Center on Budget and Policy Priorities

1275 First Street NE, Suite 1200
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

March 21, 2019

Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage

By Aviva Aron-Dine and Matt Broaddus

The Affordable Care Act (ACA) has extended health coverage to more than 20 million people and has made coverage better or more affordable for millions more. Yet about 30 million non-elderly people remain without health insurance, about 12 million of them people for whom ACA marketplace plans are the relevant coverage option.[1] Public discussion has mostly focused on how to address the affordability challenges facing people with incomes too high to qualify for the ACA's premium and cost-sharing subsidies (the subject of a companion CBPP analysis).[2] However, lower-income people are much more likely to lack insurance, and they comprise the majority of the marketplace-eligible uninsured. (See Figure 1; for state-level data, see Appendix Table 1.) Evidence from state policies and federal policy changes shows that improving subsidies is key to increasing coverage for this group and therefore to driving down overall uninsured rates.

Lower-Income People More Likely to Be Uninsured

Under the ACA, people with incomes below 400 percent of the poverty line (about $50,000 for a single person, about $100,000 for a family of four) are eligible for premium tax credits to help purchase marketplace coverage. Some have suggested that, as a result of these subsidies, health insurance is now more affordable for most families at lower income levels than higher income levels.[3] But the data on uninsured rates by income level don't support that assertion.

The ACA has indeed made health insurance far more affordable for low- and moderate-income people. Since the ACA's subsidies took effect in 2014, uninsured rates for non-elderly people with incomes between 138 and 400 percent of the poverty line have fallen dramatically, from 19.2 percent

[1] Others are eligible for Medicaid, fall into the Medicaid coverage gap, have an offer of employer coverage, or are ineligible for marketplace coverage because of their immigration status. See Linda J. Blumberg *et al.*, "Characteristics of the Remaining Uninsured: An Update," Urban Institute, July 11, 2018, https://www.urban.org/research/publication/characteristics-remaining-uninsured-update.

[2] Aviva Aron-Dine, "Making Health Insurance More Affordable for Middle-Income Individual Market Consumers," Center on Budget and Policy Priorities, March 21, 2019, https://www.cbpp.org/research/health/making-health-insurance-more-affordable-for-middle-income-individual-market.

[3] See, for example Tami Luhby, "Is Obamacare Really Affordable? Not for the Middle Class," CNN Business, November 4, 2016, https://money.cnn.com/2016/11/04/news/economy/obamacare-affordable/index.html.

in 2013 to 12.5 percent in 2017.[4] Nonetheless, uninsured rates remain higher at lower incomes. For example, the uninsured rate is:

- 15.5 percent for people with incomes between 138 and 250 percent of the poverty line[5] (those eligible for the largest subsidies);
- 9.8 percent for people with incomes between 250 and 400 percent of the poverty line (eligible for smaller subsidies); and
- 6.0 percent for people with incomes between 400 and 500 percent of the poverty line (not eligible for subsidies).

As Figure 1 shows, uninsured rates nationally decrease with income across the income scale; the same pattern also holds in nearly every state.[6]

Low- and moderate-income people are less likely to have employer-sponsored coverage, but that is not the only reason they are more likely to be uninsured. Individual market coverage take-up among those without employer (or other) coverage is also lower at lower income levels. Among people with incomes between 138 and 250 percent of the poverty line, 41 percent of those without employer, Medicare, Medicaid, or other coverage are enrolled in an individual market plan. That compares to 53 percent between 250 and 400 percent of the poverty line, 63 percent of those between 400 and 500 percent of the poverty line, and 76 percent of those above 500 percent of the poverty line. While the ACA's premium and cost-sharing subsidies are highly progressive, they do not make up for the fact that lower-income people have far less disposable income.

[4] Uninsured rates have fallen for people with incomes above 400 percent of the poverty line as well, from 5.8 percent to 4.0 percent. Except where otherwise noted, all estimates are CBPP calculations from Census' American Community Survey data available through public use files. Uninsured rates are for the non-elderly population (those younger than 65).

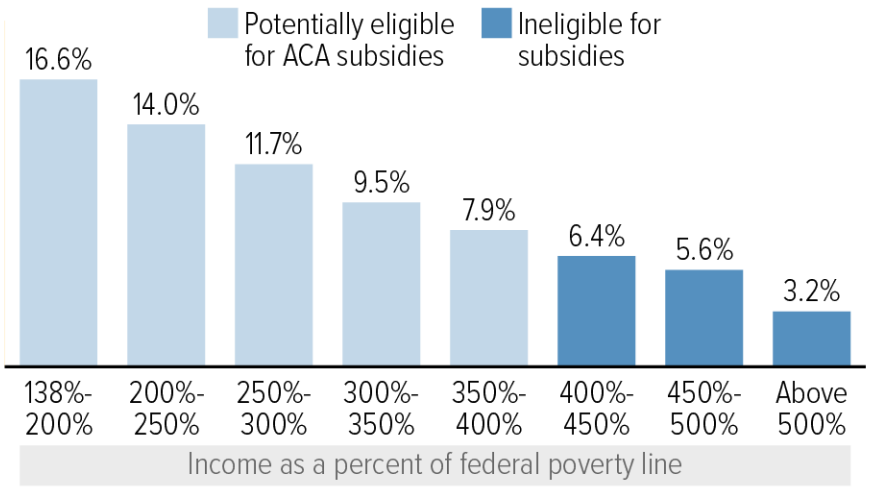
[5] We focus on those above 138 percent of the poverty line because those with incomes below that can obtain coverage through Medicaid in states that have taken up the ACA expansion. In non-expansion states, people with incomes between 100 and 138 percent of the poverty line are eligible for subsidized marketplace coverage, but people with incomes below 100 percent of the poverty line fall into a coverage gap (eligible for neither form of subsidized coverage).

[6] The exceptions are Alaska, where the uninsured rate is less for those between 250 and 400 percent of the poverty line than for those between 400 and 500 percent (though the uninsured rate for those between 138 and 250 percent of the poverty line is still higher), and the District of Columbia and Vermont, where the uninsured rate is slightly less for those between 138 and 250 percent of the poverty line than those between 250 and 400 percent. The District of Columbia provides Medicaid to people with incomes up to about 215 percent of the poverty line.

FIGURE 1

Uninsured Rates Are Higher at Lower Income Levels

Non-elderly uninsured rate, by income as a share of the federal poverty line



Note: Subsidies for Affordable Care Act marketplace coverage are available to people with income under 400% of the federal poverty line. The poverty line for a single individual is $12,490.

Source: CBPP analysis of Census 2017 American Community Survey data

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG

Increasing Coverage Will Require Improving Subsidies

Uninsured people at all income levels consistently cite cost as the greatest barrier to coverage.[7] Improving outreach and making it easier to enroll in marketplace plans can significantly increase enrollment, especially among subsidy-eligible people who may not realize how much financial assistance they qualify for.[8] But sharply reducing uninsured rates and improving access to care will also require making financial assistance more adequate. Importantly, reducing *sticker price* premiums generally does not make coverage more affordable for people who are eligible for subsidies. (See box, "How ACA Subsidies Work.")

[7] Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty, "Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?" Commonwealth Fund, September 2017, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_sep_collins_2017_aca_tracking_survey_ib_v2.pdf.

[8] See for example Joshua Peck, "Testimony Submitted to the House Appropriations Subcommittee on Labor, Health, and Human Services," February 6, 2019, https://docs.house.gov/meetings/AP/AP07/20190206/108858/HHRG-116-AP07-Wstate-PeckJ-20190206.pdf.

How ACA Subsidies Work

Under the ACA, consumers with incomes below 400 percent of the poverty line are eligible for premium tax credits. For these consumers, net premiums for benchmark coverage are capped at a fixed share of income, ranging from 3.42 percent of income for someone earning 138 percent of the poverty line ($17,236 for a single adult) to 9.86 percent of income for someone earning more than 300 percent of the poverty line ($37,470).

Premium tax credits are calculated as the difference between the sticker price of the benchmark plan and the relevant percentage of income. The benchmark plan is the second-lowest-cost "silver" plan offered in the consumer's area. Silver plans are those with "actuarial values" of about 70 percent, meaning that about 70 percent of expected health costs are covered by the premium, while about 30 percent are covered by deductibles and other cost sharing.

In addition to premium tax credits, consumers with incomes below 250 percent of the poverty line are eligible for cost-sharing assistance. That assistance raises the actuarial value of benchmark coverage from 70 percent to as much as 94 percent (for those with incomes below 150 percent of the poverty line). Where a typical 70 percent actuarial value plan has a deductible of about $4,000, a typical 94 percent actuarial value plan has a deductible of about $200.

The ACA's subsidy structure means that policies that reduce sticker price premiums, such as reinsurance programs, generally don't help subsidized consumers.[a]

To see why, consider the example of a subsidized consumer in Baltimore, Maryland, a state that saw significant drops in sticker price premiums from 2018 to 2019 due to introducing a reinsurance program. For a single 45-year-old earning $24,000 (about twice the poverty line), the 2018 benchmark plan had a sticker price premium of $516 per month. But the net premium was set at 6.29 percent of income, or $126 per month, with a premium tax credit of $390 making up the difference ($390 = $516 – 6.29%*$24,000/12).

In 2019 the sticker price premium for such a consumer's benchmark plan fell by about 8 percent, to $474 per month. But the net premium remained almost unchanged, at $129 per month. The premium tax credit declined to $345 due to the lower sticker price.

By lowering sticker prices, reinsurance programs can make coverage more affordable for unsubsidized consumers (those with incomes over 400 percent of the poverty line). But making coverage more affordable for subsidized consumers requires improving subsidies.[b]

a Reinsurance programs reduce premiums by reimbursing insurers for some of the costs associated with high-cost enrollees.

b Extending subsidies to people with incomes over 400 percent of the poverty line is generally also the better approach to helping these consumers. See Aron-Dine, "Making Health Insurance More Affordable for Middle-Income Individual Market Consumers."

Evidence from state policies and recent federal policy changes confirms that subsidy improvements substantially increase take-up of marketplace coverage and reduce uninsured rates.

- **States that offer extra financial assistance have lower uninsured rates.** Most striking, Massachusetts offers sizable additional subsidies that greatly reduce premiums for marketplace enrollees with incomes below 300 percent of the poverty line. The state's supplemental assistance also reduces cost sharing (compared to the levels under the ACA), especially for people with incomes between 200 and 300 percent of the poverty line. For example, people with incomes between 138 and 150 percent of the poverty line are guaranteed a $0 premium plan option, compared to premiums of $48 to $63 for benchmark coverage in other states. Similarly, people with incomes between 200 and 250 percent of the poverty line pay $85 per month for the lowest-cost plan in Massachusetts, compared to $132 to $211 per month for

the benchmark plan in other states.[9] Massachusetts has the lowest overall non-elderly uninsured rate in the nation (3.2 percent), as well as the lowest uninsured rate for people with incomes between 138 and 250 percent of the poverty line.

Several other states offer some, though generally less, additional help to low- and moderate-income consumers. Minnesota and New York both have Basic Health Programs open to people with incomes between 138 and 200 percent of the poverty line, with premiums lower than what these consumers would pay for marketplace coverage. The District of Columbia allows people with incomes up to about 215 percent of the poverty line to enroll in Medicaid, and Vermont provides supplemental financial assistance to people with incomes between 200 and 300 percent of the poverty line. While these states (as well as Massachusetts) have also adopted other policies that help increase coverage, it's noteworthy that all have below average uninsured rates, even compared to other states that have expanded Medicaid.

- **A rigorous study of the Massachusetts program finds extra financial assistance greatly increases take-up of marketplace coverage.** Massachusetts' subsidies are structured such that premiums increase by about $40 per month at 150 percent, 200 percent, and 250 percent of the federal poverty level. That means that researchers can estimate the impact of lower premiums by comparing enrollment rates among people just above versus just below those cut-offs. Using that approach, a study by Massachusetts Institute of Technology and Harvard economists finds that cutting premiums by about $40 per month increases take-up of individual market coverage among eligible people by 14 to 24 percentage points, with larger effects at lower income levels.[10] (For example, they estimate that 70 percent of eligible people in Massachusetts with income just above 150 percent of the poverty line took up marketplace coverage in 2011, compared to 94 percent of people with incomes just below 150 percent of the poverty line.)

  Notably, the additional people who enroll due to lower premiums are healthier and have lower health care spending, on average, than those who enroll with less financial assistance. For example, monthly costs are 14 percent higher among people with incomes just above 150 percent of the poverty line (facing higher net premiums) than just below 150 percent of the poverty line (facing lower net premiums), the researchers estimate. That suggests that improving financial assistance would not only increase coverage rates but also strengthen the marketplace risk pool, which would reduce sticker price premiums.

- **"Silver loading," which increases financial assistance, appears to have increased take-up of marketplace coverage.** In late 2017, the Trump Administration decided to stop reimbursing marketplace insurers for the cost-sharing reductions (CSRs) they are required to provide to lower-income consumers. While President Trump was clear that he expected stopping CSR payments would destabilize the marketplaces,[11] his decision ended up benefiting consumers.

---

[9] The plans consumers can obtain for these premiums in Massachusetts also have lower out-of-pocket costs than benchmark coverage in other states, taking into account the ACA's cost-sharing assistance. On the other hand, since the benchmark plan is the second-lowest-cost silver plan, consumers in other states can purchase the lowest-cost silver plan for a lower net premium than they pay for benchmark coverage.

[10] Amy Finkelstein, Nathaniel Hendren and Mark Shepard, "Subsidizing Health Insurance for Low-income Adults: Evidence from Massachusetts," National Bureau of Economic Research, June 2018, https://economics.mit.edu/files/15852.

[11] Michael C. Bender, Louise Radnofsky, and Peter Nicholas, "Trump Threatens to Withhold Payments to Insurers to Press Democrats on Health Bill," *Wall Street Journal*, April 12, 2017, https://www.wsj.com/articles/trump-threatens-to-withhold-payments-to-insurers-to-press-democrats-on-health-bill-1492029844.

Ending CSR reimbursements gave rise to "silver loading," or insurers building the cost of CSRs into their marketplace silver plan premiums. Because premium tax credits are based on silver plan premiums, that approach makes financial assistance more generous. (See box, "How Silver Loading Is Making Coverage More Affordable.") But the extent to which silver loading increased financial assistance in 2018 varied significantly by state.

Looking across states, marketplace enrollment in 2018 increased more in states where silver loading had a greater impact on premium tax credits. Moreover, the correlation was greatest for consumers with incomes between 250 and 400 percent of the poverty line, who benefit the most from silver loading; it was weaker for consumers with incomes between 200 and 250 percent of the poverty line, who benefit some; and was approximately 0 for consumers with incomes below 200 percent of the poverty line, who benefit little.[12] Consistent with these data, the Congressional Budget Office estimates that silver loading is reducing the number of uninsured by 500,000 to 1 million people.[13]

[12] The correlation was slightly negative for consumers with incomes above 400 percent of the poverty line, whose incentive under silver loading often is to instead enroll in individual market plans offered outside the marketplaces, meaning they would not be counted in these data. Specifically, the correlation between the percent change in enrollment and the state-level gap between the premium increase for the benchmark silver plan versus the lowest-cost bronze plan (in HealthCare.gov states) was 0.05 for people with incomes between 100 and 150 percent of the poverty line, 0.02 from 150 to 200 percent of the poverty line, 0.29 from 200 to 250 percent of the poverty line, 0.40 from 250 to 300 percent of the poverty line, 0.39 from 350 to 400 percent of the poverty line, and -0.17 for those above 400 percent of the poverty line or with unknown income.

[13] Congressional Budget Office, "Appropriation of Cost-Sharing Reduction Subsidies," March 19, 2018, https://www.cbo.gov/publication/53664.

How Silver Loading Is Making Coverage More Affordable

Under the ACA, insurers are required to provide reduced cost sharing (lower deductibles, co-pays, and co-insurance) to lower-income consumers who enroll in silver tier marketplace plans; the federal government is then supposed to compensate insurers through cost-sharing reduction payments. After the Trump Administration halted these payments in October 2017, insurers in most states began instead defraying their costs by charging higher silver plan premiums, a practice referred to as "silver loading."

That shift in how insurers are compensated for cost-sharing assistance has resulted in more affordable coverage options for many people. The ACA's premium tax credits are based on the premium of the second-lowest-cost *silver* plan where a person lives, but consumers can also use these tax credits to purchase bronze (lower premium, higher deductible) or gold (higher premium, lower deductible) plans. Their net premium is the difference between the sticker price premium for the plan they select and their tax credit.

Because of the Administration's decision to halt cost-sharing reduction payments, silver plan premiums — and therefore premium tax credits — increased more rapidly than bronze or gold plan premiums for 2018. The result is that many subsidized consumers can now purchase bronze plans with very low net premiums, or can purchase lower-deductible gold plans for less than silver plans. Meanwhile, unsubsidized consumers can largely avoid the premium increases resulting from silver loading by purchasing bronze or gold plans or, in many states, by purchasing silver plans outside the ACA marketplaces.

In 2018, millions of consumers were able to lower their premiums, cost sharing, or both due to silver loading. The benefits involved are significant: a typical 45-year-old purchasing a bronze or gold plan is paying $1,085 less per year than without silver loading, while a 60-year-old is paying $2,039 less.[a] And (as noted elsewhere) the Congressional Budget Office (CBO) estimates silver loading is increasing coverage by 500,000 to 1 million people.

The uninsured-rate data cited in this analysis predate silver loading, but other data confirm that, even though silver loading has made coverage more affordable for subsidized consumers, it has not reversed the basic finding that lower-income people are much more likely to be uninsured.[b] Nonetheless, silver loading has been a significant step in the direction of making coverage more affordable at lower income levels. Reversing silver loading by restoring direct payments of cost-sharing reductions — without compensating improvements in subsidies — would cut over $10 billion per year from federal subsidies, according to CBO estimates, making coverage less affordable for millions of people and increasing uninsured rates.

H.R. 5155, the House ACA improvement bill discussed in this analysis, would restore direct payments of cost-sharing reductions, undoing silver loading. However, it would couple that change with increases in subsidies that would more than make up for the loss of silver loading (and would use the federal savings from ending silver loading to partially pay for those improvements).

[a] Aviva Aron-Dine, "Individual Market Stabilization Proposals Should Avoid Raising Costs for Consumers," Center on Budget and Policy Priorities, March 9, 2018, https://www.cbpp.org/research/health/individual-market-stabilization-proposals-should-avoid-raising-costs-for-consumers.

[b] Based on the National Health Interview Survey, in the first nine months of 2018, the uninsured rate was 20.6 percent among non-elderly adults with incomes between 138 and 250 percent of the poverty line, 11.8 percent for those with incomes from 250 to 400 percent of the poverty line, and 4.6 percent above 400 percent of the poverty line. National Center for Health Statistics, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-September 2018," February 27, 2019, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201902.pdf.

Policy Options for Improving Financial Assistance

Several legislative proposals introduced in the previous Congress would significantly improve the ACA's subsidies, reducing both premiums and out-of-pocket costs (deductibles, co-insurance, and co-payments) for subsidized consumers. H.R. 5155, introduced by Representatives Frank Pallone, Richard Neal, and Bobby Scott (now the chairs of the three House committees with jurisdiction over the ACA), would significantly increase both premium tax credits and cost sharing assistance, lowering net premiums for subsidized ACA consumers to closer to Massachusetts levels. The bill would also extend subsidies to people above 400 percent of the poverty line.

Legislation introduced by Senator Elizabeth Warren (S. 2582) would make similar changes. Other proposals would make more limited but targeted improvements, for example lowering premiums for young adults (S. 2529, introduced by Senator Tammy Baldwin). All of these proposals would advance the goals of expanding coverage and making premiums and out-of-pocket costs more affordable for those who are already insured.

Major subsidy improvements along the lines of those included in H.R. 5155 would likely extend coverage to at least several million people, at a cost of several hundred billion dollars over ten years.[14] One option for offsetting the cost would be to roll back a portion of the tax cuts in the 2017 tax bill, which will cost nearly $2 trillion over ten years. Notably, the 2017 tax bill cut $314 billion over ten years from health programs by repealing the ACA's individual mandate penalty, leading fewer people to sign up for subsidized coverage.[15] Undoing tax cuts worth that amount could pay for major subsidy improvements.

[14] The Urban Institute found that a similar set of changes would have cost $221 billion from 2016 to 2025. Linda J. Blumberg and John Holohan, "After *King v. Burwell*: Next Steps for the Affordable Care Act," Urban Institute, August 2015, https://www.urban.org/sites/default/files/publication/65196/2000328-After-King-v.-Burwell-Next-Steps-for-the-Affordable-Care-Act.pdf. Costs would be higher in the 2020-2029 budget window, but would be partially offset by undoing silver loading; see box, "How Silver Loading Is Making Coverage More Affordable."

[15] Aviva Aron-Dine, "Senate Tax Bill Would Add 13 Million to Uninsured to Pay for Tax Cuts of Nearly $100,000 Per Year for the Top 0.1 Percent," Center on Budget and Policy Priorities, November 15, 2017, https://www.cbpp.org/blog/senate-tax-bill-would-add-13-million-to-uninsured-to-pay-for-tax-cuts-of-nearly-100000-per-year.

Appendix Table: Non-Elderly Uninsured, by Income, 2017

State	Non-elderly uninsured						Non-elderly uninsured rate (%)					
	Below 138% FPL	138%-250% FPL	250%-400% FPL	400%-500% FPL	Above 500% FPL	Total	Below 138% FPL	138-250% FPL	250-400% FPL	400-500% FPL	Above 500% FPL	Total
Alabama	214,810	114,260	69,990	20,570	29,220	448,850	20.6	13.6	8.1	5.2	3.5	11.3
Alaska	19,670	30,150	20,100	11,980	15,880	97,790	17.5	27.0	14.8	18.0	7.4	15.3
Arizona	228,990	219,960	132,690	43,310	53,160	678,100	17.3	18.0	10.7	7.8	4.0	12.0
Arkansas	87,540	69,540	46,600	13,920	14,440	232,040	13.6	12.1	8.8	5.9	3.2	9.5
California	871,290	803,460	588,360	177,120	298,100	2,738,320	12.8	12.5	9.0	5.8	2.8	8.2
Colorado	105,360	124,490	100,730	31,310	43,110	404,990	13.9	14.6	9.9	5.9	2.8	8.6
Connecticut	47,590	50,960	47,500	15,490	30,780	192,320	11.2	11.9	8.5	5.2	2.6	6.6
Delaware	14,310	16,370	11,780	3,750	4,360	50,570	9.4	13.4	7.7	4.1	1.8	6.6
DC	5,800	5,430	6,390	1,260	4,690	23,580	4.7	7.4	8.3	2.5	1.9	4.1
Florida	932,910	769,480	538,040	153,200	212,180	2,605,800	25.0	20.6	14.8	9.8	5.6	15.9
Georgia	557,200	377,970	233,010	77,220	98,160	1,343,560	27.0	20.9	12.9	8.8	4.4	15.3
Hawaii	15,300	12,550	9,790	5,120	7,070	49,820	9.4	6.6	3.7	3.4	1.9	4.4
Idaho	64,320	52,560	38,540	10,480	14,000	179,890	21.1	14.3	11.3	8.0	5.0	12.6
Illinois	281,360	251,540	183,420	58,230	61,380	835,930	13.5	13.3	8.3	5.1	1.9	7.9
Indiana	194,200	163,250	105,080	37,180	37,370	537,080	16.7	14.7	8.2	6.0	2.9	9.8
Iowa	36,700	42,570	33,860	8,690	9,420	131,240	8.5	8.5	5.5	2.7	1.4	5.2
Kansas	98,040	69,840	45,790	8,010	17,060	238,750	21.6	14.2	8.0	3.1	2.8	10.0
Kentucky	93,420	69,170	45,880	11,700	13,440	233,610	9.8	9.2	5.7	3.3	1.8	6.4
Louisiana	149,050	103,850	62,450	23,410	35,080	373,850	13.1	13.6	8.6	6.2	4.0	9.6
Maine	36,930	29,350	20,440	7,430	7,460	101,610	18.8	15.6	8.4	5.6	2.6	9.8
Maryland	95,250	97,800	82,040	25,110	55,860	356,060	13.5	12.9	8.9	4.5	2.7	7.1
Massachusetts	44,000	41,930	42,980	16,650	32,970	178,540	5.2	5.9	4.5	2.8	1.4	3.2
Michigan	167,300	157,240	102,060	23,510	42,330	492,450	9.3	10.1	5.6	2.9	2.0	6.1
Minnesota	72,280	74,450	56,530	14,400	24,070	241,720	10.4	10.0	5.7	2.5	1.5	5.2

Appendix Table: Non-Elderly Uninsured, by Income, 2017

State	Non-elderly uninsured						Non-elderly uninsured rate (%)					
	Below 138% FPL	138%-250% FPL	250%-400% FPL	400%-500% FPL	Above 500% FPL	Total	Below 138% FPL	138-250% FPL	250-400% FPL	400-500% FPL	Above 500% FPL	Total
Mississippi	161,320	98,070	57,160	14,310	15,980	346,850	22.2	17.6	10.9	6.5	3.9	14.2
Missouri	228,170	149,580	97,480	23,770	33,310	532,290	21.2	15.0	8.5	4.3	2.8	10.7
Montana	28,080	27,550	19,590	6,070	10,530	91,830	16.4	15.5	10.4	6.6	5.0	10.9
Nebraska	64,120	41,900	31,790	10,760	9,370	157,930	23.1	13.6	7.6	5.6	2.4	10.0
Nevada	105,270	97,860	64,990	22,030	30,940	321,080	19.8	17.4	11.0	8.6	5.6	12.9
New Hampshire	17,120	18,990	22,430	6,760	7,760	73,070	13.5	12.4	9.6	4.7	1.9	6.8
New Jersey	204,600	172,050	143,860	49,600	89,080	659,180	18.7	16.2	11.0	6.2	2.8	8.8
New Mexico	67,500	52,150	40,610	9,010	12,810	182,070	13.4	14.2	11.1	5.8	4.1	10.7
New York	335,770	279,590	230,500	85,410	154,720	1,085,990	9.8	10.4	7.7	5.2	2.8	6.7
North Carolina	446,620	308,770	185,460	53,010	67,050	1,060,920	23.0	17.7	10.1	6.3	3.3	12.6
North Dakota	19,250	14,520	11,970	3,580	4,750	54,070	20.9	13.2	7.6	4.8	2.5	8.6
Ohio	213,990	208,730	130,700	43,630	54,550	651,600	10.5	11.6	6.1	4.1	2.2	6.9
Oklahoma	213,500	153,500	88,390	31,450	40,780	527,630	26.0	20.9	12.4	9.8	6.3	16.3
Oregon	77,650	87,840	60,840	19,500	26,640	272,480	11.2	13.6	8.0	5.6	2.9	8.1
Pennsylvania	209,740	198,250	151,070	40,950	76,120	676,130	10.8	11.6	6.7	3.6	2.4	6.6
Rhode Island	14,450	13,400	9,090	3,290	5,030	45,260	9.9	9.3	5.5	3.6	1.7	5.3
South Carolina	241,800	143,320	95,720	21,590	36,870	539,290	24.0	16.3	10.8	5.6	4.2	13.4
South Dakota	34,180	20,020	17,190	2,270	3,550	77,210	24.8	15.1	9.3	3.0	2.1	11.0
Tennessee	249,080	168,520	108,920	35,420	49,410	611,350	19.1	14.4	8.6	6.4	4.1	11.1
Texas	1,767,930	1,404,410	941,930	246,690	383,370	4,744,330	31.7	27.7	18.3	10.7	6.2	19.5
Utah	88,870	85,840	57,660	17,240	23,430	273,040	20.7	14.0	8.0	5.2	3.7	10.0
Vermont	3,380	6,500	7,610	2,800	4,390	24,690	3.9	6.3	7.0	5.0	3.3	5.1
Virginia	237,640	192,930	154,350	48,510	72,190	705,610	21.1	17.0	10.7	6.3	2.9	10.1
Washington	128,460	116,100	99,330	34,630	54,840	433,370	12.4	11.1	7.7	5.0	2.6	7.0

Appendix Table: Non-Elderly Uninsured, by Income, 2017

State	Non-elderly uninsured						Non-elderly uninsured rate (%)					
	Below 138% FPL	138%-250% FPL	250%-400% FPL	400%-500% FPL	Above 500% FPL	Total	Below 138% FPL	138-250% FPL	250-400% FPL	400-500% FPL	Above 500% FPL	Total
West Virginia	37,200	25,460	21,010	8,420	8,680	100,760	9.1	9.4	6.7	5.6	3.1	7.1
Wisconsin	92,990	93,690	61,350	15,310	23,830	287,170	11.4	10.8	5.7	2.5	1.8	6.1
Wyoming	24,640	19,520	12,970	5,110	6,850	69,080	28.6	20.5	11.6	7.8	5.8	14.4
United States	**9,746,900**	**7,947,200**	**5,548,020**	**1,660,150**	**2,468,430**	**27,370,700**	**17.5**	**15.5**	**9.8**	**6.0**	**3.2**	**10.2**

Source: CBPP analysis using the Census Bureau's 2017 American Community Survey data. FPL = federal poverty line. Non-elderly refers to those under age 65. All figures are rounded to the nearest ten. All figures are for those in the Census Bureau's poverty universe, the group of people for whom the Census Bureau gathers information on poverty status. This excludes those who are institutionalized or foster care children. Income cut-offs correspond to $17,236, $31,225, $49,960, and $62,450 for a single adult, or $35,535, $64,375, $103,000, and $128,750 for a family of four.

People with incomes between 138 and 400 percent of the poverty line are generally eligible for subsidized marketplace coverage, although our analysis does not allow us to separate out those who are ineligible for marketplace coverage because of their immigration status or ineligible for subsidies because they have an offer of employer coverage. People with incomes below 138 percent of the poverty line are generally eligible for Medicaid in states that have taken up the ACA expansion. In non-expansion states, adults with incomes between 100 and 138 percent of the poverty line can obtain subsidized marketplace coverage, but adults with incomes below 100 percent of the poverty line are caught in a "coverage gap," unable to access either form of subsidized coverage. People with incomes above 400 percent of the poverty line are ineligible for subsidies because of their incomes.