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Insight on the Issues

How Unaffordability of Nongroup Health Insurance Threatens the Health Security of Older Adults

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Millions of older Americans ages 50 to 64 rely on the nongroup (or individual) health insurance market for coverage. However, high premium and out-of-pocket costs can pose a major burden for those with coverage and prevent uninsured older adults from gaining coverage. Health care affordability challenges can negatively impact access to care.

INTRODUCTION

The nongroup (or individual) health insurance market plays a key role in providing access to health insurance coverage for older Americans below the age of 65—the age when most become eligible for Medicare. While the majority of older adults ages 50 to 64 receive health coverage through an employer (group coverage) or public program (such as Medicaid), over 5 million purchase coverage on their own in the nongroup market. For some, such as self-employed individuals, the nongroup market is the only option for health coverage. For others, such as individuals facing transitions such as job loss or career change, or early retirement, it serves as a vital safety net.

Congress enacted the Affordable Care Act (ACA) of 2010 with the primary goal of making affordable health insurance accessible to more people. Among its provisions, the law made important reforms to nongroup health insurance. As a result, more older Americans gained health insurance coverage and fewer reported having unmet needs due to cost or difficulty paying medical bills.[1] The uninsured rate for older adults also improved significantly in the period following ACA enactment, dropping from a high of 14 percent in 2013 to a low of 8 percent in 2016.[2]

AARP® Real Possibilities

Despite these significant improvements in coverage, health care affordability remains a large and growing concern for millions of Americans, including many older adults. Among older adults with nongroup coverage, many still face significant premiums and out-of-pocket costs. Nearly half of older adults without employer or public coverage were uninsured in 2018, with many choosing not to enroll in the nongroup market due to cost.

This *Insight on the Issues* focuses on the nongroup market because of its critical role in overall health care affordability for older adults. The paper discusses the affordability of health coverage for older nongroup enrollees using data from the KNG Health Reform Model[3] and affordability definitions from the Commonwealth Fund's Health Care Affordability Index (see the Analysis and Findings section). Policy recommendations to address affordability challenges illuminated by the data are included in the final section of the paper.

BACKGROUND

With the goal of improving access to affordable health coverage, the ACA made major reforms to the nongroup health insurance market. The law established online health insurance Marketplaces in every state where individuals can purchase nongroup coverage. To address affordability, the ACA made financial assistance (subsidies) available for people with low and moderate incomes (based on a sliding scale), bringing down the cost of premiums and cost-sharing for coverage purchased on the Marketplaces.[4,5] Individuals can also still purchase nongroup coverage outside of the Marketplaces, often referred to as "off-Marketplace," but subsidies are only available for Marketplace coverage.

Other ACA provisions were also critical to improving affordability of coverage, including requiring plans to cover essential health benefits and prohibiting insurers from charging higher rates or denying coverage due to preexisting conditions like diabetes or cancer.[6]

For older adults, the ACA rules around pricing of health insurance present both an important consumer protection and an obstacle to affordability. The ACA restricted the insurer practice of age rating, or charging older adults higher premiums based on their age, to a limit of three to one. This means that an insurance company may not charge older adults in the nongroup market more than three times the amount they charge a younger person for the same coverage.[7] While the limit is important, this still means that older adults will face higher nongroup premiums than younger adults.

ANALYSIS AND FINDINGS

Since enactment of the ACA, the nongroup market has become a critical source of health insurance coverage for older adults ages 50 to 64.

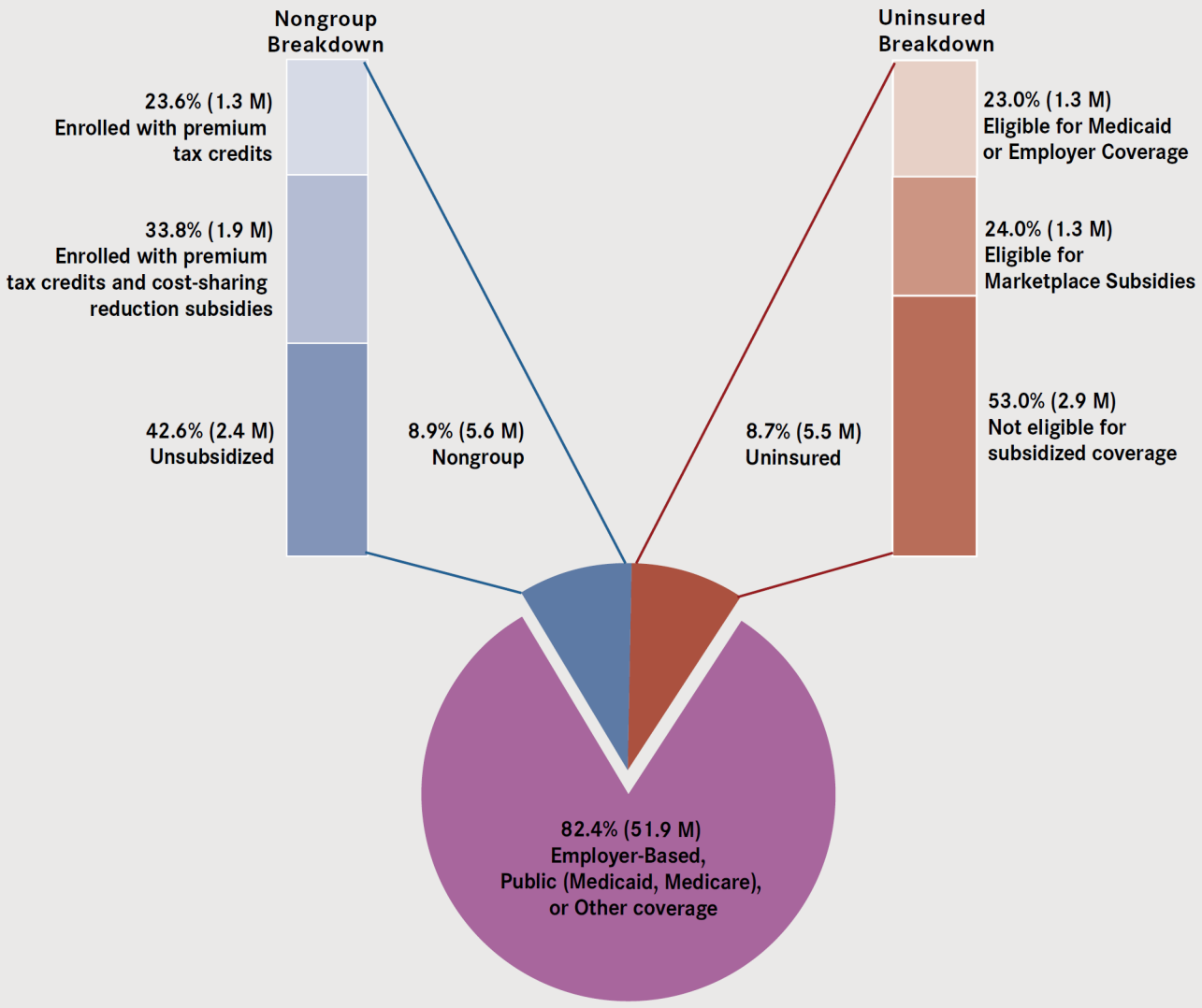
Among Americans ages 50 to 64, 5.6 million have health insurance coverage through the nongroup market (figure 1), comprising 9 percent of all older adults in that age group. While only a relatively small share of older adults have nongroup coverage, older adults rely more heavily on this market than other age groups. The percentage of older adults enrolled in the nongroup market has also increased over time.

Similar to trends across other age groups, uninsured rates for older adults have decreased overall as nongroup enrollment has increased since enactment of the ACA. Between 2013 and 2018, the uninsured rate for older Americans fell 39 percent while older adult enrollment in the nongroup market rose 47 percent.

Despite these improvements in coverage, however, a significant number of older adults are still uninsured. In 2018, nearly half of older adults without employer or public coverage remained uninsured. At the same time, many older adults who do have nongroup coverage still face problems affording their health insurance and out-of-pocket costs.

FIGURE 1

Sources of Health Insurance Coverage for Adults Ages 50 to 64, 2018



Note: Premium tax credits help lower premium costs and cost-sharing reductions help lower out-of-pocket costs. Source: 2019 analysis using the KNG Health Reform Model.

Many older adults in the nongroup market, particularly those who are unsubsidized, face unaffordable health insurance.

While there are different ways to measure the affordability of coverage, "unaffordable" coverage is defined in this paper as having premiums that exceed 10 percent of household income or having out-of-pocket costs that exceed 7 percent (see sidebar).[8]

Using this measure, over 40 percent of older adults in the nongroup market—including both those receiving subsidies and those not receiving subsidies—face coverage that is deemed "unaffordable."

Among older enrollees without subsidies, an especially high share—nearly three-quarters (74 percent)—have unaffordable coverage. Such unsubsidized individuals are either enrolled outside of the health insurance Marketplaces (1.8 million) or are enrolled through the Marketplaces but have incomes that fall outside of the range for financial assistance (0.6 million).

Over time, older adults in the nongroup market have become significantly more likely to receive subsidies. In 2014, shortly after the ACA was implemented, the majority (66 percent) of older adults enrolled in the nongroup market were unsubsidized and therefore paid full premiums. This share dropped to 43 percent by 2018 (figure 2). This enrollment trend is seen across most states, although trends vary due in part to geographic differences in health care costs and market dynamics (see appendix A).

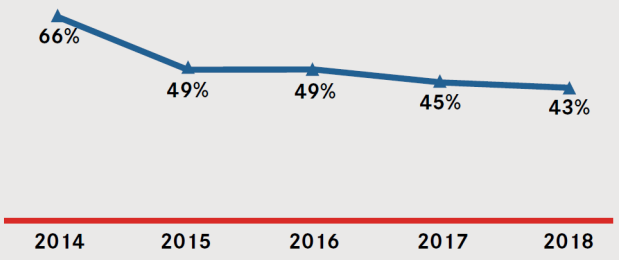
The shift to more older enrollees receiving subsidies could be attributable, at least in part, to the rising cost of nongroup premiums. Rising costs in the nongroup market may lead older adults who are ineligible for financial assistance to decide to forgo coverage. Unsubsidized older nongroup enrollees faced an average annual Silver plan premium of $9,652 in 2018, an increase from $5,525 in 2014.

In large part due to the lower premium cost, a much smaller share of *subsidized* older nongroup enrollees have unaffordable coverage than those who are unsubsidized (figure 3). Only about one-fifth of those with subsidies have unaffordable coverage, compared to nearly three-quarters of those without subsidies. When comparing older Marketplace to off-Marketplace enrollees, 81 percent of those enrolling off-Marketplace (inherently all unsubsidized) have unaffordable premiums, compared to 21 percent of Marketplace enrollees (mostly subsidized).

DEFINING AFFORDABILITY: COMMONWEALTH FUND'S HEALTH CARE AFFORDABILITY INDEX

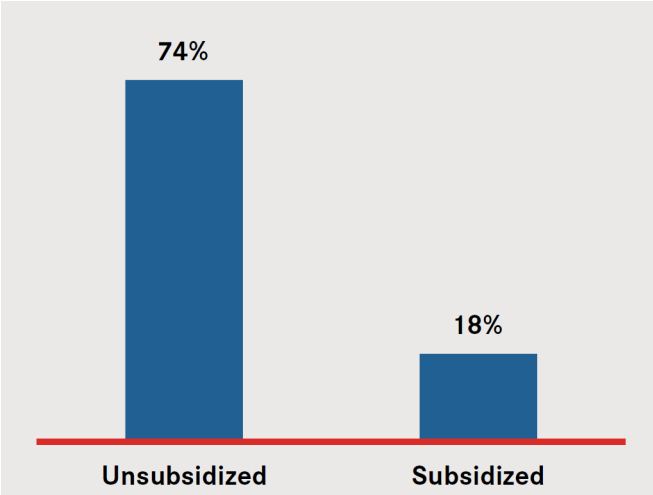
To define affordability, this report uses Commonwealth Fund's Health Care Affordability Index, which categorizes a health insurance plan as affordable based on the consumer's income level and percentage of income that their premiums or out-of-pocket costs represent. For low-income adults (earning less than 200 percent of the Federal Poverty Level), coverage is considered unaffordable if premiums (after subsidies) exceed 7 percent of income or out-of-pocket costs exceed 5 percent of income. For other enrollees (earning more than 200 percent of FPL), coverage is considered unaffordable if premiums (after subsidies) exceed 10 percent of income or out-of-pocket costs exceed 7 percent of income.

FIGURE 2
Share of Unsubsidized Adults Ages 50 to 64 in Nongroup Market, 2014–2018



Source: 2019 analysis using the KNG Health Reform Model.

FIGURE 3
Share of Nongroup Enrollees Ages 50 to 64 with Unaffordable Out-of-Pocket Costs or Premiums, by Subsidy Status, 2018



Source: 2019 analysis using the KNG Health Reform Model.

THE SUBSIDY CLIFF IN PRACTICE

Joseph is 64 years old and earns $48,000, which puts him at just below 400 percent of the Federal Poverty Level (FPL) in 2018.[9] With the ACA's tax credit he pays $382 for his monthly health insurance premium, or **$4,589 per year**. Meanwhile, Maryanne is 64 years old and earns just slightly more than Joseph at $49,000 a year, which is just over 400 percent of FPL. Maryanne is therefore ineligible for premium assistance and faces a silver plan premium of $1,127 per month, or **$13,521 per year**.

A single 64-year-old earning $49,000 in 2018—slightly above the eligibility threshold for subsidies—faces an average premium that is nearly 30 percent of their income

The "subsidy cliff" presents a significant affordability challenge for many older nongroup enrollees.

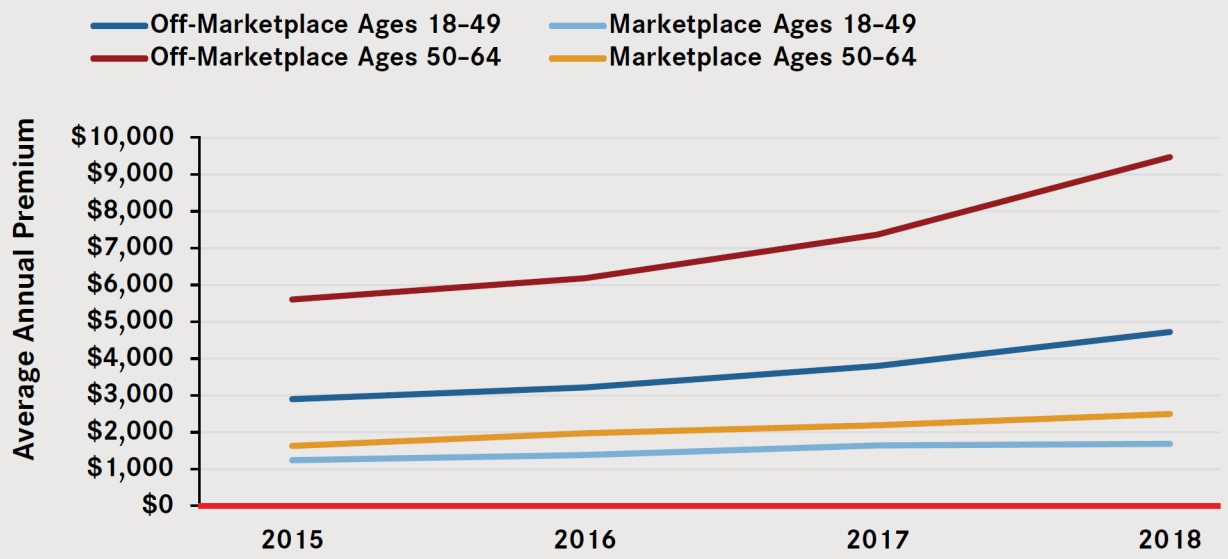
The ACA established premium tax credits that lower premium costs for Marketplace enrollees with incomes between 100 and 400 percent of the Federal Poverty Level (FPL). Tax credits are not available to individuals above 400 percent of FPL (or $48,560 annual income for an individual in 2018), regardless of the relative burden premiums may impose for people at their income level.

As a result of the eligibility cutoff for tax credits, premium costs jump for Marketplace enrollees with incomes over 400 percent of FPL, creating a "subsidy cliff." Feeling the effects of that cliff the most are enrollees with incomes just slightly above 400 percent of FPL. While only 7.6 percent of older nongroup enrollees have incomes between 400 and 500 percent of FPL, it is likely that there are many more older adults within this income range who are not counted in this figure because they are unwilling or unable to enroll in nongroup coverage due to the high premiums.

Older nongroup enrollees face higher premiums and out-of-pocket costs than younger enrollees.

Although a similar share of both older and younger nongroup enrollees receive premium assistance, older adults in the nongroup market pay higher premiums overall due to age rating (explained in the Background section). Rising premium costs impact everyone, but they can be especially difficult for unsubsidized older adults who already face high premiums due to their age. In 2018, off-Marketplace 50- to 64-year-olds paid on average $9,469 in annual premiums, compared to $4,721 among off-Marketplace adults ages 18 to 49 (figure 4). A single 64-year-old earning $49,000 in 2018—just slightly above the eligibility threshold for subsidies—faces an average premium that is nearly 30 percent of their income.

FIGURE 4
Average Annual Premiums in Nongroup Market, 2015–2018

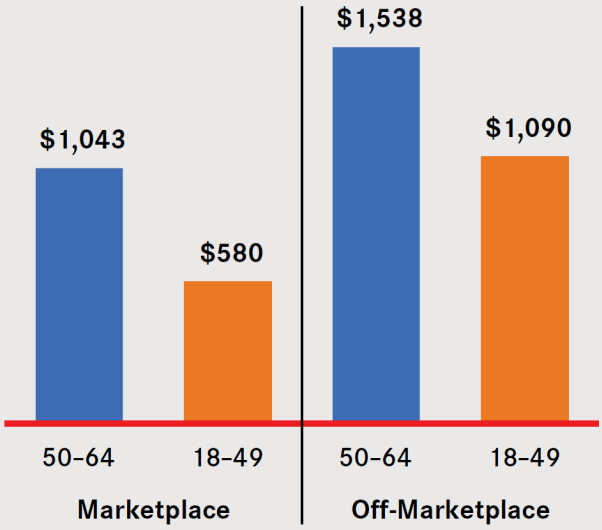


Source: 2019 analysis using the KNG Health Reform Model.

Older adults in the nongroup market also face higher out-of-pocket costs than younger adults. In 2018, the average out-of-pocket cost for nongroup enrollees ages 50 to 64 was $1,241, compared to $785 for adults ages 18 to 49. For both age groups, out-of-pocket costs are higher among off-Marketplace enrollees than Marketplace enrollees because they do not receive any cost-sharing reduction subsidies. Older off-Marketplace enrollees faced an average out-of-pocket cost of $1,538 compared to $1,043 for older Marketplace enrollees (figure 5).

These higher premium and out-of-pocket costs are part of the reason older nongroup enrollees are more likely than younger enrollees to have coverage that is deemed unaffordable. Among older enrollees, 8 percent face unaffordable out-of-pocket costs, compared to 4 percent of younger enrollees. Thirty-nine percent of older enrollees face unaffordable premiums, compared to 21 percent of younger enrollees. Overall, 42 percent of older enrollees have either unaffordable out-of-pocket costs or unaffordable premiums, compared to 23 percent of younger adults.

FIGURE 5
Average Annual Out-of-Pocket Spending in Nongroup Market, by Marketplace Participation and Age Group, 2018



Source: 2019 analysis using the KNG Health Reform Model.

Older nongroup enrollees in some states are more likely to experience affordability issues.

While affordability problems among older nongroup enrollees are widespread, there is significant variation among states (figure 6 and appendix B).

In 16 states, health care (either premiums or out-of-pocket costs) is unaffordable for the majority (over 50 percent) of older nongroup enrollees. In 10 states, health care is unaffordable for 60 percent of older nongroup enrollees. In Minnesota and the District of Columbia, more than 70 percent of older nongroup enrollees face unaffordable health care.

AFFORDABILITY ISSUES HAVE NEGATIVE HEALTH IMPLICATIONS FOR OLDER ADULTS

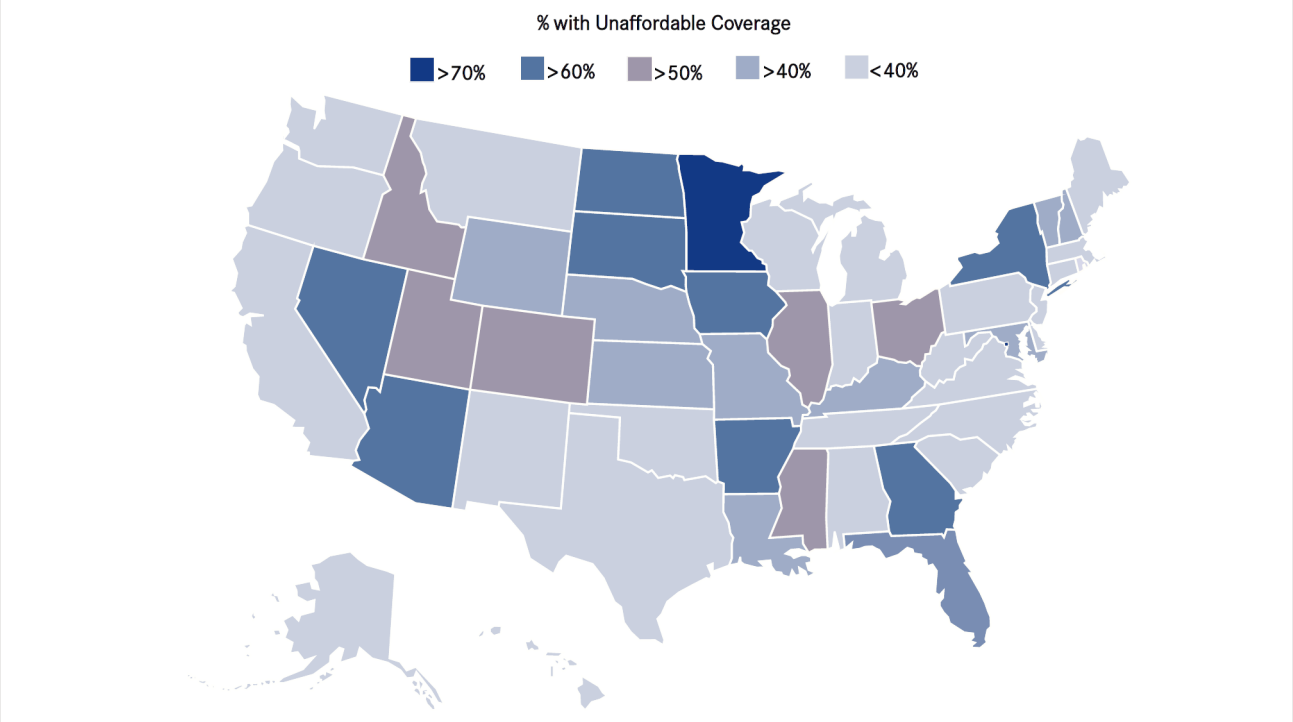
Unaffordable coverage leads to delaying or forgoing care.

Our analysis found that greater affordability challenges faced by older adults in the nongroup market are associated with delays in obtaining needed health care. Nearly one-fifth of older Marketplace enrollees report delaying care and 12 percent report forgoing care due to out-of-pocket health care costs (like deductibles and copayments; figure 7). Compared to younger Marketplace enrollees, older enrollees are more likely to delay or forgo care due to cost.

Fewer off-Marketplace enrollees report delaying or forgoing care due to cost compared to Marketplace enrollees, despite the greater out-of-pocket affordability challenges for off-Marketplace enrollees discussed earlier. Among older off-Marketplace enrollees, 12 percent report delaying care due to cost and 7 percent report forgoing care due to cost. One possible explanation for off-Marketplace enrollees reporting less delayed or forgone care due to cost than Marketplace enrollees is that off-Marketplace enrollees may have higher incomes and are not as impacted by high

FIGURE 6

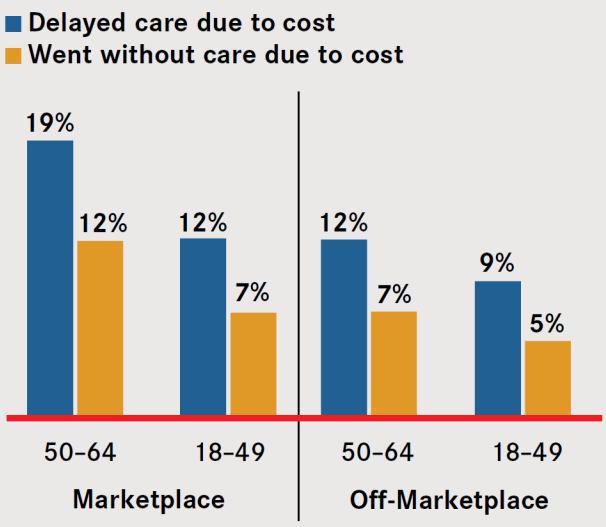
State Variation in Health Care Affordability among Nongroup Enrollees Ages 50 to 64, 2018



Source: 2019 analysis using the KNG Health Reform Model.

FIGURE 7

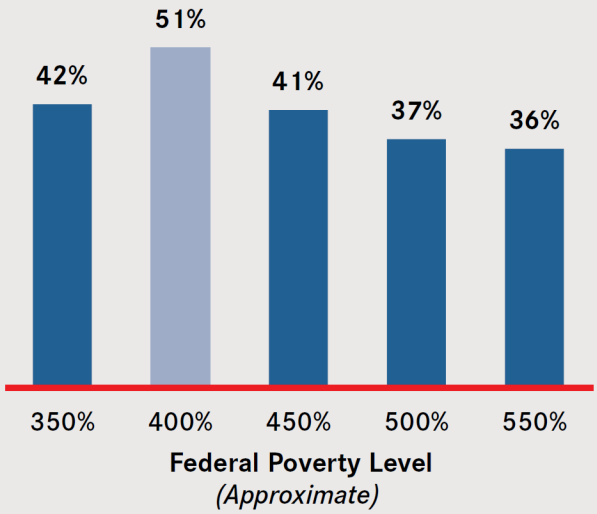
Share of Marketplace and Off-Marketplace Enrollees Delaying or Forgoing Care Due to Cost, 2018



Source: 2019 analysis using the KNG Health Reform Model.

FIGURE 8

Uninsured Rate among Adults Ages 50 to 64 without Public or Employer Coverage, by Income Level, 2018



Notes: Uninsured rate differs from overall uninsured rate among adults ages 50 to 64 at these income levels because denominator excludes those with public or employer coverage. Each bar represents a range of 50 percent of FPL. For example, "Approx. 350%" means people with incomes between 325 and 375 percent of FPL. Source: 2019 analysis using the KNG Health Reform Model.

out-of-pocket costs, even if those costs make up a large share of their income. Older off-Marketplace enrollees are also more likely to delay or forgo care due to cost than younger off-Marketplace enrollees.

Affordability issues that result in delaying or forgoing care broadly impact older adults, not just those in the nongroup market. According to a 2019 poll by AARP and the University of Michigan, 13 percent of adults ages 50 to 64 reported not receiving medical care due to cost.[10] Delaying or forgoing care can lead to worse health consequences for older adults as well as increased health care utilization and costs down the road.

Unaffordable coverage leads to more uninsured.

Our analysis also found that unaffordable premiums in nongroup coverage may be leading to lower rates of insurance coverage among older adults. The uninsured rate among adults ages 50 to 64 without public or employer coverage generally declines as income increases. The exception is among those with incomes just above 400 percent of FPL, the cutoff for subsidy eligibility, at which the uninsured rate sharply increases (figure 8). About half (51 percent) of older adults with incomes around 400 percent of FPL are uninsured, compared to 42 percent of those with incomes around 350 percent of FPL (who are eligible for subsidies in the Marketplaces). For those with incomes slightly above 400 percent of FPL, the effective price of coverage jumps, rendering coverage unaffordable for many and resulting in more forgoing coverage.

At the state level, a similar illustration shows that higher premiums correlate with higher uninsured rates among adults ages 50 to 64. States with higher unsubsidized premiums had significantly larger shares of uninsured 50- to 64-year-olds without public or employer coverage than states with lower unsubsidized premiums. Nationally, the average

unsubsidized premium was around $10,000 in 2018. States with average premiums exceeding this amount had a 20 percent higher uninsured rate than those with average premiums lower than this amount (48 vs. 40 percent; figure 9).

Other studies suggest that affordability concerns could make some people more likely to forgo health coverage. For example, the aforementioned 2019 survey by AARP and the University of Michigan found that one in four adults ages 50 to 64 had little or no confidence in being able to afford the cost of their health insurance over the next year and 11 percent reported considering going without health insurance in the previous year.[11]

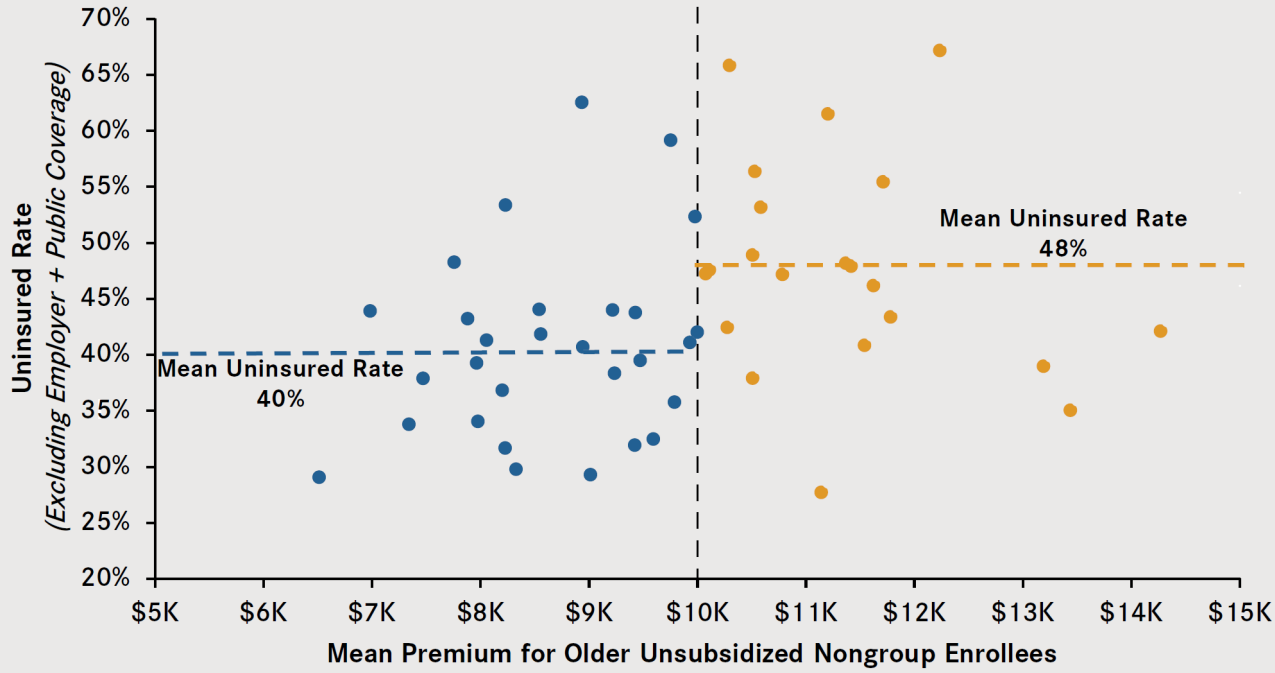
Loss of coverage can have negative impacts on access to and affordability of health care, and it can be particularly problematic for older adults. Uninsured people are more likely to report problems getting needed care and less likely to report regular outpatient visits than insured people.[12] As a result, they are at increased risk of negative health outcomes, such as being diagnosed at later stages of diseases, including cancer. Older adults are also more likely to have chronic conditions than younger adults and tend to require more care to manage their conditions.[13] Recent evidence suggests that lack of insurance coverage increases mortality, and this effect may be disproportionately large for older adults.[14,15]

MOVING FORWARD: POLICY RECOMMENDATIONS

Nongroup coverage plays a critical role in ensuring older adults ages 50 to 64 have access to health coverage. While the Affordable Care Act (ACA) has

FIGURE 9

Higher Shares of Uninsured 50- to 64-year-olds in States with Higher Nongroup Premiums, 2018



Notes: Uninsured rate differs from overall uninsured rate among adults ages 50 to 64 because denominator excludes those with public or employer coverage. In states where average unsubsidized premiums exceed $10,000, the average uninsured rate is 48 percent, compared to 40 percent when the average premium is below $10,000. Source: 2019 analysis using the KNG Health Reform Model.

made nongroup coverage more accessible, nearly half of all older adults without employer or public coverage still remain uninsured, and affordability of health coverage is a significant concern for many older adults with nongroup coverage.

It is critical to build on the ACA's improvements in health care access and coverage and continue to improve health care affordability for older adults in the nongroup market. Federal and state policy makers should consider policy proposals to make health care more affordable by increasing financial assistance available to consumers, reducing or slowing the growth of premiums and out-of-pocket costs, and improving the functioning of the overall nongroup market.

Improve Coverage Affordability

1. Expand premium assistance to people above the "subsidy cliff."

Policy makers should enact policy changes to bring down premium costs for people with incomes above 400 percent of the Federal Poverty Level who are currently ineligible for premium tax credits under the ACA. Expanding premium assistance would make coverage more affordable for many older nongroup enrollees, as well as likely attract new enrollees. A 2017 Commonwealth Fund analysis project found that extending tax credits for those above 400 percent of FPL would increase insurance enrollment by 1.2 million people and would be especially beneficial to middle-income adults ages 50 to 64.[16] These new and likely healthy enrollees would help improve nongroup market risk pools, which would lower premiums for all enrollees. Capping premium responsibility to a share of income would continue to help target resources to people with the greatest financial need, though policy makers should also explore other strategies to expand premium assistance to this group.

2. Improve premium assistance available for lower-income enrollees.

Policy makers should also consider proposals to reduce premium burden for individuals receiving limited subsidies. Nearly one-fifth of older nongroup enrollees who receive subsidies still face unaffordable costs, and over half of older adults without public or employer coverage who are between 100 and 400 percent of FPL (i.e., eligible for subsidies) remain uninsured. Premium costs may be especially challenging for those with incomes too high to receive full tax credit subsidies. One policy option would be to increase subsidies for individuals who receive less than full subsidies.

3. Fix the "family glitch."

To be eligible for financial assistance in the nongroup market, consumers must not otherwise have access to affordable employer coverage. But some have access to employer coverage that, while not actually affordable, is deemed affordable because it is based on the cost of individual coverage, not the cost of a family plan. As a result, these consumers are unable to afford employer coverage and are simultaneously ineligible for financial assistance in the nongroup market. Policy makers should work to fix this "family glitch," which may require amending language in the ACA.

4. Expand reinsurance.

Policy makers should expand reinsurance, either through a federal reinsurance program or by helping states enact their own state reinsurance programs. Reinsurance protects health insurers from unpredictable and high health care claims, allowing insurers to set lower premiums and improving market stability by encouraging insurers to participate. A 2019 Avalere analysis found that states with reinsurance programs reduce nongroup market premiums by an average 19.9 percent in the first year.[17] Reinsurance programs have also been effective in increasing enrollment in coverage and retaining insurer participation.[18]

Improve Out-of-Pocket Affordability

1. Lower out-of-pocket health care costs.

While the ACA requires plans to cap out-of-pocket spending, many enrollees, including older adults, still have unaffordable out-of-pocket costs. Policy makers should consider proposals to further

limit out-of-pocket costs for those not eligible for subsidies and those who may receive limited financial assistance for cost-sharing.

2. Protect Essential Health Benefits.

The ACA limits the amount that enrollees can pay out of pocket for Essential Health Benefits (EHB), which are services that nongroup and small group plans must cover. These out-of-pocket limits do not apply to services that are not EHB. Policy makers should protect EHB and oppose proposals that would weaken or include fewer services for EHB in order to shield older consumers from high out-of-pocket costs.

Improve Overall Market Functioning

1. Improve health care price transparency.

Meaningful health care price transparency can help consumers better predict out-of-pocket costs and make informed decisions about their care. While the burden of reducing health care prices should never fall primarily on the consumer, policy makers should enact policies to make health care costs more transparent. Such efforts could include expanding use of All-Payer Claims Databases– large state databases with medical, pharmacy and other claims from private and public payers.[19] Transparency efforts could also include requiring hospitals to disclose both the list and actual health care prices to consumers in a way that consumers can easily understand and use.

2. Prohibit surprise billing.

Policy makers should also implement policies that address and prohibit the practice of surprise billing. Surprise billing occurs when a consumer receives care from a provider outside of their insurer's network despite their best effort to stay within the network, and they receive an unexpected bill for the amount their insurance does not cover. This type of practice results in higher costs not only for consumers who receive surprise bills, but also in higher premiums for everyone with private coverage.[20] State and federal strategies to address surprise billing are important for improving affordability of health care and protecting consumers from potentially catastrophic costs.

3. Pursue proposals that increase overall nongroup enrollment.

Policy makers should consider various proposals that expand nongroup enrollment overall, as this can help people get needed coverage while improving the overall health of the risk pool and thereby lowering premiums. For example, policy makers should restore adequate funding for Marketplace advertising and consumer assistance. With many people losing employment during the COVID-19 pandemic, efforts should also include promotion and education around coverage options for people losing employer-sponsored coverage, such as ACA special enrollment periods, Medicaid eligibility, and COBRA continuation coverage. Policy makers should also adopt changes to the nongroup market that would facilitate health coverage enrollment or incentivize greater insurer participation, as well as restore penalties for not abiding by the ACA's requirement to have health coverage (the individual mandate). This penalty is intended to ensure that everyone has adequate health coverage, and it can help increase enrollment in the nongroup market.

4. Block harmful policy proposals and rules that keep nongroup premiums high.

Policy makers should oppose proposals such as the 2017 and 2018 federal regulations that expand non-ACA-compliant plans such as short-term limited-duration plans and association health plans, as well as ensure robust oversight of such plans to ensure they do not negatively impact the nongroup market.[21] These types of coverage are not required to adhere to ACA consumer protections important for older adults, such as the requirement to cover EHB; protect people with preexisting conditions; or adhere to community rating standards (like age rating). While premiums for these plans may be less expensive than for ACA-compliant plans, expansion of these plans can increase premiums for everyone, including those who remain in the nongroup market. This is because expansion of noncompliant plans may encourage healthier individuals to leave the nongroup market, leaving

a less healthy and more costly pool of individuals in the nongroup market.

CONCLUSION

The Affordable Care Act has made health coverage more accessible for millions of Americans, including many older adults. However, nongroup health insurance remains unaffordable for many, leaving major gaps in coverage for older adults not yet eligible for Medicare.

The COVID-19 pandemic has only underscored the importance of the nongroup market as a vital safety net. The pandemic and associated economic downturn resulted in historic job losses, displacing millions of individuals from their jobs. People who lose workplace health coverage due to the pandemic can enroll in the nongroup market through a special enrollment period or during open enrollment. This critical safety net guaranteed by the ACA allows for continuity of health coverage during all times and is even more important during a public health crisis. The pandemic has highlighted both the importance of the nongroup market and the urgency for addressing health care costs for enrollees in the nongroup market. Many enrollees—even those receiving financial assistance—still face high premiums and out-of-pocket costs, which may be challenging to afford during this economic crisis. Delaying or forgoing care because of cost concerns can lead to worse health, and doing so during a pandemic could be particularly dangerous.[22]

METHODS

The data in this paper rely on the KNG Health Reform Model population file. This file combines many data sources, primarily the American Community Survey and the National Health Interview Survey. KNG Health also calibrates the file to be consistent with administrative data from the Centers for Medicare & Medicaid Services and estimates from the Congressional Budget Office. This file allows for many types of integrated estimates that would not be possible with any single data source. However, many of this report's findings are modeled estimates that may vary from other published resources.

APPENDIX

APPENDIX A.
Share of Subsidized vs. Unsubsidized Older Nongroup Enrollees in 2014 and 2018, by State

State	Year	% Subsidized	% Unsubsidized
Alabama	2014 2018	32% 59%	68% 41%
Alaska	2014 2018	46% 65%	54% 35%
Arizona	2014 2018	21% 54%	79% 46%
Arkansas	2014 2018	12% 14%	88% 86%
California	2014 2018	46% 52%	54% 48%
Colorado	2014 2018	20% 34%	80% 66%
Connecticut	2014 2018	30% 55%	70% 45%
Delaware	2014 2018	34% 68%	66% 32%
District of Columbia	2014 2018	6% 4%	94% 96%
Florida	2014 2018	45% 69%	55% 31%
Georgia	2014 2018	26% 72%	74% 28%
Hawaii	2014 2018	11% 43%	89% 57%
Idaho	2014 2018	38% 42%	62% 58%
Illinois	2014 2018	28% 50%	72% 50%
Indiana	2014 2018	43% 56%	57% 44%
Iowa	2014 2018	13% 35%	87% 65%
Kansas	2014 2018	28% 52%	72% 48%
Kentucky	2014 2018	28% 45%	72% 55%
Louisiana	2014 2018	27% 56%	73% 44%
Maine	2014 2018	53% 74%	47% 26%
Maryland	2014 2018	20% 41%	80% 59%
Massachusetts*	2015 2018	52% 63%	48% 37%
Michigan	2014 2018	34% 55%	66% 45%
Minnesota	2014 2018	5% 35%	95% 65%
Mississippi	2014 2018	32% 44%	68% 56%
Missouri	2014 2018	34% 59%	66% 41%
Montana	2014 2018	45% 63%	55% 37%
Nebraska	2014 2018	26% 54%	74% 46%

APPENDIX A.

Share of Subsidized vs. Unsubsidized Older Nongroup Enrollees in 2014 and. 2018, by State *continued*

State	Year	% Subsidized	% Unsubsidized
Nevada	2014 2018	22% 61%	78% 39%
New Hampshire	2014 2018	39% 39%	61% 61%
New Jersey	2014 2018	38% 60%	62% 40%
New Mexico	2014 2018	33% 60%	67% 40%
New York	2014 2018	33% 35%	67% 65%
North Carolina	2014 2018	38% 71%	62% 29%
North Dakota	2014 2018	19% 30%	81% 70%
Ohio	2014 2018	30% 46%	70% 54%
Oklahoma	2014 2018	27% 67%	73% 33%
Oregon	2014 2018	32% 55%	68% 45%
Pennsylvania	2014 2018	32% 65%	68% 35%
Rhode Island	2014 2018	54% 62%	46% 38%
South Carolina	2014 2018	39% 66%	61% 34%
South Dakota	2014 2018	16% 32%	84% 68%
Tennessee	2014 2018	26% 59%	74% 41%
Texas	2014 2018	35% 67%	65% 33%
Utah	2014 2018	20% 58%	80% 42%
Vermont	2014 2018	53% 62%	47% 38%
Virginia	2014 2018	31% 68%	69% 32%
Washington	2014 2018	39% 45%	61% 55%
West Virginia	2014 2018	43% 72%	57% 28%
Wisconsin	2014 2018	50% 68%	50% 32%
Wyoming	2014 2018	41% 62%	59% 38%
United States	**2014** **2018**	**34%** **57%**	**66%** **43%**

**2015 data is reported for Massachusetts because 2014 data was incomplete. Source: 2019 analysis using the KNG Health Reform Model.*

APPENDIX B.

Share of Nongroup Enrollees Ages 50 to 64 with Unaffordable Health Coverage, 2018

State	% with Unaffordable Health Coverage
Alabama	40%
Alaska	37%
Arizona	64%
Arkansas	65%
California	35%
Colorado	53%
Connecticut	38%
Delaware	32%
District of Columbia	76%
Florida	56%
Georgia	61%
Hawaii	46%
Idaho	53%
Illinois	52%
Indiana	36%
Iowa	64%
Kansas	44%
Kentucky	45%
Louisiana	41%
Maine	29%
Maryland	42%
Massachusetts	27%
Michigan	40%
Minnesota	83%
Mississippi	56%
Missouri	47%

State	% with Unaffordable Health Coverage
Montana	30%
Nebraska	44%
Nevada	68%
New Hampshire	50%
New Jersey	31%
New Mexico	32%
New York	60%
North Carolina	32%
North Dakota	63%
Ohio	46%
Oklahoma	32%
Oregon	34%
Pennsylvania	33%
Rhode Island	31%
South Carolina	35%
South Dakota	63%
Tennessee	39%
Texas	28%
Utah	52%
Vermont	49%
Virginia	29%
Washington	40%
West Virginia	32%
Wisconsin	32%
Wyoming	41%
United States	**42%**

Note: Health coverage costs include both premiums and out-of-pocket costs. Data include both subsidized and unsubsidized nongroup enrollees. Source: 2019 analysis using the KNG Health Reform Model.

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3 Data in this report are from 2018 and come from KNG Health Reform Model 2019, a microsimulation model developed by KNG Health Consulting, LLC. Some state-level data are included in the appendix of this paper and more data are available on AARP DataExplorer (dataexplorer.aarp.org), an interactive data website developed by AARP Public Policy Institute.

4 Cost-sharing includes out-of-pocket costs like deductibles, coinsurance, and copayments. Premium tax credits help lower premiums for eligible enrollees who have incomes between 100 and 400 percent of the Federal Poverty Level. Cost-sharing reduction subsidies are available to help reduce out-of-pocket costs for eligible consumers between 100 and 250 percent of the Federal Poverty Level.

5 Individuals who enroll on-Marketplace without subsidies and those who enroll off-Marketplace are "unsubsidized."

6 This is particularly significant for older adults, given that an AARP analysis found that 40 percent of adults ages 50 to 64 have a declinable preexisting condition that could result in insurers denying them coverage if they sought to buy a plan in the nongroup market before the ACA was passed. Source: Claire Noel-Miller and Jane Sung, "In Health Reform, Stakes Are High for Older Americans with Preexisting Health Conditions," AARP Public Policy Institute, March 2017, https://www.aarp.org/ppi/info-2017/affordable-care-act-protects-millions-of-older-adults-with-pre-existing-conditions.html.

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