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ISSUE BRIEF

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Improving Access to Affordable and Equitable Health Coverage: A Review from 2010 to 2024

Recent legislative and administrative policy initiatives have built on the Affordable Care Act's (ACA) expansion of health insurance coverage and improvements in access to and utilization of health care services. The important health and economic benefits that insurance coverage provides has been documented by a large body of research, including many studies evaluating the impact of the ACA.

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KEY POINTS

- In the decade prior to the passage of the Affordable Care Act (ACA), a steady erosion of private health insurance coverage—which is the primary source of coverage for people under 65—led to an increase in the number of uninsured Americans. In 2010, roughly 48 million Americans, or 16 percent of the population, lacked health insurance coverage.
- The ACA reformed the private health insurance market and introduced new affordable coverage options. The law's main coverage provisions—tax credits for private coverage purchased through newly established Marketplaces and the expansion of Medicaid eligibility—went into effect in 2014. The uninsured rate fell substantially between 2013 and 2016 from 14.4 to 9.0 percent.
- Legislative and administrative policies of the Biden-Harris Administration—including enhanced and expanded Marketplace premium tax credits, 12-month postpartum coverage extension in Medicaid and the Children's Health Insurance Program (CHIP), 12-month continuous Medicaid and CHIP eligibility for children, and streamlining enrollment in Medicaid, the CHIP, and Basic Health Programs—have built on the ACA, leading to further increases in insurance coverage. As of 2023, the national uninsured rate has reached 7.7 percent, which is the first year the uninsured rate was below 8 percent since this statistic has been tracked in Federal surveys and a decrease of nearly 50 percent since before the ACA.
- Since 2021, the ACA Marketplaces have expanded insurance coverage from 12 million Americans to over 21 million Americans, an increase of more than 77 percent.
- A large body of research has shed light on the important health benefits of health insurance coverage. Studies find that the ACA coverage expansions improved access to care, thereby reducing morbidity and mortality.
- Other research finds important financial benefits of coverage expansion. In states that expanded Medicaid under the ACA, hospital uncompensated care fell, and hospital financial margins improved. By reducing medical debt among patients, the ACA led to a reduction in the use of payday loans, personal bankruptcy, and evictions.

INTRODUCTION

Health insurance is critical to providing affordable access to medical care and improving health and well-being. It offers individuals financial protection from out-of-pocket spending for needed health care and is associated with improved health outcomes, lower death rates, and improved productivity. Health coverage provided by or subsidized by the federal government and states acts as an important component of the social safety net and ensures that low-income individuals and older adults can get the care they need in an affordable, accessible manner.

The Patient Protection and Affordable Care Act (ACA), which was enacted in 2010 to bolster this health care safety net, was the most significant health policy legislation since the establishment of Medicare and Medicaid in 1965. Through its reforms for private insurance, the creation of a new source of affordable health insurance through the Marketplaces, and the expansion of Medicaid, it led to a significant increase in insurance coverage. By 2015, the year after the main coverage provisions of the law went into effect, over 90 percent of all Americans benefitted from health insurance coverage.

The Biden-Harris Administration has continued to build on the ACA through legislation and administrative actions that have improved affordability and strengthened the quality of coverage. After enrollment stagnated from 2016 to 2021, the ACA Marketplaces have experienced double-digit growth in enrollment each year since 2021. As a result of legislation enacted in 2021 and 2022, consumers' share of Marketplace premiums has fallen, with the majority of HealthCare.gov enrollees being able to choose a zero-premium plan, and enrollment has expanded by more than 77 percent to over 21 million Americans. Enrollment in Medicaid and the Children's Health Insurance Program (CHIP) has also grown as four additional states (North Carolina, Missouri, South Dakota, Oklahoma) adopted the ACA Medicaid expansion since 2021. New continuous eligibility rules make it easier for children and new mothers to retain Medicaid coverage. Today, over 300 million Americans have health insurance coverage and by the fourth quarter of 2023 the uninsured rate, as measured by the National Health Interview Survey (NHIS), fell to 7.7. percent.[1] 2023 was the first year that the uninsured rate was below 8 percent since this statistic has been tracked in Federal surveys.

The purpose of this Issue Brief is to discuss recent ACA-related policy initiatives to support and strengthen health insurance coverage, with a focus on the non-elderly population, in the context of past policy changes and the large body of evidence on the important benefits that coverage conveys.

BACKGROUND

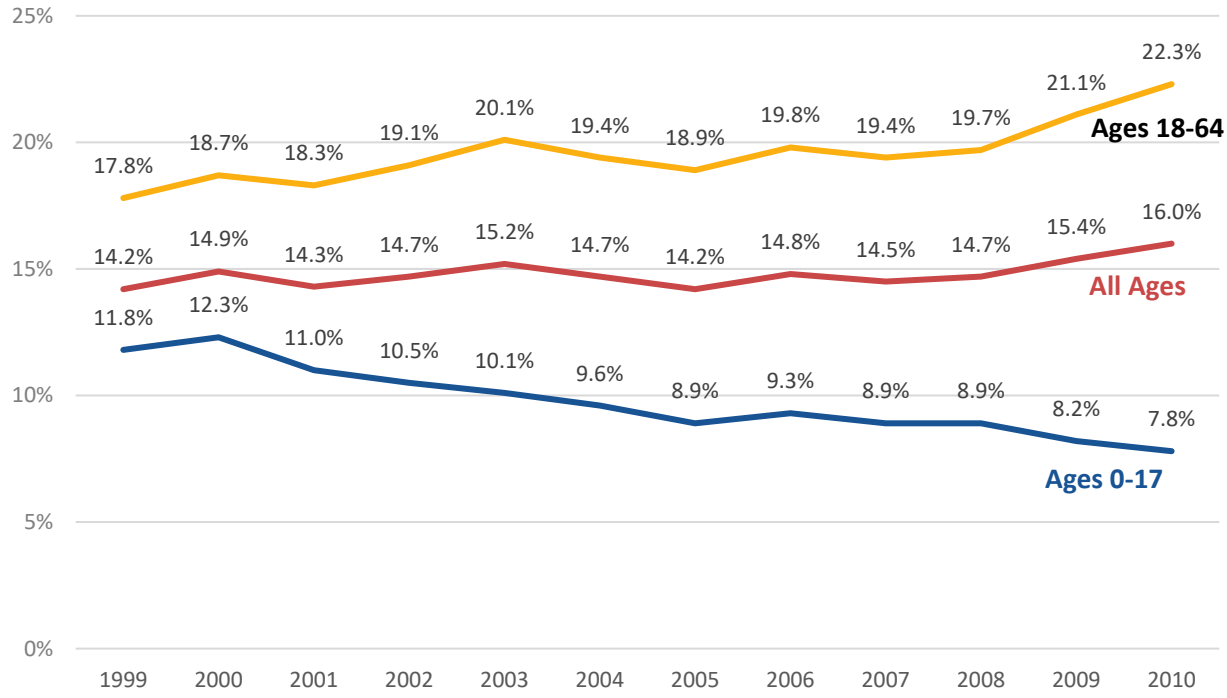
Pre-2010: Before the ACA

Prior to 2010, when the ACA was enacted, rates of private health insurance coverage had been gradually declining for more than a decade. In 2010, 61.1 percent of individuals under age 65 had private coverage, down from 73.1 percent in 1999.[2] A majority of individuals with private coverage were enrolled in employer-sponsored insurance (ESI), which also experienced a decline during this same timeframe, from 67.3 percent of non-elderly adults with ESI in 1999 to 56.3 percent in 2010.[3] These declines in the rates of private insurance coverage were most pronounced in periods when premiums were rising faster than the average income, signaling an issue with the affordability of private coverage.[4] In addition, individuals who were losing private coverage did not necessarily gain other forms of insurance – the uninsured rate increased during this same period, from 16.0 percent in 1999 to 18.2 percent in 2010 for individuals under age 65, which translated to roughly 48 million Americans without health insurance coverage.[5,6]

Among all ages, the uninsured rate increased from 14.2 percent in 1999 to 16.0 percent in 2010 (Figure 1). This increase in the overall uninsured rate was driven by declining coverage among adults. In 2010, 22.3 percent of

adults between the ages 18 and 64 were uninsured, compared to 17.8 percent in 1999. The uninsured rate for children actually decreased during this timeframe, from 11.8 percent in 1999 to 7.8 percent in 2010.[5]

Figure 1. Change in the Uninsured Rate, 1999-2010



Source: NCHS, Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2010, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201106.pdf

These divergent trends can be explained by differences in eligibility for public insurance. Because of Medicaid eligibility expansions for pregnant women and children in the 1980s and 1990s and the creation of CHIP in 1997, children had much greater access to public health insurance than adults.[7] By 2010, federal policy had established minimum income eligibility standards of 133 percent of the federal poverty level (FPL) for children under age 6 and 100 percent of FPL for children between the ages of 6 and 18 (Table 1). In nearly every state, the income eligibility limit for children was substantially higher: in 46 states (including DC) the eligibility limit for Medicaid or CHIP was above 200 percent of FPL. In contrast, Medicaid income eligibility limits for parents were generally much lower. In January 2012, prior to Medicaid expansion to low-income adults, 17 state Medicaid programs had income limits for parents at less than 50 percent of the FPL, 16 states had income limits for parents with incomes between 50 and 99 percent of the FPL, and 18 states and the District of Columbia had income limits for parents with incomes at 100 percent of the FPL or greater.[8] Coverage options were even more limited for non-disabled adults without children. In January 2012, 26 states provided no coverage, 4 states provided only premium assistance, 13 states provided coverage that was more limited than Medicaid, and 7 states and the District of Columbia provided coverage that was comparable to Medicaid. Thus, adults – especially those without children or a disability– lacked a safety net and had the most to gain from the ACA (Table 1).

Table 1: Medicaid Eligibility Requirements Before the ACA

Eligibility Group	Federal Requirements
Ages 0-5	Up to 133 percent of the FPL
Ages 6-18	Up to 100 percent of the FPL
Parents and Caretaker Relatives over 18	Based on financial eligibility requirements for the former Aid to Families with Dependent Children (AFDC) program
Non-disabled adults without dependent children over 18	Excluded from Medicaid unless covered under a 1115 demonstration

EFFORTS TO PROMOTE INSURANCE COVERAGE

2010-2016: Implementation of the ACA

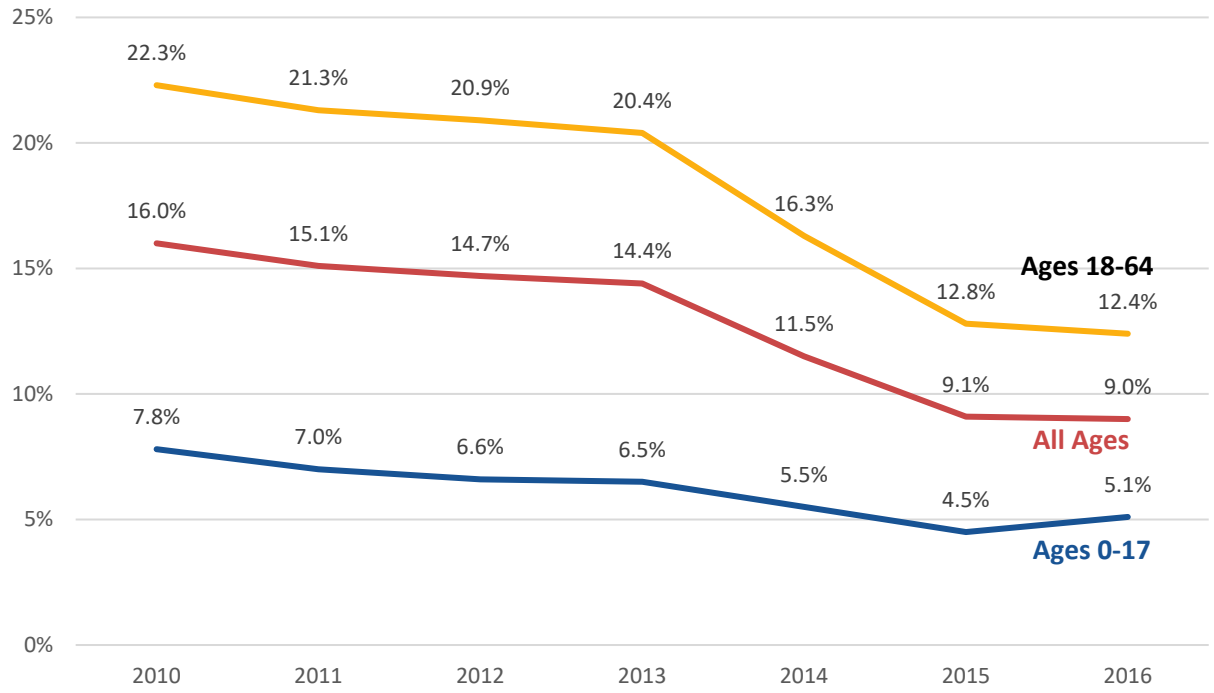
In recognition of the growing uninsured rate and the increasing unaffordability of health insurance coverage, the ACA sought to provide new opportunities for individuals to access affordable, comprehensive coverage. To accomplish this, it included three key coverage provisions: allowing young adults to remain as a dependent on their parents' health insurance coverage until age 26; the expansion of Medicaid to low-income adults; and the creation of the Health Insurance Marketplaces and accompanying premium tax credits. The dependent coverage provision went into effect in September 2010. Other provisions, including the coverage guarantee for pre-existing conditions and community rating, which eliminated gender differences in premiums, also expanded the opportunity for people to gain affordable coverage. The Medicaid expansion and the ACA Marketplaces went into effect in January 2014, with variations in state implementation, including states that expanded early, states that chose not to expand, states creating State-based Marketplaces, and states utilizing the Federally facilitated platform, HealthCare.gov.*

The impact of these coverage provisions was immediately evident, with coverage among young adults increasing by 6.7 percentage points from September 2010 to September 2011.[9] Between 2010 and 2014, coverage increased in several states that took advantage of an ACA provision that allowed them to expand Medicaid early, with the highest enrollment rates among people with health-related limitations.[10] While these early expansion states had some form of state or county-funded program for low-income uninsured adults prior to the ACA, early opt-in allowed them to receive federal matching funds for some or all of the enrollees in their existing programs.[11]

The biggest effect of the ACA came after 2014. In 2013, the national uninsured rate was 14.4 percent. By 2015 it was down to 9.1 percent (Figure 2).[1] One study estimated that Medicaid expansion accounted for about 60 percent of the initial increase in coverage caused by the ACA and 40 percent was attributable to the Marketplaces.[12] While the increase in Medicaid coverage was caused mainly by the expansion of eligibility, coverage also increased among groups that were previously eligible, including children.[13] This "welcome mat" effect can be attributed to increased awareness, as well as the streamlining of Medicaid applications and enhanced outreach.

*As a result of the Supreme Court's decision in *National Federation of Independent Business (NFIB) v Sebelius*, states were able to choose whether to adopt Medicaid expansion, resulting in some states adopting expansion at a later date and some states choosing not to expand Medicaid.

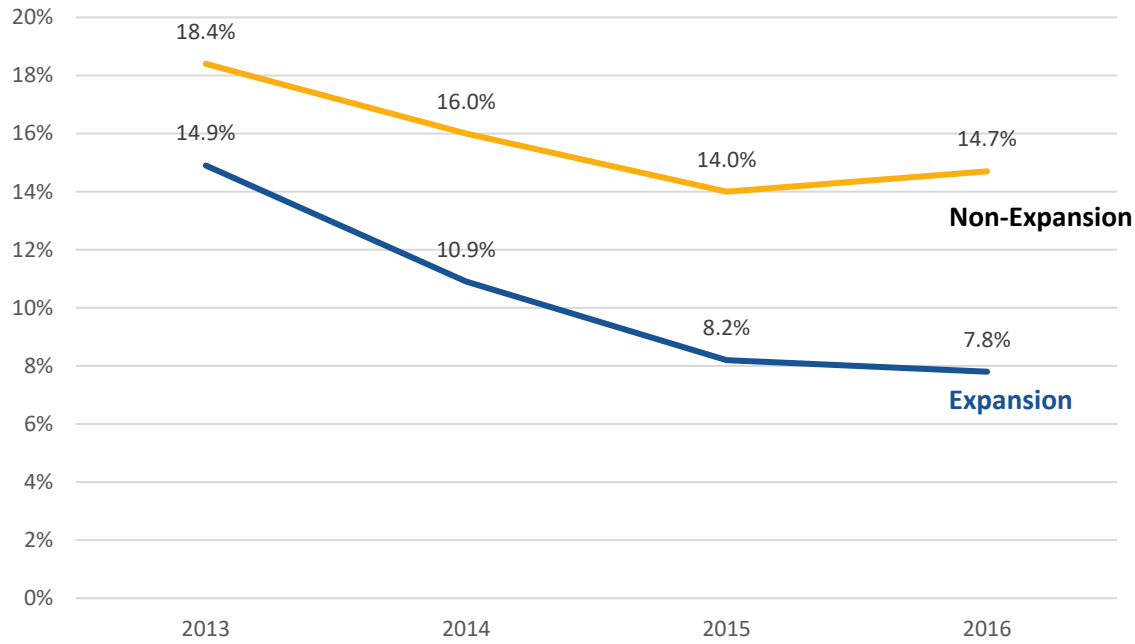
Figure 2. Change in the Uninsured Rate, 2010-2016



Source: NCHS, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf

Every state experienced an increase in insurance coverage, though the change was larger in Medicaid expansion states.[14] Between 2013 and 2015, the uninsured rate fell by 6.7 percentage points in expansion states compared to a decline of 4.4 percentage points in non-expansion states (Figure 3). Within both expansion and non-expansion states, coverage increased more in areas that had higher rates of uninsurance in the pre-ACA period.[15]

Figure 3. Change in the Uninsured Rate, 2013-2016, by Expansion Status (Under Age 65)



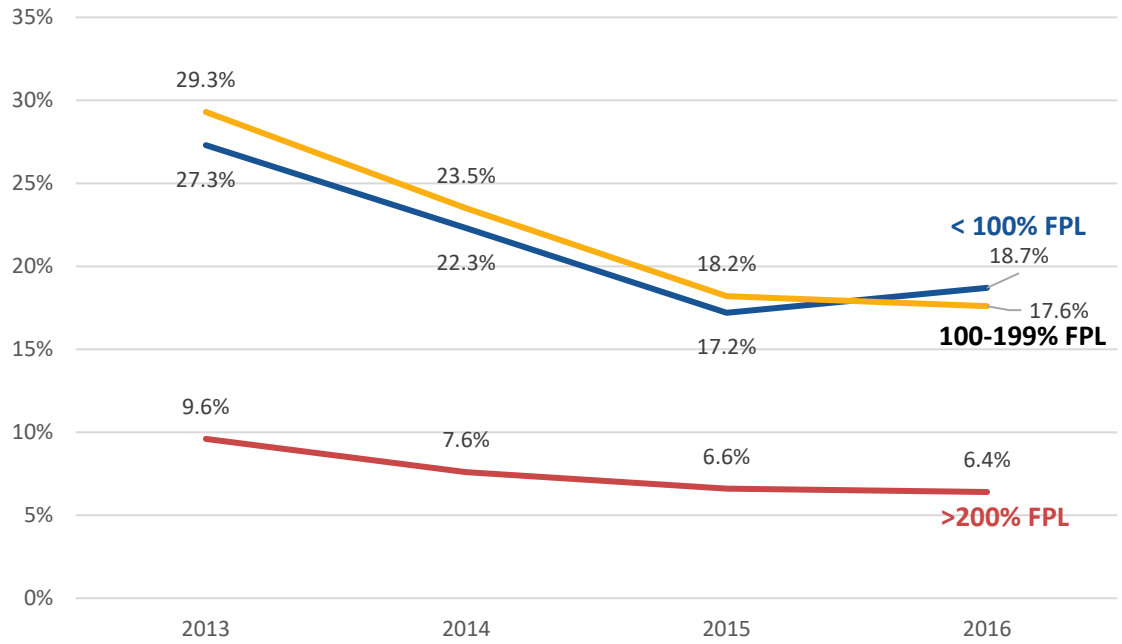
Source: NCHS, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf

Although the gains in coverage were widespread, they were especially large among demographic groups that were more likely to be uninsured prior to the ACA. The Medicaid expansion provided eligibility for individuals in families with incomes up to 138 percent of the FPL[†] and the Marketplace premium tax credits were greatest for families between 100 and 200 percent of FPL. As a result, lower-income Americans were most likely to benefit from the ACA. In 2013, the uninsured rate for non-elderly individuals with incomes below 200 percent of the FPL was roughly three times the rate for individuals with incomes above 200 percent of the FPL (Figure 4). By 2016, individuals in these lower income groups were still more likely to be uninsured, but the gap relative to individuals with incomes above 200 percent of FPL had fallen by over 40 percent.

Prior to the ACA, residents of rural areas were slightly more likely to be uninsured than individuals living in urban areas. One study found that the ACA had a stronger effect on coverage in rural areas, causing this gap to decrease.[15] Other research documented larger increases in Medicaid coverage attributable to the ACA in rural areas compared to urban areas.[16,17]

[†] The ACA specifies that the eligibility levels for the expansion population is 133 percent of the FPL, but includes a 5 percentage point disregard, bringing the eligibility level to 138 percent of the FPL.

Figure 4. Change in the Uninsured Rate, 2013-2016, by Income (Under Age 65)

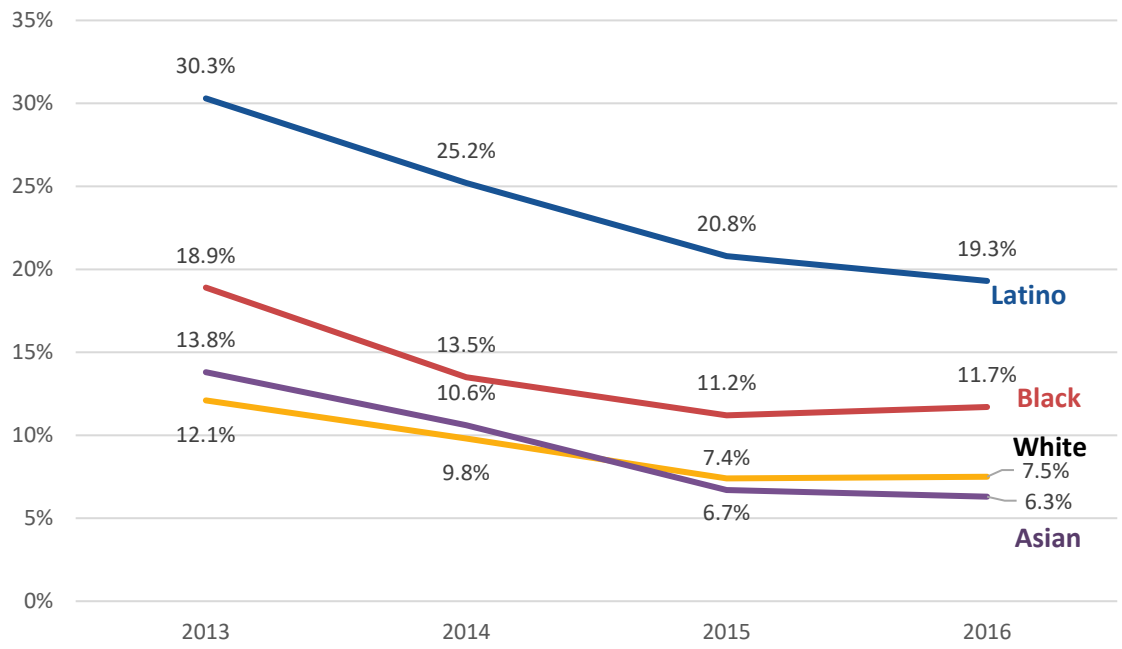


Source: NCHS, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016,, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf

The ACA also reduced coverage disparities related to race and ethnicity. In 2013, non-elderly Latino‡ adults were more than 2.5 times as likely to be uninsured and non-elderly Black adults were 70 percent more likely to be uninsured than non-elderly White adults.[18] After 2014, the uninsured rate had fallen for all three groups, though Latinos and Blacks experienced substantially greater gains in coverage. As a result, by 2017 the coverage gaps for Latinos and Black relative to Whites had fallen significantly (Figure 5).

‡ This brief uses the term "Latino" to refer to all individuals of Hispanic or Latino origin.

Figure 5. Change in the Uninsured Rate, 2013-2016, by Race and Ethnicity (Under Age 65)



Source: NCHS, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf

The coverage gains were also pronounced for groups with limited access to ESI, which was and remains the most important source of coverage for non-elderly Americans. Because of the link between the workplace and insurance, becoming unemployed often results in losing insurance coverage. Prior to the ACA, unemployed workers were roughly three times as likely to be uninsured as employed workers. Between 2013 and 2017, the uninsured rate for unemployed workers in non-expansion states fell by 20 percent and the uninsured rate for unemployed workers in expansion states fell roughly in half.[19] Coverage also increased more for working age adults with disabilities relative to those without disabilities.[20]

Prior to the ACA, there were also significant disparities in insurance coverage related to sexual orientation. In 2013, the uninsured rate for LGBT adults was 8.4 percentage points higher than the rate for non-LGBT adults. By 2019, this coverage gap had been completely closed.[21] Although it is difficult to precisely attribute this change to specific policies, the ACA's consumer protections are especially important for groups like gay men who were often subject to restrictive underwriting practices in the non-group insurance market. Another important factor unrelated to the ACA is the 2015 Supreme Court decision legalizing same-sex marriage, which made it easier for LGBT adults to obtain employer-sponsored health insurance as a dependent.[22]

The ACA also improved the quality of coverage for those that had insurance prior to the ACA by increasing coverage of preventive services without cost-sharing in most group and individual health plans and for many Medicaid beneficiaries. These preventive services include coverage for vaccinations, well-child visits, screening for HIV and sexually transmitted infections, HIV pre-exposure prophylaxis, contraceptives, and cancer screening. A previous ASPE analysis estimates that more than 150 million people with private insurance, 20 million Medicaid adult expansion enrollees, and 61 million Medicare beneficiaries can benefit from this coverage.[23]

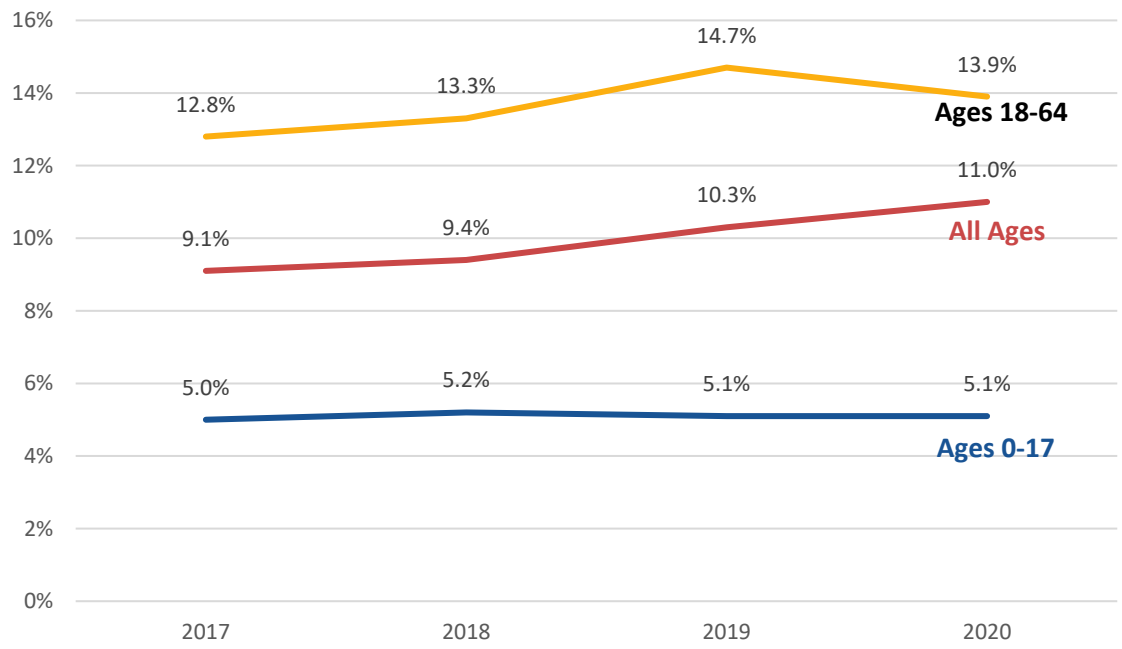
2017-2020: Increasing Uninsurance and COVID-19

In 2017, there were legislative attempts to repeal the ACA, which ultimately were not successful.[24,25] After these statutory attempts failed, the Trump Administration undertook several administrative efforts to change the health insurance landscape including eliminating federal cost-sharing reduction payments in 2017, reducing the individual mandate penalty to $0 in 2019 and reducing federal investments in the Federally-facilitated Marketplace Navigator grants from $63 million in 2016 to $36 million in 2017 and $10 million in 2018 to 2020.[26] Together, these changes adversely affected the ACA Marketplaces, contributing to increased premiums, decreased insurer participation, and decreased enrollment.[27]

In addition, under federal guidance in place during this time, some states implemented policies that had the likely effect of reducing Medicaid enrollment, including work requirements and premiums.[28,29] State administrative procedures and federal program integrity efforts increased administrative burdens for Medicaid enrollees.[30] While such policy initiatives seek to mitigate perceived work disincentives, target benefits, or reduce moral hazard, research has demonstrated that these types of barriers reduce Medicaid coverage and increase rates of uninsurance.[31,32,33,34] In addition, regulatory changes were made to revise the test for legal immigrants who are not yet citizens to be considered public charges (primarily dependent on Government resources) to include enrollment in Medicaid and other non-cash benefits.[35] Even though the rule was challenged in the courts, which led to partial implementation, this change likely created a chilling effect on Medicaid enrollment among legal immigrants who were eligible for the program.[36]

The decisions by several states to adopt the ACA Medicaid expansion mitigated coverage losses caused by these administrative policy changes. Between 2017 and 2020, five states (Virginia, Maine, Idaho, Utah, and Nebraska) expanded Medicaid. These states had some of the largest decreases in their uninsured rate between 2019 and 2021, which encompasses the period in which they expanded Medicaid. Maine and Idaho had the largest percentage point decreases in their uninsured rates among all states during this period, with a 3.2 and 2.1 percentage point decrease, respectively.[37] In addition, Medicaid expansion states overall experienced a smaller percentage point increase in their uninsured rate for individuals under age 65 between 2017 and 2020 (0.9 percentage points), compared to non-expansion states (1.5 percentage points).[38,39] Nationally, the uninsured rate for all ages increased between 2017 and 2020, from 9.1 percent in 2017 to 11.0 percent in 2020 (Figure 6). As in the pre-ACA period, the growth in the uninsured rate was driven by the trend for adults.

Figure 6. Change in the Uninsured Rate, 2017-2020



Source: NCHS, Health Insurance Coverage: Estimates from the National Health Interview Survey, https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm

In 2020, the COVID-19 Public Health Emergency (PHE) created a new urgency to ensure that individuals had access to health insurance coverage and highlighted the critical role played by Medicaid and CHIP. The Families First Coronavirus Response Act (FFCRA) conditioned an increase in federal Medicaid funding on state compliance with a number of conditions, including maintaining enrollment for nearly all Medicaid enrollees, regardless of changes in eligibility. This continuous enrollment condition helped to mitigate coverage losses and stabilize the uninsured rate beginning in 2020.

2021 – Present: Growing Coverage and Affordability

Upon taking office, the Biden-Harris Administration put into place numerous policies to build on and strengthen the Marketplaces and Medicaid coverage. President Biden has issued several executive orders aimed at expanding access to and improving the quality of coverage and making coverage more affordable. In January 2021, Executive Order 14009, *Strengthening Medicaid and the Affordable Care Act*, directed HHS to expand access to ACA coverage and to bolster the Medicaid program, and in April 2022, Executive Order 14070, *Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage*, reiterated these goals, as well as 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.[40,41]

The American Rescue Plan of 2021 (ARP) extended advance payments of the premium tax credit (APTC) for Marketplace coverage to include individuals earning more than 400 percent of the FPL and increased the generosity of APTC available to individuals earning between 100 and 400 percent of the FPL. These APTC enhancements were extended under the Inflation Reduction Act of 2022 (IRA).

Aligned with President Biden's Executive Order on *Strengthening Medicaid and the Affordable Care Act,* the Administration took a number of administrative actions to increase awareness of Marketplace coverage options and to better facilitate enrollment. Several special enrollment periods (SEPs), which provide

opportunities to enroll in coverage outside of the annual open enrollment period, were added between 2021 and 2023. These included an SEP during the COVID-19 pandemic, an SEP for individuals with household incomes at or below 150 percent of the FPL, and an SEP for individuals disenrolled from Medicaid due to the end of the continuous enrollment condition. In addition, in 2022 and 2023 HHS increased funding for Navigators, who help people enroll in coverage, nearly 10-fold from 2020 levels, with more than 1,500 Navigators assisting consumers with applying for and enrolling in Marketplace coverage in 2023.[26]

The enhanced tax credits and various policies related to outreach and enrollment, along with a change in the way that the affordability of ESI coverage is defined for the purposes of determining tax credit eligibility (the "family glitch" fix), contributed to strong growth in Marketplace enrollment. The total number of people making plan selections during Open Enrollment grew from 11.4 million in 2020 to 21.4 million in 2024.[26] The percentage of HealthCare.gov enrollees receiving APTC increased from 87 percent to 95 percent over this period. Between 2020 and 2023, enrollment among Black and Latino individuals in states using HealthCare.gov roughly doubled and all other race/ethnic groups experienced double-digit enrollment growth.[42] Because benchmark premiums tend to be higher in rural areas, the enhanced tax credits are especially important for making coverage affordable for rural consumers.[43] In 2021, over three-quarters of Marketplace enrollees in rural areas of states using HealthCare.gov could select a zero-premium plan, representing a 13 percentage point increase from the availability of a zero-premium plan option before the ARP.[44]

The Biden-Harris Administration has also partnered with states to strengthen Medicaid and CHIP. The ARP provided states with the option to provide 12 months of postpartum coverage , an option that was made permanent by the Consolidated Appropriations Act,2023 (CAA).[§] Postpartum health coverage is vital to reducing maternal morbidity and mortality, with 53 percent of pregnancy-related deaths occurring between one week and one year after childbirth.[45] Research on Medicaid indicates that, prior to postpartum extension, more than 20 percent of individuals with pregnancy-related Medicaid coverage became uninsured within six months postpartum – and that in non-expansion states, this rate is nearly twice as high at 37 percent.[46] As of May 2024, 46 states, the District of Columbia, and the U.S. Virgin Islands have implemented this change, resulting in an estimated 694,000 individuals gaining additional months of postpartum Medicaid coverage.[47,48] If the remaining four states were to adopt this policy, a total of approximately 1.5 million people would have 12 months of postpartum coverage each year.

The CAA also required states to provide 12 months of continuous eligibility for children in Medicaid and CHIP beginning on January 1, 2024. While children continue to be the group that is least likely to be uninsured, short-term changes in household size or income may cause a gap in their Medicaid or CHIP coverage, resulting in periods of uninsurance.[49,50] Such gaps in coverage are associated with increased risk of unmet health needs, delayed care, lower vaccination coverage, unfilled prescriptions, and increased asthma exacerbations and asthma-related emergency department visits. Under the continuous eligibility requirement, average monthly Medicaid and CHIP eligibility is estimated to increase by 3.5 percent in states without a 12-month continuous eligibility policy in place, with more than 17 million Medicaid and CHIP-eligible children potentially benefitting from the change.[51]

The Centers for Medicare & Medicaid Services (CMS) has approved section 1115 demonstration authority that allow states to go above and beyond the 12-month continuous eligibility requirement to provide multi-year continuous eligibility.[52] As of December 2023, CMS has approved section 1115 demonstration authority in New Mexico, Oregon, and Washington to provide continuous eligibility for children ages 0-6 and, as of May 2024, CMS has six pending requests from states interested in adopting continuous eligibility for children. Other

[§] States with a separate CHIP that elect to extend postpartum coverage in Medicaid must also extend coverage in their separate CHIP.

section 1115 demonstration opportunities that CMS has encouraged states to apply for have also facilitated access to coverage. For example, the Medicaid Reentry Section 1115 Demonstration Opportunity, which has been approved in California, Montana, and Washington, allows state Medicaid programs to cover services that address various health concerns for individuals who are incarcerated in the period immediately prior to their release, with the goal of helping them succeed during reentry by establishing connections to community providers.[53]

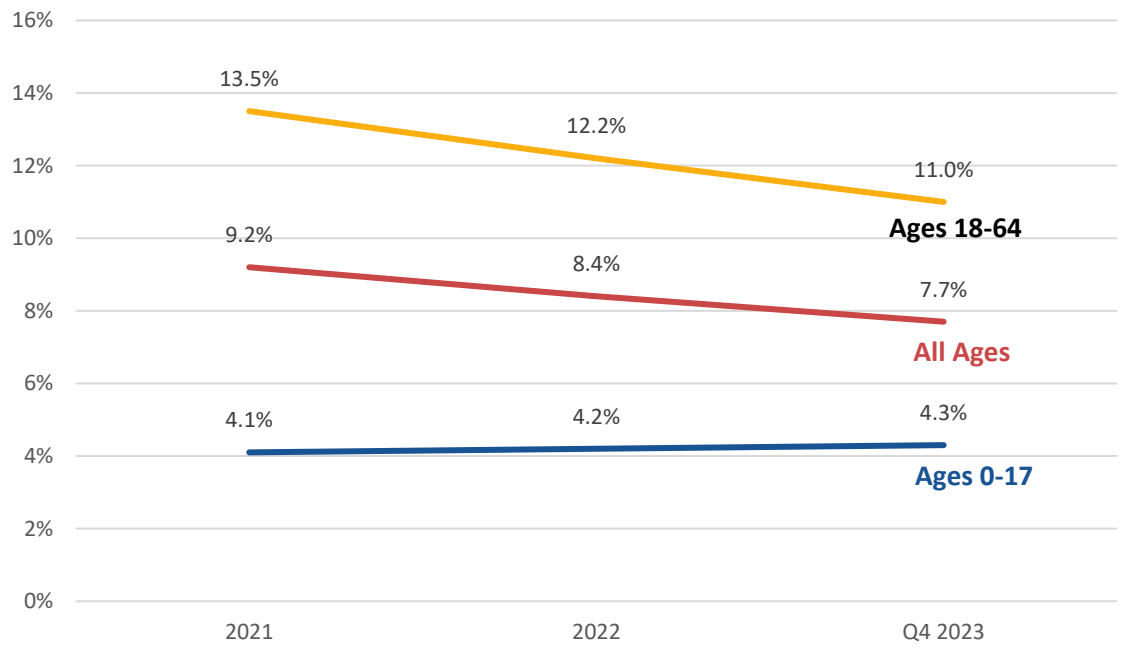
The *Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* final rule, released in March 2024, includes changes to simplify eligibility requirements, streamline application processes and remove administrative hurdles and unnecessary barriers to enrollment.[54] The rule brings consumer protections available under the ACA to all enrollees in Medicaid and CHIP, including eliminating annual and lifetime limits on children's coverage in CHIP; ending the practice of locking children out of CHIP coverage if a family is unable to pay premiums; eliminating waiting periods for CHIP coverage so children can access health care immediately; improving the transfer of children seamlessly from Medicaid to CHIP when a family's income rises; requiring states to provide all individuals with at least 15 days to provide any additional information when applying for the first time and 30 days to return documentation when renewing coverage; and prohibiting states from conducting renewals more frequently than every 12 months and requiring in-person interviews for older adults and those with disabilities.

The ARP also made permanent federal fiscal incentives initially enacted in 2020 for states that newly expand Medicaid. This incentive provides a five percentage point increase in the federal match rate for two years for non-expansion enrollees, which account for most state Medicaid costs.[55] The 10 states that have not expanded Medicaid are each projected to receive between $60 million and $5 billion in federal incentives, depending on the size of their non-expansion population, should they choose to expand Medicaid.[56]

Between 2020 and early 2024, the number of people enrolled in the ACA Medicaid expansion eligibility category grew by nearly 50 percent, from 15.5 million to 23.2 million.[57] This growth can be attributed to the FFCRA continuous enrollment condition as well as the expansion of Medicaid in five states during that time. Altogether, the number of people with ACA-related coverage (Marketplace, Medicaid expansion, and Basic Health Program enrollment) reached 45 million in 2024. In addition, between March 2020 and March 2023, the share of non-elderly people with ESI experienced a small, but significant increase from 59.2 percent to 60.4 percent.[58]

Together, these actions have resulted in continued decreases in the uninsured rate since 2020, reversing the increase seen between 2016 and 2020 (Figure 7). In Q4 2023, the most recent period for which NHIS data are available, the national uninsured rate for all ages was 7.7 percent. Between 2021 and Q4 2023, the uninsured rate for non-elderly adults fell from 13.5 to 11 percent. For children, there was no statistically significant change between 2021 and the end of 2023.[1]

Figure 7. Change in the Uninsured Rate, 2021-Q4 2023



Source: NCHS, Health Insurance Coverage: Estimates from the National Health Interview Survey, https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm

Over the course of the PHE, total Medicaid and CHIP grew in enrollment from 71 million to a peak of 94 million. Following the expiration of the Medicaid continuous enrollment condition on March 31, 2023, states resumed regular eligibility renewals for all enrollees in Medicaid and CHIP. Since the outset of this "unwinding" process, the U.S. Department of Health and Human Services (HHS) has worked with states and stakeholders to mitigate coverage loss and support coverage transitions. CMS supported state efforts to prepare for the end of the continuous enrollment condition by providing guidance to address numerous challenges, such as how to distribute and conduct renewals consistent with federal requirements, manage the increased volume of renewals, and coordinate resources with the Marketplaces to support transitions in coverage.[59,60]

In addition, the Biden-Harris Administration provided states with strategies to streamline renewals and to help eligible people renew their coverage. CMS has approved nearly 400 uses of these strategies (also called section 1902(e)(14)(A) waivers) across nearly all states.[61] CMS also engaged with states to improve their systems and increase *ex parte* renewal rates nationally from an average of 25 percent in April 2023 to 45 percent in March 2024. CMS is reviewing all section 1902(e)(14)(A) waiver strategies to determine which can be implemented on a longstanding basis and has already made three of these strategies available without a waiver when the Eligibility and Enrollment Final Rule published in March becomes effective in June 2024.

In addition to Medicaid and CHIP renewals, coverage transitions have been important during Medicaid unwinding to people maintaining coverage. As noted above, CMS established and extended an SEP for individuals losing Medicaid or CHIP during the unwinding period to facilitate transitions to the Marketplace. Although complete data on other types of coverage, most notably ESI, are not yet available, several studies have used data from prior to the PHE to project enrollment patterns after the continuous enrollment condition ended.[62,63,64,65] While the exact estimates varied, all studies projected that the majority of people who left Medicaid would transition to employer-sponsored insurance or some other source of coverage.

Like the Obama-Biden Administration, the Biden-Harris Administration has also sought to make improvements to the coverage that Medicaid and CHIP provides, including through the regulatory actions described above. This includes providing 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, the mandatory entitlement to comprehensive benefits for children, as well as other Medicaid and CHIP authorities.[66] This guidance highlights strategies to improve prevention and early identification of health conditions; increase access to treatment across the continuum of care; expand provider capacity; and increase integration of behavioral health and primary care. In addition, as required by the Bipartisan Safer Communities Act, CMS released new guidance on delivering Medicaid services in school-based settings, which seeks to increase access to care by making it easier for schools to deliver and receive payment for health care services furnished to children enrolled in Medicaid and CHIP.[67] School-based services have been associated with improved health and educational outcomes, including improvements in vaccination rates, use of preventive services, asthma morbidity, emergency department use, grade point average, grade promotion, suspension, and non-completion rates, among others.[68,69]

The *Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality* final rule, released in April 2024, helps to improve the quality of care for Medicaid beneficiaries enrolled in managed care plans by strengthening standards for timely access to care and states' monitoring and enforcement efforts; enhancing equality and fiscal program integrity standards for state directed payments; providing clarity on how in lieu of services and settings can be used to better address health-related social needs; further specifying medical loss ratio requirements; and establishing a quality rating system for Medicaid and CHIP managed care plans.[70] In addition, the *Ensuring Access to Medicaid Services* final rule, also released in April 2024, advances access to care and quality of care for Medicaid beneficiaries by increasing transparency and accountability, standardizing data and monitoring, and creating opportunities for states to actively engage beneficiaries in their Medicaid programs.[71]

The Biden-Harris Administration has taken additional steps to improve the quality of private health insurance. Since 2021, the Administration has worked to implement the surprise billing protections authorized under the No Surprises Act. Industry data shows that in the first nine months of implementation, these surprise billing protections prevented one million surprise medical bills per month.[72] The Administration has implemented requirements that insurers provide continuity of care at in-network prices following termination of network agreements, maintain accurate provider directories and bear financial responsibility for inaccuracies, and publish price information and make price calculator tools available to enrollees.[73] The Administration has also taken steps to ensure Americans have access to quality health care by limiting the availability of short-term limited duration insurance and association health plans, which do not comply with the ACA's critical consumer protections, including guaranteeing coverage for people with pre-existing conditions and prohibiting discrimination based on health status, age, or gender.[74]

RESEARCH ON THE BENEFITS OF HEALTH INSURANCE

The design of the ACA was informed by a large academic literature on the economics of health care and health insurance, including numerous studies showing that insurance coverage leads to better access to and utilization of care.[75,76] The ACA coverage expansions, in turn, have fueled a dramatic growth of studies that have contributed to our understanding of the effects of health insurance on both health outcomes and other outcomes related to individual and societal well-being. [77] This research finds effects of health insurance coverage on improved access to care, increased utilization of preventive care, better health outcomes, financial benefits, and reduced income inequality.

The impacts of increased health insurance coverage on access were quickly evident following the implementation of the ACA's key coverage provisions. Studies documented improvements in rates of self-reported access, including having a primary care physician, having easy access to medicine, ability to afford care, and the percentage of days with activities limited by health.[78,79] Measures of access and affordability, such as having a routine checkup and fewer problems accessing care, improved for adults at all income levels and regardless of state expansion status, though some impacts, such as reductions in problems paying family medical bills, unmet needs for care because of cost, and not having a usual source of care, were more pronounced for lower income groups[80] As disparities in health insurance coverage related to race and ethnicity decreased, so too did disparities in access to care.[18,19,21]

Importantly, because of the role Medicaid expansion played in increasing access to coverage, as compared to non-expansion states, Medicaid expansion states saw larger increases in the number of low-income adults reporting a usual source of care, an increase in visits to a health professional, an increase in preventive visit and use of recommended preventive services, a decrease in problems paying medical bills, and reduced difficulty in accessing medication.[78] Medicaid expansion has also been associated with a 20 percent reduction among adults foregoing mental health care or counseling due to cost.[81]

Increases in coverage and access leads to increased utilization of care and improved health outcomes. Since the enactment of the ACA, studies have found increased use of cancer screening, HPV vaccination completion rates, influenza vaccinations, Medicare wellness visits, contraception usage, and blood pressure and cholesterol screenings.[82] Studies have also shown increased utilization of prescription drug treatments, with individuals who gained insurance coverage through Medicaid or private insurance filling more prescriptions and having a lower out-of-pocket spending on prescriptions.[69,83]

Improved access to preventive services leads to more timely and appropriate treatment of both acute and chronic conditions. Studies have linked insurance expansions under the ACA to increases in early-stage cancer diagnosis, which is associated with better cancer outcomes; improved blood pressure and glucose control; and reductions in the probability of pre-term birth.[82,84]

Importantly, several studies find strong evidence that the ACA coverage expansions led to sizeable declines in mortality. One study found that mortality among older adults in Medicaid expansion states fell significantly relative to non-expansion states. [85] The results of that study indicate that if all states had expanded their Medicaid programs, over 15,000 deaths could have been averted between 2014 and 2017. Other research using alternative data and research designs also finds that the ACA Medicaid expansion significantly reduced mortality. [86] There is also evidence that the expansion of private insurance coverage brought about by the ACA saved lives. An innovative study leveraged an intervention by the Internal Revenue Service in which informational letters were sent to some, but not all, households that paid a tax penalty under the ACA due to a lack of health insurance. Taxpayers who received this letter were more likely to purchase health insurance and had a lower mortality rate than otherwise similar individuals who did not receive a letter.[87]

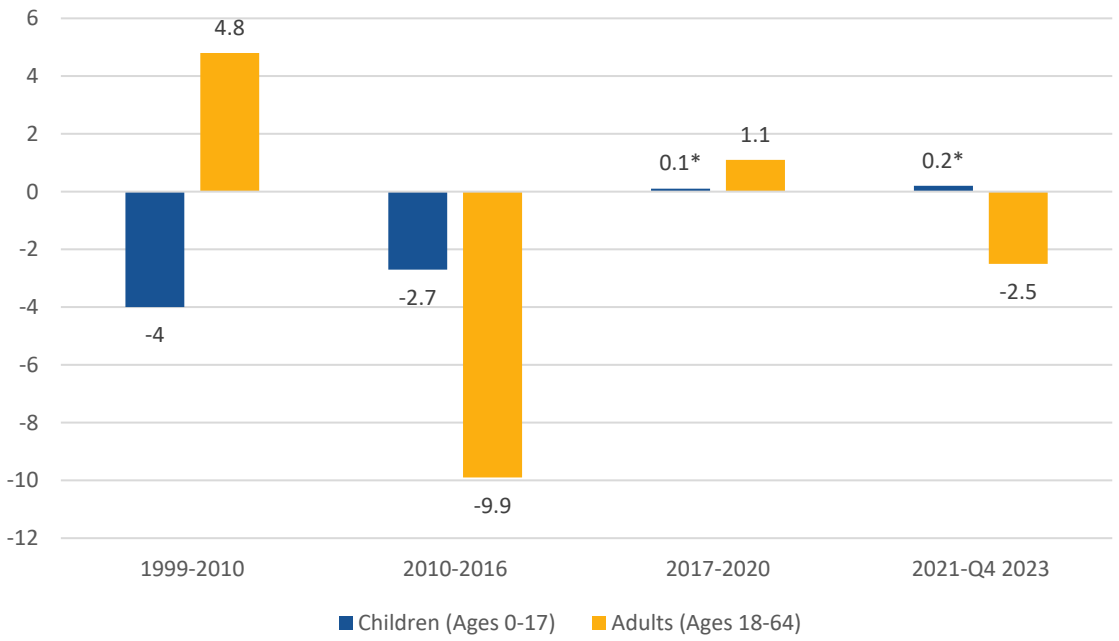
Research on the ACA shows that in addition to these health benefits, health insurance coverage produces substantial financial benefits to both patients and providers.[88] ACA Marketplace subsidies were found to reduce consumer bankruptcies, severe auto delinquency, and third-party collections, while Medicaid expansions were associated with a decrease in medical debt, the number of unpaid bills, the amount of unpaid balances in collections, and the use of payday loans, as well as an increase in financial satisfaction.[8990,91,92,93] Research documents a decline in home evictions in Medicaid expansion states as compared to non-expansion states, despite comparable rates prior to expansion.[94] Further, expansion has been associated with a reduction

in the poverty rate, with one study estimating that nearly 700,000 fewer Americans were living in poverty as a result of Medicaid expansion.[95]

In 2012, just prior to the ACA coverage expansions, hospitals in the U.S. provided over $46 billion in uncompensated care.[96] After 2014, hospital uncompensated care expenditures fell significantly in Medicaid expansion states, though not in non-expansion states. [97,98] The reduction in uncompensated care and improvements in hospital financial performance was greater in states where the ACA Medicaid expansion had larger effects on Medicaid eligibility. [99] The ACA Medicaid expansion was associated with lower rates of hospital closure, especially in rural areas and areas with high rates of uninsurance prior to the ACA.[100]

Although it is too soon to evaluate the most recent coverage and affordability expansions, this literature suggests that they too will provide meaningful benefits. This is further supported by recent research on the impact of continuous coverage during the COVID-19 PHE. A study looking at postpartum continuity of coverage during the Medicaid continuous enrollment condition found an increase in continuity of coverage and suggests that states that extend postpartum coverage are likely to see gains in continuity of coverage as well.[101] A separate study also found that in Colorado, extended Medicaid postpartum coverage was associated with lower out-of-pocket spending and increased treatment for perinatal mood and anxiety disorders.[102] Similarly, research on states newly adopting continuous Medicaid coverage for children during the pandemic found that compared to states with previous continuous eligibility policies, such states had a 4.6 percent relative increase in Medicaid participation for children.[103]

Figure 8. Percentage Point Change in the Uninsured Rate by Period



Source: NCHS, Health Insurance Coverage: Estimates from the National Health Interview Survey, https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm
*Changes were not statistically significant.

LOOKING FORWARD

In the first decade of the twenty-first century, the rising cost of health care led to a gradual, but steady, decline in private health insurance coverage. While children were able to maintain health coverage through Medicaid and CHIP, for non-elderly adults, this decline in private insurance led to an increase in uninsurance (Figure 8). Since 2010, the impact of policy changes that have supported or weakened access to health coverage can be clearly seen in changes to the uninsured rate. The uninsured rate fell dramatically immediately after the main coverage provisions of the ACA went into effect and continued to decline, albeit more gradually, through the end of the Obama Administration as more states adopted the ACA Medicaid expansion and the ACA Marketplaces became more firmly established. By 2016, the uninsured rate for nonelderly adults was roughly 10 percentage points lower than in 2010 and the rate for children was nearly 3 points lower. Although the Trump Administration did not succeed at repealing the ACA, through several policies it made the law less effective. Between 2017 and 2020, the uninsured rate for nonelderly adults increased by roughly one percentage point.

The Biden-Harris Administration has built on the ACA's foundation of expanded access to and quality of health insurance coverage through actions that continue to increase and improve coverage. Legislative and administrative actions have made coverage through the ACA Marketplaces more affordable and more accessible. These actions helped to increase Marketplace coverage and Medicaid enrollment between 2021 and 2023, which has resulted in a decrease in the uninsured rate of roughly 2 percentage points for nonelderly adults while there was no statistically significant change in percent of children without insurance.

Going forward, federal and state policies will continue to fundamentally shape the insurance coverage of non-elderly Americans. Medicaid enrollment remains higher than it was before the pandemic with about 12 million more people enrolled in March 2024 as compared to February 2020. As states return to normal Medicaid renewal operations and enrollment settles at a post-PHE equilibrium, the effect on coverage will depend on the extent to which individuals who are no longer eligible for Medicaid are able to transition to other forms of coverage. Data on Marketplace enrollment both during and outside the annual Open Enrollment period suggests that a significant number of individuals leaving Medicaid have obtained Marketplace coverage. The enhancements to Marketplace APTC enacted by the ARP and extended by the IRA through 2025 ensure that Marketplace coverage is affordable to individuals who are ineligible for Medicaid but do not have access to affordable employer-sponsored insurance. If these enhanced subsidies are allowed to expire, the Congressional Budget Office projects that Marketplace coverage will decline by roughly one-quarter.[63]

Overall, coverage will also depend on the ability of individuals who are eligible for Medicaid to obtain and retain that coverage. CMS has approved nearly 400 waivers that allow states to improve renewal systems and processes. Together, changes initiated by these waivers, administrative simplifications brought about by the final Enrollment and Eligibility rule and the 12-month continuous eligibility extensions for children and postpartum coverage have the potential to increase insurance coverage by reducing churn. Children experiencing churn are more likely to have decreased utilization and negative health outcomes, including increased risk of unmet health needs, delayed and decreased care, lower vaccination coverage, unfilled prescriptions, and increased asthma exacerbations, while stable health coverage in the postpartum period can improve maternal health outcomes.[104,105,106]

The insurance coverage of low-income Americans could be increased further if every state implemented the ACA Medicaid expansion. It is estimated that if the 10 states that have not yet expanded did so, 2.3 million people would gain access to coverage.[107] As with earlier expansions, the coverage gains would be greater for Blacks and Latinos, causing coverage disparities to decrease even more. As noted above, the evidence developed over the past decade and more show that coverage gains will translate to improved health and

financial well-being for millions of Americans, providing benefits to those who are newly covered, as well as broader financial and societal benefits. Thus, efforts to extend health insurance coverage to the uninsured and maintain coverage for those already insured will not only impact the health and well-being of these individuals but will also have greater benefits beyond these direct impacts.

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