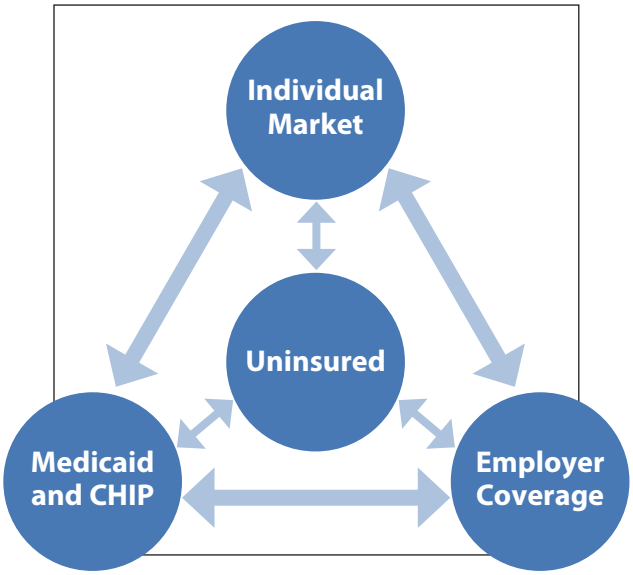
The Interconnectedness of Health Coverage Sources for the Under-65 Population

The U.S. health insurance system is a complex tapestry, with coverage provided through a mix of public and private sources, including Medicaid, Medicare, employer-sponsored insurance, and the individual market. Each type of coverage is generally governed by distinct laws and regulations, which can lead policymakers to consider them in isolation. However, these markets are interconnected, and changes to policies governing one source can have significant ripple effects across the broader system.

This synopsis highlights key connections among health coverage sources for the under-65 population. Most individuals in this age group obtain coverage through an employer, Medicaid or the Children's Health Insurance Program (CHIP), the individual market, or remain uninsured. These sources interact with one another and with the uninsured population. Individuals often move between these sources due to changes in employment, income, family status, or other circumstances. Other options—such as Medicare, Basic Health Plans, TRICARE, or VA care—are also available to some individuals under age 65, but are not addressed here.



Employer-sponsored insurance is the largest source of health coverage for the nonelderly, providing coverage to workers and their dependents. This coverage is more common in larger firms, unionized workplaces, higher-wage companies, and for full-time employees. Lacking this option, individuals may qualify for Medicaid, turn to the individual market, or remain uninsured. Key employer-related policies with cross-market implications include the employer mandate and subsidy firewall, the tax exclusion for employer coverage, and rules regarding association health plans and Individual Coverage Health Reimbursement Accounts (ICHRAs).

Medicaid and CHIP cover low-income individuals and other vulnerable groups, including children, pregnant women, individuals with disabilities, parents, and some childless adults. These programs are jointly funded and regulated by federal and state governments, with significant variation in eligibility and benefits by state. Expanded Medicaid access reduces the uninsured rate and shifts some enrollment from private coverage, especially federally subsidized individual market coverage, to Medicaid. Medicaid enrollment also fluctuates with economic conditions, serving as a safety net during economic downturns. Other Medicaid policies with cross-market effects include state expansion decisions, work requirements, federal match rates, and the eligibility determination and redetermination processes.

The **individual market** generally serves people who do not qualify for Medicaid, lack access to affordable employer-sponsored coverage, or are self-employed. Coverage is primarily obtained via state or the federal marketplace, with some individuals opting to remain uninsured. Premium tax credits improve affordability for eligible low- and moderate-income individuals and reduce uninsured rates; however, they are restricted to those with exchange coverage who are not Medicaid-eligible nor have access to affordable employer coverage. Key policies that influence other markets include premium tax credit availability, cost-sharing reduction funding, single risk-pool requirements, essential health benefits, enrollment and eligibility verification processes, risk adjustment, and reinsurance.

Many people remain **uninsured** due to the lack of access to employer coverage, ineligibility or unawareness of subsidies in the individual market, or Medicaid eligibility gaps—especially in non-expansion states. While some individuals forego coverage because they don't perceive a need, they remain financially vulnerable to unexpected health costs. A significant share of the uninsured are low income and live in households with at least one full-time worker who may not be able to access employer-provided insurance due to unavailability, cost, or lack of dependent coverage.

The interconnected nature of the coverage landscape underscores the importance of evaluating public policy proposals holistically. Changes in one part of the system can significantly affect the availability of other coverage sources, premium levels, and the uninsured rate. For example, interest is growing in ICHRAs, which allow employers to contribute funds that employees use to purchase individual market coverage. Policies that improve individual market affordability and stability could make these arrangements more attractive. Conversely, policies that increase premiums or reduce market stability may dampen employer interest.

Similarly, tightening Medicaid eligibility or imposing more burdensome enrollment procedures could increase the number of uninsured. Some individuals may shift to private coverage, which may affect private insurance premiums if their health status differs from existing enrollees.

Understanding the broader implications of policy decisions across the coverage spectrum can support more effective, coordinated policymaking and reduce unintended consequences. Considering how changes in one market affect others can help build a more stable, accessible, and affordable health insurance system.

This discussion brief was developed by Cori Uccello, Senior Health Fellow and lead author, and members of the Individual and Small Group Markets Committee of the American Academy of Actuaries.

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