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# Health Insurance Coverage and Access to Care Among Black Americans: Recent Trends and Key Challenges

Since the implementation of the Affordable Care Act's coverage provisions, the uninsured rate among nonelderly Black Americans decreased by 10 percentage points, from 20.9 percent in 2010 to 10.8 percent in 2022.

## KEY POINTS

- Between 2010 and 2022, the uninsured rate among Black Americans under age 65 fell nearly in half, decreasing from 20.9 percent to 10.8 percent. Holding the total Black population constant at 2022 levels, this implies a 3.3 million increase in the number of Black Americans with health insurance coverage. Accounting for population growth, the number of Black Americans with health insurance coverage increased by 3.4 million.
- The 10-percentage point decline in the uninsured rate was driven by increases across all sources of coverage: Employment based, Direct Purchase (e.g., Marketplace), and Medicaid.
- In 2010, the uninsured rate for Black Americans was nearly 8 percentage points higher than the rate for White Americans. By 2022, the gap was down to 4 percentage points.
- The American Rescue Plan (ARP) and the Inflation Reduction Act (IRA) significantly expanded and enhanced tax credits for purchasing health insurance through the ACA Marketplaces. This plus a major investment in Navigator funding, outreach and education led to a 95 percent increase in Marketplace enrollment among Black Americans from 2020 to 2023, with 1.7 million Black Americans enrolled in Marketplace coverage in 2023.
- The three states with the largest Black populations—Texas, Florida, and Georgia—have not implemented the ACA Medicaid expansion.
- While access to care improved for Black Americans between 2010 and 2022, disparities in affordability of health care between Black and White Americans persist.

## BACKGROUND

In 2022, there were an estimated 47.9 million people in the U.S. who self-identified as Black, making up 14.4 percent of the country's population. This marks a 32 percent increase since 2000, when there were 36.2 million Black people living in the U.S.[1] Black Americans are younger on average than the U.S. population as a whole, with more than half (58 percent) being less than 40 years old. The median age of Black people in 2022 was 32.1 years, nearly six years younger than the U.S. population's median age of 38.0. Roughly 30 percent of the entire Black population was below the age of 20 while 12 percent were 65 or older.[2] The number of Black Americans in the U.S. is growing and is expected to increase 13 percent by 2045.[3]

Black Americans are diverse in their racial and ethnic identity and experiences. In 2022, more than half (56 percent) of Black Americans in the U.S. lived in the South.[4] Another 17 percent each lived in the Midwest and Northeast, and 10 percent lived in the West. The ten states in which Black Americans make up the largest share of the population were Alabama, Arkansas, Delaware, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, and Virginia.[5] The three states with the largest Black populations are Texas with about 4.2 million Black residents, Florida with 3.9 million, and Georgia with 3.7 million.[6]

The Affordable Care Act (ACA) increased availability of affordable coverage options via Medicaid expansion in participating states and Marketplace coverage with premium subsidies. Studies show that the ACA's coverage expansions narrowed racial and ethnic health disparities in coverage and access to care.[7] [8] [9] This Issue Brief adds to this literature by analyzing changes in health insurance coverage and access to care among Black Americans using data from 2010-2022. This Issue Brief is part of a series of ASPE Issue Briefs examining the change in coverage rates among select racial and ethnic populations after implementation of the Affordable Care Act (ACA), the American Rescue Plan (ARP), and the Inflation Reduction Act (IRA). It is an update to an ASPE brief released in 2021.[10] This brief uses federal survey data from 2010 to 2022 to analyze changes in health insurance coverage and access to and affordability of care among Black Americans.

## DATA SOURCES AND METHODS

This Issue Brief relies on data from the American Community Survey (ACS) and the National Health Interview Survey (NHIS). The ACS is a national household survey conducted by the Census Bureau that collects demographic information, including race and ethnicity, and source of health insurance. This brief uses ACS data from selected years between 2010 and 2022 to estimate the percentage of individuals who are uninsured and to estimate changes in coverage by source. The NHIS, which is administered by the National Center for Health Statistics within the Centers of Disease Control and Prevention, is the largest federal survey that collects health information on the U.S. population. The NHIS provides several self-reported measures of access to care: lacking a usual source of care, delaying care due to cost, delaying filling prescription medications to save money, and being worried about medical bills. We analyze trends in these outcomes for Black Americans for selected years between 2010 and 2022. Both the coverage and access analyses are weighted to represent the noninstitutionalized population and to adjust for complex survey design.

This Issue Brief presents data from several federal data sources. Estimates of insurance coverage estimates are from the American Community Survey (ACS), the largest national survey of households, which is conducted by the Census Bureau. The Census Bureau surveys almost 300,000 households each month for the ACS and collects health insurance and demographic information, including race and ethnicity, along with other types of information. This brief used ACS data for selected years between 2010 and 2022 for population, health insurance coverage and demographic estimates. Individuals were defined as uninsured if they did not report having private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plan, or military plan at the time of interview; respondents were also defined as uninsured if they only had Indian Health Service coverage. This brief uses the term "Latino" to refer to all individuals of Hispanic or Latino origin.

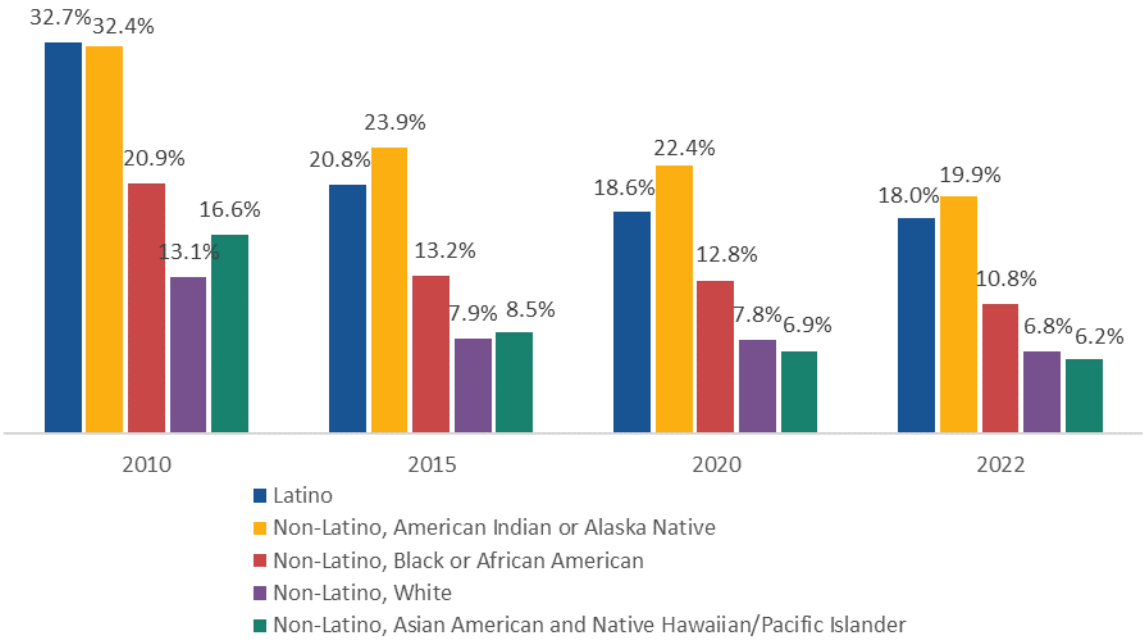
We assess trends in several self-reported measures of health care access for Black Americans using data from the National Health Interview Survey (NHIS) for selected years between 2010 and 2022. The measures we analyze are: not having a usual source of care, delaying medical care due to cost, worrying about medical bills, and delaying prescription refills to save money.

Analyses using the ACS and the NHIS were weighted to reflect the noninstitutionalized population and to adjust for complex survey design.

## HEALTH INSURANCE COVERAGE

Since the implementation of the ACA's coverage provisions, the uninsured rate among nonelderly Black Americans decreased by 10 percentage points, from 20.9 percent in 2010 to 10.8 percent in 2022 (Figure 1). Most of this decrease took place between 2010 and 2015, with smaller but still statistically significant decreases between 2015 and 2020 and between 2020 and 2022. American Indians and Alaska Natives had the highest uninsured rate in 2022 (19.9 percent), followed by Latinos of all races (18.0 percent). Throughout the period, Asian American and Native Hawaiian and Pacific Islanders and White Americans were least likely to be uninsured.

**Figure 1. Uninsured Rate Among U.S Population (Ages 0-64) by Race and Ethnicity, Selected Years from 2010-2022**



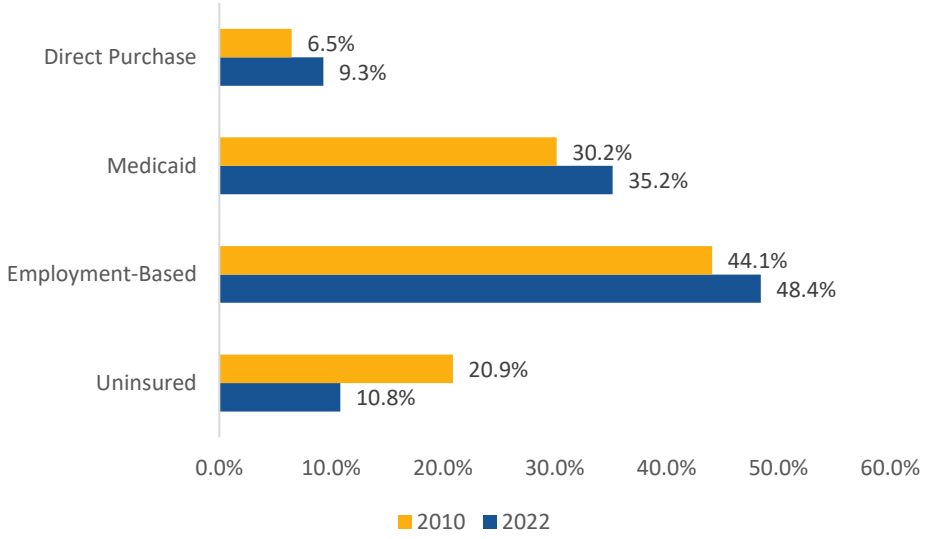

Source: American Community Survey Public Use Microdata, 2010-2022.

Notes: In this analysis, individuals were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Latino is defined as anyone who identified as Latino or Hispanic of any race. Non-Latino, American Indian or Alaskan Native is defined as anyone who identified as non-Latino American Indian/Alaska Native alone without any other race. Non-Latino, White is defined as anyone who identified as non-Latino White alone without any other race. Non-Latino, Black or African American is defined as anyone who identified as non-Latino Black or African American alone without any other race. Non-Latino, Asian American and Native Hawaiian/Pacific Islander is defined as anyone who identified non-Latino Asian American, Native Hawaiian, and Pacific Islander alone without another race. Results are ACS survey-weighted estimates. Due to pandemic-related survey collection concerns, the Census Bureau urges caution when comparing the experimental 2020 ACS dataset to previous years.

Figure 2 presents changes in insurance coverage by source among nonelderly Black Americans between 2010 and 2022. The results indicate that the 10-percentage point decline in the uninsured rate for Black Americans was driven by increases in all sources of coverage. Direct purchase private health insurance, which includes

coverage obtained through the ACA Marketplaces, increased by nearly 3 percentage points, which is larger than the increase for White Americans (1.6 percentage points, data not shown). Medicaid coverage and employment-based coverage increased by 5.0 and 4.3 percentage points, respectively. White Americans experienced a smaller increase in Medicaid coverage (3.3 percentage points) and a slightly larger increase in employment-based insurance (4.9 percentage points).

**Figure 2. Insurance Coverage Type Among Black Americans (Ages 0-64), 2010 and 2022**




Source: American Community Survey Public Use Microdata, 2010 and 2022.
Notes: Uninsured classified as a respondent not having any health insurance coverage at the time of interview; respondents can indicate more than one source of coverage in the survey.

Table 1 shows the change in uninsured rate among Black Americans from 2010 to 2022 by income (as a percentage of the federal poverty level, or FPL) and age group. The second column represents the distribution of subgroups across the overall non-Latino Black population in 2022, while the next four columns show the uninsured rate for each subgroup in selected years. All income groups experienced a reduction in the uninsured rate over the 12-year period. Black Americans with incomes between 101 and 200 percent FPL experienced the largest change in the uninsured rate from 2010 to 2022, a decrease of nearly 14 percentage points. The second largest decrease in the uninsured rate was for Black Americans with incomes up to 100 percent FPL: nearly 12 percentage points. Both of these lower income groups experienced a 2 to 3 percentage point decrease in the uninsured rate between 2020 and 2022. The uninsured rate for Black Americans with incomes above 200 percent of the FPL decreased between 2010 and 2015 before increasing in 2020. By 2022, the uninsured rate for the top two income groups listed in Table 1 were back down to 11 and 6 percent respectively, roughly the same level as in 2015. In 2022, the uninsured rate for Black Americans earning above 400 percent FPL was 6.2 percent, 2.2 points higher than the rate White Americans in the same income group (data for Whites not shown).

Throughout the analysis period, Black children were much less likely to be uninsured than Black adults. The uninsured rate for Black children fell from 7.8 percent in 2010 to 4.6 percent in 2015 before increasing slightly, to 4.9 percent in 2020. In 2022, 4.4 percent of Black children were uninsured, a rate that is comparable to that of White children. Between 2020 and 2022, 19- to 25-year-old Black Americans experienced the greatest decrease in their uninsured rate, relative to the other age groups. However, this age group still has the second-highest uninsured rate in 2022 (15.5 percent), behind 26-34 year-olds (17.5 percent). In 2022, the

uninsured rates for these two age groups were about 6 percentage points higher than the rate for their non-Latino White peers.

**Table 1. Uninsured Rate Among Black American Subpopulations (Ages 0-64), Selected Years from 2010-2022**

| | Share in 2022 | 2010 | 2015 | 2020 | 2022 |
|---|---|---|---|---|---|
| ***Percentage of Poverty Level*** | | | | | |
| **0-100** | 23.5% | 27.2% | 19.6% | 18.2% | 15.6% |
| **101-200** | 19.2% | 25.9% | 15.2% | 14.9% | 12.2% |
| **201-400** | 29.5% | 18.4% | 10.9% | 12.5% | 10.5% |
| **>400** | 27.8% | 9.5% | 6.1% | 6.8% | 6.2% |
| ***Age Group*** | | | | | |
| **0-18** | 28.6% | 7.8% | 4.6% | 4.9% | 4.4% |
| **19-25** | 12.0% | 38.0% | 21.7% | 19.5% | 15.5% |
| **26-34** | 15.7% | 33.1% | 21.8% | 19.8% | 17.5% |
| **35-50** | 24.2% | 24.6% | 16.0% | 15.7% | 13.2% |
| **51-64** | 19.6% | 18.2% | 11.2% | 11.2% | 9.0% |

Source: American Community Survey Public Use Microdata, 2010-2022.
Note: Due to pandemic-related survey collection concerns, the Census Bureau urges caution when comparing the experimental 2020 ACS dataset to previous years. Share in 2022 refers to the share of Black Americans in each subcategory in 2022.

Table 2 shows the change in the uninsured rate among nonelderly Black Americans between 2010 and 2022, by state. States with the lowest uninsured rates among Black Americans in 2022 were Massachusetts, the District of Columbia, and Oregon (compared to 2010 states: Massachusetts, the District of Columbia, and Delaware). States that experienced the largest decreases in their uninsured rate over the 12-year-period were Louisiana, Oregon, and Florida.

States with the largest population share of Black Americans (the District of Columbia, Mississippi, and Louisiana) all experienced decreases in the Black American uninsured rate between 2010 and 2022, as did the three states with the largest Black population—Texas, Georgia, and Florida.

**Table 2. Uninsured Rate Among Black Americans (Ages 0-64) by State, 2010 and 2022**

| State | Number (2022) | Black Share (2022) | 2010 Uninsured Rate | 2022 Uninsured Rate | Percentage Point Change (2010 to 2022) |
|---|---|---|---|---|---|
| **Alabama** | 1,110,905 | 26.7% | 19.8% | 13.2% | -6.7 |
| **Alaska** | ** | | | | |
| **Arizona** | 285,288 | 4.8% | 16.9% | 16.0% | -0.9 |
| **Arkansas** | 380,871 | 15.2% | 23.1% | 11.6% | -11.5 |
| **California** | 1,718,928 | 5.2% | 18.1% | 6.6% | -11.5 |
| **Colorado** | 192,880 | 3.9% | 21.2% | 10.6% | -10.6 |
| **Connecticut** | 310,018 | 10.5% | 14.7% | 7.4% | -7.3 |
| **Delaware** | 186,299 | 23.1% | 11.2% | 7.3% | -3.9 |
| **District of Columbia** | 234,123 | 40.1% | 9.7% | 5.1% | -4.6 |
| **Florida** | 2,821,725 | 16.2% | 29.4% | 15.3% | -14.1 |
| **Georgia** | 2,948,331 | 31.8% | 24.3% | 13.9% | -10.4 |
| **Hawaii** | ** | | | | |

| State | Number (2022) | Black Share (2022) | 2010 Uninsured Rate | 2022 Uninsured Rate | Percentage Point Change (2010 to 2022) |
|---|---|---|---|---|---|
| Idaho | ** | | | | |
| Illinois | 1,421,251 | 13.6% | 22.0% | 8.3% | -13.6 |
| Indiana | 555,621 | 9.8% | 22.8% | 9.9% | -12.9 |
| Iowa | 111,598 | 4.3% | 18.1% | 8.1% | -10.0 |
| Kansas | 124,813 | 5.1% | 22.6% | 15.9% | -6.7 |
| Kentucky | 300,052 | 8.1% | 21.6% | 8.2% | -13.5 |
| Louisiana | 1,227,369 | 32.2% | 25.6% | 8.3% | -17.3 |
| Maine | ** | | | | |
| Maryland | 1,542,961 | 30.1% | 14.6% | 6.1% | -8.6 |
| Massachusetts | 408,176 | 7.1% | 8.0% | 3.6% | -4.5 |
| Michigan | 1,128,032 | 13.8% | 18.4% | 7.0% | -11.4 |
| Minnesota | 354,951 | 7.5% | 20.9% | 7.2% | -13.7 |
| Mississippi | 925,973 | 38.2% | 24.6% | 15.0% | -9.6 |
| Missouri | 573,162 | 11.3% | 22.7% | 11.9% | -10.8 |
| Montana | ** | | | | |
| Nebraska | 77,445 | 4.7% | 16.5% | 11.3% | -5.2 |
| Nevada | 253,086 | 9.6% | 25.5% | 13.4% | -12.1 |
| New Hampshire | ** | | | | |
| New Jersey | 955,230 | 12.5% | 16.5% | 7.7% | -8.8 |
| New Mexico | ** | | | | |
| New York | 2,227,266 | 13.8% | 16.1% | 5.7% | -10.3 |
| North Carolina | 1,847,656 | 20.9% | 21.6% | 11.4% | -10.2 |
| North Dakota | ** | | | | |
| Ohio | 1,212,052 | 12.6% | 18.6% | 9.2% | -9.4 |
| Oklahoma | 238,885 | 7.1% | 22.8% | 14.6% | -8.2 |
| Oregon | 69,236 | 2.0% | 22.1% | 5.6% | -16.5 |
| Pennsylvania | 1,126,894 | 10.8% | 18.1% | 8.7% | -9.5 |
| Rhode Island | ** | | | | |
| South Carolina | 1,113,163 | 26.0% | 23.5% | 11.9% | -11.6 |
| South Dakota | ** | | | | |
| Tennessee | 941,255 | 16.1% | 19.3% | 12.1% | -7.2 |
| Texas | 3,128,976 | 12.0% | 24.6% | 17.4% | -7.2 |
| Utah | ** | | | | |
| Vermont | ** | | | | |
| Virginia | 1,361,436 | 18.9% | 17.9% | 8.3% | -9.6 |
| Washington | 273,686 | 4.2% | 17.5% | 8.1% | -9.4 |
| West Virginia | ** | | | | |
| Wisconsin | 311,689 | 6.5% | 16.6% | 10.4% | -6.2 |
| Wyoming | ** | | | | |

Source: American Community Survey Public Use Microdata, 2010-2022.

**ACS population estimates of less than 65,000 are not shown.

### Marketplace Coverage

The American Rescue Plan (ARP) of 2021 expanded eligibility for premium tax credits and increased subsidies for coverage on the Federally-facilitated Marketplace, HealthCare.gov. Under the ARP, roughly two-thirds of uninsured Black Americans were able to select a zero-premium plan in 2021 and three-quarters could have enrolled in a plan with a premium of less than $50 a month in 2021.[11] To help mitigate high unemployment and potential loss of health insurance coverage during the COVID-19 pandemic, the Biden-Harris Administration opened a Special Enrollment Period (SEP) on HealthCare.gov. To encourage enrollment and increase health insurance coverage uptake among uninsured Black Americans during the 2021 SEP, the Administration partnered with Black organizations to conduct a campaign for outreach and increase media attention.[12] [13] In total, 2.1 million individuals enrolled in new coverage on HealthCare.gov during the 2021 Marketplace SEP.[14] Among SEP enrollees reporting their race and ethnicity, the share of Black enrollees increased from 9 percent in 2019 to 15 percent in 2021. [15] In advance of the 2022 Marketplace open enrollment period, the Administration announced increased Navigator funding to the highest amount to date, $80 million, and extended the enrollment period by one month, leading to further gains in Marketplace enrollment.[16]

These gains in Marketplace enrollment should be reflected in the 2022 data reported in this brief, though more recent increases will not. Between 2020 and 2023, Marketplace enrollment among Black Americans in HealthCare.gov states nearly doubled from approximately 870,000 to 1.7 million.[17] At the close of the open enrollment period for plan year 2024, total Marketplace enrollment was over 21 million.[18]

### Medicaid Coverage

Medicaid and the Children's Health Insurance Program (CHIP) provide coverage to low-income individuals including children, pregnant women, parents and caretaker relatives, adults, people with disabilities, the blind, and those age 65 and over. In 2020, Black Americans made up 21 percent of Medicaid and CHIP enrollment. This includes 3.6 million adults covered through the ACA expansion eligibility pathway.

The Families First Coronavirus Response Act of 2020 (FFCRA) provided states increased financial support in return for suspending most renewal and redetermination operations. This continuous enrollment condition was in place in 2022 when the most recent ACS data presented in this brief were collected but ended in March 2023. More recent data from the NHIS provide estimates of the uninsured rate during the first 9 months of the Medicaid "unwinding" process.[19] During this period, the uninsured rate has remained constant, suggesting that most individuals who left Medicaid because they were no longer eligible moved to other sources of coverage, such as through an employer or the ACA Marketplaces.

## ACCESS TO CARE

Table 3 presents several self-reported measures of access to care and affordability from the NHIS. The results suggest that the gains in coverage documented in Figures 1-2 and Table 1 translated to improved access and affordability. The percentage of Black Americans saying that they lack a usual source of care decreased from 14.9 percent to 8.9 percent. The estimate for 2022 is the same as that for White Americans (data not shown). The percentage saying that they delayed seeking care or filling a prescription because of cost also fell by 5 to 6 percentage points between 2010 and 2022. In 2022, there was no meaningful difference in these outcomes between Black and White Americans. Since 2010, there was also a 7-percentage-point decrease in the percentage of Black adults who said that they worried about medical bills, though such worries remain common. In the most recent data almost half of Black adults reported being worried about medical bills.

**Table 3. Access to Care Among Black Americans, Selected Years from 2010-2022**

| | 2010 | 2015 | 2020 | 2022 |
|---|---|---|---|---|
| No Usual Source of Care | 14.9% | 11.9% | 9.3% | 8.9% |
| Delayed Care Due to Cost | 10.8% | 7.5% | 6.9% | 6.0% |
| Worried About Medical Bills (18-64)* | 55.2% | 48.3% | 51.8% | 47.9% |
| Delayed Filling Prescriptions (18-64)* | 13.4% | 12.8% | 10.1% | 7.0% |

Source: National Health Interview Survey (NHIS), 2010-2022.
Notes: 1) Respondents are classified as worried about paying medical bills if they reported being very worried or somewhat worried about paying medical bills. 2) Respondents were only asked about delaying refilling prescription medications if they reported using prescriptions in the past 12 months. *Data on worrying about medical bills or delayed prescriptions is available starting from 2011 and is only consistently asked among those ages 18-64.

## DISPARITIES IN HEALTH AND RELATED OUTCOMES

Despite the substantial progress that has been made in increasing health insurance coverage and access to care among Black Americans, significant disparities in health outcomes persist. A large body of research shows that centuries of racism and discrimination in the U.S. has had a profound and negative impact on the physical and mental health of Black Americans.[20 21 22 23] Some barriers to improved access to care among Black Americans are also rooted in systemic racism.[24] Both implicit and explicit bias among health care providers, inconvenient provider office hours, limited providers who see patients with public insurance due to lower reimbursement rates, and transportation barriers are all contributors to decreased access to care and worse health outcomes for Black Americans.[25 26 27 28 29 30]

As a result of these factors, Black Americans are more likely to live with or die prematurely from preventable health conditions and diseases compared to their White counterparts.[31 32] Chronic disease burden, morbidity, and mortality are all significantly higher among young adult Black Americans than the U.S. population as a whole.[33 34] According to the U.S. Census Bureau, Black Americans' life expectancy in 2021 was 5.6 years shorter than non-Latino White Americans and declined 0.7 years between 2020 and 2021.[35] In 2020, the leading causes of death among Black Americans were heart disease, cancer, and COVID-19.[36] With respect to maternal and child health, while state adoption of the ACA Medicaid expansion to low-income adults has in some cases slowed the increase in maternal mortality among Black mothers,[37] maternal and infant mortality among Black mothers and babies remains significantly higher than non-Latino White Americans.[38] Black American infants have a death rate of 10.4 deaths per 1,000 live births – over twice the national average (4.4 deaths per 1,000 live births).[39] Additionally, Black Americans are nearly three times more likely to die from pregnancy-related causes than their White counterparts.[40]

The COVID-19 pandemic exposed and exacerbated longstanding economic and health inequities.[41 42] Many Black Americans lacked sufficient income and wealth to offset the economic crises such as job losses that arose from the COVID-19 pandemic.[43] Additionally, Black Americans are overrepresented in essential worker occupations and are more likely to hold labor and hourly wage jobs that cannot be performed from home.[44 45 46] In turn, Black Americans have been at an increased risk for contracting COVID-19, becoming hospitalized, and/or dying from COVID-19 compared to their White counterparts.[47] This relationship has held even after controlling for insurance coverage.[48] While telehealth has been an important source of care during the pandemic, recent research indicates that Black Americans are less likely to have video-enabled telehealth services, highlighting another potential dimension of care in need of attention to promote equitable care.[49]

## CONCLUSION

Since 2010, the uninsured rate among Black Americans has fallen substantially. Improvements in coverage between 2010 and 2015 can be traced to the new affordable options created by the ACA, including expanded Medicaid coverage and new tax credits for private health insurance purchased through the newly established Marketplaces. Between 2015 and 2022, the uninsured rate fell even further, as more states implemented the ACA Medicaid expansion and Marketplace tax credits were enhanced and expanded by the ARP and the IRA. The increase in coverage has made health care more accessible and affordable for Black Americans, who are less likely to lack a usual source of care, delay care because of cost, or report worrying about medical bills. Nearly half of Black Americans worry about medical bills, suggesting that more progress on affordability of health care is needed.

Despite these successes, the uninsured rate among Black Americans is still higher than that for White Americans. As of 2024, the three states with the largest Black population—Texas, Florida, and Georgia—have not implemented the ACA Medicaid expansion. According to a previous ASPE analysis, if the 10 remaining states expanded Medicaid, the number of Medicaid eligible uninsured Americans is projected to decrease by 19 percent, and according to the Urban Institute, the number of Black Americans without health insurance would decrease by 43.2 percent.[50] [51] Moreover, if the enhanced Premium Tax Credits made available under the ARP and IRA are not extended, Marketplace enrollees would face greater costs. Such increasing costs would make health insurance less affordable to Marketplace consumers and could impact the recent coverage gains made within the Black American population.

## REFERENCES


[1] M. Moslimani, C. Tamir, A. Budiman, L. Noebusta, L. Mora. Facts About the U.S. Black Population. January 18, 2024. Accessed at: https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population.
[2] M. Moslimani, C. Tamir, A. Budiman, L. Noebusta, L. Mora. Facts About the U.S. Black Population. January 18, 2024. Accessed at: https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population.
[3] U.S. Census Bureau. 2023 National Population Projections Tables: Main Series. Table 4: Projected Population by Sex, Race, and Hispanic Origin. Accessed at: https://www.census.gov/data/tables/2023/demo/popproj/2023-summary-tables.html
[4] M. Moslimani, C. Tamir, A. Budiman, L. Noebusta, L. Mora. Facts About the U.S. Black Population. January 18, 2024. Accessed at: https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population.
[5] U.S. Department of Health and Human Services, Office of Minority Health. (May 2024). Black/African American Health. Accessed at: https://minorityhealth.hhs.gov/blackafrican-american-health
[6] M. Moslimani, C. Tamir, A. Budiman, L. Noebusta, L. Mora. Facts About the U.S. Black Population. January 18, 2024. Accessed at: https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population.
[7] Buchmueller, T.C., Levinson, Z.M., Levy, H.G., Wolfe, B.L. (2016). Effect of the Affordable Care Act on racial and ethnic disparities in health insurance coverage. American Journal of Public Health, 106(8), 1416–1421. Accessed at: https://doi.org/10.2105/AJPH.2016.303155
[8] Chaudry, A., Jackson, A., Glied, S.A. (2019). Did the affordable care act reduce racial and ethnic disparities in health insurance coverage. New York, NY, The Commonwealth Fund, 10. Accessed at: https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/did-ACA-reduce-racial-ethnic-disparities-coverage
[9] Guth, M., Artiga, S., Pham, O. (September 30, 2020). Effects of the ACA Medicaid expansion on racial disparities in health and health care. Kaiser Family Foundation. Accessed at: https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/
[10] Health Insurance Coverage and Access to Care Among Black Americans: Recent Trends and Key Challenges. (Issue Brief No. HP-2022-07). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. February 2022. Accessed at: https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-black-americans
[11] Branham, D.K., Conmy, A.B., DeLeire, T., Musen, J., Xiao, X., Chu, R.C., Peters, C., Sommers, B.D. (April 1, 2021). Access to Marketplace Plans with Low Premiums on the Federal Platform, Part II: Availability Among Uninsured Non-Elderly Adults Under the American Rescue Plan (Issue Brief No. HP-2021-08). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/access-marketplace-plans-low-premiums-uninsured-american-rescue-plan
[12] U.S. Department of Health and Human Services. HHS, National Partners Combine to Boost Black American Enrollment at HealthCare.gov. (April 26, 2021). Accessed at: https://www.cms.gov/newsroom/press-releases/hhs-national-partners-combine-boost-black-american-enrollment-healthcaregov
[13] U.S. Department of Health and Human Services. (July 15, 2021). Biden-Harris Administration Launches "Summer Sprint to Coverage" Campaign for Final 30 Days of Special Enrollment Period. Accessed at: https://www.cms.gov/newsroom/press-releases/biden-harris-administration-launches-summer-sprint-coverage-campaign-final-30-days-special
[14] U.S. Department of Health and Human Services. (September 8, 2021). 2021 Final Marketplace Special Enrollment Period Report. Accessed at: https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf
[15] U.S. Department of Health and Human Services. (September 8, 2021). 2021 Final Marketplace Special Enrollment Period Report. Accessed at: https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf
[16] HHS Announces the Largest Ever Funding Allocation for Navigators. (April 21, 2021). U.S. Department of Health and Human Services. Accessed at: https://www.cms.gov/newsroom/press-releases/hhs-announces-largest-ever-funding-allocation-navigators-and-releases-final-numbers-2021-marketplace
[17] Warrier, A., Branham, D.K., Finegold, K., Peters, C., De Lew, N., Buchmueller, T. (March 22, 2024). HealthCare.gov Enrollment by Race and Ethnicity, 2015-2023 (Issue Brief HP-2024-07). Office of the Assistant Secretary for Planning and

Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/marketplace-enrollment-race-ethnicity-2015-2023

[18] Health Insurance Marketplaces: 10 Years of Affordable Private Plan Options (Issue Brief No. HP-2024-09). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. March 2024. Accessed at: https://aspe.hhs.gov/reports/10-years-health-insurance-marketplaces

[19] National Uninsured Rate Remains Largely Unchanged at 7.7 Percent in the Third Quarter of 2023. (Issue Brief No. HP-2024-02). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. February 2024. Accessed at: https://aspe.hhs.gov/reports/national-uninsured-rate-q3-2023

[20] Centers for Disease Control and Prevention. (Updated September 18, 2023). Racism and Health. Accessed at: https://www.cdc.gov/minorityhealth/racism-disparities/index.html

[21] Bailey, Z.D., Feldman, J.M., Bassett, M.T. (2021). How structural racism works — Racist policies as a root cause of U.S. racial health inequities. New England Journal of Medicine. 2020;384(8), 768-773. Accessed at: https://www.nejm.org/doi/full/10.1056/NEJMms2025396

[22] Gee, G.C., Ford, C.L. (2011). Structural racism and health inequities: Old issues, new directions. Du Bois Review: Social Science Research on Race, 8(1), 115-132. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4306458/

[23] Churchwell, K., Elkind, M. S., et al. (2020). Call to action: structural racism as a fundamental driver of health disparities: a presidential advisory from the American Heart Association. American Heart Association, Circulation, 142(24), e454-e468. Accessed at: https://www.ahajournals.org/doi/10.1161/CIR.0000000000000936

[24] Dunn, A., Gottlieb, J.D., Shapiro, A.H., Sonnenstuhl, D.J., Tebaldi, P. (2023). A Denial a Day Keeps the Doctor Away (NBER Working Paper No. 29010). July 2021 (Revised January 2023). National Bureau of Economic Research. Accessed at: https://www.nber.org/papers/w29010

[25] Bailey, Z.D., Feldman, J.M., Bassett, M.T. (2020). How structural racism works — Racist policies as a root cause of U.S. racial health inequities. New England Journal of Medicine. 2020;384(8):768-773. Accessed at: https://www.nejm.org/doi/10.1056/NEJMms2025396

[26] William J. Hall et al. (December 1, 2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. American Journal of Public Health 105, no. 12: e60-e76. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638275/

[27] Decker, S.L. (August 2012). In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. Health Affairs. 2012;31(8):1673-1679. Accessed at: https://pubmed.ncbi.nlm.nih.gov/22869644/

[28] Perloff, J.D., Kletke, P., Fossett, J.W. (April 1995). Which physicians limit their Medicaid participation, and why. Health Services Research. 1995;30(1):7-26. Accessed at: https://pubmed.ncbi.nlm.nih.gov/7721586

[29] Wolfe, M.K., McDonald, N.C., Holmes, G.M. (June 2020). Transportation barriers to health care in the United States: Findings from the National Health Interview Survey, 1997–2017. American Journal of Public Health. 2020;110(6):815-822. Accessed at: https://pubmed.ncbi.nlm.nih.gov/32298170/

[30] Probst, J.C., Laditka, S.B., Wang, J-Y., Johnson, A.O. (March 2007). Effects of residence and race on burden of travel for care: cross sectional analysis of the 2001 US National Household Travel Survey. BMC Health Services Research. 2007;7:40. Accessed at: https://pubmed.ncbi.nlm.nih.gov/17349050/

[31] Centers for Disease Control and Prevention. (May 2017). African American Health: Creating Equal Opportunities for Health. Vital Signs. Accessed at: https://stacks.cdc.gov/view/cdc/45439

[32] Caraballo, C., Massey, D.S., Ndumele, C.D. (2023). Excess mortality and years of potential life lost among the Black population in the US, 1999-2020. JAMA. 2023;329(19):1662-1670. Accessed at: https://doi.org/10.1001/jama.2023.7022

[33] Noonan, A.S., Velasco-Mondragon, H.E. Wagner, F.A. (2016). Improving the health of African Americans in the USA: an overdue opportunity for social justice. Public Health Reviews. 2016; 37, 12. Accessed at: https://doi.org/10.1186/s40985-016-0025-4

[34] Centers for Disease Control and Prevention. (May 2017). African American Health: Creating Equal Opportunities for Health. Vital Signs. Accessed at: https://stacks.cdc.gov/view/cdc/45439/cdc_45439_DS1.pdf

[35] Arias E., Tejada-Vera B., Kochanek K.D., Ahmad F.B. (2022). Provisional Life Expectancy Estimates for 2021. Vital Statistics Rapid Release (Report No. 23). National Center for Health Statistics, Centers for Disease Control and Prevention. August 2022. Accessed at: https://dx.doi.org/10.15620/cdc:118999

[36] Curtin, S.C., Tejada-Vera B., Bastian, B.A. (2023). Deaths: Leading Causes for 2020. National Vital Statistics Reports: Vol. 72, No. 13. National Center for Health Statistics, Centers for Disease Control and Prevention. (December 5, 2023). Accessed at: https://dx.doi.org/10.15620/cdc:133059
[37] Eliason, E.L. (2020). Adoption of Medicaid expansion is associated with lower maternal mortality. Womens Health Issues: 30(3):147-152. Accessed at: https://pubmed.ncbi.nlm.nih.gov/32111417/
[38] Fleszar, L.G., Bryant, A.S., Johnson, C.O., et al. Trends in state-Level maternal mortality by racial and ethnic group in the United States. JAMA. 2023;330(1):52–61. Accessed at: https://doi.org/10.1001/jama.2023.9043
[39] U.S. Department of Health and Human Services, Office of Minority Health. (July 2021). Infant Mortality and African Americans. Accessed at: https://minorityhealth.hhs.gov/infant-mortality-and-african-americans
[40] Pregnancy Mortality Surveillance System. Accessed at: https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance/
[41] Paremoer, L., Nandi, S., Serag, H., Baum, F. (2021). COVID-19 pandemic and the social determinants of health. BMJ, 372:n129. Accessed at: https://www.bmj.com/content/372/bmj.n129
[42] Simmons, A., Chappel, A., Kolbe, A.R., Bush, L., Sommers, B.D. (March 16, 2021). Health Disparities by Race and Ethnicity During the COVID-19 Pandemic: Current Evidence and Policy Approaches (Issue Brief). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/health-disparities-race-ethnicity-during-covid-19-pandemic-current-evidence-policy-approaches
[43] Hardy, B.L., Logan, T.D. (2021). The Way Back: Assessing Economic Recovery Among Black Americans During COVID-19. The Hamilton Project, Brookings Institute. Accessed at: https://www.brookings.edu/wp-content/uploads/2021/09/20210929_Hamilton_HardyLogan_TheWayBack.pdf
[44] Hardy, B.L., Logan, T.D. (2021). The Way Back: Assessing Economic Recovery Among Black Americans During COVID-19. The Hamilton Project, Brookings Institute. Accessed at: https://www.brookings.edu/wp-content/uploads/2021/09/20210929_Hamilton_HardyLogan_TheWayBack.pdf
[45] National Institute for Health Care Management Foundation (NIHCM). (May 13, 2020, Updated October 20, 2020). Population Health— COVID-19's Differential Impact on Workers. Accessed at: https://nihcm.org/publications/covid-19s-differential-impact-on-workers
[46] Centers for Disease Control and Prevention. (Updated July 24, 2020). Health Equity Considerations and Racial and Ethnic Minority Groups. Accessed at: https://stacks.cdc.gov/view/cdc/91049
[47] Centers for Disease Control and Prevention. (Updated May 25, 2023). Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity. Accessed at: https://archive.cdc.gov/#/details?url=https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html
[48] Miller, S., Wherry, L.R., Mazumder, B. (July 2021). Estimated mortality increases during the COVID-19 pandemic by socioeconomic status, race, and ethnicity. Health Affairs. 2021;40(8). Accessed at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00414
[49] Karimi, M., Lee, E.C., Couture, S.J., Gonzales, A.B., Grigorescu, V., Smith, S.R., De Lew, N., Sommers, B.D. (February 2022). National Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services. (Research Report No. HP-2022-04). Office of the Assistant Secretary for Planning and Evaluation, U. S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/hps-analysis-telehealth-use-2021
[50] Rudich, J., Branham, D.K., Peters, C., Sommers, B.D. (2022). Estimates of Uninsured Adults Newly Eligible for Medicaid If Remaining 12 Non-Expansion States Expand Medicaid: 2022 Update (Data Point No. HP-2022-06). Office of the Assistant Secretary for Planning and Evaluation, U. S. Department of Health and Human Services. February 2022. Accessed at: https://aspe.hhs.gov/reports/updated-estimates-medicaid-eligibility-non-expansion-states
[51] Buettgens, M., Ramchandani, U. (October 2023). Urban Institute (October 2023). 2.3 Million People Would Gain Health Coverage in 2024 if 10 States Were to Expand Medicaid Eligibility (Research Report). Urban Institute. Accessed at: https://www.urban.org/research/publication/23-million-people-would-gain-health-coverage-2024-if-10-states-were-expand

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