NATIONAL CENTER FOR HEALTH STATISTICS
National Health Interview Survey Early Release Program

High-deductible Health Plans and Financial Barriers to Medical Care: Early Release of Estimates From the National Health Interview Survey, 2016

by Robin A. Cohen, Ph.D., and Emily P. Zammitti, M.P.H.,
Division of Health Interview Statistics, National Center for Health Statistics

Highlights

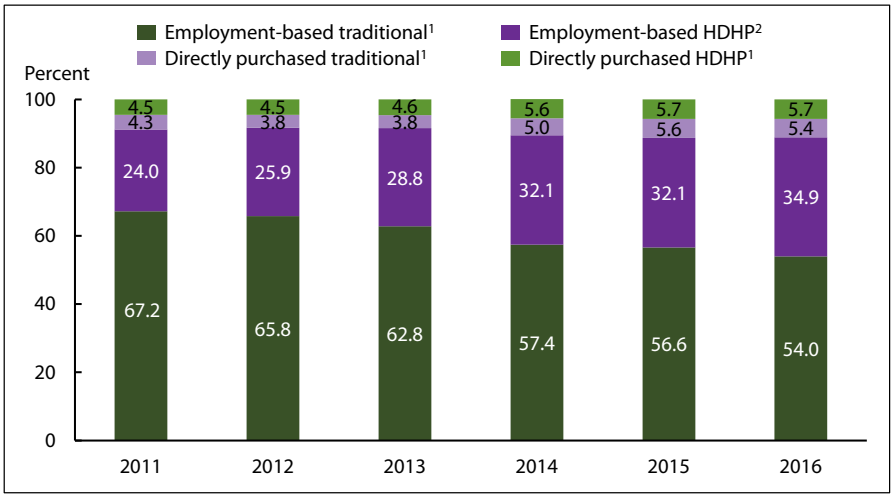
- The percentage of adults aged 18–64 with employment-based coverage enrolled in a high-deductible health plan (HDHP) increased, from 26.3% in 2011 to 39.3% in 2016.
- In 2016, among privately insured adults aged 18–64 with employment-based coverage, those enrolled in an HDHP were more likely to experience the two financial barriers to care analyzed in this report than those enrolled in a traditional plan.
- In 2016, among privately insured adults aged 18–64 with directly purchased coverage, the percentage of those who had experienced financial barriers to health care did not differ by type of coverage (HDHP or traditional).
- In 2016, among privately insured adults aged 18–64 with employment-based coverage, income distributions were similar between those with an HDHP and those with a traditional plan.
- In 2016, among privately insured adults aged 18–64 with directly purchased coverage, those enrolled in an HDHP had higher household incomes than those enrolled in a traditional plan.

Introduction

High-deductible health plans (HDHPs) are health insurance policies with higher deductibles than traditional plans. In 2016, HDHP was defined as a health plan with an annual deductible of at least $1,300 for self-only coverage or $2,600 for family coverage. Traditional plans have annual deductibles below these levels. Relative to traditional plans, HDHPs tend to have lower premium costs. Because of the higher deductibles, persons enrolled in HDHPs can have higher out-of-pocket costs in the initial stages of care. Previous studies have shown that adults with HDHPs are more likely to forgo or delay care due to cost (1,2), and low-income adults with HDHPs are less confident that they can afford care compared with those with traditional plans (3).

These previous studies have focused on employment-based coverage or have not disaggregated employment-based coverage from directly purchased coverage. This report provides recent estimates from the National Health Interview Survey (NHIS) for the percentage of privately insured adults aged 18–64 who experienced financial barriers to care in the past 12 months by source (employment-based or directly purchased) and type (traditional or HDHP) of private coverage. Because income is also associated with financial barriers to care, income distribution by source and type of private coverage is also shown. All estimates in this report are based on preliminary data. This report is produced by the NHIS Early Release (ER) Program, which releases selected preliminary estimates prior to final microdata release.

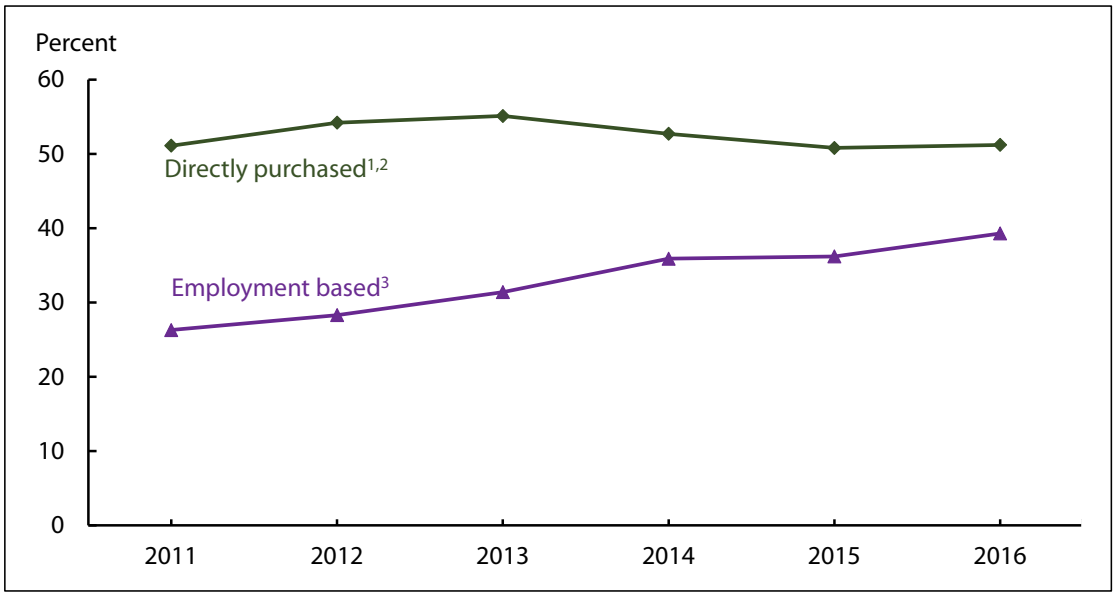
Figure 1. Percent distribution of privately insured adults aged 18–64, by source and type of private coverage: United States, 2011–2016



[1]Significant cubic trend from 2011 through 2016 ($p < 0.05$).
[2]Significant linear increase from 2011 through 2016 ($p < 0.05$).
NOTES: HDHP is a high-deductible health plan. Estimates may not add to 100.0% due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2011–2016.

- In 2016, among privately insured adults aged 18–64, 54.0% were enrolled in an employment-based traditional plan, 34.9% were enrolled in an employment-based HDHP, 5.4% were enrolled in a directly purchased traditional plan, and 5.7% were enrolled in a directly purchased HDHP (Figure 1).
- The percentage of adults aged 18–64 enrolled in an employment-based HDHP increased, from 24.0% in 2011 to 34.9% in 2016.
- The percentage of privately insured adults aged 18–64 enrolled in an employment-based traditional plan generally decreased, from 67.2% in 2011 to 54.0% in 2016. However, the decrease was not linear; there were significant changes in the percentage between 2011 (67.2%) and 2012 (65.8%) and between 2014 (57.4%) and 2015 (56.6%).
- The percentage of privately insured adults aged 18–64 enrolled in a directly purchased HDHP remained stable from 2011 (4.5%) to 2013 (4.6%), it increased from 4.6% in 2013 to 5.6% in 2014, and then it remained stable from 2014 to 2016 (5.7%).
- The percentage of privately insured adults aged 18–64 enrolled in a directly purchased traditional plan decreased from 2011 (4.3%) to 2012 (3.8%), it increased from 3.8% in 2012 to 5.6% in 2015, and then it remained stable from 2015 to 2016.

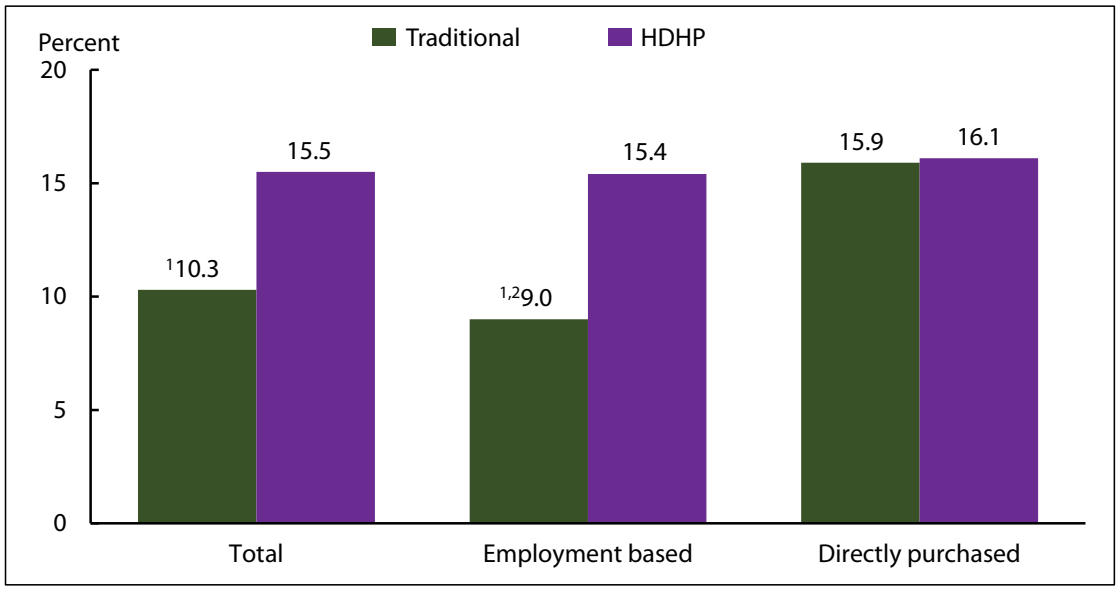
Figure 2. Percentage of privately insured adults aged 18–64 enrolled in a high-deductible health plan, by source of private coverage: United States, 2011–2016



[1]Significantly different from those with employment-based high-deductible health plan coverage within each year from 2011 through 2016 ($p < 0.05$).
[2]Significant quadratic trend from 2011 through 2016 ($p < 0.05$).
[3]Significant linear increase from 2011 through 2016 ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2011–2016.

- The percentage of adults aged 18–64 with employment-based coverage enrolled in an HDHP increased, from 26.3% in 2011 to 39.3% in 2016 (Figure 2).
- The percentage of adults aged 18–64 with directly purchased coverage enrolled in an HDHP increased, from 51.1% in 2011 to 55.1% in 2013, it decreased from 55.1% in 2013 to 50.8% in 2015, and then it remained stable between 2015 and 2016 (51.2%). There was no significant difference in the percentage of adults enrolled in an HDHP between 2011 (51.1%) and 2016 (51.2%).
- Within each year from 2011 through 2016, enrollment in an HDHP was lower among adults aged 18–64 with employment-based coverage than among those with directly purchased coverage.

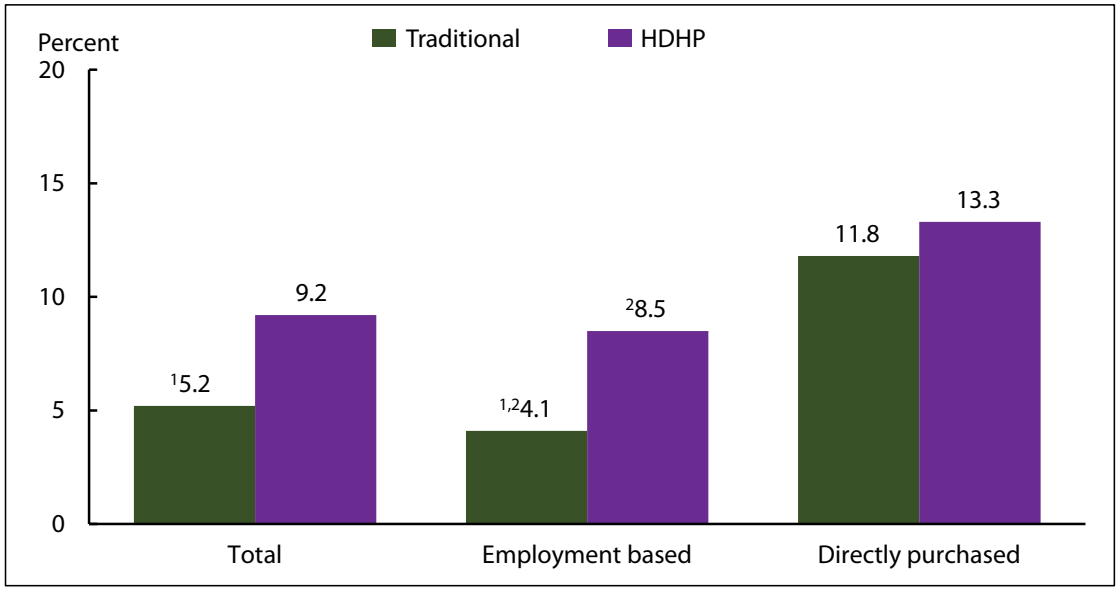
Figure 3. Percentage of privately insured adults aged 18–64 in families having problems paying medical bills in the past 12 months, by source and type of private coverage: United States, 2016



[1]Significantly different from those with HDHP ($p < 0.05$).
[2]Significantly different from those with directly purchased traditional and directly purchased HDHP ($p < 0.05$).
NOTES: HDHP is a high-deductible health plan. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2016.

- In 2016, among privately insured adults aged 18–64, the percentage of those in families having problems paying medical bills in the past 12 months was significantly higher for those with an HDHP (15.5%) than those with a traditional plan (10.3%) (Figure 3).
- In 2016, among privately insured adults aged 18–64 with employment-based coverage, the percentage of those in families having problems paying medical bills was significantly higher for those with an HDHP (15.4%) than those with a traditional plan (9.0%).
- In 2016, among privately insured adults aged 18–64 with directly purchased coverage, there was no significant difference between those with a traditional plan (15.9%) and those with an HDHP (16.1%).
- Regardless of the type of directly purchased private coverage, adults with directly purchased coverage were as likely as those with an employer-based HDHP to be in families having problems paying medical bills in the past 12 months, and they were more likely than those with employer-based traditional plans to be in families having problems paying medical bills.

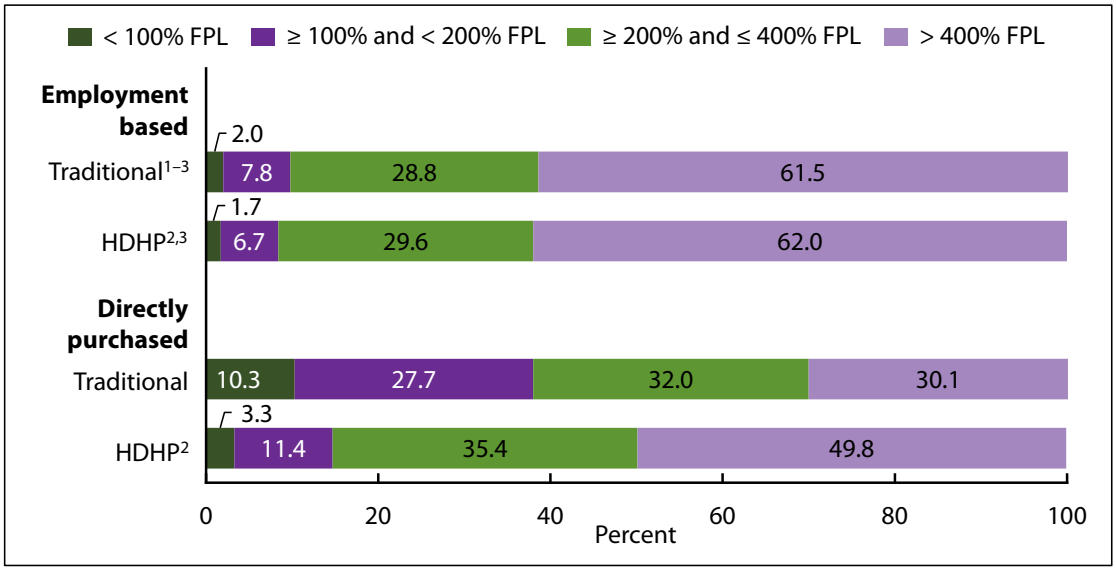
Figure 4. Percentage of privately insured adults aged 18–64 who did not get or delayed medical care due to cost in the past 12 months, by source and type of private coverage: United States, 2016



[1]Significantly different from those with HDHP ($p < 0.05$).
[2]Significantly different from those with directly purchased traditional and directly purchased HDHP ($p < 0.05$).
NOTES: HDHP is a high-deductible health plan. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2016.

- In 2016, among privately insured adults aged 18–64, the percentage of those who did not get or delayed medical care due to cost in the past 12 months was significantly higher for those with an HDHP (9.2%) than for those with a traditional plan (5.2%) (Figure 4).
- In 2016, among privately insured adults aged 18–64 with employment-based coverage, the percentage of those who did not get or delayed medical care due to cost in the past 12 months was significantly higher for those with an HDHP (8.5%) than for those with an employment-based traditional plan (4.1%).
- In 2016, among privately insured adults aged 18–64 with directly purchased coverage, there was no significant difference between those with a traditional plan (11.8%) and those with an HDHP (13.3%).
- Regardless of the type of directly purchased private coverage, adults with directly purchased coverage were more likely to not get or delay medical care due to cost than those with employment-based coverage.

Figure 5. Percent distribution of privately insured adults aged 18–64, by source and type of private coverage and poverty status: United States, 2016



[1]Significantly different from those with employment-based HDHPs for those with incomes FPL ≥ 100% and < 200% FPL ($p < 0.05$).
[2]Significantly different from those with directly purchased traditional plans for those with incomes < 100% FPL, FPL ≥ 100% and < 200% FPL, and > 400% FPL ($p < 0.05$).
[3]Significantly different from those with directly purchased HDHPs for all income levels ($p < 0.05$).
NOTES: FPL is federal poverty level. HDHP is a high-deductible health plan. Estimates may not add to 100.0% due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2016.

- In 2016, among privately insured adults aged 18–64 with employment-based coverage, the income distributions were mostly similar for those with traditional and those with HDHP coverage. The only significant difference was among those with incomes from 100% to less than 200% of the federal poverty level (FPL). The percentage with incomes from 100% to less than 200% FPL was higher among those with a traditional plan (7.8%) than those with an HDHP (6.7%) (Figure 5).
- In 2016, among privately insured adults aged 18–64 with directly purchased coverage, those with traditional coverage were more likely than those with an HDHP to have incomes less than 100% FPL (10.3% compared with 3.3%) and incomes from 100% to less than 200% FPL (27.7% compared with 11.4%). Those with traditional coverage were less likely than those with an HDHP to have incomes greater than 400% FPL (30.1% compared with 49.8%).
- Privately insured adults aged 18–64 with either traditional (61.5%) or HDHP (62.0%) employment-based coverage were more likely to have incomes greater than 400% FPL than those enrolled in either a directly purchased traditional plan (30.1%) or a directly purchased HDHP (49.8%).
- Privately insured adults aged 18–64 with directly purchased traditional plans (27.7%) were more likely than those with employment-based traditional coverage (7.8%), employment-based HDHP coverage (6.7%), or directly purchased HDHP coverage (11.4%) to have incomes from 100% to less than 200% FPL.
- Privately insured adults aged 18–64 with directly purchased traditional plans (10.3%) were three to five times more likely than those with employment-based traditional coverage (2.0%), employment-based HDHP coverage (1.7%), or directly purchased HDHP coverage (3.3%) to have incomes less than 100% FPL.

Summary

Among privately insured adults aged 18–64 with employment-based coverage, those enrolled in an HDHP were more likely than those enrolled in a traditional plan to forgo or delay medical care and to be in a family having problems paying medical bills. However, among privately insured adults aged 18–64 with directly purchased coverage, the pattern of results was different. In 2016, there was no significant difference in financial barriers to health care according to type of plan (traditional or HDHP) in the direct purchase market.

The differences observed in this report between adults in employment-based HDHPs and adults with employment-based traditional plans have been observed in previous studies. For example, analyses of 2007 and 2008 NHIS data also found that adults with HDHPs were more likely to forgo or delay care than those with traditional plans (2). In the employment-based market, the income distributions for those with traditional plans and HDHPs were similar. Therefore, factors other than income may contribute to the differences seen in financial barriers to health care between those with employment-based HDHPs and those with traditional plans.

Few previous studies have examined the differences between adults in directly purchased HDHPs and adults with directly purchased traditional plans. No significant differences in financial barriers to care were observed in this report between these two groups. However, these two groups differ significantly in their income distributions. Those with directly purchased traditional plans generally have lower household income (relative to the federal poverty level) than those with directly purchased HDHPs. Different deductible levels coupled with different income distributions might account for the same percentage of adults facing barriers among those with traditional and those with HDHP directly purchased private insurance.

As the dynamics of the private health insurance market change, the NHIS will continue to monitor the association between type and source of private health insurance and financial barriers to needed health care.

Table 1. Percentage (standard error) of adults aged 18–64 with private coverage and percent distribution (standard error) of privately insured adults aged 18–64, by source and type of coverage and year: United States, 2011–2016

Source and type of private coverage	2011	2012	2013	2014	2015	2016
Percentage with private coverage	64.2 (0.45)	64.1 (0.42)	64.2 (0.47)	67.3 (0.43)	69.7 (0.43)	69.2 (0.41)
Percent distribution						
Employment-based[1] traditional[2]	67.2 (0.50)	65.8 (0.55)	62.8 (0.62)	57.4 (0.65)	56.6 (0.64)	54.0 (0.59)
Employment-based[1] HDHP[3]	24.0 (0.44)	25.9 (0.51)	28.8 (0.58)	32.1(0.64)	32.1 (0.64)	34.9 (0.58)
Directly purchased[4] traditional[2]	4.3 (0.18)	3.8 (0.17)	3.8 (0.18)	5.0(0.21)	5.6 (0.21)	5.4(0.23)
Directly purchased[4] HDHP[3]	4.3 (0.18)	4.5 (0.19)	4.6 (0.17)	5.6 (0.22)	5.7 (0.24)	5.7 (0.22)

[1]Private insurance originally obtained through a present of former employer or union or through a professional association.

[2]Defined in 2016 as a health plan with an annual deductible of less than $1,300 for self-only coverage and $2,600 for family coverage. The deductible is adjusted annually for inflation. Deductibles for previous years are included in the Technical Notes.

[3]HDHP is a high-deductible health plan. It was defined in 2016 as a health plan with an annual deductible of at least $1,300 for self-only coverage and $2,600 for family coverage. The deductible is adjusted annually for inflation. Deductibles for previous years are included in the Technical Notes.

[4]Private insurance that was originally obtained through direct purchase or other means not related to employment. Since 2014, this category includes plans purchased through the Health Insurance Marketplace or state-based exchanges.

NOTES: Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2011–2016.

Table 2. Percentage (standard error) of privately insured adults aged 18–64 enrolled in a high-deductible health plan, by source of coverage and year: United States, 2011–2016

Type of private coverage	2011	2012	2013	2014	2015	2016
All private health coverage	28.5 (0.49)	30.4 (0.54)	33.4 (0.64)	37.6 (0.68)	37.9 (0.67)	40.6 (0.60)
Employment based[1]	26.3 (0.49)	28.3 (0.56)	31.4 (0.64)	35.9 (0.70)	36.2 (0.70)	39.3 (0.63)
Directly purchased[2]	51.1 (1.44)	54.2 (1.55)	55.1 (1.39)	52.7 (1.36)	50.8 (1.39)	51.2 (1.36)

[1]Private insurance originally obtained through a present of former employer or union or through a professional association.

[2]Private insurance originally obtained through direct purchase or other means not related to employment. Since 2014, this category includes plans purchased through the Health Insurance Marketplace or state-based exchanges.

NOTES: Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A high-deductible health plan was defined in 2016 as a health plan with an annual deductible of at least $1,300 for self-only coverage and $2,600 for family coverage. The deductible is adjusted annually for inflation. Deductibles for previous years are included in the Technical Notes. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2011–2016.

Table 3. Percentage (standard error) of privately insured adults aged 18–64 in families having problems paying medical bills and who did not get or delayed medical care in the past 12 months, by source and type of private coverage: United States, 2016

Source and type of private coverage	Problems paying medical bills	Delayed or did not get medical care
Total	12.4 (0.37)	6.5 (0.18)
Source of coverage		
Employment based[1]	11.7 (0.41)	5.7 (0.18)
Directly purchased[2]	16.0 (0.87)	12.0 (0.69)
Type of coverage		
Traditional[3]	10.3 (0.37)	5.2 (0.23)
HDHP[4]	15.5 (0.64)	9.2 (0.33)
Source and type of coverage		
Employment-based[1] traditional[3]	9.0 (0.38)	4.1 (0.19)
Employment-based[1] HDHP[4]	15.4 (0.73)	8.5 (0.34)
Directly purchased[2] traditional[3]	15.9 (1.42)	11.8 (1.23)
Directly purchased[2] HDHP[4]	16.1 (1.32)	13.3 (1.01)

[1]Private insurance originally obtained through a present of former employer or union or through a professional association.

[2]Private insurance originally obtained through direct purchase or other means not related to employment. This category includes plans purchased through the Health Insurance Marketplace or state-based exchanges.

[3]Defined in 2016 as a health plan with an annual deductible of less than $1,300 for self-only coverage and $2,600 for family coverage.

[4]HDHP is a high-deductible health plan. It was defined in 2016 as a health plan with an annual deductible of at least $1,300 for self-only coverage and $2,600 for family coverage.

NOTES: Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016.

Table 4. Percent distribution (standard error) of privately insured adults aged 18–64, by source and type of private coverage and poverty status: United States, 2016

Source and type of private coverage and poverty status	Percent distribution within source and type of coverage
Employment-based[1] HDHP[2]	
< 100% FPL[3]	1.7 (0.19)
≥ 100% and < 200% FPL[3]	6.7 (0.34)
≥ 200% and ≤ 400% FPL[3]	29.6 (0.66)
> 400% FPL[3]	62.0 (0.74)
Employment-based[1] traditional[4]	
< 100% FPL[3]	2.0 (0.15)
≥ 100% and < 200% FPL[3]	7.8 (0.32)
≥ 200% and ≤ 400% FPL[3]	28.8 (0.54)
> 400% FPL[3]	61.5 (0.64)
Directly purchased[5] HDHP[2]	
< 100% FPL[3]	3.3 (0.63)
≥ 100% and < 200% FPL[3]	11.4 (1.34)
≥ 200% and ≤ 400% FPL[3]	35.4 (2.03)
> 400% FPL[3]	49.8 (2.06)
Directly purchased[5] traditional[4]	
< 100% FPL[3]	10.3 (1.13)
≥ 100% and < 200% FPL[3]	27.7 (1.50)
≥ 200% and ≤ 400% FPL[3]	32.0 (1.86)
> 400% FPL[3]	30.1 (1.86)

[1]Private insurance originally obtained through a present of former employer or union or through a professional association.

[2]HDHP is a high-deductible health plan. It defined in 2016 as a health plan with an annual deductible of at least $1,300 for self-only coverage and $2,600 for family coverage.

[3]FPL is federal poverty level, based on family income and family size, using the U.S. Census Bureau's poverty thresholds. For more information on poverty status, see Technical Notes. Estimates may differ from estimates that are based on both reported and imputed income.

[4]Defined in 2016 as a health plan with an annual deductible of less than $1,300 for self-only coverage and $2,600 for family coverage.

[5]Private insurance originally obtained through direct purchase or other means not related to employment. This category includes plans purchased through the Health Insurance Marketplace or state-based exchanges.

NOTES: Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2016.

Technical Notes

The National Center for Health Statistics (NCHS) is releasing selected estimates of difficulties with access to care for the civilian noninstitutionalized U.S. population based on data from the 2016 National Health Interview Survey (NHIS). The estimates are being released prior to final data editing and final weighting to provide access to the most recent information from NHIS. Differences between estimates calculated using preliminary data files and final data files are typically less than 0.1 percentage point. All estimates in this report were based on preliminary data files.

Data source

Data used to produce this Early Release (ER) report are derived from the NHIS Family Core and Supplemental components from 2011 through 2016. These components collect information on all family members in each household. Data analysis for 2016 was based on information collected on 58,157 adults aged 18–64 in the Family Core and Supplemental components. Visit the NHIS website at https://www.cdc.gov/nchs/nhis.htm for more information about the design, content, and use of NHIS.

Estimation procedures

NCHS creates survey weights for each calendar quarter of the NHIS sample. The NHIS data weighting procedure is described in more detail at https://www.cdc.gov/nchs/data/series/sr_02/sr02_165.pdf. Estimates were calculated using the NHIS survey weights, which are calibrated to census totals for sex, age, and race and ethnicity of the U.S. civilian noninstitutionalized population. Weights for the 2011 NHIS data were derived from 2000 census-based population estimates. Weights for the 2012, 2013, 2014, 2015, and 2016 NHIS data were derived from 2010 census-based population estimates.

Point estimates and estimates of their variances were calculated using SUDAAN software (RTI International, Research Triangle Park, N.C.) to account for the complex sample design of NHIS. The Taylor series linearization method was chosen for variance estimation. Trends were evaluated using logistic regression analysis.

Unless otherwise noted, all estimates shown meet the NCHS standard of having less than or equal to 30% relative standard error. Differences between percentages or rates were evaluated using two-sided significance tests at the 0.05 level. Terms such as "more likely" and "less likely" indicate a statistically significant difference unless otherwise noted. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant.

Definitions of selected terms

Delayed or did not get medical care due to cost—Based on the following four questions: "During the past 12 months, [have you delayed seeking medical care/has medical care been delayed for anyone in the family] because of worry about the cost?" If yes, "For which family member was medical care delayed?" "During the past 12 months, was there any time when [you/someone in the family] needed medical care, but did not get it because [you/the family] couldn't afford it?" If yes, "Who didn't get needed care?"

Directly purchased coverage—Private insurance originally obtained through direct purchase or other means not related to employment.

Employment-based coverage—Private insurance originally obtained through a present or former employer, union, or professional association.

Family—Defined as an individual or a group of two or more related persons who are living together in the same occupied housing unit (i.e., household) in the sample. In some instances, unrelated persons sharing the same household, such as an unmarried couple living together, may also be considered one family.

High-deductible health plan (HDHP)—For persons with private health insurance, a question was asked regarding the annual deductible of each private health insurance plan. HDHP was defined in 2015 and 2016 as a private health plan with an annual deductible of at least $1,300 for self-only coverage or $2,600 for family coverage. The deductible is adjusted annually for inflation. For 2013 and 2014, the annual deductible was $1,250 for self-only coverage and $2,500 for family coverage. For 2011 and 2012, the annual deductible was $1,200 for self-only coverage and $2,400 for family coverage.

Private health insurance—Includes persons who had any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. Data on health insurance status were edited using an automated system based on logic checks and keyword searches. For comparability, the estimates for all years were created using these same procedures. Health insurance information is collected for all persons in a family and is reported on an individual basis.

Poverty status—Poverty categories are based on the ratio of the family's income in the previous calendar year to the appropriate poverty threshold (given the family's size and number of children), as defined by the U.S. Census Bureau.

Problems paying medical bills in the past 12 months—Based on the following question: "In the past 12 months, did [you/anyone in the family] have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care." This question was answered by the family respondent on behalf of everyone in the family.

Traditional health plan—For persons with private health insurance, a question was asked regarding the annual deductible of each private health insurance plan. A traditional health plan was defined in 2016 as a private health plan with an annual deductible less than $1,300 for self-only coverage or $2,600 for family coverage.

Additional Early Release Program Products

Additional reports are published through the Early Release (ER) Program. *Early Release of Selected Estimates Based on Data From the National Health Interview Survey* is published quarterly and provides estimates of 15 selected measures of health. Measures of health include estimates of health insurance, having a usual place to go for medical care, obtaining needed medical care, influenza vaccination, pneumococcal vaccination, obesity, leisure-time physical activity, current smoking, alcohol consumption, HIV testing, general health status, personal care needs, serious psychological distress, diagnosed diabetes, and asthma episodes and current asthma.

Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey is published quarterly and provides detailed estimates of health insurance coverage.

Wireless Substitution: Early Release of Estimates From the National Health Interview Survey is published biannually and provides selected estimates of telephone coverage in the United States.

In addition to these reports, preliminary microdata files containing selected National Health Interview Survey (NHIS) variables are produced as part of the ER Program. For the 2016 NHIS, these files were made available four times: in September 2016, November 2016, February 2017, and May 2017. NHIS data users can analyze these files through the National Center for Health Statistics Research Data Center without having to wait for the final annual NHIS microdata files to be released.

New measures may be added as work continues and in response to changing data needs. Feedback on these releases is welcome (nhislist@cdc.gov).

Announcements about Early Releases, other new data releases, publications, or corrections related to NHIS will be sent to members of the HISUSERS e-mail list. To join, visit the Centers for Disease Control and Prevention website at https://www.cdc.gov/subscribe.html.

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Suggested citation

Cohen RA, Zammitti EP. High-deductible health plans and financial barriers to health care: Early release of estimates from the National Health Interview Survey, 2016. National Center for Health Statistics. 2017. Available from: https://www.cdc.gov/nchs/nhis/releases.htm.