, which has a stricter definition of being uninsured for an entire year, has expectedly lower results. The CPS ASEC has also experienced some methodology changes which make longitudinal comparisons a challenge. The MEPS results, which are only available through 2018 and has a similarly strict definition as the CPS ASEC, are a notably low outlier. The Gallup results are a notably high outlier, particularly the most recent data point, and Gallup has not continued its annual measurement cycle. For purposes of analyzing recent trends in the uninsured rate, the ACS and the NHIS provide the most reasonable results. The ACS is more robust and can be analyzed at a geographical level, while the NHIS results are continuously produced and provide earlier indicators of changing results.

Figure 3

UNINSURED RATE OVER TIME FROM SELECTED SURVEYS



Section 3: Uninsured Rate Discrepancies

While various reports assessing the uninsured rate utilize different survey methods and report on different time periods and population groups, results have usually tracked in the same direction or minimally in different directions. Generally, uninsured rate reports complement each other.

Unsurprisingly, there was consensus agreement that the uninsured rate declined significantly in 2014 and 2015 as major ACA programs were being implemented. The initial years of enhanced federal funding for a newly eligible Medicaid population and new individual marketplace subsidies were marked by increased enrollment in both markets. In the third and final year of the ACA's transitional phase,[22] all organizations reported a continued decline in the uninsured rate but a noticeable flattening from the two prior years.[23]

Significant premium increases in the individual market in 2017 resulted in enrollment reductions and the uninsured rate increased for the first time since ACA implementation. Multiple policy changes in 2018 were believed to have an impact on ACA market enrollment and consequently the uninsured rate. The two primary changes had difficult to measure but directionally opposite impact. First, President Trump reduced the funding available for advertising and enrollment assistance. Second, the defunding of Cost-Sharing Reduction (CSR) payments resulted in larger premium subsidies and lower net premiums for consumers.[24] Each of these changes had varying impact at the state level, and the uninsured rate in 2018 was of greater interest than prior years, due to the enhanced level of policy changes.

3.1 2018 NHIS EARLY RELEASE

In November 2018, the CDC released the NHIS results for the first six months of 2018. The report showed a decline in the uninsured rate in states that had not expanded Medicaid after an increase in 2017. Results are displayed in Table 2. Comparatively, the uninsured rate in Expansion states was relatively flat both years. Overall, a logical combination of both state groupings suggested a nationwide reversal in the uninsured rate in 2018 while the NHIS report qualitatively noted that results were "not significantly different from 2017."[25]

[22] Federal reinsurance and risk corridors were a risk mitigators to encourage insurers to participate in new markets with a large degree of uncertainty. Both programs were temporary from 2014 to 2016.
[23] All uninsured rate measures in the table reflect a greater than 1% reduction in 2014 and 2015, and a reduction less than 1% in 2016.
[24] Fann, Greg. August 1, 2017. The Cost-Sharing Reduction Paradox: Defunding Would Help ACA Markets, Not Make Them Implode. *Axene Health Partners, LLC*. The Cost-Sharing Reduction Paradox: Defunding Would Help ACA Markets, Not Make Them Implode – Axene Health Partners, LLC (axenehp.com)
[25] Martinez, Michael E., Zammitti, Emily P., and Cohen, Robin A. November 2018. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2018. *National Center for Health Statistics, Centers for Disease Control*. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January – June 2018 (cdc.gov)

Table 2
UNINSURED RATE OVER TIME

Uninsured Rate: Early Release of Estimates from the National Health Interview Survey, January–June 2018		
Year	Expansion States	Non-Expansion States
2010	16.4%	20.3%
2011	15.3%	19.6%
2012	15.0%	19.2%
2013	14.9%	18.4%
2014	10.9%	16.0%
2015	8.2%	14.0%
2016	7.8%	14.7%
2017	7.6%	15.7%
2018 (Jan-June)	7.6%	14.8%

Mathematically, the 2018 distinction between Medicaid expansion states and non-expansion states was directionally logical. CSR defunding reduced non-silver individual market premiums for subsidized enrollees. Because premium subsidies are determined by silver premium levels and removal of CSR funding necessitated higher silver premium levels, premium subsidies rose. The amount of the subsidy increase was dependent on the rise in silver premiums, which varied based on the income composition of enrollees in silver plans. Effectively, silver premiums were based on the average actuarial value[26] of silver enrollees. As actuarial value varies by income and individuals with incomes between 100% of the Federal Poverty Level (FPL) and 138% of the FPL are in Medicaid in Expansion states and in the individual marketplace in Non-Expansion states, Non-Expansion States on average have a higher silver actuarial value and resulting higher premium subsidies and lower premiums. Table 3 displays the applicable actuarial values associated with each income group.

Table 3
SILVER PLAN ACTUARIAL VALUES

Silver Enrollees' Actuarial Value by FPL		
Actuarial Value	Expansion States	Non-Expansion States
94%	138%-150%	100%-150%
87%	150%-200%	150%-200%
73%	200-250%	200-250%
70%	>250%	>250%

At the end of 2018, the reported evidence suggested that the 2017 increase in the uninsured rate had been neutralized, and perhaps reversed due to lower ACA market premiums resulting from CSR defunding, particularly in states that had not expanded Medicaid.

3.2 THE 2018 GALLUP REPORT

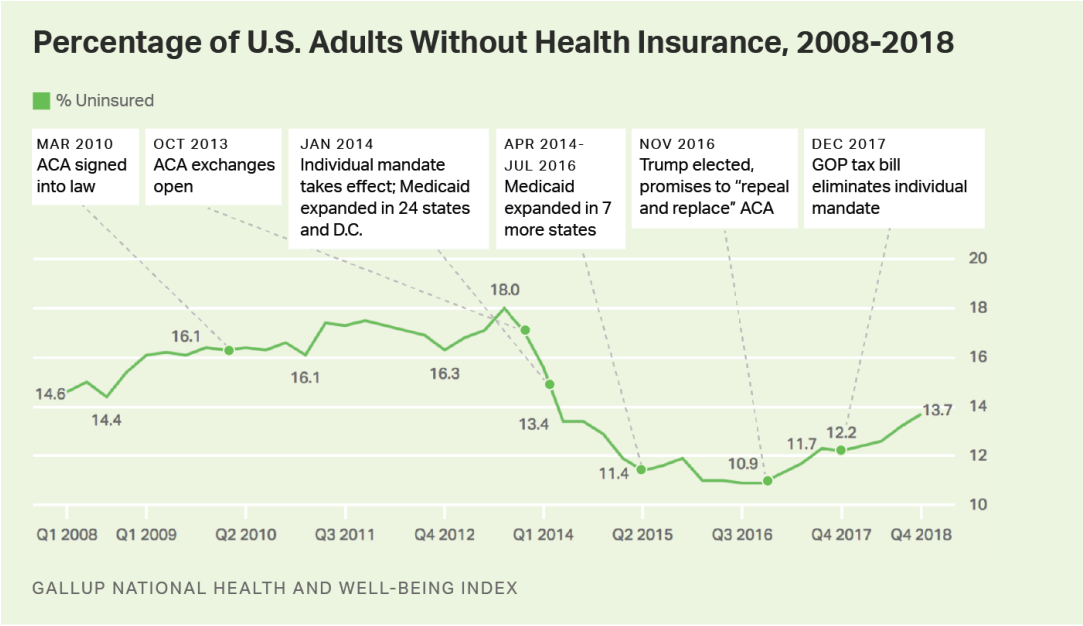
Gallup's National Health and Well-Being Index reporting on the 2018 uninsured rate was released in January 2019 as expected. The magnitude of the change in the uninsured rate was not expected.

[26] Some states and insurers implemented experience rating mechanisms on silver plans rather apply straightforward actuarial value calculations, which generally decreased silver premiums.

Gallup reported that the adult uninsured rate in the fourth quarter of 2018 was 13.7%, a full 1.5% higher than the fourth quarter in 2017. Longitudinal results are displayed in Figure 4.[27] The results created an uproar in the news media and the health policy community, and naturally ignited politically charged responses. "The number of Americans lacking health insurance has increased by 7 million since Donald Trump became president", the Fiscal Times noted while referencing the Gallup report.[28] Newsmax reported, "The American adult uninsured rate rose to its highest level in four years, registering at 13.7 percent in the fourth quarter of 2018".[29] Andy Slavitt, who served as the Centers for Medicare and Medicaid Services (CMS) during the Obama administration, said "7 million Americans have lost insurance under Trump as he has steadily undermined the law & people."[30] These reactions were a mere two months after a government report told the opposite story about 2018. KFF's Larry Levitt decisively noted, "We have a somewhat murky picture of insurance coverage right now."[31] While previous differences in uninsured reports had been mild and not contradictory, there was clearly some differences to resolve before responding with policy action.

Figure 4

GALLUP NATIONAL HEALTH AND WELL-BEING INDEX



[27] Gallup, U.S. Uninsured Rate Rises to Four-Year High, January 23, 2019. https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx. Copyright © 2019 Gallup, Inc. All rights reserved. Reprinted with permission.

[28] Rainey, Michael. January 23, 2019. 7 Million More Uninsured Under Trump *The Fiscal Times*. 7 Million More Uninsured Under Trump | The Fiscal Times

[29] Freeman, Brian. January 23, 2019. Gallup: Uninsured Rate Among Americans Spikes. *Newsmax.* Gallup: Uninsured Rate Among Americans Spikes | Newsmax.com

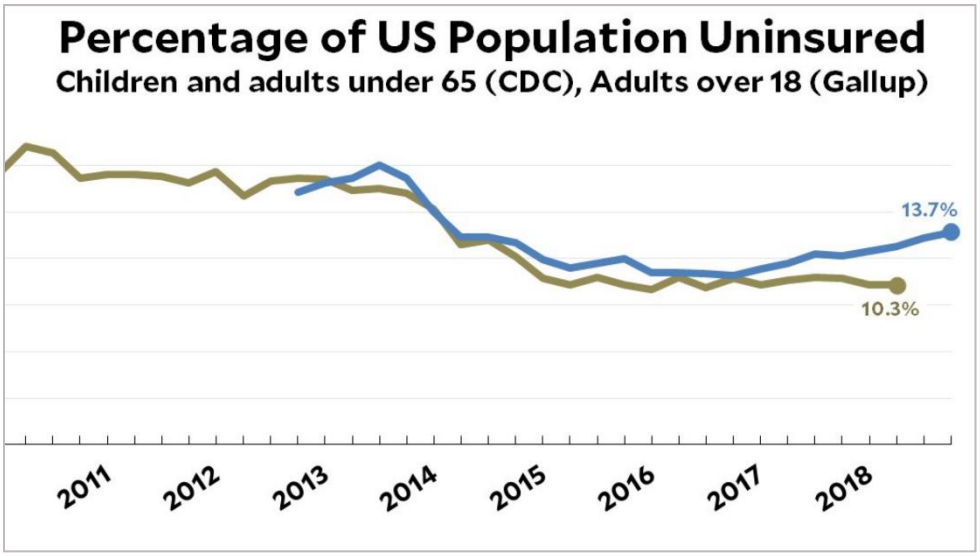
[30] Hayden, Jen. January 24, 2019. 7 million Americans have lost their healthcare insurance under Donald Trump — so far. *Alternet*. 7 million Americans have lost their healthcare insurance under Donald Trump — so far - Alternet.org

[31] Levitt, Larry. January 23, 2019. *Twitter* https://twitter.com/larry_levitt/status/1088083503604916230

It was not long before questions[32] were asked about the accuracy of the Gallup Report. A Slate article was titled "Gallup Says the Uninsured Rate Is Rising. Is It?".[33] Similarly, Factcheck asked "Did the Uninsured Increase by 7 Million?".[34] Politifact judged Senator Maria Cantwell's claim "7 million more Americans are uninsured now than when President Trump was elected" as half-true, noting that she cited "one study of health insurance coverage, the one undertaken by Gallup. However, she ignores two closely watched government studies that showed much smaller changes in uninsured Americans, and in one instance, actually found a modest reduction in the number of people without insurance."[35] Mr. Levitt believed[36] the aggregate policy impacts would cause 2018 ACA enrollment to fall but was skeptical[37] of Gallup's latest uninsured numbers, as he was in 2017[38] and 2018.[39] As full year reporting of 2018 emerged, reports generally suggested mild changes in the uninsured rate. The Commonwealth Fund reported "the adult uninsured rate was 12.4 percent in 2018, statistically unchanged from the last time we fielded the survey in 2016."[40] A longitudinal comparison of Gallup and results from the CDC NHIS is displayed in Figure 5.[41]

Figure 5

COMPARSION OF GALLUP AND CDC RESULTS



The Gallup results were ultimately seen as an outlier and the reported increase was not viewed as representative of a real change in the uninsured rate, but the initial reporting created quite a stir that could

[32] Robertson, Lori. February 12, 2019. Did the Uninsured Increase by 7 Million? *Factcheck.org*. Did the Uninsured Increase by 7 Million? - FactCheck.org

[33] Weissmann, Jordan. January 23, 2019. Gallup Says the Uninsured Rate Is Rising. Is It? *Slate*. New Gallup survey says the unisured rate is spiking under Trump. (slate.com)

[34] Did the Uninsured Increase by 7 Million? - FactCheck.org

[35] Jacobson, Louis. January 25, 2019. Have 7 million Americans become uninsured since 2016? *Politifact*. PolitiFact | Have 7 million Americans become uninsured since 2016?

[36] Alonso-Zaldivar, Ricardo and.Vineys, Kevin S. February 7, 2018. AP Count: Nearly 11.8M enroll for Obama health law in 2018. *AP News. https://apnews.com/article/north-america-wa-state-wire-ri-state-wire-ct-state-wire-tx-state-wire-837a78792b944937b6e0fca69ee55e4e*

[37] Levitt, Larry. January 23, 2019. *Twitter.* https://twitter.com/larry_levitt/status/1088087848719249415?s=20

[38] Levitt, Larry. October 20, 2017. *Twitter. https://twitter.com/larry_levitt/status/921382328592580609?s=20*

[39] Levitt, Larry. January 16, 2018. *Twitter.* https://twitter.com/larry_levitt/status/953283108454809600?s=20

[40] Collins, Sara R., Bhupal, Herman K., and Doty, Michelle M. February 7, 2019. Health Insurance Coverage Eight Years After the ACA. *The Commonwealth Fund*. https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca

[41] Mother Jones, The Uninsured Rate Has Soared Under Trump — Maybe, January 23, 2019. https://www.motherjones.com/kevin-drum/2019/01/the-uninsured-rate-has-soared-under-trump-maybe/. Reprinted with permission.

have been avoided with a better collective synthesis of uninsured rate reporting. Market observers were naturally interested in Gallup's updated report a year later. It was thought that 2018 results may be restated rather than potentially projecting a decline in the uninsured rate in 2019, coinciding with repeal of the individual mandate penalty and further reductions in advertising and outreach funding in individual marketplaces. Two years have gone by and Gallup has not reported uninsured rate statistics for 2019 or 2020. The last Gallup report still indicates a significant increase in the uninsured rate in 2018. Accordingly, federal government reports have played a more exclusive role as reliable sources for assessment of the uninsured rate in recent years.

Section 4: Rationale for Being Uninsured

As the uninsured rate has levelized since 2016 and recent changes are both more difficult to measure and more likely to be viewed as resulting from changes in the pandemic environment rather than from policy implications, some attention has shifted from precise measurements to a more qualitative understanding of the uninsured population. While ACA implementation has resulted in a material impact, the uninsured rate remains higher than desired. Notably, enrollment in the private individual marketplace is significantly lower than expected. The individual market is important as it serves as a last resort and is often the only option available to people who do not qualify for government programs or do not have access to affordable employer-sponsored insurance. After the Supreme Court decision in 2012 that gave states a choice of expanding Medicaid, CBO revised its enrollment forecast[42] to include 31 million people in the individual market in 2021.

After a rapid uninsured rate decline associated with ACA implementation and commencement of a stabilizing level, some research has focused on stakeholders' interests in individuals' rationale for being uninsured. Prior to the ACA, the rationale for being uninsured was purportedly understandable. It was perceived that there were two overwhelming rationales for being uninsured; being unable to afford basic coverage or having chronic medical conditions in a medically underwritten regulatory environment. The ACA's rating rules and subsidy formulas were specifically designed to make insurance more attractive to those with low incomes and pre-existing medical conditions.

With the ACA's implementation, a rationale for being uninsured is seemingly less transparent. Insurance is now more attractive to low-income individuals, and everyone is eligible for ACA coverage regardless of health status. General reasons for being uninsured include premium levels, lack of awareness, and a poor perception of the value of coverage. To support future efforts to improve the uninsured rates, reporting entities have begun collecting survey information to better understand the rationale of being uninsured.

4.1 COMMONWEALTH FUND BIENNIAL SURVEY

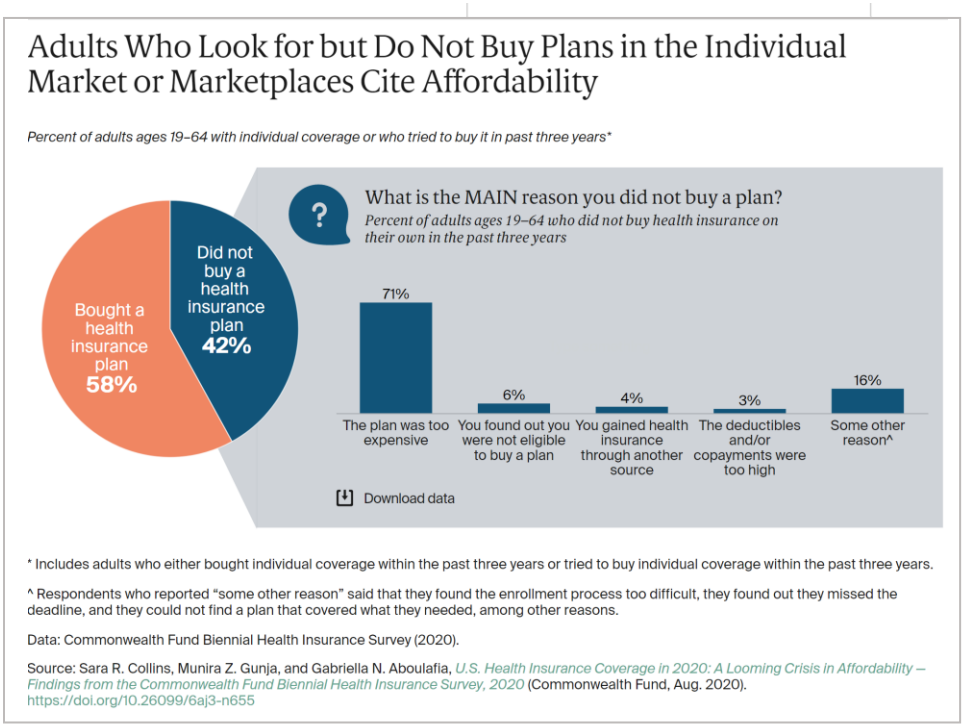
The Commonwealth Fund reports[43] that most uninsured individuals indicate that premiums are too expensive. 71% of those surveyed said that health insurance options are too expensive. Even after the implementation of the ACA, named for intentions of improving affordability, prices are still referenced as the overwhelming reason why people do not personally have health insurance. Figure 6 displays the survey results.

[42] Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. July 2012. *Congressional Budget Office*. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision (cbo.gov)

[43] Collins, Sara R., Gunja, Munira Z., and Aboulafia, Gabriella N. August 9, 2020. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. *The Commonwealth Fund*. Health Coverage Affordability Crisis 2020 Biennial Survey | Commonwealth Fund

Figure 6

REASONS FOR NOT BUYING MARKETPLACE COVERAGE



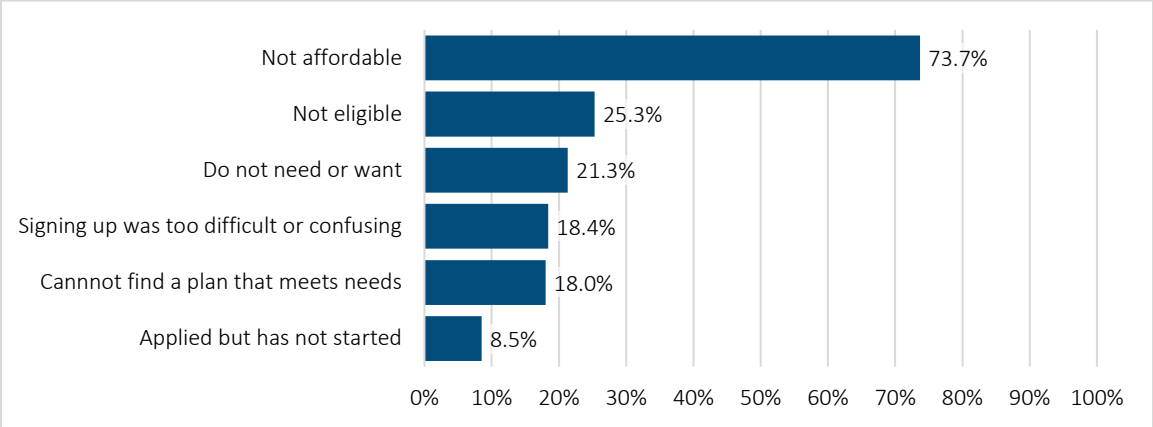
4.2 CDC NHIS

The CDC also reports "affordability" as the primary deterrent to procuring insurance with a similar response rate as the Commonwealth survey. Perhaps surprising to some advocates who understand the risk protection value of health insurance, 21.3% of people indicated they did not want coverage.[44] Figure 7 displays the survey results.

[44] Cha, Amy E. and Cohen, Robin A. September 2020. Percentage of adults aged 18–64 who identified with selected reasons for being currently uninsured: United States, 2019 *National Center for Health Statistics, Centers for Disease Control*. NCHS Data Brief, Number 382, September 2020 (cdc.gov)

Figure 7

REASONS FOR BEING UNINSURED: PERCENTAGE OF ADULTS AGED 18–64 WHO IDENTIFIED WITH SELECTED REASONS FOR BEING CURRENTLY UNINSURED: UNITED STATES, 2019



4.3 AFFORDABILITY CONSIDERATIONS

While survey questions regarding health insurance coverage are susceptible to respondent error, the rationale for not having insurance may be even more inaccurate. It is possible that many respondents who claimed that insurance was "not affordable" had not fully explored coverage options and prices. A recent KFF analysis[45] suggests that 4 million of the 15 million individuals eligible for marketplace coverage have access to free coverage. An additional 5 million people have access to subsidized coverage. Results are displayed in Table 4. Recent legislative changes in the ARPA improve consumer value and provide more Americans with access to more generous premium subsidies. A large contingent of individuals remain uninsured for reasons other than price, but accurate rationales may not be identified in current surveys.

Table 4

UNINSURED POPULATION AND MARKETPLACE SUBSIDY ELIGIBILITY

State	Total Marketplace Eligible Uninsured	Uninsured Eligible for Free Bronze Plan	Uninsured Eligible for Partial Subsidies	Uninsured Ineligible for Subsidies
US Total	14,922,400	4,004,600 (27%)	4,945,300 (33%)	5,972,500 (40%)

[45] McDermott, Daniel, Cox, Cynthia, and Claxton, Gary. January 27, 2021. Marketplace Eligibility Among the Uninsured: Implications for a Broadened Enrollment Period and ACA Outreach. *KFF Private Insurance*. Marketplace Eligibility Among the Uninsured: Implications for a Broadened Enrollment Period and ACA Outreach – Appendix Tables – 9623 | KFF

Section 5: Pathways to Coverage

As we try to better understand the rationale for people being uninsured, we are also seeking how to best understand how more people can become insured. Comprehension of likely reductions in the uninsured rate begins with understanding the likely pathways to coverage. In support of this effort, the CBO has segmented population groups eligible for various types of subsidized coverage and delineated the reasons why other groups were not eligible.[46] Many uninsured individuals eligible for subsidized coverage have access to free or near free coverage, while others, who are also eligible for financial assistance, are still required to pay a substantial premium contribution.

5.1 CBO ASSESSMENT OF UNINSURED POPULATION

In round numbers, there are around 30 million people uninsured in the United States under age 65. Most uninsured individual residents in the United States are eligible for Subsidized Coverage; among those eligible, there is a wide variance of premium contributions from free coverage to beyond pre-ACA levels. Most of this group was eligible for financial assistance prior to the ACA, but the ACA has added to the number of subsidy eligible uninsured Americans. About one-third of Americans are ineligible for financial assistance, most of whom are ineligible due to income not falling within the ACA's range of subsidy eligibility.

The largest segment of the current uninsured population was eligible for Subsidized Coverage prior to the ACA. About a quarter of the uninsured population is newly eligible for Subsidized Coverage as a direct result of the ACA. Ineligibility for Subsidized Coverage is generally the result of income level or legal status. The ACA limits subsidy eligibility from 100% to 400%[47] of the FPL; some ACA enrollees within the income range, younger people in particular, may have premium levels below the maximum enrollee contribution and not be eligible for subsidies. Everyone ineligible for Subsidized Coverage can enroll in the individual market but would be required to pay the full premiums, which are generally financially unattractive. The CBO notes that "about 48 percent of noncitizens who were not lawfully present in this country were uninsured in 2019, compared with 10 percent of citizens and other lawfully present residents".[48]

Table 5 illustrates the subsidy eligibility of various group of uninsured individuals residing in the United States. Access to Subsidized Coverage is a clear pathway to insurance for most of the uninsured population. Policy advocacy of encouraging greater levels of insurance coverage generally falls into three categories; increasing the populations eligible for Subsidized Coverage, formulaic changes in subsidy calculations to improve consumer value propositions for those already eligible, and promotion of greater consumer awareness of Subsidized Coverage availability.

[46] Who Went Without Health Insurance in 2019, and Why? September 2020. *Congressional Budget Office*. Who Went Without Health Insurance in 2019, and Why? (cbo.gov)
[47] The 400% limit was removed by ARPA.
[48] Who Went Without Health Insurance in 2019, and Why? September 2020. *Congressional Budget Office*. Who Went Without Health Insurance in 2019, and Why? (cbo.gov)

Table 5
SUBSIDIZED PATHWAYS TO COVERAGE

Population	Eligibility Reason	Population Split	Group Description
Eligible for Subsidized Coverage	Prior to the ACA	31%	Employer-Sponsored
Eligible for Subsidized Coverage	Prior to the ACA	10%	Traditional Medicaid / CHIP
Eligible for Subsidized Coverage	Result of the ACA	19%	ACA Marketplace
Eligible for Subsidized Coverage	Result of the ACA	7%	ACA Medicaid Expansion
Eligible for Subsidized Coverage	**Total Eligible**	**67%**	**All Eligible Groups**
Not Eligible for Subsidized Coverage	Income Related	11%	Income too low in non-expansion states
Not Eligible for Subsidized Coverage	Income Related	9%	Income too high for marketplace subsidies
Not Eligible for Subsidized Coverage	Not Income Related	13%	Not Lawfully Present
Not Eligible for Subsidized Coverage	**Total Not Eligible**	**33%**	**All Ineligible Groups**

5.2 IMPACT OF RECENT POLICY CHANGES

The Urban Institute's Health Insurance Policy Simulation Model (HIPSM) is "designed to estimate the cost and coverage effects of proposed health care policy options".[49]. The core data in the HIPSM is two years of the ACS. In December, baseline coverage was presented which tallied insurance coverage enrollment by income group. Notably, the HIPSM segments short-term limited duration plans and other non-ACA compliant coverage as a separate line item. This alleviates potential confusion in other surveys as to whether short-term plan enrollees may be counted as being uninsured.

The baseline data in Table 6 provides insightful distribution patterns of variances in type of insured coverage by income level.

Table 6
HEALTH INSURANCE COVERAGE BY INCOME LEVEL

	Income as a % of FPL				
Type of Coverage	<138%	138-200	200-400	400+	All
% of Population	*28.5%*	*11.2%*	*26.7%*	*33.6%*	*100.0%*
Employer-Sponsored	11.6%	38.7%	68.6%	86.0%	54.9%
Public (Medicaid/CHIP)	69.3%	31.9%	13.3%	4.4%	28.3%
Individual ACA-Compliant	3.0%	14.0%	6.4%	4.0%	5.5%
Non-ACA Compliant	0.4%	0.3%	1.3%	1.3%	0.9%
Uninsured	15.7%	15.2%	10.4%	4.3%	10.4%

The ARPA enhances the ACA's subsidy parameters by reducing the maximum premium contributions for the benchmark plan at all income levels. The Urban Institute used the HIPSM to update the baseline data and model the anticipated ARPA impact[50] using similar coverage categories; results are displayed in Table 7. Naturally, enrollment in the individual ACA-compliant market is expected to increase, the uninsured rate is expected to decrease, and little changes are expected in other categories. As net premiums decline, and

[49] Buettgens, Matthew and Banthin, Jessica. The Health Insurance Policy Simulation Model for 2020. December 2020. *Urban Institute*. The Health Insurance Policy Simulation Model for 2020: Current-Law Baseline and Methodology (urban.org)
[50] Banthin, Jessica, Buettgens, Matthew, Simpson, Michael, and Wan, Robin. April 2021. What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022. *Urban Institute*. What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022 (urban.org)

a larger proportion of the population has access to free or near free coverage, more people will be insured but many will likely remain uninsured despite financially attractive options. The focus on reducing the uninsured rate may change from reducing premiums to increasing awareness of available coverage value.

Table 7

ARPA IMPACT ON HEALTH INSURANCE COVERAGE

ARPA Impact		
Insurance Coverage	Before ARPA	After ARPA
Employer-Sponsored	53.8%	53.7%
Public (Medicaid/CHIP)	28.7%	28.9%
Individual ACA-Compliant	5.4%	7.1%
Non-ACA Compliant	0.9%	0.8%
Uninsured	11.1%	9.6%

Section 6: Pandemic Implications

For individuals interested in health insurance policy, there is anxious anticipation in September for the usual releases of uninsured rate reports from the CDC and the Census Bureau. In September 2020, the results of the uninsured rate in the prior year seemed more outdated than usual. The significant economic and health landscape changes due to COVID-19 deflated excitement for what should have been a very interesting year. After all, the individual mandate penalty no longer applied. The penalty was once thought by many stakeholders to be the linchpin holding the ACA market together. As this report is being written, the US Supreme Court is considering the constitutionality of the ACA based on the mandate's essentiality to the functioning of the law. It was thought that market enrollment would plummet without a penalty and the uninsured rate would skyrocket. Additionally, the 2018 policies of reduced advertising and enrollment assistance continued, and insurer response to CSR defunding is a multi-year phenomenon.[51] There was indeed significant interest in 2019 results, but it was all overshadowed by the landscape changes due to COVID-19.

The Census Bureau was transparent in discussing the unplanned data collection challenges. For the CPS ASEC, the Bureau collects information each spring for the prior year. Traditionally, this has included in-person interviews. In March 2020, in-person interviews ceased, and all subsequent interviews were conducted via telephone. Response rates dropped about 10%, and reductions were believed to be unevenly distributed by age, sex, race and income.

Federal agencies' efforts to apply appropriate adjustment were admirable, but they acknowledged the inherent challenges should be acknowledged by interested stakeholders and results should be viewed with more caution than usual. Perhaps more relevant than the reporting accuracy was the current relevance. The COVID-19 pandemic reshuffled the steady population of enrollees in employer-sponsored insurance, with temporary and permanent job layoffs shifting people to the individual market, Medicaid, and the ranks of the uninsured. A more speculative view on the 2019 uninsured rate was received with less fanfare and health policy stakeholders were less focused on issues unrelated to the pandemic.

Coming out of the pandemic, comparisons of the uninsured rate with prior measures may require more discernment. A growth in Medicaid eligibility is expected; as many people are eligible for Medicaid for the first time, there may be some unfamiliarity with the program. Retroactive enrollment may play a larger role; effectively, people may be uninsured until they need medical coverage. Much of the federal response to the pandemic includes temporary financial mechanisms which should reduce the uninsured rates. It remains to be seen whether some of these efforts are temporary or will be permanently extended. As stakeholders digest future updates of the uninsured rate, they will be wise to apply a greater degree of discernment, particularly in connection to understanding policy implications and using the results to inform future policy.

[51] Sprung, Andrew. June 5, 2019. Silver loading is just getting started. *Xpostfactoid Blog*. xpostfactoid: Silver loading is just getting started

Section 7: Summary

Comprehension of the uninsured rate is a necessary requirement in shaping health policy. Rich detailed information is available through multiple public and private reports produced each year. Raw data is also available for researchers interested in conducting their own research.

Multiple entities report on the uninsured rate and measure various populations using various methods. Confusion across surveys can arise without a proper understanding of what is being measured and established consistent processes. Many researchers prefer utilization of the Census Bureau's ACS due to its large sample size and credibility in small, geographic regions. Its drawback is its infrequent annual release, in September for the previous year. In the pandemic environment, the September 2020 report on 2019 seemed to be more outdated than usual. The NHIS produced by the CDC provides timelier national estimates and has tracked closely with the ACS. The Gallup report was a widely cited private source but appeared to produce outlier results in January 2019 which have not been updated.

A reduction in the uninsured rate is a major health policy goal, and applicable measures are often used to assess policy efficacy. Likewise, policy proposals are often promoted by the projected uninsured rate impact that they will purportedly have. Contradicting uninsured rate reports created confusion on the directional changes in 2018, and the interest in connecting the uninsured rate to policy implications was overshadowed by the COVID-19 pandemic as 2019 results became available.

While the uninsured rate is reactive to health policy, it is important to highlight the other determinants of the uninsured rate. Economic trends have historically had an impact on insurance rates, particularly in employer-sponsored markets. The correlation between a strong economy and insurance coverage is likely significantly less in an ACA environment that is more attractive to lower-income individuals. Also, the federal response to the COVID-19 pandemic has changed this equation through ACA subsidy enhancements and other temporary free coverage opportunities, e.g. COBRA subsidies.

Demographic trends are a significant factor, particularly age and citizenship. Noncitizens who are unlawfully present have a much higher chance of being uninsured than citizens and lawfully present noncitizens. Elderly adults are almost universally covered through Medicare, and children are more likely to be covered than non-elderly adults due to government programs designed specifically for children.

As the ACA has impacted the uninsured rate, it has changed the demographic characteristics of the uninsured population. In 2019, The Commonwealth Fund asked, "Who are the Remaining Uninsured?".[52] We now have a good understanding of the demographics of the uninsured and the likely pathways they have towards coverage. The dynamics of improving insurance coverage is different than it was a decade ago. Most of the uninsured population now has access to subsidized coverage, and it is free or near free for many eligible enrollees. The cost problem associated with high gross premiums is an expensive but transparent problem; the recognition that people remain uninsured when there is little financial burden is a different challenge for stakeholders. In aggregate, the current resulting dynamics are that the uninsured population is a growing mix of people who have access to free or attractively priced coverage and a remaining group of people who do not.[53] Namely, the ACA consumer value proposition is still highly

[52] Gunka, Munira Z. and Collins, Sara R. 2020. Who Are the Remaining Uninsured, and Why Do They Lack Coverage? *Commonwealth Fund*. August 28, 2019 Who Are the Remaining Uninsured, and Why Do They Lack Coverage? | Commonwealth Fund
[53] Fann, Greg. Land of the Free. *Axene Health Partners, LLC*. Land of the Free – Axene Health Partners, LLC (axenehp.com)

variable across age and income levels[54] despite recent attention to the ARPA removing the subsidy cliff. Further reduction of the uninsured rate will require systematic improvements, some of which are hard and financial and others which are soft and promotional. Actuaries should play a key role in educating stakeholders on the former but should also understand the dynamics of the latter and command a broader, holistic view. A transparent understanding of the uninsured rate, underlying policy implications, rationale for population groups being uninsured, and likely pathways to coverage should lead us to better clarification of market dynamics and understanding of who is uninsured and why and result in stronger policy efficacy in the future.

[54] Fann, Greg. 2021. Actuarial Clarity for Building on the ACA: Let's 86 the 8.5% Myth and Other False Narratives. *Descant Blog*. Actuarial Clarity for Building on the ACA: Let's 86 the 8.5% Myth and Other False Narratives (descant.info)

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