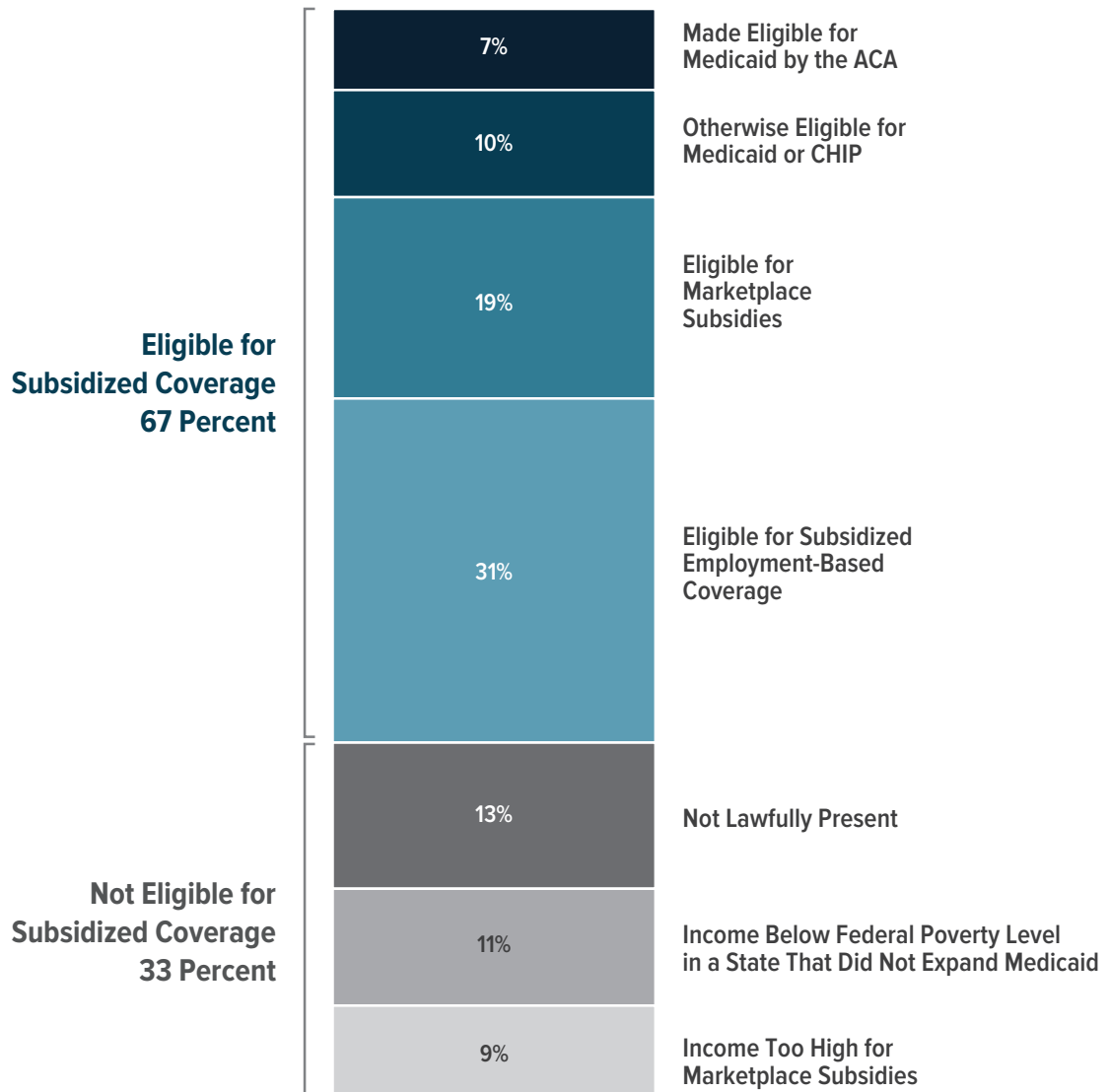


CBO

Who Went Without Health Insurance in 2019, and Why?

Total Uninsured in 2019: 29.8 Million



SEPTEMBER 2020

At a Glance

In 2019, about 12 percent of people under 65 were not enrolled in a health insurance plan or a government program that provides financial protection from major medical risks. In this report, the Congressional Budget Office describes that uninsured population. CBO's analysis sheds light on groups that were not covered by comprehensive health insurance even during the strong economy and historically low unemployment that preceded the 2020 coronavirus pandemic.

- **Characteristics and Coverage Options.** The uninsured population is heterogeneous, but some groups, including low-income people, were more likely than others to be uninsured in 2019. About two-thirds of uninsured people were eligible for some form of subsidized coverage, although the generosity of available subsidies varied on the basis of people's family income, access to employment-based coverage, and other factors. A smaller number of uninsured people had no option for coverage except a private plan purchased at full cost.
- **Financial Liability and Access to Health Care.** Uninsured people receive some types of health care and are often not required to pay the full billed charges for that care, but they have substantially less access to care and financial protection than insured people. Uninsured people who are eligible for Medicaid have more financial protection than others because they can enroll without waiting for an open enrollment period—in some cases, as they are seeking care in hospitals or other settings—and may receive coverage retroactively. However, they are still exposed to some financial risk and can have trouble accessing care.
- **Reasons for Going Without Coverage.** Many uninsured people do not enroll in coverage because of the cost; others may not know that they are eligible for subsidized coverage or may be deterred by the complexity of enrolling. Although the majority of uninsured people could obtain coverage for 10 percent or less of their income, they may not view the coverage to be worth the cost.
- **Length of Time Without Coverage.** Most people who were uninsured at a particular point in recent years went without coverage for at least one year. A smaller share lacked coverage for shorter periods.



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As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

Numbers in the text, tables, and figures may not add up to totals because of rounding.

Estimates of health insurance coverage reflect average monthly enrollment during a calendar year and include spouses and dependents covered under family policies. Those estimates are for the civilian noninstitutionalized population under age 65.

In most states, the federal poverty level in 2019 was \$12,490 for a single person and increased by \$4,420 for each additional person in a household. Income levels reflect modified adjusted gross income (MAGI) for the calendar year. MAGI equals gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and the income of dependent filers.

The term “family” is used in this report to indicate the set of individuals who could generally be covered by a family plan if an employer offered that plan. Such a grouping is also known as a health insurance unit.

This report was prepared using estimates of health insurance coverage from CBO’s baseline projections of federal spending and revenues under current law as of March 6, 2020. CBO’s estimates of the number of uninsured in 2019 did not change substantially between its March 2020 baseline and its September 2020 baseline.



Who Went Without Health Insurance in 2019, and Why?

Summary

The Congressional Budget Office estimates that at any given point in 2019, about 12 percent of the population under age 65, or 30 million people, were uninsured—that is, they were not enrolled in a private health insurance plan or a government health program that provides comprehensive major medical coverage. Examining that uninsured population in 2019 reveals groups that were often not reached by current federal programs, subsidies, and other sources of coverage even during a strong economy with historically low unemployment. Those insights will remain important in 2020 and beyond, even though the number of people without health insurance is estimated to increase as a result of the novel coronavirus pandemic, economic changes, and other factors.

Characteristics and Coverage Options of the Uninsured

The uninsured population in 2019 included a wide variety of people, but some demographic groups were more likely than others to be uninsured. CBO estimates that people in low-income households were more likely to be uninsured than those with higher income, and nonelderly adults were much more likely to be uninsured than children. Noncitizens who were not lawfully present in this country were particularly likely to be uninsured, although that group comprised just 16 percent of the uninsured population. By contrast, even though most nonelderly people with health insurance were covered through an employer, people in families in which no one worked were not markedly more likely to be uninsured than people in families with a full-time worker. The vast majority of uninsured people had at least one full-time worker in their family in 2019.

CBO classified uninsured people into mutually exclusive groups on the basis of their options for subsidized coverage or the reasons they lacked those options (see Figure 1). In CBO's assessment, about two-thirds of uninsured people had access to at least one type of fully or partially subsidized coverage. To categorize those

people into groups, CBO started with those for whom the federal subsidy would cover the greatest share of the cost, on average.

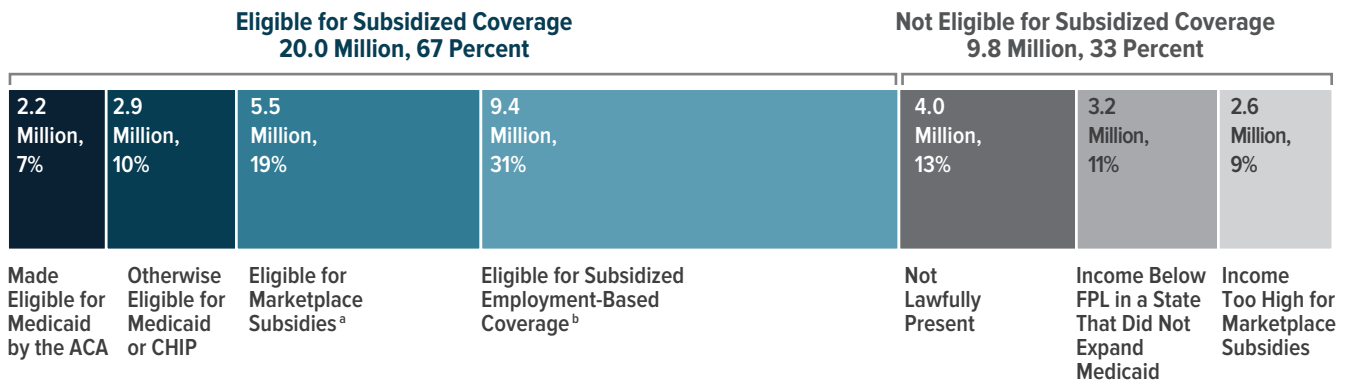
- Seven percent of nonelderly people without health insurance were adults who were eligible for Medicaid because they lived in a state that had expanded the program under the terms of the Affordable Care Act (ACA). (Specifically, those states extended eligibility to all adults with income up to 138 percent of the poverty level.)
- Ten percent were adults and children who were otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP).
- Nineteen percent were eligible for subsidized coverage through the health insurance marketplaces established under the ACA.
- Thirty-one percent had access to subsidized coverage through employment.

CBO estimates that about one-third of uninsured people generally did not have access to subsidized coverage. CBO categorized them into mutually exclusive groups on the basis of the primary reason they were not eligible for subsidies.

- Thirteen percent were noncitizens who were not lawfully present in this country and did not have access to coverage through an employer. They were generally eligible for public coverage only for emergency care; otherwise, their options for coverage were limited to private insurance plans purchased outside of the marketplaces at full cost.
- Eleven percent had income below the poverty level but were ineligible for Medicaid because they lived in a state that did not expand the program under the terms of the ACA.

Figure 1.

Eligibility for Subsidized Coverage Among the Uninsured in 2019



Source: Congressional Budget Office.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program; FPL = federal poverty level.

- a. A small number of people in this group would technically be eligible for subsidies, but those subsidies would equal zero dollars.
- b. A small number of people in this group were self-employed and could receive a subsidy by deducting their premiums from their federal income taxes.

- Nine percent had income too high to qualify for marketplace subsidies and did not have access to subsidized coverage through an employer; generally, their only option was to buy coverage directly from insurers at full cost.

Financial Liability and Access to Health Care

Uninsured people have less financial protection and access to health care than people with insurance, although the degree of those differences varies for individuals in different circumstances. Uninsured people who are eligible for Medicaid but not enrolled have more financial protection from high medical bills than other uninsured people. Medicaid allows eligible people to enroll at any point—in some cases, at the time they seek care (such as in hospital emergency departments)—and offers retroactive coverage for many enrollees. By contrast, uninsured people whose only option is to purchase a private plan often face the full billed charges for their health care, although some file for bankruptcy to avoid paying those costs or obtain discounted or charity care instead. Those high out-of-pocket costs, along with the difficulty of finding providers who will see patients without up-front payment, result in lower access to care.

Reasons for Going Without Coverage

Uninsured people have different reasons for not obtaining health insurance. The most common is the cost of

health insurance premiums. CBO estimates that roughly one-third of uninsured single adults would have to pay more than 10 percent of their income for health insurance. Uninsured people might not consider insurance to be worth the cost if it requires high deductibles, copayments, or other forms of cost sharing. Alternatively, they might be deterred by the complexity of enrolling in coverage, or they might not be aware that subsidized coverage is available.

Uninsured people who are eligible for Medicaid or CHIP can generally enroll without paying a premium and would have very low cost sharing in those programs. Again, however, unawareness of their eligibility or the complexity of the enrollment process may prevent them from applying or make it difficult for them to renew their coverage. In addition, recent immigrants may be discouraged from applying for Medicaid coverage for their citizen children because they fear it could prevent them from becoming permanent legal residents.

Length of Time Without Coverage

Some people who become uninsured are merely transitioning between different sources of coverage, whereas others remain uninsured for longer periods. In recent years, about 11 percent of the people who were uninsured at any given point in time lacked coverage for less than six months altogether, whereas 80 percent went

Box 1.**The Impact of the Coronavirus Pandemic on the Uninsured Population in 2020 and Beyond**

Since the end of 2019, the spread of the novel coronavirus has resulted in increases in unemployment, substantial changes in household income, and increasing strains on the health care delivery system. Recent legislation in response to the pandemic has included federal funding for testing for COVID-19 (the disease caused by the coronavirus), treatment for uninsured people, and tax credits for employers that continue contributing to the health insurance premiums of furloughed employees; it has also required health insurance plans to cover COVID-19 testing with no cost sharing.

Against the backdrop of those changes, in the Congressional Budget Office's estimation, the number of people without health insurance will increase to about 31 million in 2020.¹ That uninsured population in 2020 will include most of the approximately 30 million people who would have been uninsured in the absence of the coronavirus pandemic, plus additional

1. For further discussion of CBO's estimates of the number of uninsured people in 2020, see Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030* (September 2020), www.cbo.gov/publication/56571.

people who lose health insurance coverage on account of the pandemic (for example, because of a layoff or business closure) and do not obtain alternative coverage. Therefore, understanding the people who lacked insurance before the pandemic remains relevant even in a rapidly changing economy.

The increase in the uninsured population in 2020 and beyond will be mitigated by several factors. First, although millions of people have lost their jobs, those job losses have been concentrated in industries—such as leisure and hospitality—that often do not offer employment-based insurance. Second, some of the people who lose insurance will obtain alternative coverage through Medicaid, CHIP, the health insurance marketplaces, or a family member's employer. Third, even among those who were already uninsured before the pandemic, changes in household income will affect people's eligibility for subsidized coverage. Some of those people might become eligible for and enroll in Medicaid, CHIP, or plans offered through the marketplaces during special enrollment periods. Fourth, some people will be able to continue their enrollment in Medicaid longer than they otherwise could have, thanks to the extension of continuous-eligibility rules during the pandemic.

without coverage for a year or more. People with lower income tended to remain uninsured for longer periods, and adults remained uninsured longer than children.

Estimating the number of people who are uninsured at one moment in time is only one way to measure the uninsured population. An alternative way is to estimate the number of people who are uninsured at any point over a given period. Although only 12 percent of people under 65 were uninsured at a given moment in 2019, a larger percentage went without coverage for some amount of time over a longer period. In recent years, for example, about one-quarter of the nonelderly population went without coverage at some point over a two-year period.

CBO's Analysis of the Uninsured Population After 2019

This report reflects CBO's analysis of the population without health insurance coverage in 2019, based on data from that year and earlier years. In 2020, the novel coronavirus pandemic has disrupted the economy

and caused millions of people to lose their jobs—and, in some cases, their employment-based coverage (see Box 1). Information about the effects of the pandemic is changing quickly, and new developments may affect CBO's assessments of the number of people without health insurance coverage, the composition of that population, their options for coverage, how long they will remain uninsured, and other topics addressed in this report. CBO will continue to monitor the uninsured population in 2020 and how increases in that population affect the outcomes analyzed here.

What Are the Demographic Characteristics of Uninsured People?

CBO's analysis of uninsured people focused on four demographic characteristics: age, family income, citizenship and legal status, and employment. Those characteristics affect people's options for coverage and the cost of those options. Government health insurance programs and income-based subsidies for coverage are often available to members of low- and moderate-income families and to children, but those options are generally

Table 1.

Characteristics of Nonelderly People Without Health Insurance, 2019

	Millions of Uninsured People	Percentage of Group Without Insurance	Percentage of the Uninsured Population
Age			
Less than 19	5	6	16
19 to 64	25	14	84
Family Income Relative to the Poverty Level			
Less than 138 percent	10	14	35
138 to 249 percent	7	14	22
250 to 399 percent	6	13	20
400 percent or more	7	8	23
Sex			
Male	15	12	52
Female	14	11	48
Family Size			
Single person	14	13	48
Two or more people	15	10	52
Family Employment Status			
At least one full-time worker	24	11	82
Part-time workers only	2	15	7
No work	3	12	11
Legal Status			
Citizens and lawfully present noncitizens	25	10	84
Noncitizens not lawfully present	5	48	16
Total Nonelderly Population	30	12	100

Source: Congressional Budget Office, using the Health Insurance Simulation Model, which incorporates survey and administrative data from a variety of sources. See Jessica Banthin and others, *Sources and Preparation of Data Used in HISIM2—CBO’s Health Insurance Simulation Model*, Working Paper 2019-04 (Congressional Budget Office, April 2019), www.cbo.gov/publication/55087.

The term “family” is used in this report to indicate the set of individuals who could generally be covered by a family plan if an employer offered that plan. Such a grouping is also known as a health insurance unit.

not available to people with higher income (who often have access to subsidized insurance through an employer) or to noncitizens who are not lawfully present in the United States.

CBO’s analysis of the relationships between demographic characteristics and coverage is based on the agency’s estimates of those factors for 2019. Over the past several years, those relationships changed somewhat as an increasing number of states expanded eligibility for their Medicaid programs, premiums increased in the nongroup market (that is, for plans purchased directly from insurance companies), and the penalty

for the individual mandate (a provision of the ACA that required most people to have health insurance) was repealed. They could change more dramatically in 2020 as a result of changing economic conditions.

Although the uninsured population includes individuals from all age and income groups, some groups are more likely to be uninsured than others. In 2019, adults were more than twice as likely as children to be uninsured, and people in low-income households were more likely to be uninsured than those with higher income (see Table 1). CBO estimates that 14 percent of people with income below 250 percent of the poverty level were

uninsured in 2019, compared with 8 percent of people with income over 400 percent of the poverty level. Men were slightly more likely to be uninsured than women, and single people were somewhat more likely to be uninsured than people in families. Legal status was also strongly associated with coverage: 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.

By contrast, employment status was not strongly linked to coverage in 2019. Although most nonelderly people are covered by employment-based insurance, not all employers offer coverage, and people are less likely to be enrolled in Medicaid if they or their family members are working full time. Thus, CBO estimates that full-time workers and their family members were nearly as likely to be uninsured as people in families in which no one worked. People in families with only part-time workers, who made up just 5 percent of the overall nonelderly population, were somewhat more likely to be uninsured.

The demographic composition of the uninsured population reflects both the likelihood of being uninsured within each demographic group and the size of each group as a share of the total nonelderly population. For example, according to CBO's estimates, 48 percent of noncitizens who were not lawfully present were uninsured in 2019, but only 16 percent of uninsured people fell into that category because it accounts for a relatively small share of the overall population. Although lower-income people were more likely to be uninsured, 23 percent of uninsured people had income above 400 percent of the poverty level (the limit for qualifying for marketplace subsidies). Finally, 82 percent of uninsured people were in families with at least one full-time worker, similar to the 84 percent of the overall population under age 65. However, uninsured workers were less likely to have jobs that offered health insurance.

What Types of Coverage Are Available to Uninsured People?

CBO classified uninsured people into mutually exclusive groups on the basis of their options for subsidized coverage or the reasons they lacked those options in 2019 (see Table 2). To estimate the number of people in each group, CBO assigned uninsured people to the most heavily subsidized option available to them (see Figure 2). Many uninsured people had no available options for subsidized coverage. CBO categorized those people into

groups based on the primary reason they were not eligible for such coverage.¹

People Eligible for Subsidized Coverage

About two-thirds of uninsured people had access to subsidized coverage, in CBO's assessment. Subsidized coverage was available to people with low to moderate income and to those eligible for subsidized employment-based insurance.

Medicaid and CHIP. CBO estimates that 17 percent of uninsured people in 2019 were eligible for coverage through Medicaid or CHIP.² Fewer than half were adults who were eligible for Medicaid because they lived in states that had expanded the program under the ACA; the rest were adults and children who were otherwise eligible for Medicaid (regardless of whether their state had expanded Medicaid under the ACA) or CHIP. Before the ACA's enactment, Medicaid primarily covered children, pregnant women, disabled individuals, and parents with very low income; income limits for the program varied somewhat by state and by eligibility category. The ACA allowed states to expand Medicaid eligibility to all adults with family income up to 138 percent of the poverty level.³

Because eligibility for Medicaid and CHIP is based on income, uninsured people with low income were much more likely to have the option of enrolling. Uninsured single adults were also more likely to be eligible for

1. CBO's estimates may differ from estimates published elsewhere for two main reasons. First, whereas many outside estimates are based on data from a single survey, the primary source of these estimates is CBO's health insurance simulation model, which begins with data from the Census Bureau's Current Population Survey but enhances and adjusts those data to incorporate information from other sources and to match administrative data on enrollment, income, and other details. Second, the order in which CBO assigns uninsured people who may be eligible for multiple sources of coverage into mutually exclusive groups (also known as the hierarchy) may differ from the order chosen by other researchers.
2. Although CHIP primarily covers children, pregnant women can enroll in the program in some states.
3. As originally enacted, that expansion was required for states to obtain federal matching funds for any part of their Medicaid program. The Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius* allowed states to choose whether to expand eligibility for coverage under their Medicaid program under the terms of the ACA. In 2019, 33 states and the District of Columbia had done so.

Table 2.

Eligibility for Subsidized Coverage Among the Uninsured, 2019

Percent

	Overall	Family Income Relative to the Poverty Level			Family Size	
		Less Than 138 Percent	138 to 400 Percent	More Than 400 Percent	Single Adults	Two or More People
Eligible for Subsidized Coverage						
Made eligible for Medicaid by the ACA	7	16	4	0	14	1
Otherwise eligible for Medicaid or CHIP	10	16	9	1	7	11
Eligible for marketplace subsidies ^a	19	6	39	0	23	15
Eligible for subsidized employment-based coverage ^b	31	8	36	58	20	43
Not Eligible for Subsidized Coverage						
Not lawfully present	13	24	11	2	14	13
Income below the FPL and living in a state that has not expanded Medicaid	11	31	0	0	17	4
Income too high for marketplace subsidies	9	0	0	38	4	12

Source: Congressional Budget Office, using the Health Insurance Simulation Model, which incorporates survey and administrative data from a variety of sources. See Jessica Banthin and others, *Sources and Preparation of Data Used in HISIM2—CBO’s Health Insurance Simulation Model*, Working Paper 2019-04 (Congressional Budget Office, April 2019), www.cbo.gov/publication/55087.

Some people may be eligible for multiple sources of coverage. CBO classified uninsured people into mutually exclusive groups (also known as the hierarchy) on the basis of the most heavily subsidized option available to them or the primary reason they were ineligible for subsidized coverage.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program; FPL = federal poverty level.

a. A small number of people in this group would technically be eligible for subsidies, but those subsidies would equal zero dollars.

b. A small number of people in this group were self-employed and could receive a subsidy by deducting their premiums from their federal income taxes.

those programs but not enrolled in them than uninsured people in families.

Subsidized Coverage Through Health Insurance Marketplaces. Another 19 percent of uninsured people were eligible for subsidized coverage through the marketplaces established under the ACA. Marketplace subsidies are primarily provided through premium tax credits, which are generally available to people with income between 100 and 400 percent of the poverty level, but only if they are lawfully present in the United States, are not eligible for public coverage (such as Medicaid or CHIP), and do not have an affordable offer of employment-based coverage. (In 2019, the threshold for affordability was set at 9.86 percent of income for a single plan—that is, a plan that covers one person.) Eligible people can use those tax credits to lower their monthly premiums.

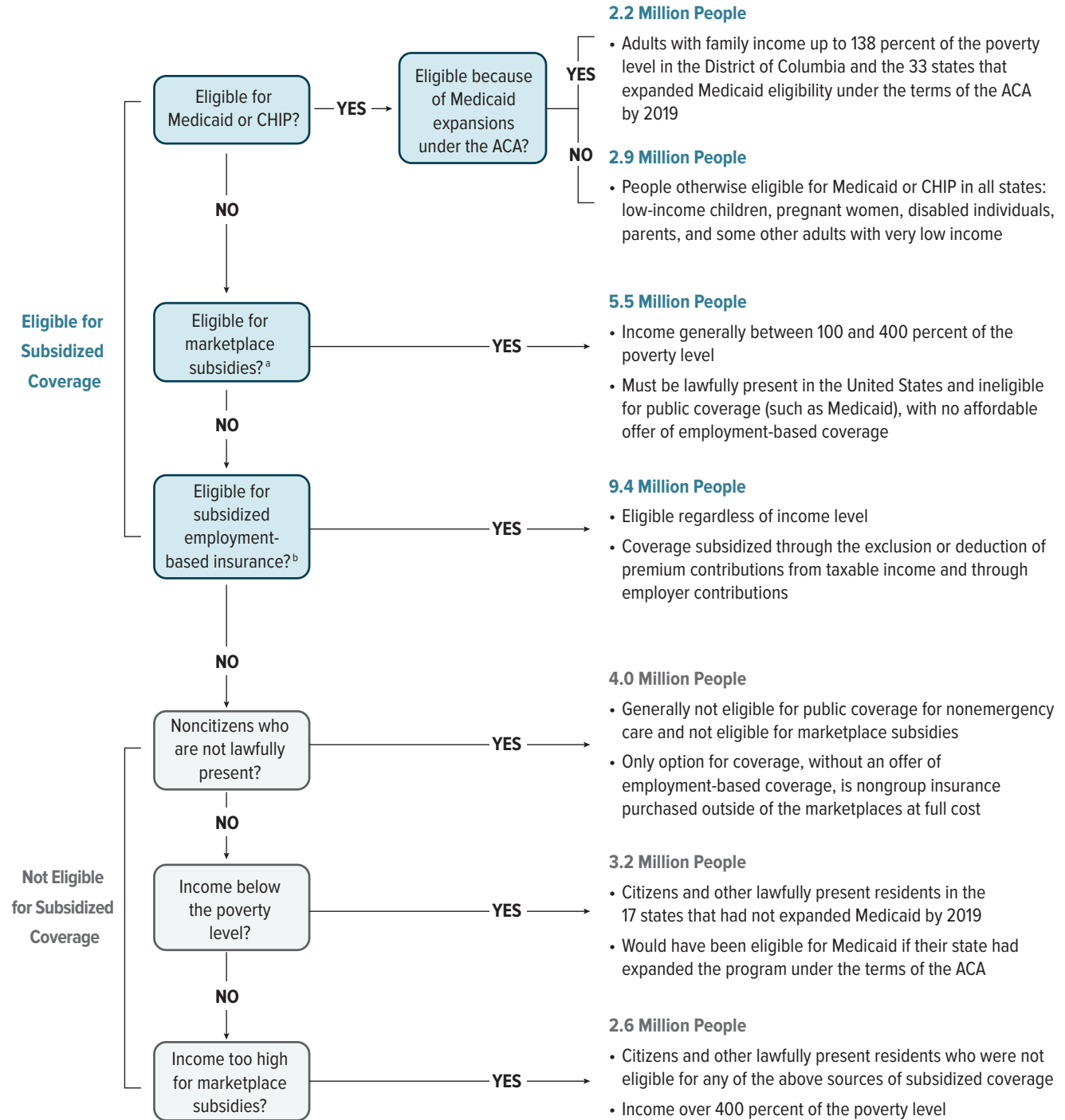
More than one-third of uninsured people with income between 138 and 400 percent of the poverty level were

eligible for subsidized coverage through the marketplaces. People who were eligible for premium tax credits were somewhat more likely to be uninsured if their income was above 250 percent of the poverty level, in part because they were not eligible for cost-sharing reductions (subsidies that lower deductibles, copayments, and coinsurance payments for lower-income people who purchase silver plans) and in part because people with higher income pay a larger share of their income toward marketplace coverage.⁴ For a small number of people in areas with lower premiums, available subsidies would have equaled zero dollars because their premium for a silver plan (the benchmark for calculating subsidies) would already cost less than the percentage of income they were expected to pay.

4. For example, in 2019, people with income between 100 and 138 percent of the poverty level were expected to pay 2.08 percent of their income toward premiums, whereas people with income between 300 and 400 percent of the poverty level were expected to pay 9.86 percent of their income.

Figure 2.

How CBO Categorized Uninsured People Into Groups Based on Their Options for Subsidized Coverage or the Reasons They Lacked Those Options



Source: Congressional Budget Office.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program.

a. A small number of people in this group would technically be eligible for subsidies, but those subsidies would equal zero dollars.

b. A small number of people in this group were self-employed and could receive a subsidy by deducting their premiums from their federal income taxes.

Subsidized Employment-Based Insurance. Thirty-one percent of uninsured people had access to subsidized coverage through employment (their own or that of a family member), in CBO's estimation. That includes a small number of people who were self-employed and could receive a subsidy by deducting their premiums from their federal income taxes. About one-third of uninsured people with income between 138 and 400 percent of the poverty level and over half of those with higher income fell into this group. Only a small share of uninsured people with income below 138 percent of the poverty level had an offer of employment-based coverage and did not fall into either of the categories above.⁵

CBO estimates that 43 percent of uninsured people in families had access to coverage through an employer. For workers in about one-quarter of those families, the employee contribution for a single plan would not exceed the ACA's standard for affordability (9.86 percent of income), but the employee contribution for a family plan would. Those workers and their family members were not eligible for subsidized coverage through the marketplaces because eligibility is based on the cost of a single employment-based plan.

People Ineligible for Subsidized Coverage

In CBO's assessment, about one-third of the uninsured population in 2019 did not have access to any of the subsidized options above. Those people were ineligible for subsidized coverage for different reasons.

Noncitizens Who Were Not Lawfully Present. CBO estimates that 13 percent of uninsured people were noncitizens who were not lawfully present in this country and did not have access to coverage through an employer (their own or that of a family member). Without legal residency, noncitizens are generally not eligible for public coverage for nonemergency care, and they cannot purchase insurance (with or without subsidies) through health insurance marketplaces. Thus, if they lack access to employment-based coverage, the only way for them to obtain coverage is to purchase private, or nongroup,

insurance outside of the marketplaces at full cost.⁶ People in this group made up a large share of uninsured people with low income and only a small share of uninsured people with high income.

Income Below the Poverty Level and Not Eligible for Medicaid. Another 11 percent of uninsured people were adults who had income below the poverty level but were ineligible for Medicaid and did not have access to employment-based coverage. Those people lived in states that did not expand eligibility for Medicaid to all adults with income up to 138 percent of the poverty level, as allowed under the ACA.⁷ In those states, although adults with income between 100 and 138 percent of the poverty level are thus not typically eligible for Medicaid, they are eligible for subsidized coverage through the marketplaces established under the ACA. Some adults with income below the poverty level are eligible for Medicaid because they meet other criteria (for example, women who are pregnant). For the remaining adults with income below the poverty level, those options for subsidized coverage are not available. Moreover, few people with income below the poverty level have someone in their family who is eligible for health insurance through their job.

Consequently, for nearly all people in this group, the only option was to purchase nongroup coverage at full cost. People in this category made up nearly one-third of uninsured people with income below 138 percent of the poverty level in 2019.

Income Too High for Marketplace Subsidies. CBO estimates that the remaining 9 percent of uninsured people had income greater than 400 percent of the poverty level (\$49,960 for a single person and \$103,000 for a family of four) and were not eligible for subsidized coverage through the government or an employer. Those people could obtain coverage by purchasing private nongroup health insurance at full cost.

What Does It Mean to Be Uninsured?

CBO classifies people as uninsured if they are not enrolled in a private health insurance plan or a government health program that provides comprehensive major

5. About 14 percent of all uninsured people with income below 138 percent of the poverty level had an offer of employment-based coverage in 2019, but more than half of those offers would not meet the ACA's standard for affordability because the employees' share of the premium exceeded 9.86 percent of their family income. About half the people in this group were eligible for Medicaid, CHIP, or subsidized coverage through the marketplaces.

6. Some uninsured people who were noncitizens and not lawfully present had access to subsidized coverage through an employer and are included in the 29 percent of uninsured people with access to employment-based coverage.

7. In 2019, about one-third of the total population under 65 lived in states that did not expand Medicaid under the ACA.

medical coverage.⁸ People without such coverage have less financial protection and access to health care than people who are enrolled in coverage. People who are eligible for Medicaid or CHIP but are not enrolled have more financial protection than other uninsured people because they can enroll at any time and may receive retroactive coverage for services rendered before their enrollment. Still, uninsured people who are eligible for those programs have less financial protection than they would if they were enrolled, and they may have difficulties accessing health care.

Financial Liability

Uninsured people generally face much more exposure to financial risk from using health care than insured people. Several types of protection reduce uninsured people's out-of-pocket costs for health care, but those protections often provide only a modest reduction in financial exposure.

First, some uninsured patients receive services for free or at highly discounted prices through safety-net providers, such as community health centers and free clinics, or through other sources of charity care.⁹ Highly discounted care is typically targeted toward low-income people, and sources of such care have limited funding and capacity.¹⁰ Uninsured people who are not qualified for or are

otherwise unable to obtain free or discounted care may face the providers' full charges, which are typically higher than the discounted rates paid by private insurers.

Second, uninsured people can avoid paying for care they receive by not paying some or all of their medical bills, which may not be fully collected by providers and can be discharged through bankruptcy.¹¹ However, leaving medical bills unpaid can reduce people's access to credit and disrupt other aspects of their lives.¹² For example, medical bills can be a source of stress and lead people to cut back on other types of spending.¹³ Research shows that people without health insurance have more unpaid medical bills, more bills in collection, and higher rates of bankruptcy.¹⁴ The financial cost of unpaid medical

Garfield, Kendal Orgera, and Anthony Damico, *The Uninsured and the ACA: A Primer—Key Facts About Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act* (Kaiser Family Foundation, January 2019), <https://tinyurl.com/yb4fdk8p>.

8. CBO considers such people to be uninsured even if they are eligible to immediately enroll in a plan or government program that would retroactively pay for previously incurred health care expenses. In CBO's view, that definition of being uninsured aligns with the concept underlying data from the National Center for Health Statistics, which relies on individuals to report their insurance status in surveys. CBO's definition of coverage includes all plans that are compliant with the ACA and some that are not compliant but still provide coverage for high-cost physician and hospital care. For more details, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.
9. Community health centers, many of which are funded in part by federal grants, provide comprehensive primary care services and use a sliding scale based on income to set patients' fees. Free and charitable clinics, which are generally funded through private donations and grants and are primarily staffed by volunteers, also provide free or highly discounted care to uninsured patients. Safety-net hospitals are another major source of charity care, and nearly all other hospitals provide charity care to some degree. Various other sources, including local health departments and other public and private clinics, also provide free or discounted care to uninsured patients. Some private, office-based providers also provide a limited amount of charity care.
10. One survey found that 27 percent of uninsured adults received at least some care for free or at a reduced cost in 2015. See Rachel

11. For a discussion of the role bankruptcy plays in protecting people from large medical expenses, see Neale Mahoney, "Bankruptcy as Implicit Health Insurance," *American Economic Review*, vol. 105, no. 2 (February 2015), pp. 710–746, <https://doi.org/10.1257/aer.20131408>.
12. One study found that uninsured people who were admitted to a hospital experienced a substantial increase in unpaid medical bills, a small increase in the probability of bankruptcy, and a small decline in borrowing limits. See Carlos Dobkin and others, "The Economic Consequences of Hospital Admissions," *American Economic Review*, vol. 108, no. 2 (February 2018), pp. 308–352, <https://doi.org/10.1257/aer.20161038>.
13. In one survey, 53 percent of uninsured households reported that they had problems paying medical bills. Within that group, 39 percent said they were unable to pay for basic necessities such as food, heat, or housing as a result. See Liz Hamel and others, *The Burden of Medical Debt: Results From the Kaiser Family Foundation/New York Times Medical Bills Survey* (Kaiser Family Foundation, January 2016), <https://tinyurl.com/yb4sqxl6>.
14. For an example of how insurance coverage affects patients' unpaid medical bills and bills in collection, see Luoqia Hu and others, "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," *Journal of Public Economics*, vol. 163 (July 2018), pp. 99–112, <https://doi.org/10.1016/j.jpubeco.2018.04.009>. Other studies have found that expanding health insurance reduces rates of consumer bankruptcy. See Tal Gross and Matthew J. Notowidigdo, "Health Insurance and the Consumer Bankruptcy Decision: Evidence From the Expansion of Medicaid," *Journal of Public Economics*, vol. 95, no. 7–8 (August 2011), pp. 767–778, <https://doi.org/10.1016/j.jpubeco.2011.01.012>; and Bhashkar Mazumder and Sarah Miller, "The Effects of the Massachusetts Health Reform on Household Financial Distress," *American Economic Journal: Economic Policy*, vol. 8, no. 3 (August 2016), pp. 284–313, <http://dx.doi.org/10.1257/pol.20150045>.

bills, referred to as bad debt, is predominantly borne by hospitals.¹⁵

Third, some of the people CBO classifies as uninsured have partial protection against high-cost medical events because they are enrolled in a noncomprehensive health plan or are eligible for coverage under a plan offered by their previous employer.

- **Enrollment in noncomprehensive health plans.** Some health plans cover a limited set of services and, in most cases, a limited amount of total costs, which means that participants who receive costly medical care may be responsible for very large bills.¹⁶ CBO estimates that in 2019, about 5 percent of people without comprehensive health coverage (roughly 1.5 million people) were enrolled in a noncomprehensive plan. More than half of those people were enrolled in health care sharing ministries, which act as cooperatives through which members pay one another's bills.
- **Eligibility for COBRA coverage.** Workers separating from a job where they had employment-based coverage typically have at least 60 days to enroll in COBRA coverage (named for the Consolidated Omnibus Budget Reconciliation Act, which established it) and can receive retroactive coverage for any health care expenses incurred during that period.¹⁷ Because the ability to obtain retroactive

coverage often applied for only 60 days, this option was available to only a small segment of the uninsured population in 2019.

Uninsured people who are eligible for Medicaid or CHIP coverage have an even greater degree of partial protection against high-cost medical events and are discussed in more detail below.

Finally, uninsured people may put off seeking care when doing so is feasible and have that care covered later, by enrolling in a plan during the next open enrollment period.¹⁸ However, the ability to enroll in coverage in the future does not protect uninsured people from high costs associated with unexpected and urgent health events.

Access to Health Care

Even people with insurance may have trouble accessing health care, but in general, uninsured people face more barriers.¹⁹ People tend to be less willing to seek care when they face high out-of-pocket costs, and uninsured patients who cannot pay the full billed charges for care often have difficulty finding a provider who will see them. Although some types of subsidized care are available to uninsured people, the providers often have limited capacity, which can result in long wait times for uninsured patients. Some providers may be unwilling to treat uninsured people who cannot pay the full price up front, or they may see only a limited number of those patients.

15. See Craig Garthwaite, Tal Gross, and Matthew J. Notowidigdo, "Hospitals as Insurers of Last Resort," *American Economic Journal: Applied Economics*, vol. 10, no. 1 (January 2018), pp. 1–39, <https://doi.org/10.1257/app.20150581>; and David Dranove, Craig Garthwaite, and Christopher Ody, "Uncompensated Care Decreased at Hospitals in Medicaid Expansion States but Not at Hospitals in Nonexpansion States," *Health Affairs*, vol. 35, no. 8 (August 2016), pp. 1471–1479, <https://doi.org/10.1377/hlthaff.2015.1344>.

16. Such plans include policies with limited insurance benefits (known as mini-med plans); some types of short-term, limited-duration policies; "dread disease" policies, which cover only specific diseases; supplemental plans that pay for medical expenses another policy does not cover; fixed-dollar indemnity plans, which pay a predetermined lump sum in the event of an illness or hospitalization; health care sharing ministries; and single-service plans, such as dental- or vision-only policies.

17. COBRA protections apply to workers separating from private-sector employers with at least 20 employees or from state and local government employers. COBRA also guarantees that those workers can continue to purchase their employment-based coverage at full cost (paying both the employee and employer shares of the premium, plus a small administrative fee) for up

to 18 months. The deadline for enrolling in COBRA coverage was extended in 2020 because of the coronavirus pandemic; see Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak, 85 Fed. Reg. 26351 (May 4, 2020), <https://go.usa.gov/xwHua>.

18. Under current law, most comprehensive health plans are required to accept all eligible applicants regardless of preexisting health conditions. As a result, delaying care for such conditions, when feasible, would not prevent applicants from enrolling in a plan and having much of the cost of their treatment covered.

19. In a 2018 survey of nonelderly adults, 26 percent with Medicaid or CHIP coverage, 18 percent with private coverage, and 36 percent who were uninsured reported delaying medical care because of barriers to access. Cost was much more likely to be such a barrier for those who were uninsured than those who were insured. See Medicaid and CHIP Payment and Access Commission, "Measures of Access to Care Among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage," Exhibit 46 in *MACStats: Medicaid and CHIP Data Book* (December 2019), www.macpac.gov/macstats/.

As a result of those factors, uninsured people receive less health care than they would if they were insured. Research shows that people substantially increase their use of health care services after gaining health insurance.²⁰ Additionally, uninsured people report going without care and delaying care at much higher rates than insured people.²¹ And even when they do obtain care, uninsured people may not receive the same level of treatment as insured people.²²

For those reasons, it is likely that being uninsured results in worse health outcomes, at least for some people. Determining how going without coverage affects health is challenging, however, because insured and uninsured people differ along many other dimensions that affect health outcomes. To overcome those challenges, researchers have tried to study what happens when people lose or gain insurance for reasons unrelated to their health. Those studies have found that gaining insurance leads to improvements in some measures of overall health, including self-reported health and mortality.²³ However,

evidence for effects on specific health conditions has been less consistent. Those inconsistent results might imply that health insurance improves some aspects of health but not others or that its effects on certain aspects of health (particularly those relevant to only a subset of the population) are more challenging to measure.²⁴

Uninsured people's access to care may depend on the type of care and the provider. Hospital emergency departments usually present the lowest barriers to care because they are required to assess and stabilize all patients regardless of their insurance status.²⁵ However, emergency departments cannot provide all types of care, and the care they do provide often results in large medical bills for uninsured people (many of which go unpaid). In particular, emergency departments are not likely to offer a stable supply of medication or ongoing treatment for chronic diseases.

Many uninsured people receive primary care through community health centers, which charge highly discounted rates for low-income patients, or through other safety-net clinics or local health departments.²⁶

20. For example, see Amy Finkelstein and others, "The Oregon Health Insurance Experiment: Evidence From the First Year," *Quarterly Journal of Economics*, vol. 127, no. 3 (August 2012), pp. 1057–1106, <https://doi.org/10.1093/qje/qjs020>.

21. For example, 25 percent of nonelderly U.S. residents without insurance reported delaying medical care because of the cost in 2018, compared with 6 percent of those with private insurance and 5 percent of those with Medicaid or other public coverage. Similarly, forgoing medical care because of the cost was reported by far more uninsured people (19 percent) than people with private insurance (3 percent) or public coverage (4 percent). See Centers for Disease Control, National Center for Health Statistics, *Summary Health Statistics: National Health Interview Survey, 2018*, Table P-9c (accessed July 12, 2020), www.cdc.gov/nchs/nhis/shs/tables.htm.

22. One study found that uninsured patients who were hospitalized after severe auto accidents received less intensive care than insured patients and had higher mortality rates. See Joseph J. Doyle Jr., "Health Insurance, Treatment, and Outcomes: Using Auto Accidents as Health Shocks," *Review of Economics and Statistics*, vol. 87, no. 2 (May 2005), pp. 256–270, <https://doi.org/10.1162/0034653053970348>.

23. For a recent review of the literature, see Benjamin Sommers, Atul Gawande, and Katherine Baicker, "Health Insurance Coverage and Health—What the Recent Evidence Tells Us," *The New England Journal of Medicine*, vol. 377, no. 6 (August 2017), pp. 586–593, <https://doi.org/10.1056/nejmsb1706645>. For more recent evidence that gaining insurance reduces mortality, see Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, *Health Insurance and Mortality: Experimental Evidence From Taxpayer Outreach*, Working Paper 26533 (National Bureau of Economic Research, December 2019), <https://www.nber.org/papers/w26533>; and Sarah Miller and others, *Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data*,

Working Paper 26081 (National Bureau of Economic Research, August 2020), <https://www.nber.org/papers/w26081>. For a detailed review of the evidence from recent Medicaid expansions, see Madeline Guth, Rachel Garfield, and Robin Rudowitz, *The Effects of Medicaid Expansion Under the ACA: Updated Findings From a Literature Review* (Kaiser Family Foundation, March 2020), <https://tinyurl.com/y9xb6y1g>.

24. For example, a study of the Oregon Health Insurance Experiment showed that participants who gained Medicaid coverage had reduced rates of depression, but it did not detect statistically significant improvements in measures of hypertension or high cholesterol; however, the lack of statistically significant improvements in those measures was due in part to the small number of participants who had those conditions. See Katherine Baicker and others, "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes," *The New England Journal of Medicine*, vol. 368, no. 18 (May 2013), pp. 1713–1722, <https://doi.org/10.1056/NEJMsa1212321>. Another study did detect improved control of hypertension in federally funded community health centers after expansions of Medicaid. See Megan B. Cole and others, "At Federally Funded Health Centers, Medicaid Expansion Was Associated With Improved Quality of Care," *Health Affairs*, vol. 36, no. 1 (January 2017), pp. 40–48, <https://doi.org/10.1377/hlthaff.2016.0804>.

25. Those requirements were established by the Emergency Medical Treatment and Labor Act in 1986.

26. More than 6 million uninsured patients received care at a community health center in 2018. See Kaiser Family Foundation, "Community Health Center Patients by Payer Source" (accessed July 12, 2020), <https://tinyurl.com/ybzb86mv>.

Other types of care are generally less accessible for uninsured people who cannot afford to pay the full price of treatment. For example, one study found that in 2016, 85 percent of uninsured patients were not able to schedule an appointment with a private, office-based primary care provider unless they could pay the full price of the visit up front.²⁷ Specialty care, including cardiac and orthopedic procedures, is not often offered through community health centers and is described as difficult to access by uninsured patients who report a need for it.²⁸

Finally, prescription drugs can be difficult for uninsured patients to obtain. Many community health centers provide subsidized prescription drugs to their patients, and prescription drug manufacturers offer a limited number of subsidized drugs to low-income patients without insurance through patient-assistance programs.²⁹ However, not all uninsured people are able to fill their prescriptions through those channels; as a result, many uninsured people are unable to fill their prescriptions at all (or can fill them only sporadically).

Special Considerations for People Eligible for Medicaid and CHIP

People who are eligible for Medicaid or CHIP but not enrolled have a greater degree of financial protection than other uninsured people, but they can still have difficulties accessing care.

Eligible people can enroll in Medicaid or CHIP throughout the year, without waiting for an open enrollment

period. That flexibility in enrollment is a major distinction between those programs and private health insurance, in which people can typically enroll only during open enrollment periods that occur once per year.

Medicaid and some states' CHIP programs also offer additional protections for some people who are eligible but not enrolled. Hospitals and some other providers are authorized to presumptively enroll individuals in Medicaid at the point of service on the basis of a simplified income screen that indicates whether they appear to be eligible.³⁰ And in many states, people who enroll in Medicaid can receive retroactive coverage for any medical expenses incurred up to three months before they applied.³¹ Such retroactive coverage allows providers to receive payment for services that are rendered before their patients can submit a complete application for the program. The presumptive-eligibility and retroactive-coverage rules of states' Medicaid programs also apply to CHIP programs that were implemented through Medicaid expansions, which include the entire CHIP program in 8 states and a portion of the CHIP program (for example, coverage for enrollees below a particular age or income level) in an additional 41 states. Some states also allow additional providers and entities to make presumptive-eligibility determinations for CHIP.

However, even for people covered by the presumptive-eligibility and retroactive-coverage rules, those rules do not provide complete protection. Individuals are not always presumptively enrolled, particularly when they are seeking care outside of a hospital, and they may not be aware that they can apply for retroactive coverage. Moreover, many providers do not accept patients who cannot present proof of enrollment or pay the full cost out of pocket.

27. See Brendan Saloner and others, "Most Primary Care Physicians Provide Appointments, but Affordability Remains a Barrier for the Uninsured," *Health Affairs*, vol. 37, no. 4 (April 2018), pp. 627–634, <https://doi.org/10.1377/hlthaff.2017.0959>.

28. For evidence on the availability of specialty care for community health center patients, see Michael K. Gusmano, Gerry Fairbrother, and Heidi Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs*, vol. 21, no. 6 (November 2002), pp. 188–194, <https://doi.org/10.1377/hlthaff.21.6.188>. For a comparison of uninsured and insured patients' reported difficulties in accessing specialty care for chronic conditions, see Anita Soni, *Specialist Need and Access Among Adults With Multiple Chronic Conditions, U.S. Civilian Noninstitutionalized Population, 2012*, Statistical Brief 482 (Agency for Healthcare Research and Quality, Department of Health and Human Services, November 2015), <https://go.usa.gov/xw654>.

29. Community health centers and other safety-net providers receive discounted prescription drugs through the federal 340B drug pricing program.

30. Under the ACA, all states are required to allow hospitals to conduct presumptive eligibility determinations for Medicaid. Some states also allow other providers and entities to make those determinations. For more details on specific state policies, see Tricia Brooks and others, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings From a 50-State Survey* (Kaiser Family Foundation, March 2020), <https://tinyurl.com/ya5sa3y7>.

31. In recent years, an increasing number of states have received approvals for waivers to limit retroactive coverage. See Medicaid and CHIP Payment and Access Commission, *Medicaid Retroactive Eligibility: Changes Under Section 1115 Waivers* (August 2019), <https://go.usa.gov/xw65W> (PDF, 275 KB).

People who are eligible for but not enrolled in Medicaid or CHIP are also probably less likely to seek health care than enrollees, for several reasons: They may be unaware that they are eligible for those programs and could have the cost of treatment covered; they are less likely to have a usual source of care; and they do not have a connection to a health plan and network of providers. As a result, they probably have more difficulties accessing care than people who are actually enrolled in those programs.

What Factors Deter People From Obtaining Health Insurance?

People may forgo coverage for various reasons. The most common is the high out-of-pocket cost of health insurance premiums; others include a lack of awareness of program eligibility, the hassle of enrolling in coverage, and high cost sharing required by some health plans.

Premiums

Higher out-of-pocket premiums tend to reduce people's willingness to purchase health insurance. Research has shown that the likelihood of enrolling in insurance falls as out-of-pocket premiums increase, particularly among low-income populations.³²

CBO estimated how expensive it would be for different types of uninsured people to enroll in coverage, focusing first on the estimated cost of obtaining coverage for single adults. Determining the cost of obtaining health insurance for families is more complex because members of the same family may be eligible for different types of coverage. For example, CBO estimates that in 28 percent of uninsured families, at least one member is eligible for Medicaid or CHIP but at least one other member is not and would have to purchase a private plan. (Such situations often arise when a program's income threshold for eligibility is higher for children than for parents.) The gross premium for a family plan (that is, the cost before taxes and subsidies) is generally higher than that for a single plan because family plans cover more people.

CBO estimates that for people who were uninsured in 2019, the average gross premium for the least generous type of single plan in the private nongroup market (a bronze plan, which on average pays for about 60 percent of covered benefits) would have been about \$7,700.

32. For example, see Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, "Subsidizing Health Insurance for Low-Income Adults: Evidence From Massachusetts," *American Economic Review*, vol. 109, no. 4 (April 2019), pp. 1530–567, <https://doi.org/10.1257/aer.20171455>.

However, most uninsured people had lower-cost options because they were eligible for premium tax credits, employment-based coverage, or public programs.³³ Using its health insurance simulation model, CBO determined the average price of the lowest-cost option for health insurance for people with access to various subsidized sources of coverage as well as those without access to subsidies. (See the appendix for more details on CBO's methods.)

The generosity of coverage provided by the lowest-cost option varied for different people. Medicaid, CHIP, and the plans offered through most employers would have covered a larger share of health care costs than most plans available through the nongroup market. People purchasing plans in the nongroup market would face even higher premiums if those plans were as generous as the average employment-based plan.

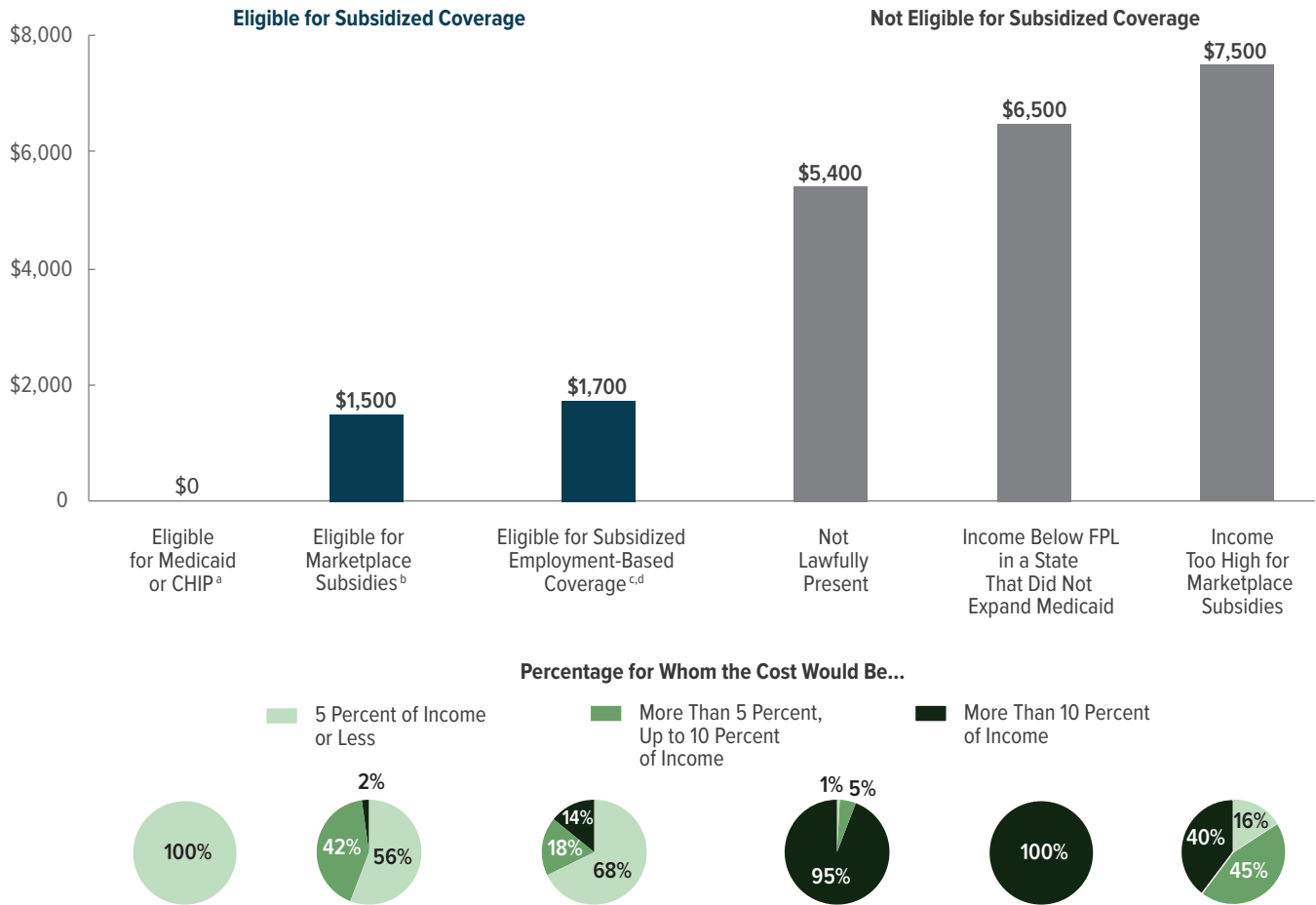
Premiums for Single Adults. For some groups of uninsured single adults, the cheapest available coverage in 2019 would have cost zero dollars; for other groups, it would have cost more than \$7,000, on average (see Figure 3). Those who were eligible for Medicaid or CHIP would have been responsible for no or nearly no premiums if they enrolled.³⁴ At the other end of the spectrum, CBO estimates that people with income too high for marketplace subsidies and no other option but to purchase nongroup coverage at full cost would have faced an average cost of \$7,500 to enroll in the least expensive (and least generous) plan available to them. Adults below the poverty level who were ineligible for Medicaid would have faced costs that were nearly as high to enroll in a nongroup plan. For uninsured people who were eligible for subsidized coverage through the marketplaces, the average cost of enrolling in the least expensive option would have been about \$1,500 per year; for those

33. CBO estimates that the average gross premium for a bronze plan was about \$8,300 in 2019. Younger people's premiums would generally be lower than that average, and older people's premiums would generally be higher. In some states, other types of plans with lower premiums are available, but they may cover fewer types of health care services, exclude coverage for pre-existing conditions, be priced on the basis of people's health care status, or deny coverage to people with high expected health care costs.

34. Most state programs do not charge premiums for adults or children, but a small number of states charge a small premium to enroll in Medicaid, and more than half of states charge a modest premium to enroll in CHIP. For more details, see Tricia Brooks, Lauren Roygardner, and Samantha Artiga, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings From a 50-State Survey* (Kaiser Family Foundation, March 2019), <https://tinyurl.com/yc7b3dg2>.

Figure 3.

Annual Out-of-Pocket Cost of Premiums for Uninsured Single Adults' Least Expensive Option for Health Insurance, 2019



Source: Congressional Budget Office.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL = federal poverty level.

CBO classified people with zero income who were eligible for Medicaid and CHIP as having an option that would cost 0 to 5 percent of income. (Such people generally face zero or very small premiums.) Other people with zero income (or negative income) were classified as having an option that would cost more than 10 percent of income.

- a. Most state Medicaid programs do not charge premiums for adults or children, but a small number of states do charge a small premium. Over half of states charge a modest premium to enroll in CHIP. On average, the costs of premiums for those programs still round to zero dollars.
- b. A small number of people in this group would technically be eligible for subsidies, but those subsidies would equal zero dollars.
- c. A small number of people in this group were self-employed and could receive a subsidy by deducting their premiums from their federal income taxes.
- d. CBO imputes health insurance premiums with a simplified representation of how premiums are actually constructed by firms and group insurers, which slightly underestimates the fraction of workers with large out-of-pocket premiums.

with access to subsidized employment-based coverage, it would have been about \$1,700 per year.³⁵ (For subsidized marketplace coverage, that amount reflects the cost of a bronze plan; for employment-based coverage, that amount reflects the cost of a plan that is typically more generous.) Those figures are averages; the actual cost faced by individuals for their cheapest coverage option could vary widely depending on their age, location, family size, income, and tobacco use.³⁶

The affordability of premiums depends not only on their absolute cost but on how that cost compares to one's family income. CBO estimated the percentage of uninsured people who could have obtained coverage for no more than 10 percent or 5 percent of their income. Although those thresholds are one indication of affordability, some people, particularly those with low income, may find it difficult to spend even 5 percent of their income on health insurance because they have competing financial obligations (such as housing or other bills).

CBO estimates that 64 percent of single adults who were uninsured in 2019 could have obtained coverage for 10 percent or less of their income, and 49 percent could have obtained coverage for 5 percent or less of their income (see Table 3). Of the people eligible for some form of subsidized coverage, the vast majority could have enrolled at a cost of 10 percent or less of their income, and a large share could have enrolled for 5 percent or less of their income. By contrast, people ineligible for subsidized coverage were far less likely to have affordable options—particularly noncitizens who were not lawfully present and were not offered employment-based coverage and people with income below the poverty line in states that had not expanded Medicaid. Among those with

income too high for marketplace subsidies and no offer of employment-based coverage, more than half could purchase coverage for 10 percent or less of their income, but fewer than one-fifth could purchase coverage for 5 percent or less of their income.

Among those who were not eligible for subsidized coverage, premiums for plans through the nongroup market tended to be lower and more affordable for younger adults than older adults. The largest age-based discrepancies were for people with income too high to qualify for marketplace subsidies. Because older adults are generally subject to higher premiums, their out-of-pocket costs jump significantly once their income exceeds the cutoff for subsidies.³⁷ CBO estimates that 19- to 49-year-olds over that cutoff would have paid an average of \$4,900 to enroll in their least expensive option, whereas 50- to 64-year-olds would have paid an average of \$9,800.³⁸ Those costs were also lower in relation to income for younger adults than for older adults. CBO estimates that 91 percent of the same 19- to 49-year-olds could have obtained coverage for 10 percent or less of their income, compared with only 34 percent of the 50- to 64-year-olds. A much smaller share of adults in either group could have purchased unsubsidized private coverage for 5 percent or less of their income.

Finally, some uninsured people have the option of enrolling in coverage for free—zero dollars paid out of pocket. That includes nearly all people eligible for Medicaid, many people eligible for CHIP, and the majority of people eligible for subsidized marketplace coverage.³⁹ Although people in the last group could enroll in a plan

35. Some people eligible for subsidized employment-based coverage are self-employed and have enough self-employment income to deduct health insurance premiums from their federal income taxes. The value of that deduction is much smaller than the combined value of the exclusion of premiums from income and payroll taxes and the employer contributions available to people offered coverage through an employer.

36. Some of those differences in characteristics also help to explain why different groups of uninsured people face different average gross premiums through the nongroup market. People who are eligible for marketplace subsidies, who are not lawfully present and not eligible for employment-based coverage, who have income below the poverty level and are not eligible for Medicaid, and who have income too high for marketplace subsidies and no offer of employment-based coverage all would purchase coverage through the nongroup market; however, because those groups have different distributions of ages, locations, and other factors, their average gross premiums range from \$5,400 to \$7,500.

37. For more information about the so-called subsidy cliff, see Rachel Fehr and others, *How Affordable Are 2019 ACA Premiums for Middle-Income People?* (Kaiser Family Foundation, March 2019), <https://tinyurl.com/y2lvvmkh>.

38. Age-rating regulations limit the extent to which premiums for younger adults in the nongroup market can differ from those for older adults to reflect their lower underlying health risk.

39. Zero-premium options for marketplace plans became more prevalent after the federal government terminated payments to insurers for cost-sharing reductions in October 2017. Most insurers responded by increasing their premiums for silver plans. The second-lowest-cost silver plan is the benchmark for calculating subsidies, so increasing those premiums increased federal subsidy levels. The higher subsidies enabled more people to purchase a bronze plan—and, in some cases, the lowest-cost silver plan—for zero dollars out of pocket. For more details, see Rachel Fehr, Cynthia Cox, and Matthew Rae, *How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020?* (Kaiser Family Foundation, December 2019), <https://tinyurl.com/v6wqn9f>.

Table 3.

Annual Out-of-Pocket Cost of Premiums for Uninsured Single Adults' Least Expensive Option for Health Insurance, by Age Group, 2019

	Average Cost (In 2019 dollars)		Percentage of Individuals for Whom the Cost Would Be...	
	Before Taxes and Subsidies	After Taxes and Subsidies	10 Percent of Income or Less ^f	5 Percent of Income or Less ^f
Single Adults Under Age 65	3,900	2,900	64	49
Eligible for subsidized coverage				
Made eligible for Medicaid by the ACA	0 ^e	0 ^e	100	100
Otherwise eligible for Medicaid or CHIP	0 ^e	0 ^e	100	100
Eligible for marketplace subsidies ^{a,b}	5,500	1,500	98	56
Eligible for subsidized employment-based coverage ^{c,d}	2,200	1,700	86	68
Ineligible for subsidized coverage				
Not lawfully present ^a	5,400	5,400	5	1
Income below the FPL and living in a state that has not expanded Medicaid ^a	6,500	6,500	0	0
Income too high for marketplace subsidies ^a	7,500	7,500	60	16
Single Adults Ages 19 to 49	3,000	2,300	66	50
Eligible for subsidized coverage				
Made eligible for Medicaid by the ACA	0 ^e	0 ^e	100	100
Otherwise eligible for Medicaid or CHIP	0 ^e	0 ^e	100	100
Eligible for marketplace subsidies ^{a,b}	4,400	1,500	98	56
Eligible for subsidized employment-based coverage ^{c,d}	1,800	1,400	87	69
Ineligible for subsidized coverage				
Not lawfully present ^a	4,800	4,800	6	1
Income below the FPL and living in a state that has not expanded Medicaid ^a	4,700	4,700	0	0
Income too high for marketplace subsidies ^a	4,900	4,900	91	22

Continued

for free on the basis of their yearly income, they might be reluctant to sign up for coverage if they are unsure whether future increases in their income could result in their having to repay some or all of the subsidies. In any case, premiums are not the primary barrier to enrollment for people in any of those groups, which means that other factors explain why they do not enroll in coverage.

Premiums for Families. To illustrate the cost of obtaining coverage for families, CBO focused on families in which all members were eligible for the same type of private coverage and none were eligible for public coverage. Those families accounted for 64 percent of uninsured families in 2019. In some cases, different family members might have access to different types of private coverage, but they would typically all enroll in the same plan. Some had the option to purchase a subsidized family plan through an employer or a health insurance

marketplace, whereas others would have had to purchase a family plan through the nongroup market at full cost.

- Thirty percent were eligible for employment-based coverage. CBO estimates that their average cost for family coverage would have been about \$4,000, amounting to less than 10 percent of income for about 80 percent of those families and less than 5 percent of income for about 60 percent of those families.
- Eight percent were eligible to purchase subsidized coverage through the marketplaces. CBO estimates that their average cost for family coverage under a bronze plan would have been about \$3,500, amounting to less than 10 percent of income for nearly all of those families and less than 5 percent of income for about half.

Table 3.

Continued

Annual Out-of-Pocket Cost of Premiums for Uninsured Single Adults’ Least Expensive Option for Health Insurance, by Age Group, 2019

	Average Cost (In 2019 dollars)		Percentage of Individuals for Whom the Cost Would Be...	
	Before Taxes and Subsidies	After Taxes and Subsidies	10 Percent of Income or Less ^f	5 Percent of Income or Less ^f
Single Adults Ages 50 to 64	6,700	4,800	60	44
Eligible for subsidized coverage				
Made eligible for Medicaid by the ACA	0 ^e	0 ^e	100	100
Otherwise eligible for Medicaid or CHIP	0 ^e	0 ^e	100	100
Eligible for marketplace subsidies ^{a,b}	8,700	1,700	97	58
Eligible for subsidized employment-based coverage ^{c,d}	3,300	2,500	84	64
Ineligible for subsidized coverage				
Not lawfully present ^a	8,700	8,700	4	1
Income below the FPL and living in a state that has not expanded Medicaid ^a	10,400	10,400	0	0
Income too high for marketplace subsidies ^a	9,800	9,800	34	10

Source: Congressional Budget Office, using the Health Insurance Simulation Model, which incorporates survey and administrative data from a variety of sources. See Jessica Banthin and others, *Sources and Preparation of Data Used in HISIM2—CBO’s Health Insurance Simulation Model*, Working Paper 2019-04 (Congressional Budget Office, April 2019), www.cbo.gov/publication/55087.

Some people may be eligible for multiple sources of coverage. CBO classified uninsured people into mutually exclusive groups (also known as the hierarchy) on the basis of the most heavily subsidized option available to them or the primary reason they were ineligible for subsidized coverage.

Estimates of premiums are rounded to the nearest hundred dollars. Premiums before taxes and subsidies account for employer contributions. Premiums after taxes and subsidies reflect out-of-pocket costs after applying all relevant federal subsidies (including premium tax credits and premium tax exclusions). Estimates of premiums as a share of income reflect those out-of-pocket costs divided by pre-tax income.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program; FPL = federal poverty level.

- a. Premiums reflect the cost of purchasing the least expensive bronze plan available.
- b. A small number of people in this group would technically be eligible for subsidies, but those subsidies would equal zero dollars.
- c. A small number of people in this group were self-employed and could receive a subsidy by deducting their premiums from their federal income taxes.
- d. CBO imputes health insurance premiums with a simplified representation of how premiums are actually constructed by firms and group insurers, which slightly underestimates the fraction of workers with large out-of-pocket premiums.
- e. Most state Medicaid programs do not charge premiums, but a small number charge a small premium to some enrollees. Over half of states charge a modest premium to enroll in CHIP. On average, the costs of premiums for those programs still round to zero dollars.
- f. Includes people eligible for Medicaid and CHIP but not enrolled, who generally face zero or very small premiums. Other people with zero income (or negative income) were classified as having an option costing more than 10 percent of income.

- Twenty-seven percent could have purchased family coverage only through the nongroup market at full cost. CBO estimates that their average cost for family coverage under a bronze plan would have been about \$14,000, amounting to less than 10 percent of income for about 30 percent of those families and less than 5 percent of income for about 10 percent of those families.

In the remaining families, at least some members were eligible for public coverage or different members were eligible for different types of private coverage. Families in which all members were eligible for public coverage made up only about 5 percent of uninsured families in 2019, and their cost to obtain coverage would have been close to zero. Families in which some, but not all, members were eligible for public coverage made up about 28 percent of uninsured families in 2019. Estimating

their cost to cover all members of the family is more difficult because the lowest-cost option might be to enroll different members of the family in different types of coverage.⁴⁰ In the remaining 2 percent of uninsured families, only some members of the family were eligible for premium tax credits, and estimating their cost to obtain coverage is challenging for the same reason.

Other Factors

Although premiums are the most important factor in many people's decision to forgo insurance, other factors also play a role.⁴¹ For example, lack of information, confusion, and the complexity of applying for coverage are common barriers to enrollment.

In some cases, people may simply place a low value on health insurance. For example, some people believe that they do not need health insurance, particularly if they are healthy. And in areas where free or highly subsidized care is readily available, low-income people may be accustomed to obtaining care through those channels and see little value in spending their limited resources on health insurance premiums.⁴²

Uninsured people also may not believe that a plan is worth the cost if it includes a high degree of cost sharing. Such plans offer very limited protection against expensive medical events for people who are unable to pay the associated deductibles, copayments, or other charges, which may total hundreds or thousands of dollars. (Research has suggested that for people with low to moderate income, plans with high deductibles may

provide no more financial protection than bankruptcy.)⁴³ Many people do not have sufficient savings to pay those costs before their care will be covered by insurance.⁴⁴ In one survey, about one-third of insured people and nearly half of those earning less than \$40,000 per year said they had trouble affording their deductibles in 2019.⁴⁵ Faced with the prospect of paying thousands of dollars per year for coverage under which they still might not be able to afford care, many people decide that enrolling is not worth the cost.

Even people who are eligible to enroll in subsidized coverage for a zero-dollar or very small premium—including all people who are eligible for Medicaid and CHIP and more than half of people eligible for marketplace subsidies—do not always enroll. Their reasons may include lack of awareness of the programs, uncertainty about their eligibility, administrative hurdles in applying for coverage or renewing eligibility, or resistance to reliance on government programs.⁴⁶ Among immigrant parents who are seeking citizenship, concerns about the 2019 Medicaid public charge rule appear to be reducing willingness to enroll eligible children in Medicaid and CHIP, even if those children are citizens.⁴⁷

40. For most of the families in this group, children were eligible for public coverage but their parents were not. That is because the family income limit for Medicaid and CHIP is generally higher for children than for adults.

41. See, for example, Sara R. Collins and others, *Who Are the Remaining Uninsured and Why Haven't They Signed Up for Coverage? Findings From the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016* (The Commonwealth Fund, August 2016), <https://tinyurl.com/ydyrp514>.

42. Some researchers have argued that the availability of charity care could explain why many low-income people do not purchase even highly subsidized insurance. See Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, "Subsidizing Health Insurance for Low-Income Adults: Evidence From Massachusetts," *American Economic Review*, vol. 109, no. 4, pp. 1530–1567, <https://doi.org/10.1257/aer.20171455>.

43. Neale Mahoney, "Bankruptcy as Implicit Health Insurance," *American Economic Review*, vol. 105, no. 2, pp. 710–746, <https://doi.org/10.1257/aer.20131408>.

44. One recent study found that 37 percent of people would not have been able to pay for an unexpected expense of \$400 without borrowing money in 2019. See Board of Governors of the Federal Reserve System, *Report on the Economic Well-Being of U.S. Households in 2019, Featuring Supplemental Data From April 2020* (May 2020), <https://go.usa.gov/xw6PZ> (PDF, 3.2 MB).

45. Ashley Kirzinger and others, *Data Note: Americans' Challenges With Health Care Costs* (Kaiser Family Foundation, June 2019), <https://tinyurl.com/y2oa4rjf>.

46. See Jennifer M. Haley and Genevieve M. Kenney, *Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?* (Urban Institute, May 2001), <https://tinyurl.com/y96n8rbc>.

47. Legal immigrants seeking admission or an update in status must demonstrate that they are not financially dependent on the government. Under previous policy, only enrollment in Medicaid to cover nursing home or long-term institutional care would result in inadmissibility under that "public charge rule." In 2019, the federal government expanded that definition to include more categories of Medicaid enrollment. See Joan Alker and Lauren Roygardner, *The Number of Uninsured Children Is on the Rise* (Georgetown University Health Policy Institute Center for Children and Families, October 2019), p. 6, <https://tinyurl.com/y26nogwe>.

Table 4.

Length of Time Without Coverage for People Who Are Uninsured at a Particular Point in Time

Percent

	Overall	Age		Family Income Relative to the Federal Poverty Level		
		Less Than 19	19 to 64	Less Than 138 Percent	138 to 400 Percent	More Than 400 Percent
1 to 5 Months	11	24	9	8	11	n.a.
6 to 11 Months	9	13	8	9	8	n.a.
12 Months or More	80	62	83	83	81	73

Source: Congressional Budget Office, using longitudinal data from the Medical Expenditure Panel Survey.

The estimates measure the total length of time without coverage for people who were uninsured as of the middle of the 2015–2016 and 2016–2017 panels of the Medical Expenditure Panel Survey.

Results for some groups are not applicable because the sample sizes are very small, which makes it difficult to produce precise estimates.

n.a. = not applicable.

How Long Do Uninsured People Remain Without Coverage?

The length of time individuals remain uninsured has implications for their exposure to financial risk and access to health care. A short spell without insurance exposes individuals to the financial risk of unexpected health events that could occur during that period, but it has a more limited effect on their access to routine and anticipated care.

Overall, CBO estimates that in recent years, 80 percent of people who were uninsured at a given point went without coverage for 12 months or longer (see Table 4). Adults ages 19 to 64 and people with income below 138 percent of the poverty level were the most likely to fall into this group. By contrast, children and members of families with income above 400 percent of the poverty level tended to be uninsured for shorter spells. Altogether, about 11 percent of the uninsured population lacked coverage for periods of 1 to 5 months, and another 9 percent lacked coverage for 6 to 11 months. Those shorter gaps in coverage could have occurred if

individuals changed jobs and moved from one employer’s plan to another, or if they cycled into and out of public coverage as a result of changes in income.

CBO estimated durations without coverage by taking a snapshot of the uninsured population at a particular moment and measuring how long those people were uninsured. That definition of the uninsured population corresponds to the definition CBO used to examine the characteristics and coverage options of uninsured people in 2019. However, the uninsured population could also be defined to include anyone who lost coverage at any point over a particular period. For example, whereas 12 percent of people under 65 were uninsured at a given point in 2019, roughly 25 percent spent some time without coverage over a two-year period in recent years. The latter group includes more people who were uninsured for short periods, which means the average length of time without coverage is shorter for that group than for people uninsured at a given moment. For more details on CBO’s methods and that alternative measure of time without coverage, see the appendix.



Appendix: The Data and Methods Underlying CBO's Estimates

This appendix describes the data and methods the Congressional Budget Office used to produce the estimates in this report. The methods used in this analysis are consistent with those used to construct CBO's baseline projections of coverage as of March 6, 2020. (The baseline is CBO's best estimate of how the budget would evolve if existing laws generally remained in place. CBO's estimates of the number of uninsured in 2019 did not change substantially between its March 2020 baseline and its September 2020 baseline.)

Characteristics and Coverage Options of the Uninsured Population in 2019

Many of the estimates in this report are drawn from the CBO's health insurance simulation model, HISIM2, which CBO uses to estimate the major sources of health insurance coverage and associated premiums for non-institutionalized U.S. residents under age 65.¹ Most of the data in HISIM2 come from the Annual Social and Economic Supplement of the Current Population Survey (CPS). Those data provide reliable, timely, and detailed information on many of the key variables needed to model health insurance coverage—including income, employment, and self-reported health status.

To improve the accuracy of the CPS data, CBO adjusts variables that are likely to be reported with some error, such as the number of people enrolled in Medicaid and the amount of income reported on tax returns, so that the distributions of characteristics of people in the HISIM2 sample match those found in administrative data.

1. For more information about how CBO prepares data for HISIM2, see Jessica Banthin and others, *Sources and Preparation of Data Used in HISIM2—CBO's Health Insurance Simulation Model*, Working Paper 2019-04 (Congressional Budget Office, April 2019), www.cbo.gov/publication/55087. For additional information about HISIM2, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed September 17, 2020), <https://go.usa.gov/xGQcM>.

CBO also includes variables that are not available in the CPS data. In some cases, CBO does so by matching records to observations from other surveys and administrative sources. For example, premiums for nongroup (non-employment-based) coverage are developed using administrative data on actual premiums from federal and state health insurance marketplaces. In other cases, variables are developed endogenously (that is, on the basis of the values of other variables) within the model. Premiums for employment-based insurance fall into that category: In the model, those premiums are calculated on the basis of plans' characteristics, which are imputed to observations using data from the Medical Expenditure Panel Survey—Insurance Component, and on the basis of distributions of households' spending on health care, which are imputed to observations using data from the Medical Expenditure Panel Survey—Household Component (MEPS-HC).

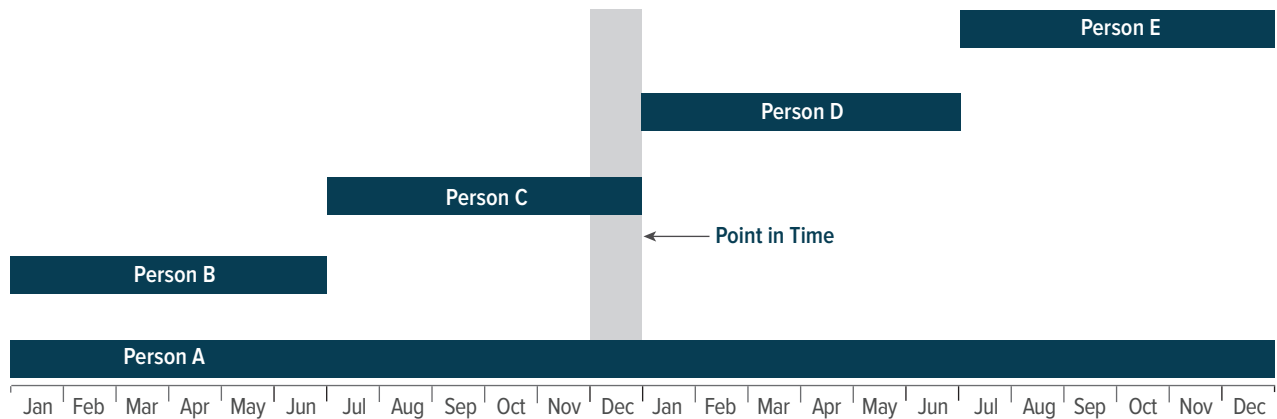
Lowest-Cost Options for Coverage

CBO uses income and other factors in its HISIM2 model to calculate each individual's eligibility for public coverage (such as Medicaid or CHIP) and for premium tax credits for nongroup coverage purchased through the marketplaces. CBO also simulates which workers will have an offer of employment-based coverage and the cost of that single or family coverage after any relevant tax subsidies and employer contributions. In addition, CBO simulates the value of the tax deduction for health insurance available to self-employed people without access to group coverage through an employer.

Using the model, CBO estimated the minimum amount that uninsured people eligible for different types of subsidized coverage would have to pay to enroll in coverage. To do so, CBO first estimated the net out-of-pocket premium each uninsured person would pay for each of his or her coverage options. The net premium reflects the out-of-pocket cost to households after applying all relevant federal subsidies (including the reduced tax liability from premium tax credits, tax deductions for nongroup

Figure A-1.

Measuring the Length of Time Without Coverage for People Who Are Uninsured at a Particular Point in Time



Source: Congressional Budget Office.

The Congressional Budget Office measured how long uninsured people usually go without coverage using the duration of uninsured spells that were in progress at a particular point in time. Consider five people who become uninsured at some point during a two-year period. Person A becomes uninsured in January of the first year and remains uninsured for the entire period. The other four people are each uninsured for six months—Person B from January through June of the first year, Person C from July through December of the first year, and so on. Using CBO’s point-in-time measure, the uninsured population in December of the first year consisted of two people (Person A and Person C); of that uninsured population, 50 percent (one of two) was uninsured for a year or more and 50 percent was uninsured for six months. If, instead, the length of time uninsured people go without coverage was measured by including all people who were uninsured at some point over the period, then 20 percent (one of five) went without coverage for a year or more and 80 percent (four of five) went without coverage for six months. The first approach characterizes the length of time without coverage for the population that is uninsured at a particular point in time, whereas the second approach does so for a broader definition of the uninsured population.

insurance, and tax exclusions for employment-based insurance premiums) and employer contributions. Then, CBO determined the least expensive of those options and used its cost as each person’s lowest-cost option for obtaining health insurance coverage. To demonstrate how federal subsidies lower the cost of health insurance, CBO also estimated the gross premiums for the least expensive options—that is, the cost after any employer contributions but before subsidies.

Length of Time Without Coverage

CBO’s estimates of the length of time uninsured people go without coverage were produced using data from the MEPS-HC. The MEPS-HC surveys the same households five times over a two-year period and reports each person’s coverage status for each month of that period. Those data allowed CBO to follow the same uninsured people over time to measure how long they remained without coverage.

Although most of the estimates in this report that are based on the HISIM2 model describe the uninsured population in 2019, CBO used data from the 2015–2016 and the 2016–2017 panels of the MEPS-HC because those were the most recent data available. CBO pooled the data from those two panels to improve the precision of its estimates, but the length of time uninsured people went without coverage in each panel was very similar.

CBO measured durations without coverage for people who were uninsured at a particular point in time. Specifically, CBO identified the people who were uninsured in December of 2015 and 2016 and estimated how long they went without coverage, looking backward and forward 12 months (see Figure A-1).

An alternative approach would be to measure the length of time without coverage for a broader definition of the uninsured population: people who were without

coverage at any point over a longer period. Defined in that way, the uninsured population would include more people who transitioned into and out of coverage relatively quickly over the course of a year. Compared with the point-in-time approach that CBO used, that

approach would reflect a shorter average length of time without coverage. Although many people go without coverage for relatively short periods, most people who are uninsured at a given moment will remain without coverage for at least a year.



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About This Document

This report was prepared at the request of the Chairman of the House Budget Committee. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the report makes no recommendations.

Allison Percy and Karen Stockley wrote the report, with guidance from Alexandra Minicozzi and Julie Topoleski. Geena Kim contributed to the analysis. Alice Burns, Sarah Masi, Robert Stewart, Emily Vreeland, and Chapin White provided useful comments. Katherine Feinerman and Christian Henry fact-checked the report.

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CBO continually seeks feedback to make its work as useful as possible. Please send any comments to communications@cbo.gov.

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Director
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