

Key Facts about the Uninsured Population

The Affordable Care Act (ACA) led to historic gains in health insurance coverage by extending Medicaid coverage to many low-income individuals and providing Marketplace subsidies for individuals below 400% of poverty. The number of uninsured nonelderly Americans decreased from over 44 million in 2013 (the year before the major coverage provisions went into effect) to just below 27 million in 2016. However, in 2017, the number of uninsured people increased by nearly 700,000 people, the first increase since implementation of the ACA. Ongoing efforts to alter the ACA or to make receipt of Medicaid contingent on work may further erode coverage gains seen under the ACA. This fact sheet describes how coverage has changed in recent years, examines the characteristics of the uninsured population, and summarizes the access and financial implications of not having coverage.

Summary: Key Facts about the Uninsured Population

How many people are uninsured?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance. Beginning in 2014, the ACA expanded coverage to millions of previously uninsured people through the expansion of Medicaid and the establishment of Health Insurance Marketplaces. Data show substantial gains in public and private insurance coverage and historic decreases in the number of uninsured people under the ACA, with nearly 20 million gaining coverage. However, for the first time since the implementation of the ACA, the number of uninsured increased by more than half a million in 2017.

Why do people remain uninsured?

Even under the ACA, many uninsured people cite the high cost of insurance as the main reason they lack coverage. In 2017, 45% of uninsured adults said that they remained uninsured because the cost of coverage was too high. Many people do not have access to coverage through a job, and some people, particularly poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage. Some people who are eligible for financial assistance under the ACA may not know they can get help, and undocumented immigrants are ineligible for Medicaid or Marketplace coverage.

Who remains uninsured?

Most uninsured people are in low-income families and have at least one worker in the family. Reflecting the more limited availability of public coverage in some states, adults are more likely to be uninsured than children. People of color are at higher risk of being uninsured than non-Hispanic Whites.

How does not having coverage affect health care access?

People without insurance coverage have worse access to care than people who are insured. One in five uninsured adults in 2017 went without needed medical care due to cost. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

What are the financial implications of being uninsured?

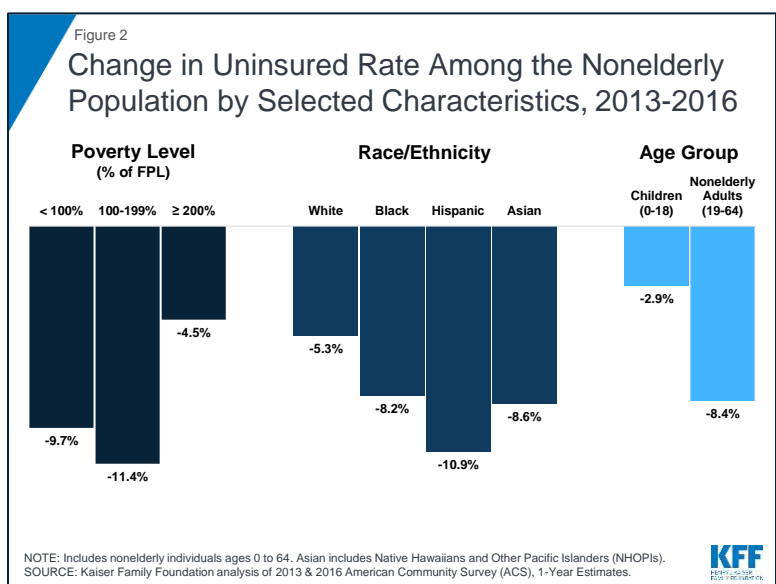
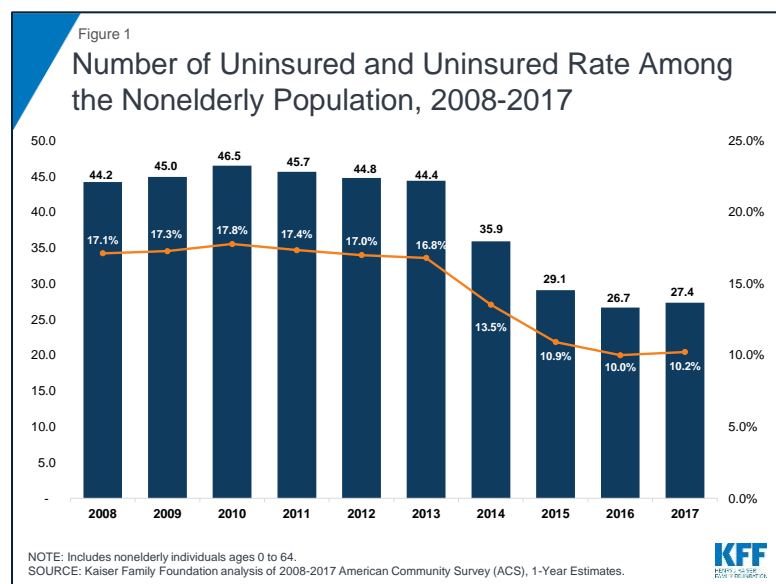
The uninsured often face unaffordable medical bills when they do seek care. In 2017, uninsured nonelderly adults were over twice as likely as their insured counterparts to have had problems paying medical bills in the past 12 months. These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.

How many people are uninsured?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance, and the number of uninsured Americans grew over time, particularly during periods of economic downturns. By 2013, more than 44 million people lacked coverage. Under the ACA, as of 2014, Medicaid coverage has been expanded to nearly all adults with incomes at or below 138% of poverty in states that have expanded their programs, and tax credits are available for people who purchase coverage through a health insurance marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate dropped to a historic low. Coverage gains were particularly large among low-income adults living in states that expanded Medicaid. Still, millions of people—27.4 million nonelderly individuals in 2017—remain without coverage.¹

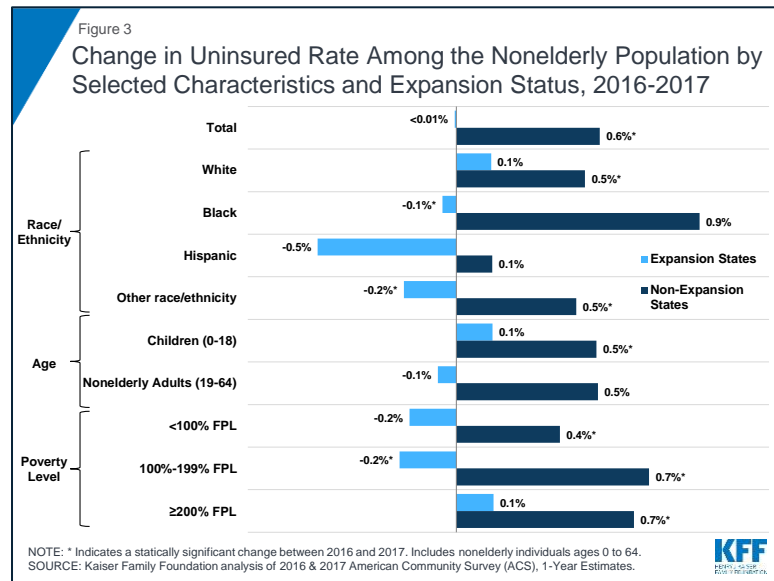
Key Details:

- The number of uninsured, and the share of the nonelderly population that was uninsured, rose from 44.2 million (17.1%) to 46.5 million (17.8%) between 2008 and 2010 as the country faced an economic recession (Figure 1). As early provisions of the ACA went into effect in 2010, and as the economy improved, the number of uninsured people and uninsured rate began to drop. When the major ACA coverage provisions went into effect in 2014, the number of uninsured and uninsured rate dropped dramatically and continued to fall through 2016, when just below 27 million people (10% of the nonelderly population) lacked coverage.
- Coverage gains from 2013 to 2016 were particularly large among groups targeted by the ACA, including adults and poor and low-income individuals. The uninsured rate among nonelderly adults, who are more likely than



children to be uninsured, dropped 8.4 percentage points from 20.6% in 2013 to 12.2% in 2016, a 41% decline.² In addition, between 2013 and 2016, the uninsured rate declined substantially for poor and near-poor nonelderly individuals (Figure 2). People of color, who had higher uninsured rates than non-Hispanic Whites prior to 2014, had larger coverage gains from 2013 to 2016 than non-Hispanic Whites. Though uninsured rates dropped across all states, they dropped more in states that chose to expand Medicaid, decreasing by 7.2 percentage points from 2013 to 2016 compared to a 6.1 percentage point drop in non-expansion states.³

- In 2017, the uninsured rate reversed course and, for the first time since the passage of the ACA, rose significantly to 10.2%. Changes in the uninsured rate in the set of states that expanded Medicaid were essentially flat overall, declining by less than 0.1 percentage points, but patterns varied by states (Appendix Table A) and by demographic group (Figure 3). In contrast, the uninsured rate in states that did not expand Medicaid increased both overall (rising by 0.6 percentage points) and for most groups (Figure 3). The largest increases in the uninsured rates in non-expansion states were among non-Hispanic Blacks and those living above poverty (Figure 3). Again, changes in coverage from 2016-2017 varied within the set of states that have not expanded Medicaid (Appendix A).



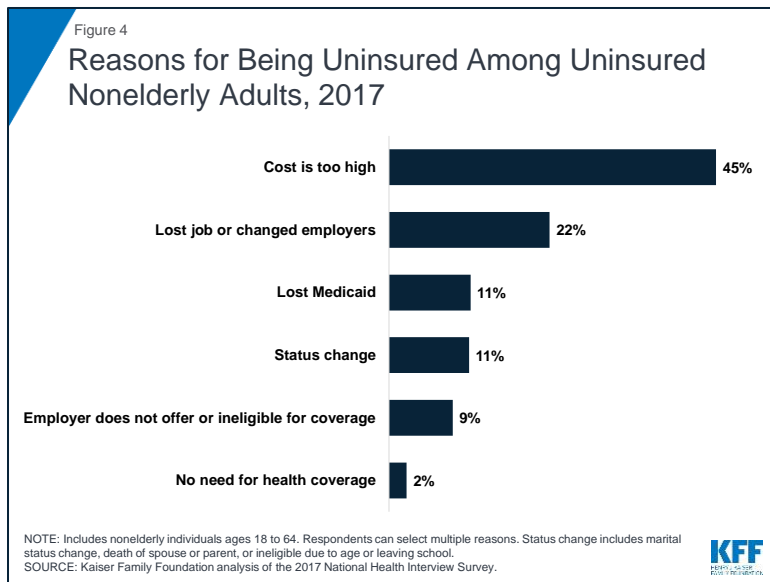
Why do people remain uninsured?

Most of the nonelderly in the United States obtain health insurance through an employer, but not all workers are offered employer-sponsored coverage or, if offered, can afford their share of the premiums. Medicaid covers many low-income individuals, and financial assistance for Marketplace coverage is available for many moderate-income people. However, Medicaid eligibility for adults remains limited in some states, and few people can afford to purchase coverage without financial assistance. Some people who are eligible for coverage under the ACA may not know they can get help, and others may still find the cost of coverage prohibitive.

Key Details:

- Cost still poses a major barrier to coverage for the uninsured. In 2017, 45% of uninsured nonelderly adults said they were uninsured because the cost is too high, making it the most common reason

cited for being uninsured (Figure 4). Though financial assistance is available to many of the remaining uninsured under the ACA,⁴ not everyone who is uninsured is eligible for free or subsidized coverage. In addition, some uninsured who are eligible for help may not be aware of coverage options or may face barriers to enrollment.⁵ Outreach and enrollment assistance was key to facilitating both initial and ongoing enrollment in ACA coverage, but these programs face challenges due to funding cuts and high demand.^{6,7}



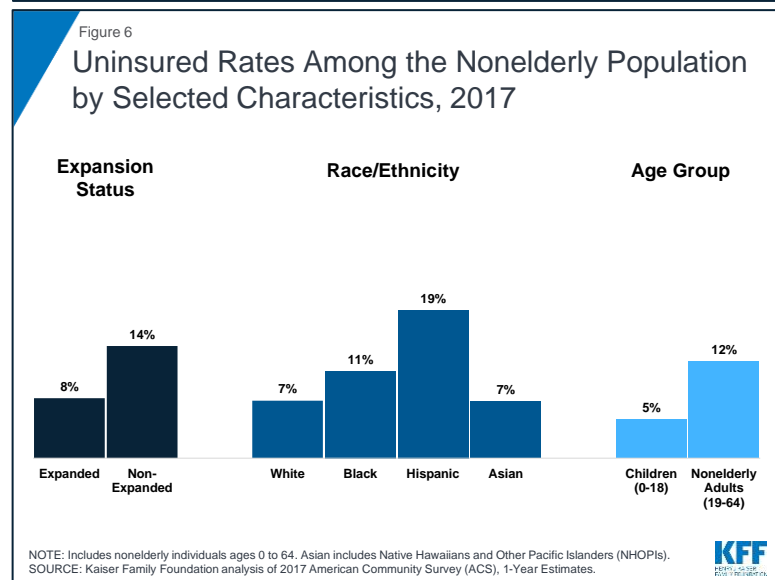
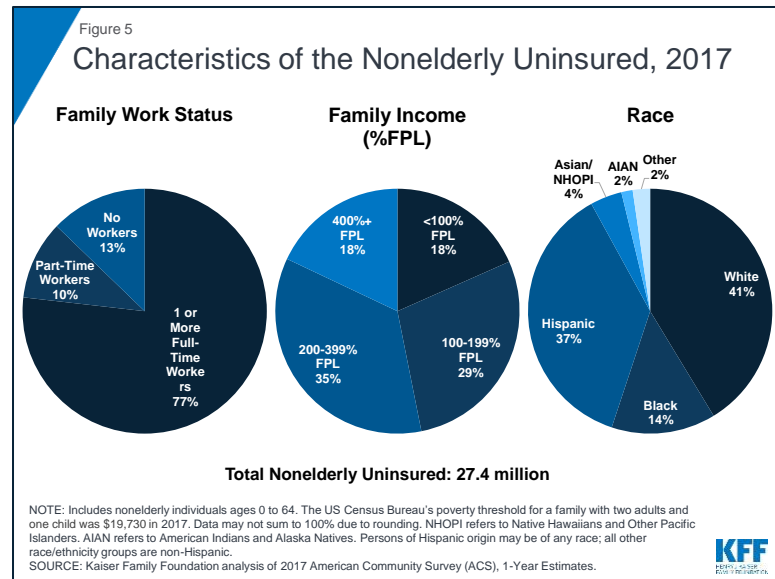
- Access to health coverage changes as a person's situation changes. In 2017, 22% of uninsured nonelderly adults said they were uninsured because the person who carried the health coverage in their family lost their job or changed employers (Figure 4). More than one in ten were uninsured because of a marital status change, the death of a spouse or parent, or loss of eligibility due to age or leaving school (11%), and some lost Medicaid because of a new job/increase in income or the plan stopping after pregnancy (11%).⁸
- As indicated above, not all workers have access to coverage through their job. In 2017, 71% of nonelderly uninsured workers worked for an employer that did not offer health benefits to the worker.⁹ Moreover, nine out of ten uninsured workers who do not take up an offer of employer-sponsored coverage report cost as the main reason for declining (90%).¹⁰ From 2008 to 2018, total premiums for family coverage increased by 55%, and the worker's share increased by 65%, outpacing wage growth.¹¹
- Medicaid and CHIP are available for low-income children, but eligibility for adults is more limited. As of November 2018, 37 states including DC adopted Medicaid expansion eligibility for adults under the ACA.^{12, 13} However, in states that have not expanded Medicaid, eligibility for adults remains limited, with median eligibility level for parents at just 43% of poverty and adults without dependent children ineligible in most cases.¹⁴ Millions of poor uninsured adults fall in a "coverage gap" because they earn too much to qualify for Medicaid but not enough to qualify for Marketplace premium tax credits.¹⁵
- Undocumented immigrants are ineligible for Medicaid or Marketplace coverage.¹⁶ While lawfully-present immigrants under 400% of poverty are eligible for Marketplace tax credits, only those who have passed a five-year waiting period after receiving qualified immigration status can qualify for Medicaid.

Who remains uninsured?

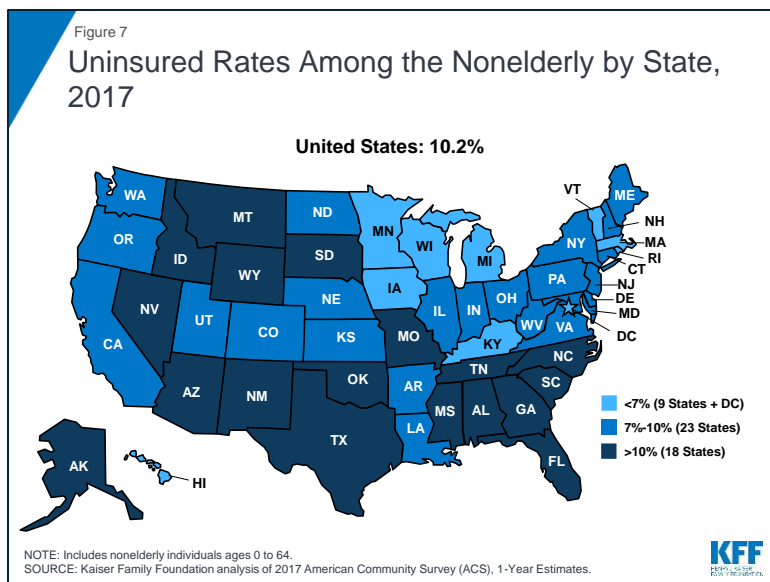
Most remaining uninsured people are in working families, are in families with low incomes, and are nonelderly adults.¹⁷ Reflecting income and the availability of public coverage, people who live in the South or West are more likely to be uninsured. Most who remain uninsured have been without coverage for long periods of time. (See Appendix Table B for detailed data on the uninsured population.)

Key Details:

- In 2017, over three quarters of the uninsured (77%) had at least one full-time worker in their family, and an additional 10% had a part-time worker in their family (Figure 5).
- Individuals below poverty¹⁸ are at the highest risk of being uninsured. In total, more than eight in ten of the uninsured were in families with incomes below 400% of poverty in 2017 (Figure 5).
- While a plurality (41%) of the uninsured are non-Hispanic Whites, people of color are at higher risk of being uninsured than Whites. People of color make up 42% of the nonelderly U.S. population¹⁹ but account for over half of the total nonelderly uninsured population (Figure 5). Hispanics and Blacks have significantly higher uninsured rates (19% and 11%, respectively) than Whites (7%) (Figure 6).²⁰
- Most (86%) of the uninsured are nonelderly adults. The uninsured rate among children was just 5% in 2017, less than half the rate among nonelderly adults (12%),²¹ largely due to broader availability of Medicaid/CHIP for children than for adults.



- Most of the uninsured (75%) are U.S. citizens, and 25% are non-citizens.²² Uninsured non-citizens include both lawfully present and undocumented immigrants. Undocumented immigrants are ineligible for federally funded health coverage, but legal immigrants can qualify for subsidies in the Marketplaces and those who have been in the country for more than five years are eligible for Medicaid.²³
- Uninsured rates vary by state and by region, with individuals living in non-expansion states being the most likely to be uninsured (Figure 6). Thirteen of the eighteen states with the highest uninsured rates in 2017 were non-expansion states as of that year (Figure 7 and Appendix A). Economic conditions, availability of employer-sponsored coverage, and demographics are other factors contributing to variation in uninsured rates across states.
- Nearly three-fourths (74%) of the nonelderly adults uninsured in 2017 have been without coverage for more than a year.²⁴ People who have been without coverage for long periods may be particularly hard to reach in outreach and enrollment efforts.

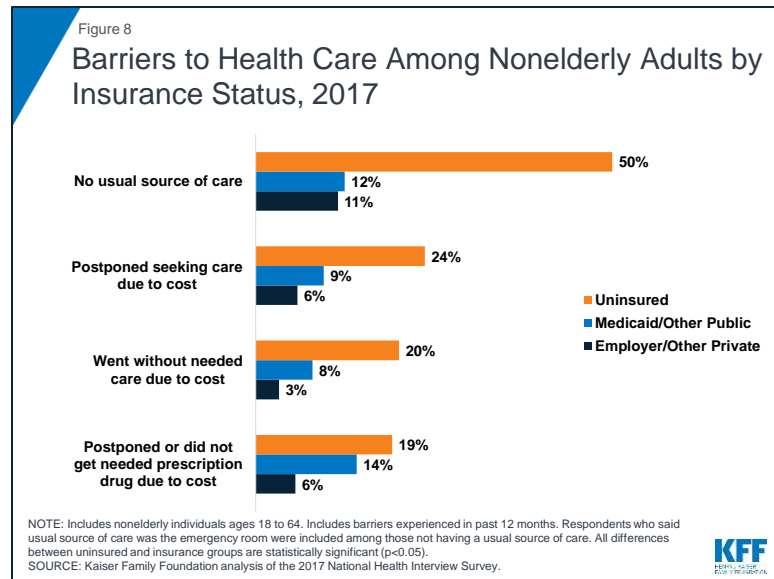


How does not having coverage affect health care access?

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured adults are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Key Details:

- Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.^{25, 26} One in five (20%) nonelderly adults without coverage say that they went without care in the past year because of cost compared to 3% of adults with private coverage and 8% of adults with public coverage. Part of the reason for poor access among the uninsured is that many (50%) do not have a regular place to go when they are sick or need medical advice (Figure 8).



- Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them. In 2017, uninsured nonelderly adults were more than three times as likely as adults with private coverage to say that they postponed or did not get a needed prescription drug due to cost (19% vs. 6%).²⁷ And while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care, people without health coverage are less likely than those with coverage to obtain all the recommended services.²⁸
- Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health. When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.^{29,30,31,32}
- Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care than their counterparts who did not gain coverage.³³ A comprehensive review of

research on the effects of the ACA Medicaid expansion finds that expansion led to positive effects on access to care, utilization of services, the affordability of care, and financial security among the low-income population.³⁴

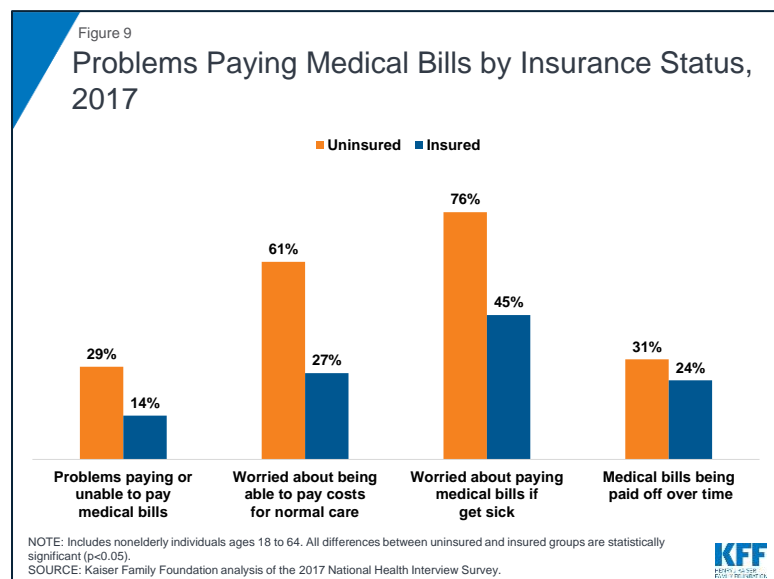
- Public hospitals, community clinics and health centers, and local providers that serve disadvantaged communities provide a crucial health care safety net for uninsured people. However, safety net providers have limited resources and service capacity, and not all uninsured people have geographic access to a safety net provider.^{35,36} High uninsured rates also contribute to rural hospital closures, leaving individuals living in rural areas at an even greater disadvantage to accessing care.³⁷

What are the financial implications of being uninsured?

The uninsured often face unaffordable medical bills when they do seek care. These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.³⁸

Key Details:

- Those without insurance for an entire year pay for one-fourth of their care out-of-pocket.³⁹ In addition, hospitals frequently charge uninsured patients much higher rates than those paid by private health insurers and public programs.^{40,41}
- Medical bills can put great strain on the uninsured and threaten their financial well-being. In 2017, nonelderly uninsured adults were over twice as likely as those with insurance to have problems paying medical bills (29% vs. 14%; Figure 9) with nearly two thirds of uninsured who had medical bill problems unable to pay their medical bills at all (65%).⁴² Uninsured adults are also more likely to face negative consequences due to medical bills, such as using up savings, having difficulty paying for necessities, borrowing money, or having medical bills sent to collection.⁴³
- Uninsured nonelderly adults are also much more likely than their insured counterparts to lack confidence in their ability to afford usual medical costs and major medical expenses or emergencies. Uninsured nonelderly adults are over twice as likely as insured adults to worry about being able to pay costs for normal health care (61% vs. 27%; Figure 9). Furthermore, over three quarters of uninsured nonelderly adults (76%) say they are very or somewhat worried about paying medical bills if they get sick or have an accident, compared to 45% of insured adults.



- Lacking insurance coverage puts people at risk of medical debt. In 2017, three in ten (31%) of uninsured nonelderly adults said they were paying off at least one medical bill over time (Figure 9). Nearly three in five consumers (59%) reported being contacted regarding a collection for medical bills in the United States.⁴⁴ More than half (53%) of uninsured people said they had problems paying household medical bills in the past year and are more likely to be in medical debt than people with insurance.⁴⁵
- Though the uninsured are typically billed for medical services they use, when they cannot pay these bills, the costs may become bad debt or uncompensated care for providers. State, federal, and private funds defray some but not all of these costs. With the expansion of coverage under the ACA, providers are seeing reductions in uncompensated care costs, particularly in states that expanded Medicaid.⁴⁶
- Research suggests that gaining health coverage improves the affordability of care and financial security among the low-income population. Multiple studies of the ACA have found larger declines in trouble paying medical bills in expansion states relative to non-expansion states. A separate study found that, among those residing in areas with high shares of low-income, uninsured individuals, Medicaid expansion significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies.⁴⁷

Conclusion

Millions of people gained coverage under the ACA, but recent trends in insurance coverage indicate that coverage gains may be eroding. In 2017, 27.4 million people lacked health coverage, up slightly from 2016. Ongoing debate about altering the ACA or limiting Medicaid to populations traditionally served by the program could lead to further loss of coverage. On the other hand, if additional states opt to expand Medicaid as allowed under the ACA, there may be additional coverage gains as low-income individuals gain access to affordable coverage. Going without coverage can have serious health consequences for the uninsured because they receive less preventive care, and delayed care often results in serious illness or other health problems. Being uninsured also can have serious financial consequences. The outcome of ongoing debate over health coverage policy in the United States has substantial implications for people's coverage, access, and overall health and well-being.

Appendix Table A: Uninsured Rate Among the Nonelderly by State, 2013-2017							
	2013 Uninsured Rate	2016 Uninsured Rate	2017 Uninsured Rate	Change in Uninsured Rate 2013-2017	Change in Number of Uninsured 2013-2017	Change in Uninsured Rate 2016-2017	Change in Number of Uninsured 2016-2017
US Total	16.8%	10.0%	10.2%	-6.6%	-17,037,000	0.2%	684,800
Expansion States	15.1%	7.7%	7.6%	-7.4%	-12,070,200	0.0%	4,400
Alaska	20.5%	16.0%	15.5%	-4.9%	-32,900	-0.5%	-4,900
Arizona	20.4%	11.9%	12.0%	-8.4%	-435,600	0.1%	11,600
Arkansas	19.0%	9.5%	9.6%	-9.5%	-230,300	0.1%	2,400
California	19.4%	8.4%	8.2%	-11.2%	-3,619,900	-0.2%	-48,700
Colorado	15.8%	8.7%	8.6%	-7.2%	-306,600	-0.1%	-3,400
Connecticut	10.9%	5.7%	6.6%	-4.3%	-129,900	0.9%	25,600
Delaware	11.8%	6.8%	6.6%	-5.2%	-38,600	-0.1%	-1,000
District of Columbia	7.2%	4.5%	4.1%	-3.1%	-15,000	-0.4%	-1,900
Hawaii	8.2%	4.1%	4.5%	-3.7%	-41,800	0.4%	3,200
Illinois	14.5%	7.5%	7.9%	-6.6%	-739,500	0.4%	37,400
Indiana	16.3%	9.4%	9.8%	-6.5%	-358,700	0.4%	23,300
Iowa	10.3%	4.8%	5.2%	-5.1%	-129,900	0.4%	9,400
Kentucky	16.8%	6.0%	6.4%	-10.4%	-380,900	0.4%	14,700
Louisiana	19.2%	11.9%	9.7%	-9.6%	-375,800	-2.2%	-85,600
Maryland	11.5%	7.0%	7.1%	-4.4%	-220,500	0.1%	6,100
Massachusetts	4.4%	2.9%	3.2%	-1.2%	-63,200	0.3%	18,900
Michigan	12.9%	6.3%	6.1%	-6.9%	-571,800	-0.2%	-19,400
Minnesota	9.6%	4.9%	5.2%	-4.3%	-194,900	0.3%	15,000
Montana	19.9%	10.1%	11.0%	-8.9%	-72,700	0.8%	7,200
Nevada	23.5%	12.8%	12.9%	-10.6%	-235,000	0.1%	6,100
New Hampshire	12.8%	7.6%	6.8%	-6.0%	-66,400	-0.8%	-9,000
New Jersey	15.4%	8.9%	8.9%	-6.5%	-488,200	0.0%	-1,000
New Mexico	22.3%	10.7%	10.7%	-11.6%	-205,600	0.1%	1,500
New York	12.5%	7.0%	6.7%	-5.8%	-961,800	-0.3%	-58,600
North Dakota	12.0%	9.1%	8.7%	-3.3%	-17,500	-0.4%	-2,700
Ohio	12.9%	6.6%	6.9%	-6.0%	-579,800	0.3%	29,100
Oregon	17.5%	7.3%	8.1%	-9.4%	-296,500	0.8%	28,900
Pennsylvania	11.5%	7.0%	6.6%	-4.8%	-508,400	-0.3%	-35,400
Rhode Island	14.1%	5.0%	5.3%	-8.7%	-74,700	0.3%	2,900
Vermont	8.3%	4.4%	5.1%	-3.2%	-17,100	0.7%	3,300
Washington	16.2%	6.9%	7.1%	-9.2%	-519,300	0.2%	15,800
West Virginia	16.3%	6.0%	7.1%	-9.2%	-141,400	1.1%	13,600
Non-Expansion States	19.6%	13.8%	14.3%	-5.3%	-4,966,700	0.6%	680,400
Alabama	16.0%	10.9%	11.3%	-4.7%	-191,700	0.4%	16,200
Florida	24.4%	15.3%	15.9%	-8.5%	-1,179,400	0.6%	133,400
Georgia	21.2%	14.8%	15.4%	-5.9%	-466,400	0.6%	62,800
Idaho	18.6%	12.1%	12.6%	-6.0%	-73,400	0.6%	10,900
Kansas	14.3%	9.8%	10.0%	-4.3%	-106,200	0.2%	4,500
Maine	13.4%	9.7%	9.8%	-3.7%	-41,500	0.0%	-200
Mississippi	19.7%	13.8%	14.3%	-5.5%	-144,000	0.5%	9,200
Missouri	15.3%	10.6%	10.8%	-4.5%	-228,800	0.2%	6,100
Nebraska	12.4%	10.3%	10.0%	-2.4%	-35,300	-0.3%	-4,500
North Carolina	18.2%	12.3%	12.7%	-5.5%	-422,500	0.4%	38,500
Oklahoma	20.6%	16.1%	16.4%	-4.2%	-130,200	0.3%	7,000
South Carolina	18.6%	11.8%	13.4%	-5.1%	-186,600	1.6%	66,100
South Dakota	14.6%	9.8%	11.0%	-3.5%	-23,900	1.2%	8,200
Tennessee	16.3%	10.8%	11.1%	-5.2%	-267,700	0.3%	23,600
Texas	24.6%	18.7%	19.6%	-5.0%	-879,100	0.9%	275,300
Utah	14.8%	9.4%	10.0%	-4.7%	-106,300	0.6%	19,800
Virginia	14.2%	10.3%	10.2%	-3.9%	-266,700	0.0%	-400
Wisconsin	10.5%	6.1%	6.1%	-4.4%	-213,900	-0.1%	-3,600
Wyoming	14.7%	12.7%	14.5%	-0.1%	-3,100	1.8%	7,400

NOTES: Includes nonelderly individuals ages 0-64. Expansion status reflects the implementation of Medicaid expansion as of 2017.

SOURCE: Kaiser Family Foundation analysis of 2013, 2016, and 2017 American Community Survey (ACS), 1-Year Estimates.

Appendix Table B: Characteristics of the Nonelderly Uninsured, 2017					
	Nonelderly (millions)	Percent of Nonelderly	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total Nonelderly	267.5	100.0%	27.4	100.0%	10.2%
Age					
Children - Total	76.1	28.5%	3.8	13.8%	5.0%
Nonelderly Adults - Total	191.4	71.5%	23.6	86.2%	12.3%
Adults 19 - 25	28.3	10.6%	4.2	15.4%	14.8%
Adults 26 - 34	39.1	14.6%	6.1	22.3%	15.6%
Adults 35 - 44	40.5	15.1%	5.5	20.2%	13.6%
Adults 45 - 54	41.8	15.6%	4.5	16.3%	10.7%
Adults 55 - 64	41.6	15.6%	3.3	12.0%	7.9%
Annual Family Income					
<\$20,000	31.8	11.9%	5.5	20.0%	17.2%
\$20,000 - <\$40,000	42.8	16.0%	7.4	27.0%	17.3%
\$40,000+	192.9	72.1%	14.5	53.0%	7.5%
Family Poverty Level					
<100%	30.4	11.4%	5.0	18.4%	16.6%
100% - <200%	45.3	16.9%	7.8	28.5%	17.2%
200% - <400%	81.9	30.6%	9.6	35.2%	11.7%
400%+	109.9	41.1%	4.9	18.0%	4.5%
Household Type					
1 Parent with Children	19.0	7.1%	1.3	4.9%	7.1%
2 Parents with Children	84.2	31.5%	6.0	22.0%	7.2%
Multigenerational	18.7	7.0%	2.2	7.9%	11.6%
Adults Living Alone or with Other Adults	111.7	41.8%	13.2	48.3%	11.8%
Other	33.9	12.7%	4.6	16.9%	13.6%
Family Work Status					
2+ Full-time	101.8	38.1%	8.6	31.5%	8.5%
1 Full-time	119.3	44.6%	12.4	45.3%	10.4%
Only Part-time	19.5	7.3%	2.8	10.4%	14.6%
Non-workers	26.9	10.1%	3.5	12.8%	13.0%
Race/Ethnicity					
White	154.3	57.7%	11.3	41.3%	7.3%
Black	34.0	12.7%	3.8	13.8%	11.1%
Hispanic	53.5	20.0%	10.1	36.9%	18.9%
Asian/N. Hawaiian and Pacific Islander	15.9	5.9%	1.1	4.2%	7.2%
American Indian/Alaska Native	1.8	0.7%	0.4	1.5%	22.0%
Two or More Races	8.0	3.0%	0.6	2.3%	7.9%
Citizenship					
U.S. Citizen - Native	230.6	86.2%	18.9	69.2%	8.2%
U.S. Citizen - Naturalized	16.7	6.2%	1.7	6.1%	10.0%
Non-U.S. Citizen, Residents for <5 Years	6.4	2.4%	1.7	6.4%	27.2%
Non-U.S. Citizen, Residents for 5+ Years	13.9	5.2%	5.0	18.3%	36.0%
NOTES: Includes nonelderly individuals ages 0-64. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was \$19,730 in 2017. Parent includes any person with a dependent child. Multigenerational/other families with children include families with at least three generations in a household, plus families in which adults are caring for children other than their own. Part-time workers were defined as working <35 hours per week. Respondents who identify as mixed race who do not also identify as Hispanic fall into the "Two or More Races" category. All individuals who identify as Hispanic ethnicity fall into the Hispanic category regardless of race. SOURCE: Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.					

Endnotes

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- ¹ Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.
- ² Kaiser Family Foundation analysis of 2013 and 2016 American Community Survey (ACS), 1-Year Estimates.
- ³ Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.
- ⁴ Rachel Garfield, Anthony Damico, Kendal Orgera, Gary Claxton, and Larry Levitt, *Estimates of Eligibility for ACA Coverage among the Uninsured in 2016* (Washington, DC: Kaiser Family Foundation, June 2018), <https://www.kff.org/uninsured/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/>.
- ⁵ Ashley Kirzinger, Liz Hamel, Cailey Muñana, and Mollyann Brodie. *Kaiser Health Tracking Poll – March 2018: Non-Group Enrollees*, (Washington, D.C.: Kaiser Family Foundation, April 2018), <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>.
- ⁶ Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee. *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Washington, DC: Kaiser Family Foundation, June 2016), <http://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/>.
- ⁷ Karen Pollitz, Jennifer Tolbert, and Maria Diaz. *Data Note: Further Reductions in Navigator Funding for Federal Marketplace States*, (Washington, D.C.: Kaiser Family Foundation, September 2018), <https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>.
- ⁸ Kaiser Family Foundation analysis of the 2017 National Health Interview Survey.
- ⁹ Kaiser Family Foundation analysis of the March 2018 Current Population Survey, Annual Social and Economic Supplement.
- ¹⁰ Kaiser Family Foundation analysis of the March 2018 Current Population Survey, Annual Social and Economic Supplement.
- ¹¹ Kaiser Family Foundation. *2018 Employer Health Benefits Survey* (Washington, DC: Kaiser Family Foundation, October 2018), <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/>.
- ¹² State Health Facts. “Status of State Action on the Medicaid Expansion Decision.” Kaiser Family Foundation, 2018, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.
- ¹³ Idaho, Nebraska, and Utah had ballot initiatives in the 2018 midterm elections on Medicaid expansion where each state voted to expand. Montana voters also had a ballot initiative that voted down the extension of Medicaid expansion, which is planned to end on June 30, 2019.
- ¹⁴ Tricia Brooks, Karina Wagnerman, Samantha Artiga, and Elizabeth Cornachione, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey* (Washington, DC: Kaiser Family Foundation, January 2018), <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/>.
- ¹⁵ Rachel Garfield, Anthony Damico, and Kendal Orgera, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* (Washington, DC: Kaiser Family Foundation, June 2018), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.
- ¹⁶ *Health Coverage of Immigrants* (Washington, DC: Kaiser Family Foundation, December 2017), <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/>.
- ¹⁷ Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.
- ¹⁸ \$19,730 for a family of three in 2017.
- ¹⁹ Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.
- ²⁰ Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.
- ²¹ Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.
- ²² Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.
- ²³ *Health Coverage of Immigrants* (Washington, DC: Kaiser Family Foundation, December 2017), <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/>.

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- ²⁴ Kaiser Family Foundation analysis of the 2017 National Health Interview Survey.
- ²⁵ Jack Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition." *JAMA* 297, no. 10 (March 2007):1073-84.
- ²⁶ Stacey McMorro, Genevieve M. Kenney, and Dana Goin, "Determinants of Receipt of Recommended Preventive Services: Implications for the Affordable Care Act," *American Journal of Public Health* 104, no. 12 (Dec 2014): 2392-9.
- ²⁷ Kaiser Family Foundation analysis of the 2017 National Health Interview Survey.
- ²⁸ Jack Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," *JAMA* 297, no. 10 (March 2007): 1073-84.
- ²⁹ Marco A Castaneda and Meryem Saygili, "The health conditions and the health care consumption of the uninsured," *Health Economics Review* (2016).
- ³⁰ Steffie Woolhandler, et al., "The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?" *Annals of Internal Medicine* 167 (June 2017): 424-431.
- ³¹ Destini A Smith, et al., "The effect of health insurance coverage and the doctor-patient relationship on health care utilization in high poverty neighborhoods." *Preventive Medicine Reports* 7 (2017): 158-161.
- ³² Andrea S. Christopher, et al., "Access to Care and Chronic Disease Outcomes Among Medicaid-Insured Persons Versus the Uninsured," *American Journal of Public Health* 106, no. 1 (January 2016): 63-69.
- ³³ Amy Finkelstein, et. al, "The Oregon Health Insurance Experiment: Evidence from the First Year" (National Bureau of Economic Research, July 2011), <http://www.nber.org/papers/w17190>.
- ³⁴ Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion on the ACA: Updated Findings From a Literature Review* (Washington, D.C.: Kaiser Family Foundation, March 2018), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicare-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.
- ³⁵ Sara Rosenbaum, Jennifer Tolbert, Jessica Sharac, Peter Shin, Rachel Gunsalus, and Julia Zur, *Community Health Centers: Growing Important in a Changing Health Care System*, (Washington, DC: Kaiser Family Foundation, March 2018), <https://www.kff.org/medicaid/issue-brief/community-health-centers-growing-importance-in-a-changing-health-care-system/>.
- ³⁶ Allen Dobson, Joan DaVanzo, Randy Haught, and Phap-Hoa Luu, *Comparing the Affordable Care Act's Financial Impact on Safety-Net Hospitals in States That Expanded Medicaid and Those That Did Not*, (New York, NY: The Commonwealth Fund, November 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/comparing-affordable-care-acts-financial-impact-safety-net>.
- ³⁷ Jane Wishner, et al., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies* (Washington, DC: The Urban Institute and Kaiser Family Foundation, July 2016), <https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/>.
- ³⁸ Sherry Glied and Richard Kronick, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills* (Washington, DC: Office of Assistant Secretary for Planning and Evaluation, HHS, May 2011), <http://aspe.hhs.gov/health/reports/2011/ValueofInsurance/rb.pdf>
- ³⁹ Philippe Gwet, Jerrod Anderson, and Steven Machlin, "Out-of-Pocket Health Care Expenses in the U.S. Civilian Noninstitutionalized Population by Age and Insurance Coverage, 2014," Agency for Healthcare Research and Quality (AHRQ), Statistical Brief #495, https://meps.ahrq.gov/data_files/publications/st495/stat495.shtml.
- ⁴⁰ Tim Xu, Angela Park, Ge Bai, Sarah Joo, Susan Hutfless, Ambar Mehta, Gerard Anderson, and Martin Makary, "Variation in Emergency Department vs Internal Medicine Excess Charges in the United States," *JAMA Intern Med.* 177(8): 1130-1145 (June 2017), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2629494%20>.
- ⁴¹ Stacie Dusetzina, Ethan Basch, and Nancy Keating, "For Uninsured Cancer Patients, Outpatient Charges Can Be Costly, Putting Treatments out of Reach," *Health Affairs* 34, no. 4 (April 2015): 584-591, <http://content.healthaffairs.org/content/34/4/584.abstract>
- ⁴² Kaiser Family Foundation analysis of the 2017 National Health Interview Survey.
- ⁴³ Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton, and Mollyann Brodie, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey*, (Washington, D.C.: Kaiser Family Foundation, Jan 2016), <http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey/>.

⁴⁴ Consumer Financial Protection Bureau, “Consumer Experiences with Debt Collection: Findings from the CFPB’s Survey of Consumer Views on Debt.” (Consumer Financial Protection Bureau: January 2017),

<https://www.consumerfinance.gov/data-research/research-reports/consumer-experiences-debt-collection-findings-cfpbs-survey-consumer-views-debt/>.

⁴⁵ Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton, and Mollyann Brodie, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey* (Washington, D.C.: Kaiser Family Foundation, January 2016), <https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/>.

⁴⁶ Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion on the ACA: Updated Findings From a Literature Review* (Washington, D.C.: Kaiser Family Foundation, March 2018), <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicare-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

⁴⁷ Ibid.