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ISSUE BRIEF

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Healthcare Insurance Coverage, Affordability of Coverage, and Access to Care, 2021-2024

Over 300 million Americans now have health insurance coverage. The U.S. uninsured rate has fallen significantly over the past four years. Gains in coverage are improving access and affordability of healthcare.

KEY POINTS

- The percentage of Americans without health insurance declined significantly between 2021 and early 2024. The uninsured rate was 7.6 percent in the second quarter of 2024.
- Over 300 million Americans now have health insurance coverage. This includes over 100 million enrolled in Medicaid/CHIP or coverage through the Health Insurance Marketplaces as of August 2024.
- The American Rescue Plan Act of 2021 and the Inflation Reduction Act of 2022 enhanced premium tax credits (PTC) for purchasing coverage in the ACA Marketplaces. Overall, PTC increased by an average of $59 per month. Rural consumers in HealthCare.gov states that are subsidy eligible received an increase of $74 in monthly PTC, which translated to an average annual savings of $890. Urban consumers received an increase of $58 per month for an average annual savings of $695.
- Enhanced PTC combined with administrative actions to facilitate enrollment contributed to robust growth in Marketplace enrollment. By December 31, 2024, more than 23.5 million Americans have selected a Marketplace plan for 2025 insurance coverage.
- Enhanced tax credits for Marketplace plans have improved affordability and access, resulting in 4 in 5 consumers finding quality health plans for $10 or less. The enhanced tax credits expire at the end of 2025, which will cause out-of-pocket premiums to increase substantially. This price increase is projected to cause between 4 and 5 million Americans to lose health insurance coverage.
- Over time, gains in coverage have coincided with improved access to care. The percentage of children and non-elderly adults reporting an annual physician visit and a usual source of care was significantly higher in 2023 than in 2010.
- The share of children delaying care due to cost fell from 4.1 percent in 2010 to 2.5 percent in 2015 and then to 1.0 percent in 2023. For adults, this measure of financial barriers fell significantly from 13.5 percent in 2010 to 9.2 percent in 2015 and then to 8.5 percent in 2023. However, while declining over the last decade, nearly half of adults are worried about paying their medical bills.

INTRODUCTION

Health insurance improves access to affordable health care, which improves health and well-being, and provides financial protection from out-of-pocket spending.[1] Employment-based health insurance coverage has historically been the predominant source of health insurance for non-elderly Americans. While there are certain advantages to employment-based coverage, there are also important limitations. Coverage through an employer or union is often not available to lower-income or part-time workers, and historically, small businesses and self-employed workers have faced barriers in obtaining health coverage. In addition, the connection between insurance coverage and employment has led to coverage declines during economic downturns.[2, 3]

The 2010 Patient Protection and Affordable Care Act (ACA) included several major reforms that expanded health insurance options for people with limited access to employment-based coverage. These changes included a provision allowing young adults to stay on their parents' insurance until age 26, expansion of Medicaid eligibility, and tax credits for purchasing private coverage through newly established Marketplaces. In addition, the ACA introduced important consumer protections, such as prohibiting insurers from denying or limiting coverage based on gender or pre-existing conditions.

The Biden-Harris Administration built on the foundation of the ACA to increase access to health insurance coverage and to enhance the quality and affordability of that coverage. This Issue Brief investigates how health insurance coverage, as well as healthcare access and affordability, has changed in recent years, with an emphasis on policies implemented from 2021 to 2024.

BACKGROUND

Trends in Health Insurance Coverage, 2000 to 2019

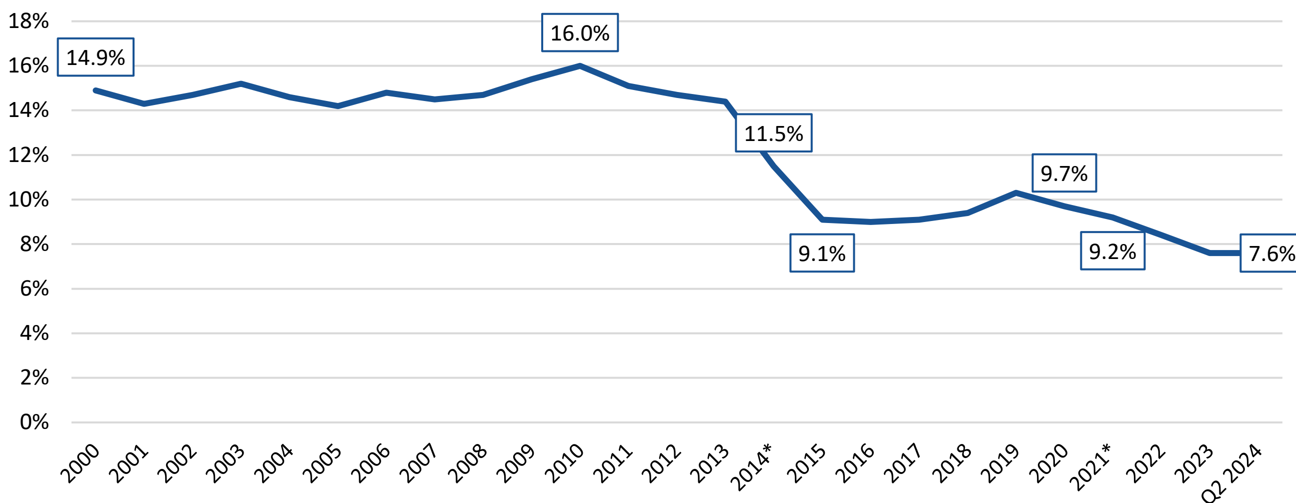
Recent policies and change in health insurance coverage are best understood in the context of longer-term trends. Figure 1 presents estimates of the national uninsured rate from 2000 to 2024. The data are from the National Health Interview Survey (NHIS), the largest nationally representative survey focused primarily on the health of the civilian, noninstitutionalized U.S. population.[4]

Between 2000 to 2010, the uninsured rate increased from 14.9 percent to 16.1 percent. This change represents the net effect of a larger decline in private health insurance that was partially offset by an increase in public health insurance coverage. The overall trend also masks important heterogeneity. In the decade leading up to the passage of the ACA, the uninsured rate for children fell significantly, because of expanded eligibility for Medicaid and the Children's Health Insurance Program (CHIP). In contrast, the uninsured rate among non-elderly adults increased from 18.7 percent in 2000 to 22.3 percent in 2010.[1] In 2010, nearly 50 million Americans were uninsured.[5]

The ACA's dependent coverage provision went into effect in September 2010 and the law's other two coverage provisions—the Medicaid expansion to low-income adults and the establishment of the ACA Marketplaces—went into effect in January 2014. By 2015, over 90 percent of all Americans had health insurance coverage. Prior research shows that Medicaid expansion accounted for about 60 percent of the initial increase in coverage caused by the ACA, and 40 percent was due to the establishment of the Marketplaces.[6] The

uninsured rate remained at roughly 9 percent until 2017 before increasing to 10.3 percent in 2019.[*] Similar to years prior to the ACA, non-elderly adults and children experienced different trends over this period. The percentage of 18 to 64-year-olds without insurance coverage increased from 12.8 percent to 14.7 percent, while the uninsured rate for children under age 18 remained essentially constant at roughly 5 percent.[1]

Figure 1. National Uninsured Rate, All Ages (2000 – Q2 2024)



Source: National Health Interview Survey's Health Insurance Coverage Reports. NHIS Early Release: Health Insurance Coverage | National Health Interview Survey | CDC; Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2023 – June 2024.

Notes: *The ACA's individual and employer responsibility provisions, state insurance Exchanges, Medicaid expansions, and subsidies went into effect in 2014. The FFCRA's additional federal financial support for maintaining enrollment of most Medicaid beneficiaries went into effect retroactively on January 1, 2020, and the Consolidated Appropriation Act (CAA) of 2023 phased out the increase over three quarters, starting on March 31, 2023, and ending on December 31, 2023. The ARP premium tax credit provisions were effective for PY2021 and PY2022, and the IRA extended these provisions for PY2023 through PY2025.

Beginning in 2004, two additional questions were added to the NHIS insurance section to reduce potential errors in reporting Medicare and Medicaid status, resulting in two methods to estimate uninsurance. Beginning in 2005, all estimates were calculated using the second Method. Please see "Technical Notes" for the Early Release of Health Insurance Estimates Based on Data From the 2010 National Health Interview Survey for more information.

The COVID-19 Pandemic and Insurance Coverage

The COVID-19 pandemic was a major shock to the nation and the U.S. economy. Between the fourth quarter of 2019 and the second quarter of 2020, total civilian employment fell by 21 million, and the unemployment rate increased from 3.6 percent to 13 percent.[7] Although employment increased later in 2020, by the end of the year total employment was 5.5 percent points lower, and the unemployment rate was 3 percentage points higher than the end of 2019.

Historically, because of the predominance of employer-sponsored health insurance, such large declines in employment would have led to a significant loss of insurance coverage, especially for men who, prior to the ACA, had less access to public insurance than women or children. However, this did not happen in 2020. While

[*] The NHIS underwent a survey redesign in 2019. The questions used to assess health insurance coverage did not change, however the questionnaire design and sample weighting were revised. A technical paper conducted by the National Center for Health Statistics concluded that the redesign "may have shifted upward by 0.7 percentage points due to the methodological change" the national estimate for the uninsured rate among adults. See https://www.cdc.gov/nchs/data/nhis/earlyrelease/EReval202009-508.pdf for further details on the NHIS redesign.

the number of people with employer-sponsored health insurance did fall, this decline was offset by increases in Medicaid and, to a lesser extent, Marketplace coverage.[8,9] This result can be attributed to the way that the ACA coverage expansions have created a more robust safety net, as well as to the 2020 Families First Coronavirus Response Act (FFCRA), which provided states additional financial support if they met certain conditions--including agreeing to maintain the enrollment of most Medicaid beneficiaries. According to the NHIS, the uninsured rate for 2020 was 9.7 percent.[†]

HEALTH INSURANCE COVERAGE UNDER THE BIDEN-HARRIS ADMINISTRATION

Policies Affecting the Number of People with Coverage

The Biden-Harris Administration has continued to build on the ACA through legislative and administrative actions that have mitigated coverage losses during the pandemic and contributed to gains in health insurance coverage.

Provisions of the American Rescue Plan Act of 2021 (ARP) were designed to bolster Medicaid coverage and reduce churn through several changes to the program. The ARP made permanent federal fiscal incentives for states to newly expand Medicaid to adults with household incomes up to 138 percent of the federal poverty level (FPL). Since this change, four additional states—Oklahoma, Missouri, South Dakota, and North Carolina—have adopted Medicaid expansion. Medicaid expansion played a key role in the declining uninsured rate in rural areas as the uninsured rate in rural areas fell from 23.8 percent in 2010 to 12.6 percent in 2023 and Medicaid coverage rates rose from 12 percent in 2010 to 21.2 percent in 2023.[10]

The ARP included a temporary option for states to provide continuous coverage for those on Medicaid for up to 12 months postpartum, which was subsequently made permanent in the Consolidated Appropriations Act, 2023 (CAA). The CAA also included a nationwide requirement for states to implement 12 months of continuous eligibility for children in Medicaid and CHIP starting in January 2024, a policy that provides protections against coverage disruptions to as many as 17 million children.[11]

Another provision of the ARP increased Marketplace subsidies for plan year 2022, lowering the percentage of income that consumers who were already eligible for premium tax credits (PTC) were expected to contribute towards their health insurance premiums and extending PTC to households with incomes above 400 percent of the FPL, who had previously been ineligible. The Inflation Reduction Act (IRA) of 2022 later extended these enhanced subsidies through 2025. The enhanced subsidies have enabled 13 states and the District of Columbia to make access to health insurance or health care services more affordable, in some cases even lowering plan deductibles or providing additional subsidies.[12] Furthermore, previous ASPE research shows that rural consumers in HealthCare.gov states who are subsidy eligible received an increase of $74 in monthly PTC, while urban consumers received an increase of $58 per month. Overall, these enhanced PTCs are saving rural enrollees an average of $890 per year, about 28% more than their urban counterparts.[10] The National Association of Insurance Commissioners (NAIC) has publicly warned that the expiration of enhanced subsidies will result in significant premium increases and coverage losses, and that the greatest decreases in coverage

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[†] Due to the COVID-19 pandemic, NHIS data collection switched to a telephone-only mode beginning March 2020. This change had little impact on Quarter 1 of 2020, however there were lower response rates and differences in respondent characteristics for Quarters 2–4 of 2020. Telephone-only data collection led to an over-representation of more affluent households, including a greater proportion of homeowners, among the participating sample (https://www.cdc.gov/nchs/data/nhis/earlyrelease/nonresponse202102-508.pdf). Though NHIS survey weights account for changes in respondent characteristics due to overall changes in the 2020 data collection, the 2020 estimate may still be impacted by these changes.

will affect young adults between 18 and 34, leading to higher insurance costs for individuals between the ages of 55 and 64.[13]

In addition to these legislative changes, the Biden-Harris Administration issued executive orders aimed at expanding coverage. Executive Order 14009, "Strengthening Medicaid and the Affordable Care Act" created a new Marketplace special enrollment period (SEP) during the COVID-19 pandemic.[14] Through this SEP, 2.1 million Americans signed up for health insurance on HealthCare.gov between February 15, 2021, and August 15, 2021. This is roughly four times the number of new plan selections made during the same period in 2019.[15] Another SEP for individuals with household incomes at or below 150 percent of the FPL was added in 2022.

The Administration also invested heavily in funding for outreach and enrollment support for both Marketplace and Medicaid coverage. This funding contributed to a four-fold increase in the number of Navigators in states using HealthCare.gov. In addition, in a 2022 final rule, the Administration eliminated the "family glitch," which made nearly five million family members newly eligible for Marketplace premium subsidies by tying eligibility for subsidies to the affordability of employment-based family coverage, as opposed to individual coverage.[16, 17]

The combined effect of these policies was to increase insurance coverage. When the PHE ended in early 2023, the national uninsured rate was down to 7.2 percent.[18] This corresponds to over 300 million Americans with health insurance coverage.

The Medicaid "Unwinding"

As the PHE ended, states began returning to regular renewal operations, a process often referred to as "Medicaid unwinding." Action was taken on multiple fronts to mitigate coverage losses during this process. CMS made available a number of Section 1902e(14)(A)[‡] waiver strategies, which allowed states to streamline Medicaid renewals and help eligible individuals maintain coverage. As of November 2024, CMS has approved over 400 waiver strategies across the 50 states and territories and has made some of these strategies, such as automatic renewal for enrollees without an *ex parte* source of income who initially had zero-dollar income or income at or below 100 percent of the FPL, permanent.[19, 20] CMS also undertook actions to make it easier to enroll in Medicaid and CHIP coverage, such as simplifying eligibility requirements, streamlining application processes and removing administrative hurdles and unnecessary barriers to enrollment.[21, 22]

CMS also worked to facilitate transitions between Medicaid and Marketplace coverage. It established an Unwinding SEP, which allowed Marketplace-eligible consumers who lost Medicaid or CHIP coverage to select qualified health plans (QHPs) between March 31, 2023, and November 30, 2024.[23] Additionally, some states with a state-based marketplace (SBM) operate a Basic Health Program (BHP), which provides coverage to individuals at certain income levels who are not eligible for Medicaid or CHIP and otherwise would be eligible for a QHP.[§] Figure 2 presents the number of Marketplace plan selections and BHP enrollment by consumers who had their Medicaid/CHIP coverage terminated between April 2023 and April 2024. Roughly 3.8 million

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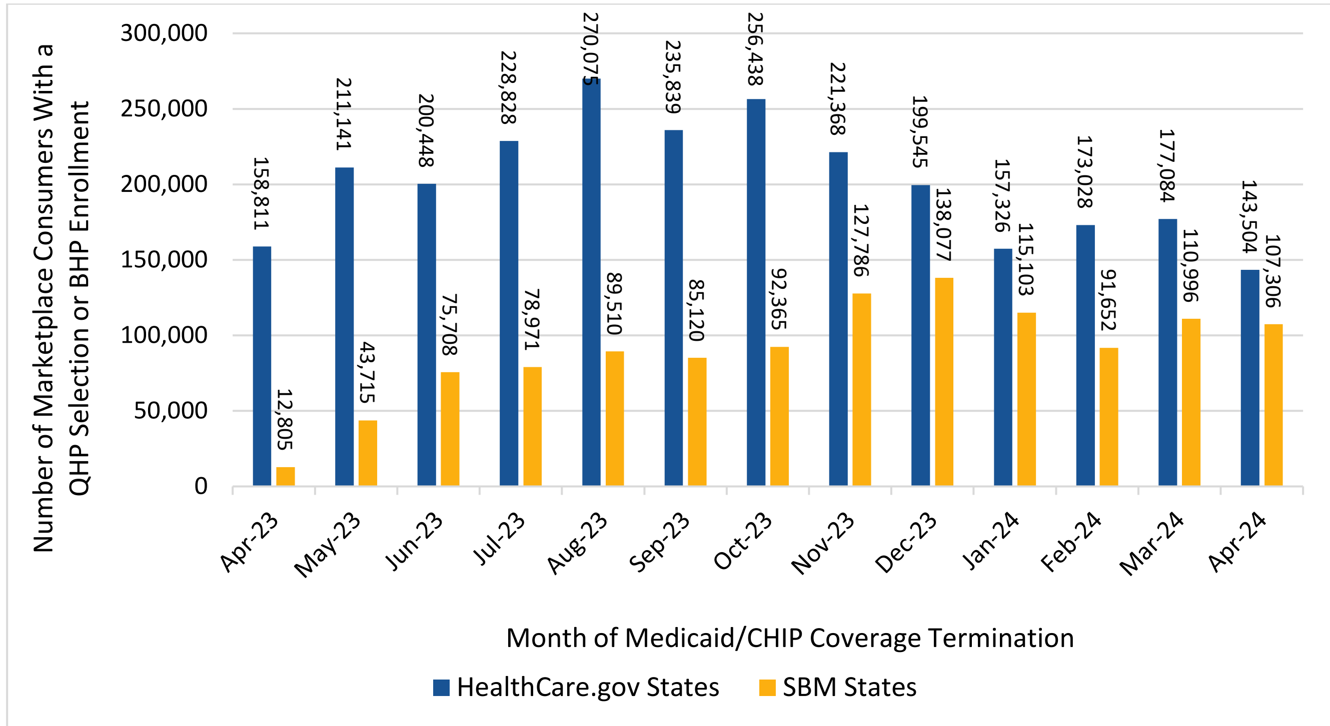
[‡] Section 1902(e)(14)(A) of the Social Security Act ("the Act") permits CMS to approve time-limited waivers of any provisions of titles XIX and XXI of the Act "as are necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries."

[§] BHP enrollment includes data reported to CMS by Minnesota and New York. Minnesota operates a BHP, which provides coverage to consumers with incomes at or below 200 percent of the FPL who are not eligible for Medicaid or CHIP and otherwise would be eligible for a QHP. Effective April 2024, NY transitioned from operating a BHP to a new coverage program, the Essential Plan Expansion (EP), that generally mirrors the state's BHP and is implemented under its approved section 1332 waiver. The EP expands eligibility to certain individuals with estimated household incomes of up to 250 percent FPL and some individuals with estimated household incomes below 250 percent FPL who would otherwise be enrolled in Medicaid coverage or in a state-funded health insurance program absent the waiver. Enrollment in this new coverage program continues to be reported in the BHP enrollment data.

individuals transitioned from Medicaid to Marketplace or BHP coverage, representing nearly one in five individuals who were disenrolled from Medicaid or CHIP during this period.[24]

Figure 2. Marketplace Plan Selections and Basic Health Program Enrollment for Consumers whose Medicaid or CHIP was Terminated

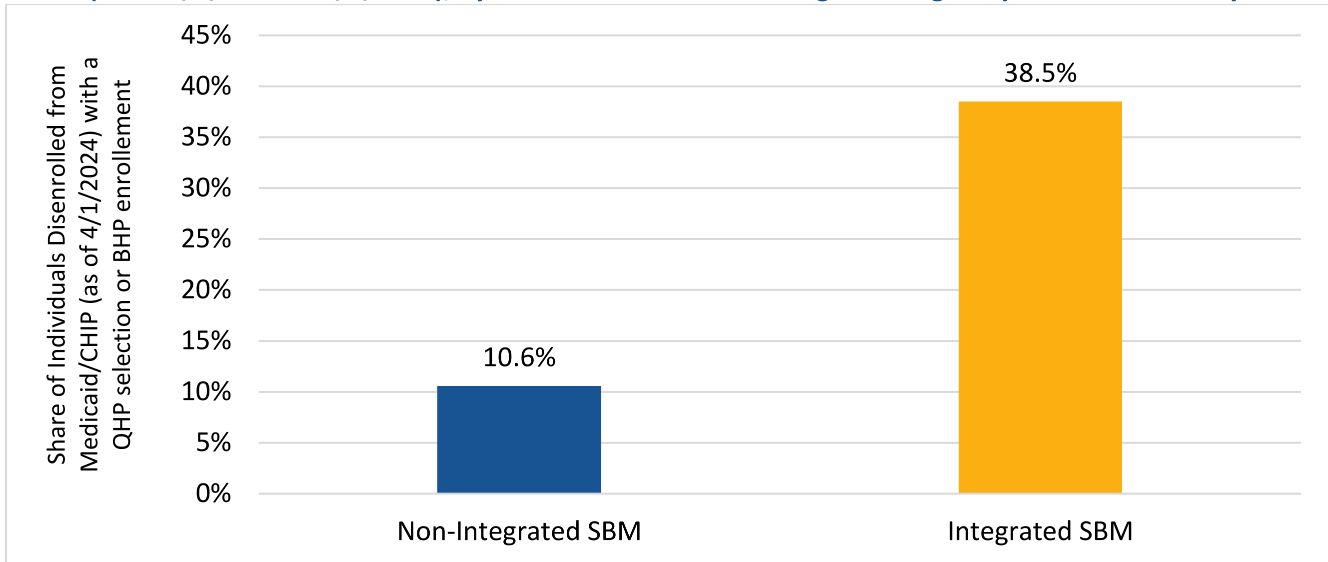


Sources: Centers for Medicare & Medicaid Services, HealthCare.gov Transitions Marketplace Medicaid Unwinding Report & State-based Marketplace (SBM) Medicaid Unwinding Report

Notes: QHP = Qualified Health Plan. BHP = Basic Health Program. HealthCare.gov counts include Marketplace consumers who submitted a HealthCare.gov application from March 6, 2023 - October 6, 2024, or who had an inbound account transfer from April 3, 2023 - November 7, 2024, who can be linked to an enrollment record in the T-MSIS analytics files (TAF) that show a last day of Medicaid or CHIP enrollment from March 31, 2023 - July 31, 2024. SBM counts come from those whose Medicaid/CHIP coverage was denied or terminated following renewal and 1) whose applications were processed by an SBM through an integrated Medicaid, CHIP, and Marketplace eligibility system or 2) whose applications/information was sent by a state Medicaid or CHIP agency to an SBM through an account transfer process. Consumers who submitted applications to an SBM that can be matched to a Medicaid/CHIP record are also included. These counts also include individuals who were identified as losing Medicaid or CHIP coverage and enrolled into a BHP in states that operate the program. The HealthCare.gov state data and the SBM state data are not directly comparable due to differences in methodology and should be compared with caution. Further information on the reporting methodology and cautions in comparing the HealthCare.gov and SBM metric sources can be found in the Data Sources and Metrics Definitions Overview document: https://www.medicaid.gov/resources-for-states/downloads/data-sources-and-definitions.pdf.

Transitions between Medicaid and the Marketplace are made easier by integrated eligibility and enrollment systems that allow for the sharing of data across programs.[25] An SBM with an integrated eligibility and enrollment system can determine eligibility for and enroll applicants in Medicaid, CHIP, Basic Health Program, or Marketplace. Figure 3 shows that SBMs with integrated eligibility and enrollment systems had a higher rate of transition to Marketplace coverage among those losing Medicaid/CHIP coverage (38.5 vs 10.6 percent) during the relevant state Medicaid unwinding renewal period and processing timeline than SBMs without integrated systems. Additionally, some SBM states with an integrated eligibility system also operate a BHP and enrolled 376,699 individuals identified as losing Medicaid or CHIP coverage into the program as of March 31, 2024.

Figure 3. Share Transitioning to Marketplace and BHP After Medicaid/CHIP Disenrollment Among SBM States (From 4/1/2023 to 4/1/2024), by Whether State Has an Integrated Eligibility and Enrollment System



Source: Centers for Medicare & Medicaid Services, State-based Marketplace (SBM) Medicaid Unwinding Report & KFF Unwinding Tracker, Medicaid Enrollment and Unwinding Tracker – State Data – Archived | KFF
Notes: QHP = Qualified Health Plan. BHP = Basic Health Program. SBMs that operate an integrated eligibility system for purposes of reporting are CA, CT, DC, KY, MA, MD, MN, NY, RI, VT, WA. SBMs that operate a non-integrated eligibility system or account transfer process for purposes of reporting are CO, ID, ME, NJ, NM, NV, PA, and VA. These counts also include individuals who were identified as losing Medicaid or CHIP coverage and enrolled into a BHP in NY and MN. The SBM Medicaid unwinding report and State Medicaid and CHIP applications, eligibility determinations, and enrollment data report may not be directly comparable due to differences in reporting methodology. SBMs report relevant Marketplace activity during a state's Medicaid unwinding renewal period and processing timeline, which vary by SBM and may not directly align with the Medicaid and CHIP enrollment data reporting timeline. QHP selection data includes consumers on applications received through an integrated Medicaid, CHIP, and Marketplace eligibility system; on account transfers and/or applications received from the Medicaid or CHIP agency in states with non-integrated systems; and on applications the consumer submitted to the Marketplace that are matched to Medicaid or CHIP data or on which the consumer attests to a loss of Medicaid or CHIP coverage. This population may also include certain consumers whose Medicaid or CHIP coverage was terminated due to procedural reasons. Further information on the reporting methodology and cautions in comparing metric sources for can be found in the Data Sources and Metrics Definitions Overview document: https://www.medicaid.gov/resources-for-states/downloads/data-sources-and-definitions.pdf.

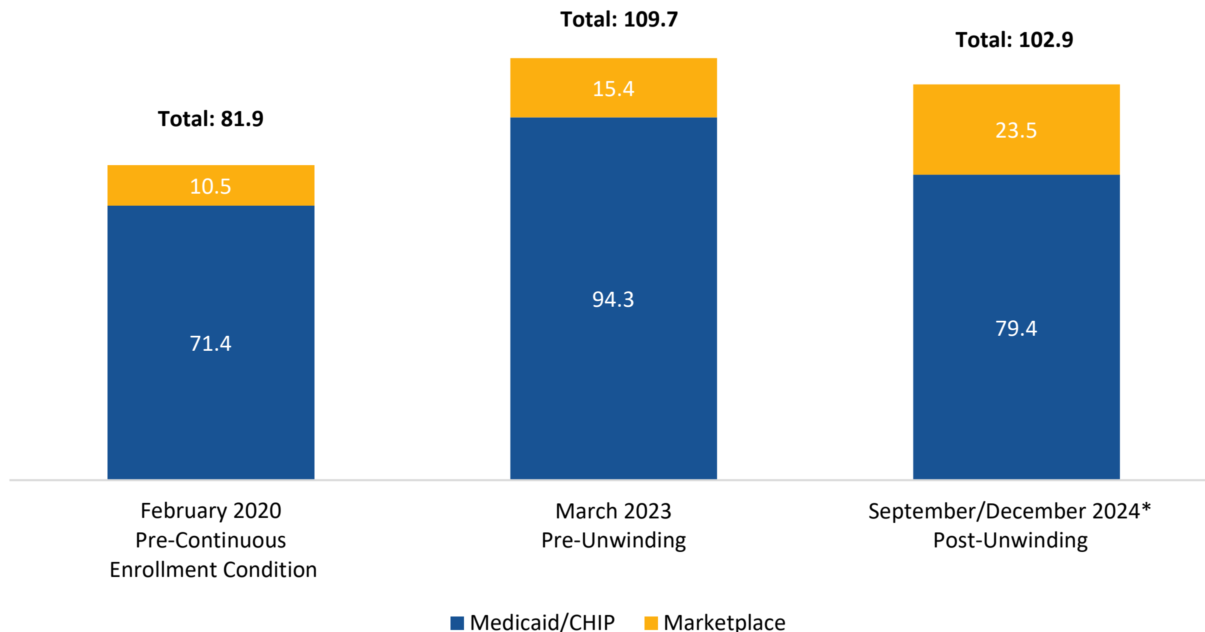
Figure 4 presents administrative data on Medicaid/CHIP and Marketplace coverage at three points in time: February 2020, just prior to the start of the PHE continuous enrollment condition; March 2023, the start of the PHE unwinding; and August 2024, at the end of the unwinding. A comparison of the first two periods provides additional evidence on how ACA-related coverage provided an essential safety net that prevented coverage loss during the pandemic and its immediate aftermath. Between February 2020 and March 2023, Medicaid/CHIP coverage increased by nearly 23 million and Marketplace coverage increased by nearly 5 million.

Medicaid/CHIP coverage fell during the unwinding, though as of September 2024 was 11 percent higher than the pre-pandemic baseline. The decline in Medicaid/CHIP coverage was slightly less than projections made based on pre-COVID data.[26,27,28] This result points to the efficacy of CMS and state efforts to minimize coverage losses during the unwinding period.

Over 23.5 million Americans selected a Marketplace plan as of December 31, 2024, more than double the number in February 2020.[29] Previous ASPE research indicates that coverage gains were especially large for

Black and Latino consumers and that the Marketplaces are an important source of coverage for small business owners and self-employed workers.[30, 31]

Figure 4. Enrollment Across Medicaid, CHIP, and Marketplace Coverage Before, Last Month of, and After (August 2024), the Medicaid/CHIP Continuous Enrollment Condition, in Millions



Source: Medicaid/CHIP enrollment is from Centers for Medicare & Medicaid Services, Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data.
Notes: Marketplace enrollment in this figure is defined as following: February 2020: The total number of individuals with an active policy at any point in February 2020 who also paid their premium (if applicable), as of March 15, 2021, as published at the link: https://www.cms.gov/files/document/full-year-effectuated-enrollment.xlsx. March 2023: The total number of individuals with an active policy at any point in March 2023 who also paid their premium (if applicable), as of September 15, 2023. *September 2024 Medicaid/CHIP enrollment comes from: September 2024 Medicaid & CHIP Enrollment Data Highlights | Medicaid and December 2024 Marketplace enrollment comes from: Newsroom Homepage | CMS. This data does not include approximately 1.7 million individuals who enrolled into a Basic Health Program (BHP) as of September 2024. Further information on states the operate as Basic Health Program can be also found in: https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-september2024.pdf.

Despite the decline in Medicaid/CHIP coverage, overall coverage remained steady as enrollment in Marketplace and employer-based insurance increased. In Q2 2024, the national uninsured rate as measured by the NHIS was 7.6 percent (Figure 1). This corresponds to an estimated 308 million people with insurance coverage.

Policies Affecting the Quality and Affordability of Health Coverage

In addition to policies aimed at increasing the number of people with health insurance, the Biden-Harris Administration undertook efforts to improve the quality of coverage and access to healthcare. A summary of the coverage and access policies enacted by this Administration is provided in Appendix Table 1.

To strengthen the quality of Medicaid/CHIP coverage, CMS provided guidance to states on the use of Medicaid and CHIP funding to provide high-quality behavioral health services to children through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.[32] CMS also released new guidance on delivering Medicaid services in school-based settings, making it easier for schools to deliver and receive payment for

health care services furnished to children enrolled in Medicaid and CHIP.[33] The *Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality* final rule strengthened standards for timeliness and quality of care for Medicaid/CHIP managed care plans.[34] The *Ensuring Access to Medicaid Services* final rule aims to increase access and quality of care for Medicaid beneficiaries by establishing new requirements for state Medicaid programs including creating a Beneficiary Advisory Council comprised of Medicaid beneficiaries, their families, and/or caregivers.[35]

The enhanced premium tax credits introduced by the ARP and extended by the IRA greatly improved the affordability of private health insurance purchased through the ACA Marketplaces. In 2024, 95 percent of consumers selecting non-catastrophic plans during Open Enrollment through HealthCare.gov received a premium tax credit, up from 88 percent in the 2020 Open Enrollment Period.[36] Because of the enhanced tax credits, in 2024, the average HealthCare.gov consumer was able to lower their monthly premiums by 48 percent.[37]

Half of all consumers purchasing coverage through the Marketplaces receive cost-sharing reduction subsidies, which reduce their out-of-pocket costs at the time they receive care.[36] For those who are not eligible for cost-sharing reductions, the enhanced tax credits made it possible to upgrade to a plan with lower deductibles and copayments.[38]

The No Surprises Act, enacted in 2020 and implemented under the Biden-Harris Administration, improves the affordability of health care for those with private insurance by removing patients from disputes between insurers and providers over certain out of network medical bills. The law also requires insurers to provide continuity of care at in-network prices following termination of network agreements. The law empowers patients to make more financially informed decisions by requiring insurers to keep accurate provider directories, publish price information, and make price calculator tools available to enrollees.[39]

The Biden-Harris Administration also has limited the availability of short-term limited duration insurance (STLDI) and independent, non-coordinated excepted benefits health plans. These plans do not comply with the ACA's critical consumer protections, as enrollees may be subject to discrimination based on health status and pre-existing condition exclusions, and these plans are not required to comply with ACA provisions banning lifetime and annual dollar limits on essential health benefits.[40] In Executive Order 14070, "Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage," President Biden directed agencies to improve linkages between the health care system and other stakeholders to address health-related needs and reduce the burden of medical debt.[41]

TRENDS IN HEALTH CARE ACCESS AND AFFORDABILITY

A primary goal of expanding health insurance coverage is to improve access to and affordability of care. The ACA targeted coverage among the non-elderly; therefore, the next set of results focus on coverage and access among this group. Table 1 presents selected years of NHIS data on self-reported access to care and healthcare affordability. In light of longstanding differences in coverage rates, results are presented separately for children (ages 0-17) and non-elderly adults (18-64).

The results suggest that the coverage gains, and enhanced consumer protections have translated into some improvements in access to care. In 2023, 95 percent of children and 81.3 percent of adults had at least one

doctor visit in the past year, up from 92.1 and 79.7 percent in 2010, the year that the ACA was passed. There was a larger change in the percentage of people saying they had a usual source of care. In 2010, 18.9 percent of adults did not have a usual source of care. This percentage fell to 16.1 percent in 2015 and then to 12.7 percent in 2023. The percentage of children without a usual source of care also declined over this period.

The share of children delaying care due to cost fell from 4.1 percent in 2010 to 2.5 percent in 2015 and then to 1.0 percent in 2023. For adults, this measure of financial barriers fell significantly from 13.5 percent in 2010 to 9.2 percent in 2015 and then to 8.5 percent in 2023. Other ASPE work finds that gains in healthcare access were especially significant for those in the American Indian/Alaska Native (AI/AN), Black, and Latino American communities, as well as for young adults ages 19-25.[42, 43, 44]

At the same time, the results in Table 1 suggest that affordability remains a significant issue for many non-elderly adults. Nearly 49 percent of adult NHIS respondents saying that they are worried about medical bills. Although this is down from 55 percent before the ACA coverage provisions went into effect, this figure remains concerning. And the percentage of non-elderly adults saying that they did not get needed mental health care because of cost increased from 2.2 percent in 2015 to 6.7 percent in 2023. These increases coincide with the rise in mental health diagnoses, especially among young adults, since the start of the PHE.[45] The Administration has taken steps to address mental health affordability and access. In September 2024, the U.S. Departments of Health and Human Services, Labor, and the Treasury released new final rules which reinforce and strengthen the Mental Health Parity and Addiction Equity Act.[46]

Table 1. Health Care Access and Affordability, Selected Years from 2009-2023

	2009	2010	2015	2020	2023
Access					
Children (0-17)					
No Usual Source of Care	4.8%	4.9%	4.0%	2.0%	2.6%
Doctor Visit (past 12 months)	91.5%	92.1%	92.9%	93.9%	95.0%
Adults (18-64)					
No Usual Source of Care	18.8%	18.9%	16.1%	11.9%	12.7%
Doctor Visit (past 12 months)	80.3%	79.7%	81.0%	80.1%	81.3%
Affordability					
Children (0-17)					
Delayed Care Due to Cost	5.0%	4.1%	2.5%	1.2%	1.0%
Did Not Get Needed Medical Care Due to Cost	2.7%	2.3%	1.4%	1.0%	1.1%
Needed But Could Not Afford Prescription Medication	3.2%	2.7%	1.6%	1.5%	1.1%
Adults (18-64)					
Delayed Care Due to Cost	14.3%	13.5%	9.2%	8.9%	8.5%
Worried About Medical Bills*		55.2%	49.3%	51.8%	48.9%
Did Not Get Needed Medical Care Due to Cost	10.2%	10.2%	6.9%	7.8%	7.5%
Did Not Get Needed Mental Health Care Due to Cost**	3.3%	3.4%	2.2%	5.2%	6.7%
Needed But Could Not Afford Prescription Medication	11.2%	11.2%	6.9%	6.3%	6.4%

Source: ASPE Analysis of 2009-2023 NHIS Microdata (IPUMS).
Notes: Respondents are classified as worried about paying medical bills if they reported being very worried or somewhat worried about paying medical bills. *Value in 2010 is based on 2011 data: the first year available, and the sample universe is ages 18+. ** Only adults 18+ are consistently asked this question over the sample period.

HEALTH COVERAGE IN 2024

Although insurance coverage has increased dramatically in the decade since the main provisions of the ACA went into effect, the U.S. has still not achieved universal coverage. Table 2 presents the estimated uninsured rate in March 2024 for different subpopulations of non-elderly Americans. The data are from the Current Population Survey Annual Socioeconomic Supplement.[47]

In March 2024, 10.1 percent of non-elderly Americans—27.7 million people—were estimated to be uninsured.[**] The uninsured rate for individuals with incomes below the federal poverty level (FPL) is nearly twice the overall rate and this group represents 21.5 percent of the total number of uninsured, nearly 6 million people. Another roughly one quarter of the uninsured have incomes between 100 and 200 percent of FPL. According to previous ASPE research, after the ARP premium tax credit enhancement went into effect in 2021, over 90 percent of uninsured individuals in this income group had access to a zero-premium Marketplace plan.[48] Without new legislation, the tax credit enhancements will expire after 2025, causing out-of-pocket premiums to increase substantially. This price increase is projected to cause between 4 and 5 million Americans to lose health insurance coverage.[49, 50]

Children remain substantially less likely than adults to be uninsured because of higher income eligibility limits for public insurance coverage. But historically, many children have lost insurance coverage, if only temporarily, because of frictions in redetermination and renewal processes. Continuous eligibility requirements have been shown to reduce such administrative "churn."[51] As noted, the 2023 CAA required all states to provide 12 months of continuous eligibility to children up to age 19 who are enrolled in Medicaid or CHIP. This policy went into effect in January 2024.

Even though Black and Latino/Hispanic Americans have experienced large gains in insurance coverage over the last decade, they are still substantially more likely to be uninsured than Whites and Asian American/Native Hawaiian/Pacific Islanders. American Indian/Alaska Natives have the highest uninsured rate of all groups defined by race/ethnicity.[52]

It is estimated that roughly 1.5 million uninsured adults live in states that have not yet implemented the ACA Medicaid expansion.[53] These individuals are often described as falling in the "coverage gap" because their incomes are too high to qualify for Medicaid, but too low to be eligible for Marketplace tax credits. Overall, the uninsured rate in non-expansion states is 70 percent higher than the rate in expansion states: 14.5 percent vs. 8.5 percent.

[**] In the NHIS, the estimated uninsured rate for non-elderly Americans in the first quarter (January-March) of 2024 is 9.8 percent, with a 95 percent confidence interval of 9.0 to 10.8 percent. For the full population, the estimated uninsured rate is 8.5 in the CPS (March 2024) and 8.2 percent in the NHIS (January-March 2024).

Table 2. The Uninsured Rate for Different Demographic Groups Under Age < 65, (as of March 2024)

	Uninsured Rate	Total Uninsured (% of All Uninsured) *
All	10.1%	27,700,000 (100%)
Income		
<100% FPL	19.1%	5,955,500 (21.5%)
100-138% FPL	17.4%	2,659,200 (9.6%)
139-199% FPL	17.0%	4,487,400 (16.2%)
200-299% FPL	14.5%	5,844,700 (21.1%)
300-400% FPL	10.3%	3,822,600 (13.8%)
>400% FPL	4.0%	4,930,600 (17.8%)
Age		
0-17	6.4%	4,653,600 (16.8%)
18-64	11.5%	23,046,400 (83.2%)
Race/Ethnicity		
White, non-Hispanic	6.8%	10,193,600 (36.8%)
Black, non-Hispanic	10.1%	3,628,700 (13.1%)
AANHPI, non-Hispanic	6.4%	1,218,800 (4.4%)
AIAN, non-Hispanic	21.8%	470,900 (1.7%)
Hispanic	19.4%	11,661,700 (42.1%)
Multi-racial, non-Hispanic	7.7%	554,000 (2.0%)
Medicaid Expansion Status		
Expansion	8.5%	16,536,900 (59.7%)
Non-Expansion	14.5%	11,163,100 (40.3%)

Source: 2024 March CPS (ASEC) Microdata from IPUMS.
Note: *Rounded to the nearest thousand.

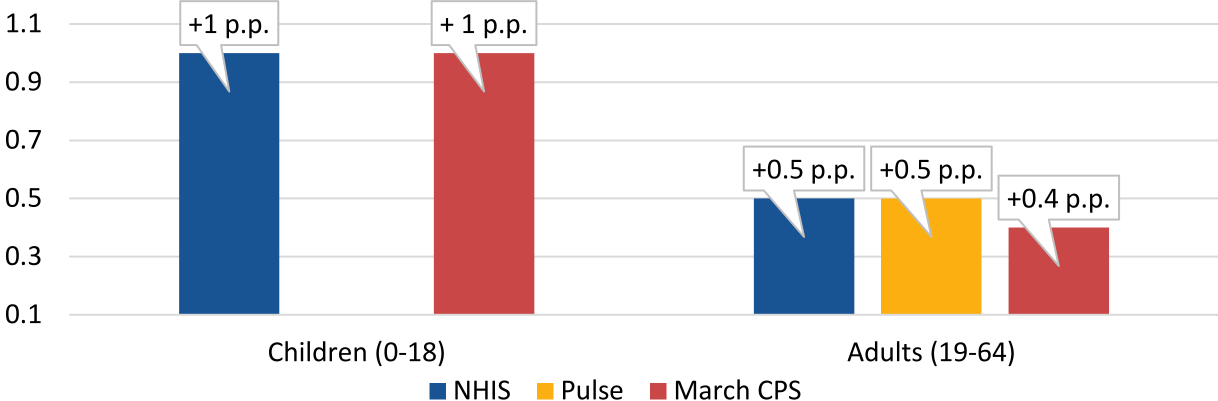
CONCLUSION

The Biden-Harris Administration worked to ensure that individuals have access to comprehensive, affordable health insurance coverage so they can afford to access health care services. The national uninsured rate has fallen by 1.6 percentage points from 9.2 percent in 2021 to 7.6 percent in the second quarter of 2024. Over 300 million Americans now have health insurance coverage. In addition to coverage expansions, the Biden-Harris Administration implemented policies to improve the quality and affordability of health care.

Despite the significant progress made to ensure access to health coverage and affordable health care, there is still room for improvement. The most recent data indicates that nearly eight percent of Americans, and roughly 10 percent of those under age 65, do not have health insurance and nearly half of adults are still worried about the cost of their medical bills.[54] Efforts to continue to build upon the work done under the ACA, ARP, IRA, NSA, and the Biden-Harris Administration will be vital to ensuring Americans continue to have access to affordable, comprehensive health coverage that enables them to meet their health care needs.

APPENDIX: UNINSURED RATE ACROSS FEDERAL SURVEYS

Appendix Figure 1. Percentage Point Change in Uninsured Rates from March 2023 to March 2024 Across Three Federal Surveys



Notes: NHIS = National Health Interview Survey, CPS =Current Population Survey, P.P. = percentage point.

Appendix Table 1. Summary of Coverage and Access Policies Enacted by the Biden-Harris Administration

Policy	*Brief Description*
Legislation	
The American Rescue Plan Act of 2021 (ARP)	*Increased Marketplace premium tax credits for individuals and families with incomes between 100 and 400 percent of the FPL and extended eligibility for premium tax credits to those with income above 400 percent of the FPL.*
	Made permanent federal fiscal incentives for states to newly expand Medicaid to adults with household incomes up to 138 percent of the federal poverty level (FPL).
	Provided a temporary option for states to provide continuous coverage for those on Medicaid for up to 12 months postpartum.
The Inflation Reduction Act of 2022 (IRA)	*Renewed ARP Marketplace tax credit enhancements through 2025.*
Consolidated Appropriations Act of 2023 (CAA)	*Provided a permanent option for states to provide continuous coverage for those on Medicaid for up to 12 months postpartum.*
	Required states to implement 12 months of continuous eligibility for children in Medicaid and CHIP starting in January 2024.
Administrative Actions	
CMS Marketplace Unwinding Special Enrollment Period (SEP)	*Allows individuals and families in Marketplaces served by HealthCare.gov to enroll in Marketplace coverage outside of the annual open enrollment period (between March 31, 2023, and July 31, 2024) provided they attest to a last date of Medicaid or CHIP coverage within the same time period.*
CMS Section 1902e(14)(A) waiver strategies	*Permits states to streamline Medicaid renewals and help eligible individuals maintain coverage.*
2024 Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule	*CMS led actions to ease enrollment in Medicaid and CHIP coverage, such as simplifying eligibility requirements, streamlining application processes and removing administrative hurdles and unnecessary barriers to enrollment.*
Executive Order 14070, "Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage"	*Directs agencies to improve linkages between the health care system and other stakeholders to address health-related needs and reduce the burden of medical debt.*
Executive Order 14009, "Strengthening Medicaid and the Affordable Care Act"	*Created a new Marketplace special enrollment period (SEP) during the COVID-19 pandemic.*
2022 Final Rule Eliminating the "Family Glitch"	*Tied eligibility for Marketplace subsidies to the affordability of employment-based family coverage, as opposed to individual coverage.*
2022 *Ensuring Access to Medicaid Services* Final Rule	*Seeks to increase access and quality of care for Medicaid beneficiaries by establishing new requirements for state Medicaid programs including creating a Beneficiary Advisory Council comprised of Medicaid beneficiaries, their families, and/or caregivers.*
2024 *Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality* Final Rule	*Strengthened standards for timeliness and quality of care for Medicaid/CHIP managed care plans.*
2024 Final Rule under the *Mental Health Parity and Addiction Equity Act* (MHPAEA)	*Reinforces and strengthens enforcement of the Mental Health Parity and Addiction Equity Act.*

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