DATA BRIEF
JANUARY 2020

How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care

Jesse C. Baumgartner
Research Associate
The Commonwealth Fund

Sara R. Collins
Vice President
The Commonwealth Fund

David C. Radley
Senior Scientist
The Commonwealth Fund

Susan L. Hayes
Former Senior Researcher
The Commonwealth Fund

The insurance coverage expansion ushered in by the Affordable Care Act (ACA) has significantly increased Americans' ability to get the health care they need since the law's main provisions went into effect in 2014. Research also indicates that the ACA narrowed racial and ethnic disparities in insurance coverage[1] — a key objective of the law, and one that enjoys substantial public support.[2]

In this brief, we examine how much the ACA also has reduced disparities in access to health care among black, Hispanic, and white adults. Using data from the federal American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) for the years 2013 to 2018, we review:

- differences in the share of black, Hispanic, and white adults who are uninsured (ages 19 to 64)
- differences in the share who went without care because of cost in the past 12 months (ages 18 to 64)
- differences in the share with a usual source of care (ages 18 to 64).

We examine the degree to which racial and ethnic differences have narrowed since the ACA went into effect, what differences exist between states that have expanded Medicaid and those that have not, and which policy options might further reduce disparities.

We hope these findings will help guide policymakers as they consider options for moving the nation closer to a more equitable, higher-performing health care system.

KEY HIGHLIGHTS

- The ACA's coverage expansions have led to historic reductions in racial disparities in access to health care since 2013, but progress has stalled and, in some cases, eroded since 2016.
- The gap between black and white adult uninsured rates dropped by 4.1 percentage points, while the difference between Hispanic and white uninsured rates fell 9.4 points.

The Commonwealth Fund

- Disparities narrowed in both states that expanded Medicaid eligibility and in those that did not. In expansion states, all three groups had better overall access to care than they did in nonexpansion states, and there were generally smaller differences between whites and the two minority groups.
- Five years after the ACA's implementation, black adults living in states that expanded Medicaid report coverage rates and access to care measures as good as or better than what white adults in nonexpansion states report.
- While black working-age adults have benefited significantly from Medicaid expansion, they disproportionately (46%) reside in the 15 states that haven't yet expanded their programs.

HOW WE CONDUCTED THIS STUDY

Indicators and Data Sources

- *Percent of uninsured adults ages 19–64:* U.S. Census Bureau, American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.
- *Percent of adults ages 18–64 who went without care because of cost during past year and Percent of adults ages 18–64 who had a usual source of care:* Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.
- *Demographics, adults ages 19–64:* American Community Survey Public Use Microdata Sample (ACS PUMS), 2018.

The ACS PUMS and BRFSS are large federal surveys used to track demographic and health characteristics of the U.S. population. The ACS samples approximately 3.5 million individuals each year, with annual response rates over 90 percent.[3] The Census Bureau makes approximately two-thirds of ACS response records available to researchers in the Public Use Microdata Sample. The Centers for Disease Control and Prevention conduct the BRFSS each year in partnership with implementing agencies in each state. The 2018 BRFSS had a response rate just under 50 percent, with approximately 437,500 completed responses; similar response rates were seen in previous years.[4]

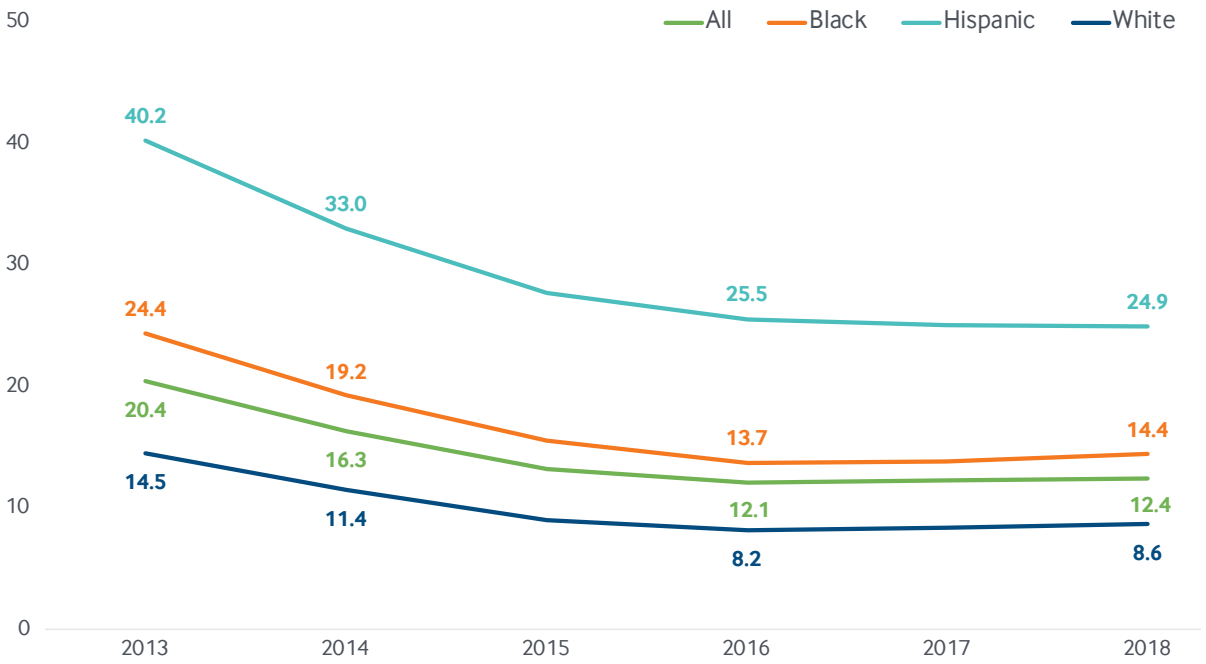
Analytical Approach

We stratified survey respondents by their self-reported race or ethnicity: white (non-Hispanic), black (non-Hispanic), or Hispanic (any race). We calculated national annual averages from 2013 to 2018 for each of the indicators listed above, stratified by race/ethnicity. We also calculated the average annual rate for white, black, and Hispanic individuals from 2013 to 2018 across two categories of states: the Medicaid expansion group included the 31 states that, along with the District of Columbia, had expanded their Medicaid programs under the ACA as of January 1, 2018; the nonexpansion group comprised the 19 states that had not expanded Medicaid as of that time (Maine and Virginia are considered nonexpansion states in this analysis because they both implemented their Medicaid expansions in 2019). Reported values for expansion/nonexpansion categories are averages across survey respondents, not averages of state rates.

In addition, for certain subpopulations in Louisiana and Georgia we calculated average annual state-specific uninsured rates from 2013 to 2018. Subpopulation rates based on small samples were suppressed. Estimates derived from ACS PUMS were suppressed if unweighted cell counts were less than 50; estimates derived from BRFSS were suppressed if the measures' unweighted cell count was less than 50 or the relative standard error (standard error divided by the estimate) was under 30 percent.

Adult uninsured rates have decreased for all groups since 2013, and disparities have narrowed significantly among whites, blacks, and Hispanics.

Percentage of uninsured adults ages 19 to 64, by race and ethnicity



Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

FINDINGS

Black, Hispanic, and white adults have all made historic insurance coverage gains under the ACA (Table 2).[5] According to the U.S. Census Bureau's American Community Survey, the U.S. working-age adult uninsured rate fell from 20.4 percent in 2013, just before the law's main provisions took effect, to 12.4 percent in 2018.[6] This improvement occurred between 2013 and 2016; since then, the rate has risen slightly.

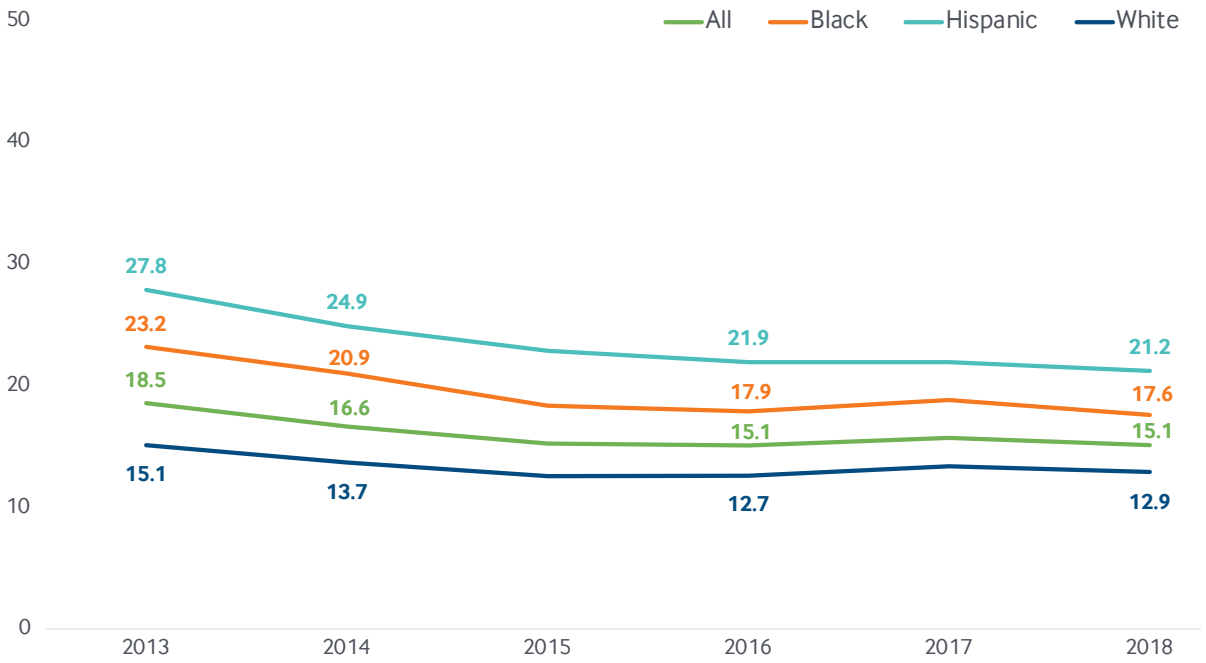
Blacks and Hispanics had the highest uninsured rates prior to the law's passage and have made the largest gains. The uninsured rate for black adults dropped from 24.4 percent in 2013 to 14.4 percent in 2018, while the rate for Hispanic adults decreased from 40.2 percent to 24.9 percent.

This progress reduced the difference between the two groups and white adults (Table 3). The black–white disparity in coverage dropped from 9.9 percentage points in 2013 to 5.8 points in 2018. The gap between uninsured Hispanics and whites, meanwhile, declined from 25.7 points to 16.3 points.

But the insurance gains made by blacks and Hispanics have stalled, and even eroded, since 2016 — much as they have for the overall population. Black adults have seen their uninsured rate tick up by 0.7 percentage points since 2016, while white adults have seen a half-percentage-point increase. This has largely halted the improvement in coverage disparities. Hispanic adults continue to report significantly higher uninsured rates than either white or black adults.

All groups are experiencing fewer financial barriers to accessing care, with black and Hispanic adults showing the largest reduction.

Percentage of adults ages 18 to 64 who avoided care because of cost in the past 12 months, by race and ethnicity



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

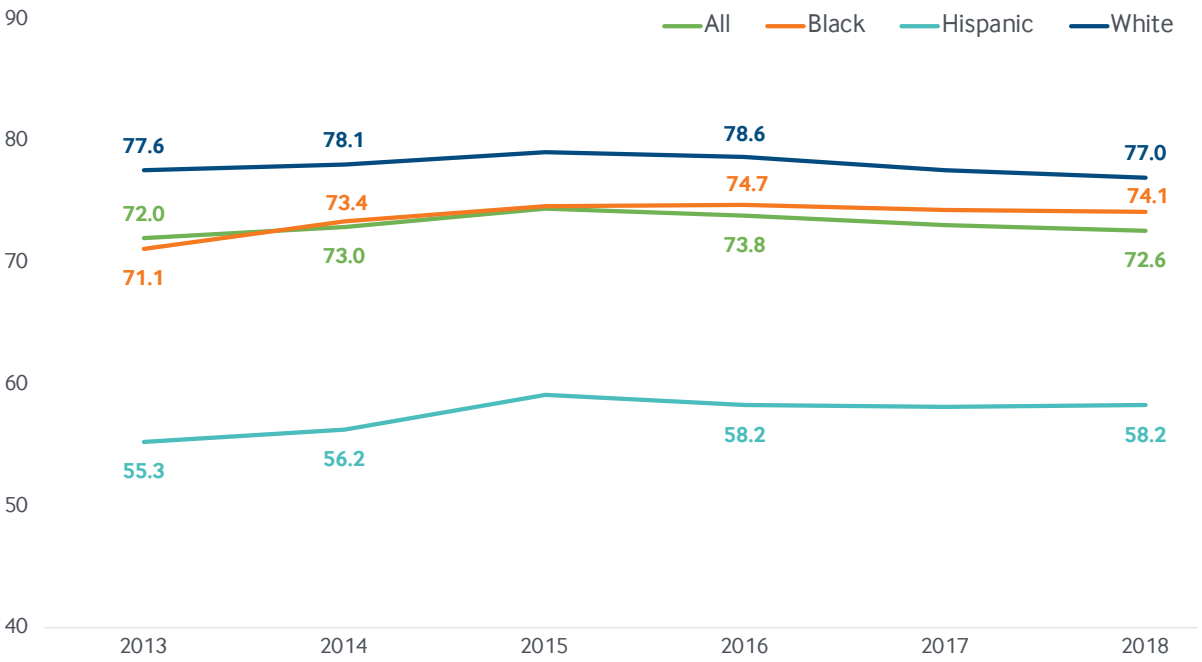
The coverage gains under the ACA made it easier for people to get health care.[7] Adults with low income have benefited the most from the law's insurance subsidies, out-of-pocket cost protections, and expansion in Medicaid eligibility.[8]

Black and Hispanic adults are almost twice as likely as white adults to have low income (less than 200% of the federal poverty level, or FPL) (Table 1) and, prior to 2013, they reported significantly higher rates of cost-related problems getting care. After the ACA's major coverage expansions in 2014, they experienced the largest overall improvements in access (Table 4). Twenty-three percent of black adults reported avoiding care because of cost in 2013, compared to 17.6 percent in 2018. Cost-related access problems among Hispanic adults fell from 27.8 percent to 21.2 percent, while those reported by whites dropped from 15.1 percent to 12.9 percent.

As a result, differences narrowed between white adults and black and Hispanic adults in cost-related access problems. The black–white disparity shrank from 8.1 percentage points in 2013 to 4.7 points in 2018, while the Hispanic–white difference fell from 12.7 points to 8.3 points (Table 3). Again, most of that improvement occurred between 2013 and 2016.

Adults with a usual source of care have modestly increased for black and Hispanic groups since 2013.

Percentage of adults ages 18 to 64 who reported a usual source of care, by race and ethnicity



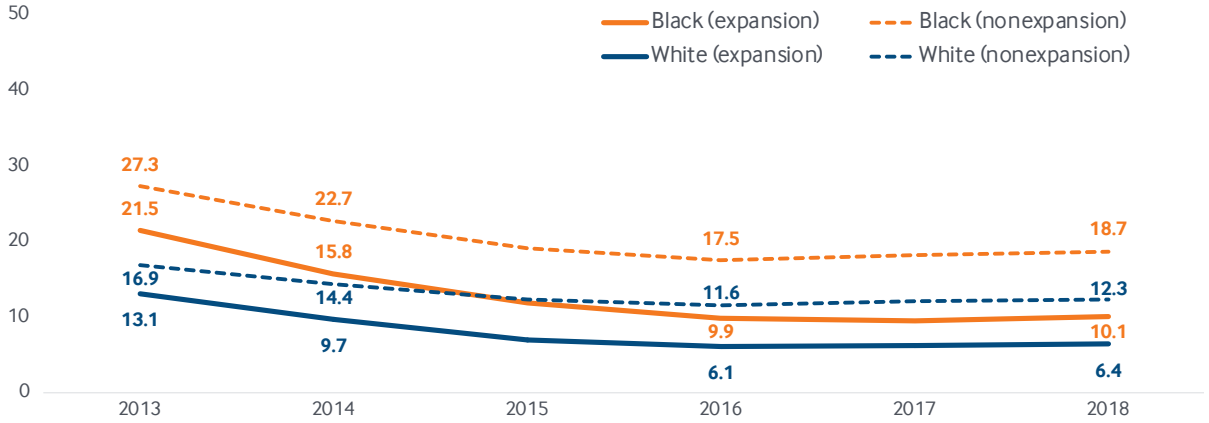
Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

Having a usual source of care — defined as a personal doctor or other health care provider like a health clinic where someone would usually go if they were sick — is generally seen as a strong indicator of health care access.[9] The share of black and Hispanic adults with a usual source of care climbed by about three percentage points between 2013 and 2018 (Table 4). This modestly reduced disparities with white adults, who continue to be the most likely to have a usual source of care among the three groups (Table 3).

The black–white disparity for reporting a usual source of care decreased from 6.5 percentage points in 2013 to 2.8 points in 2018, and the difference between Hispanics and whites dropped from 22.4 points to 18.7 points. The improvement on this measure stalled for blacks and Hispanics after 2015.

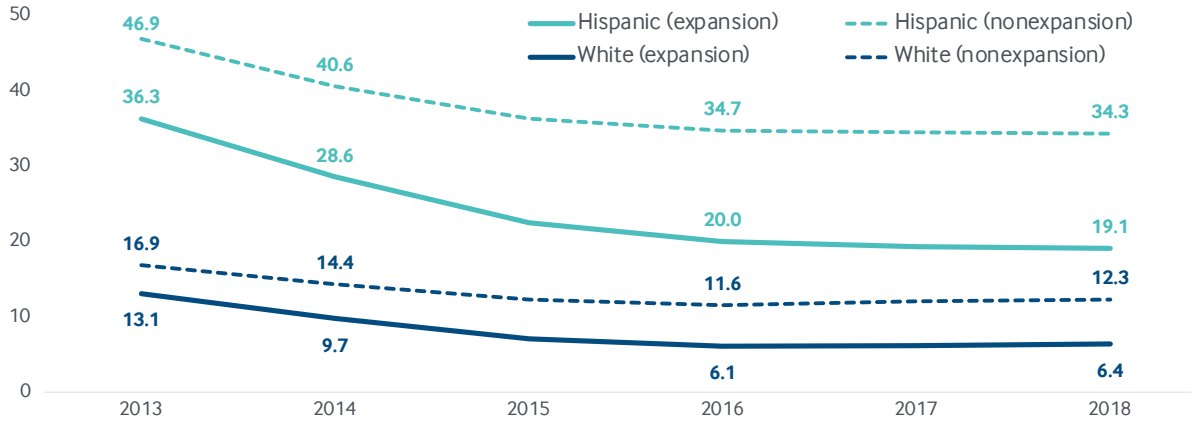
Black adults living in expansion states are now less likely to be uninsured than white adults in nonexpansion states.

Percentage of uninsured adults ages 19 to 64, race and ethnicity by Medicaid expansion status



Although Hispanic adults in both groups of states reported lower uninsured rates and reduced disparities, the gains were larger in Medicaid expansion states.

Percentage of uninsured adults ages 19 to 64, race and ethnicity by Medicaid expansion status



Note: Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

The ACA offered states the opportunity to expand eligibility for Medicaid, with the federal government picking up most of the additional cost. We examined all three of our health insurance and access measures for individuals across two categories of states — those that had expanded their Medicaid program under the ACA as of January 1, 2018, and those that had not. The 31 states that, along with the District of Columbia, had expanded their programs typically started from a stronger baseline and had smaller initial racial and ethnic disparities. This was likely because of state-specific factors, such as more generous pre-ACA Medicaid eligibility standards.[10]

Uninsured rates for blacks, Hispanics, and whites declined in both expansion and nonexpansion states between 2013 and 2018. In addition, disparities in coverage between whites and blacks and Hispanics also narrowed over that time period in both sets of states. But progress has stalled and even slightly eroded (Table 2, Table 3).

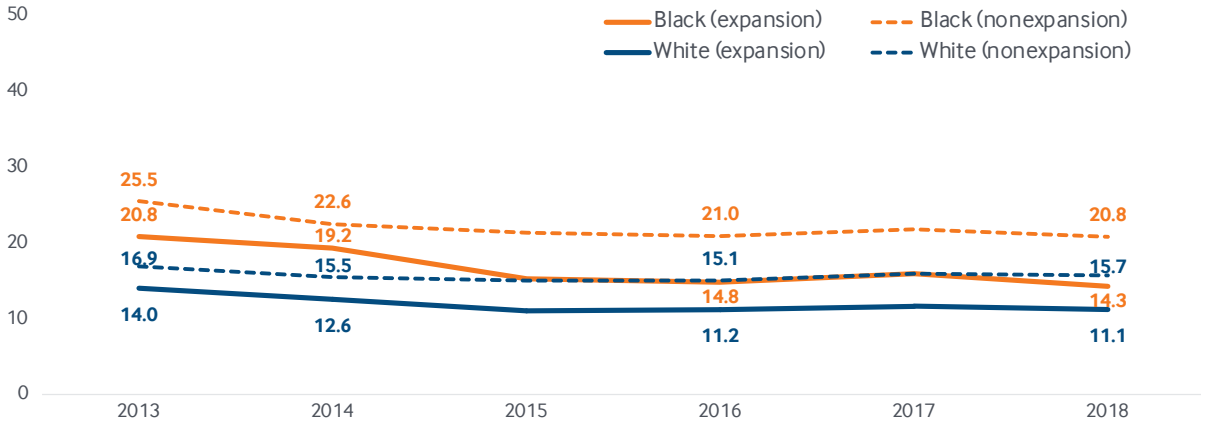
People living in Medicaid expansion states benefited the most in terms of coverage gains. All three groups reported lower uninsured rates in expansion states compared to nonexpansion states, and larger coverage improvements between 2013 and 2018.

Coverage disparities in expansion states narrowed the most over the period, even though the disparities were smaller to begin with. The black–white coverage gap in those states dropped from 8.4 percentage points to 3.7 points, while the difference between Hispanic and white uninsured rates fell from 23.2 points to 12.7 points.

Because of this progress, blacks in expansion states are now more likely to be insured than whites in nonexpansion states.

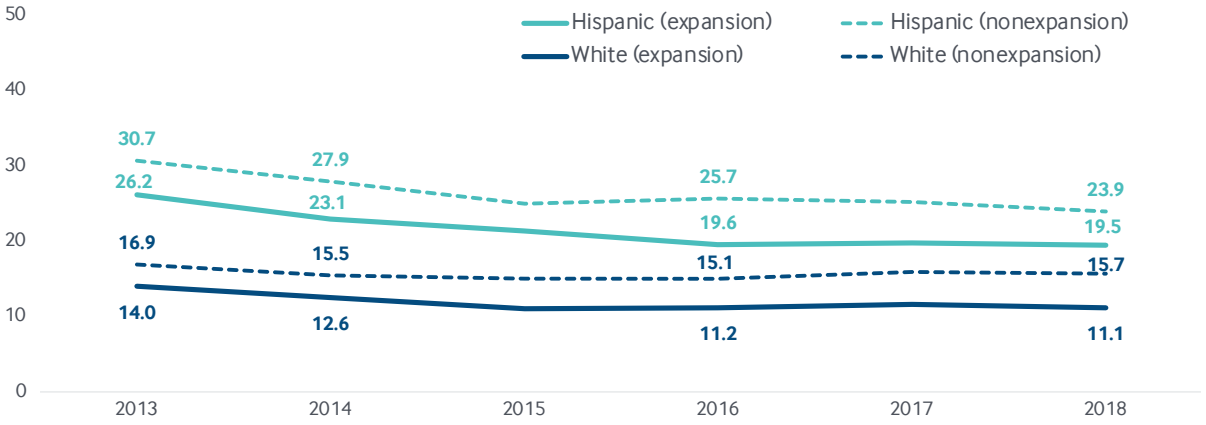
Black–white differences in cost-related access problems have narrowed in both expansion and nonexpansion states.

Percentage of adults ages 18 to 64 who avoided care because of cost in the past 12 months, race and ethnicity by Medicaid expansion status



The Hispanic–white disparity for avoiding care because of cost has dropped significantly in both expansion and nonexpansion states.

Percentage of adults ages 18 to 64 who avoided care because of cost in the past 12 months, race and ethnicity by Medicaid expansion status



Note: Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

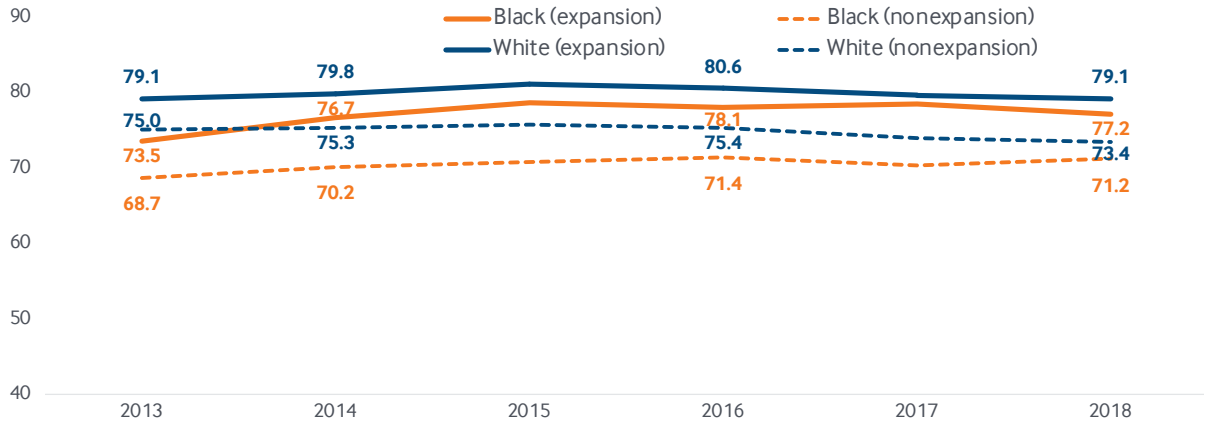
Since 2013, Hispanics, blacks, and whites in both expansion and nonexpansion states have become increasingly less likely to report that they went without health care because of cost in the past 12 months (Table 4). Disparities also have narrowed, resulting in more equitable access to care (Table 3).

Black adults in Medicaid expansion states experienced a larger reduction in cost-related access problems (6.6 percentage points) than those in nonexpansion states (4.7 points). Blacks in expansion states now report cost-related access problems at about the same rates as whites in nonexpansion states (Table 4).[11]

The gap between Hispanic and white adults reporting cost-related access problems narrowed in both expansion states (from 12.1 percentage points to 8.3 points) and nonexpansion states (from 13.8 points to 8.3 points). The larger decline in disparities in nonexpansion states was mainly because of a smaller improvement for whites in those states.

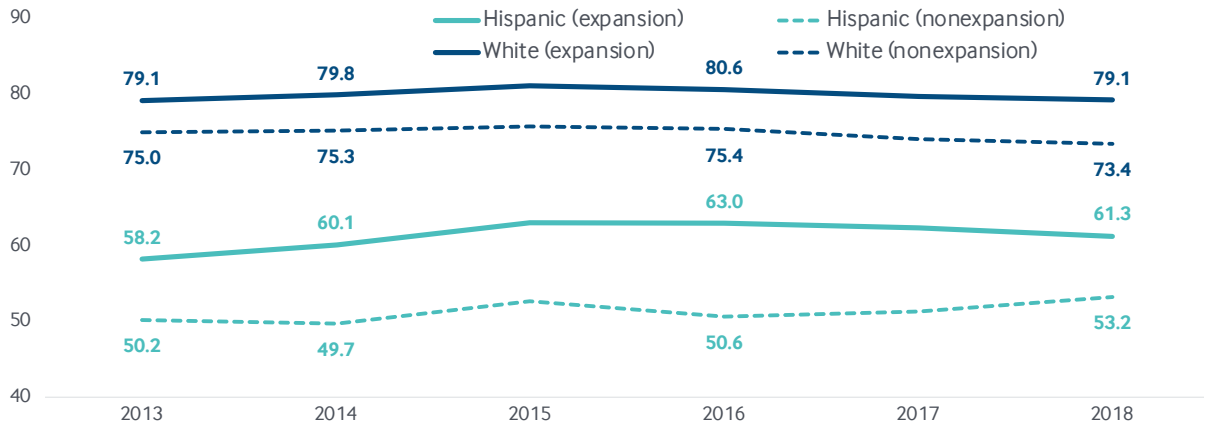
Black adults in expansion states are now almost as likely as white adults in those same states to have a usual source of care.

Percentage of adults ages 18 to 64 who reported a usual source of care, race and ethnicity by Medicaid expansion status



Hispanics in both expansion and nonexpansion states reported modestly higher rates for a usual source of care, while white adults largely maintained their higher rates.

Percentage of adults ages 18 to 64 who reported a usual source of care, race and ethnicity by Medicaid expansion status



Note: Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

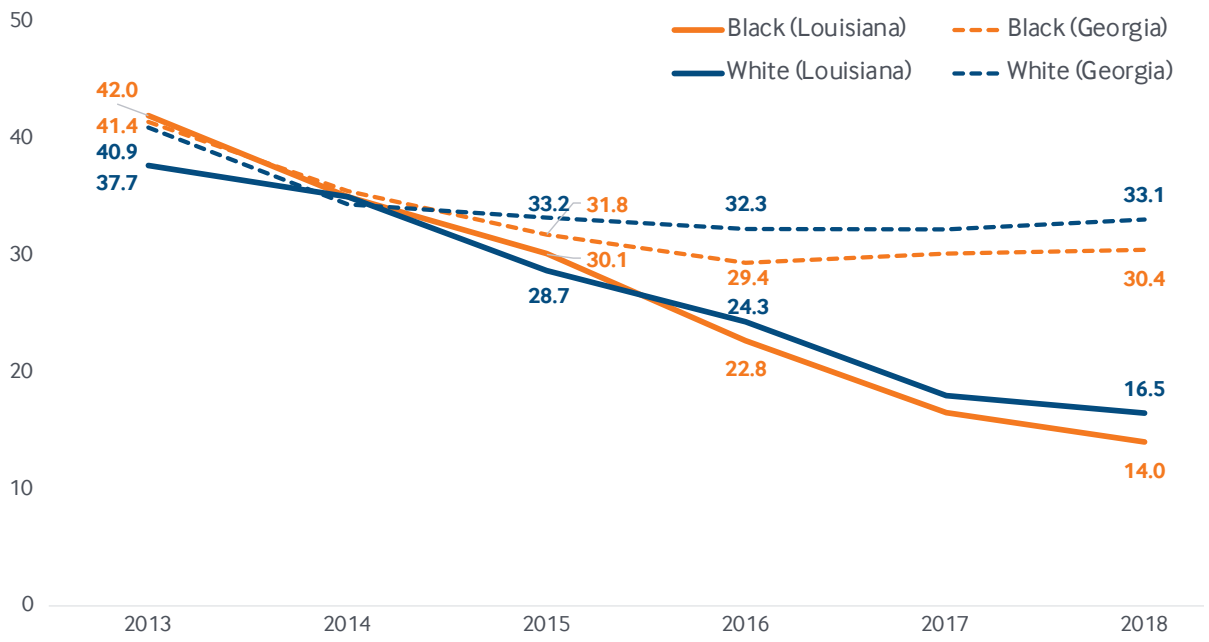
Regardless of whether they lived in a Medicaid expansion state or not, white adults did not report improvement in having a usual source of care between 2013 and 2018. Whites began the period at a comparatively higher baseline than blacks and Hispanics.

In contrast, blacks and Hispanics reported modest improvement in having a usual source of care, in both expansion and nonexpansion states (Table 4).[12] Black adults in expansion states improved the most, with 73.5 percent reporting a usual care provider in 2013 versus 77.2 percent in 2018. They are now more likely than white adults in nonexpansion states to have a usual source of care, and almost as likely as white adults in expansion states.

The gap between blacks and whites in having a usual source of care decreased in Medicaid expansion states (to 1.9 percentage points) and nonexpansion states (to 2.3 points). The difference between Hispanics and whites in expansion states dropped to 17.8 points, while in nonexpansion states it decreased to 20.2 points. Disparities actually decreased more in nonexpansion states, mainly because white adults in those states became slightly less likely to have a usual source of care during the 2013–2018 period (Table 3).

After expanding Medicaid, Louisiana's black–white insurance coverage disparity dropped rapidly in comparison to Georgia — driven largely by lower-income adults.

Percentage of uninsured adults ages 19 to 64, Louisiana and Georgia, 0–199% FPL, by race and ethnicity



Note: FPL = federal poverty level.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

Expanded Medicaid eligibility has been an important tool for improving racial equity in coverage and access to care. This is because blacks and Hispanics are disproportionately lower income.[13] But an estimated 46 percent of black working-age adults live in the 15 states that have not expanded Medicaid — a much larger share of people than the national average — along with 36 percent of Hispanics.[14] The majority of Medicaid nonexpansion states are in the South.

To illustrate the potential effects of further Medicaid expansion, we analyzed two Southern states with large black adult populations. Louisiana chose to expand Medicaid in 2016, while Georgia has yet to do so. As the exhibit shows, white and black adults with incomes under 200 percent of the federal poverty level (which is $24,980 for an individual and $51,500 for a family of four in 2020) experienced coverage gains from 2013 to 2015 in both states. But after Louisiana expanded Medicaid in July 2016, uninsured rates for both groups dropped an additional 12.2 points to 16.0 points. Georgia's uninsured rates, meanwhile, did not improve after 2016 (Table 5).

Because an estimated 54 percent of black working-age adults in Louisiana have low incomes (Table 1), Medicaid expansion helped drive the state's overall black adult uninsured rate down to 11.3 percent in 2018 (Table 5). This was lower than the rate for black adults (19.2%) and white adults (14.9%) in Georgia.

CONCLUSION

The ACA's coverage expansions have led to nationwide improvements in coverage and access to care. As our analysis and other recent studies show, the law also has led to historic reductions in racial disparities in coverage and access since 2014. This is true across most states, and especially those that have expanded Medicaid.

Still, nearly 10 years after the law's passage, notable gaps between people of color and whites remain across all regions and income levels.

Progress has also stalled for all three groups since 2016, and insurance coverage has slightly eroded for both black and white adults. That can be linked in part to congressional inaction: there has been no federal legislation since 2010 to enhance or reinforce the ACA. At the same time, recent legislation and executive actions have negatively affected Americans' coverage and access to care, including: the repeal of the individual mandate penalty for not having health insurance; substantial reductions in funding for outreach and enrollment assistance for people who may be eligible for marketplace or Medicaid coverage; and the loosening of restrictions on health plans that don't comply with the ACA's rules.

Hispanic adults also experience much larger disparities, in part because undocumented immigrants can't qualify for marketplace coverage, receive subsidies, or enroll in Medicaid.[15] These disparities could be exacerbated by the Trump administration's new "public charge" rule.[16]

Nevertheless, state and federal policymakers can take actions in the near term to further reduce the racial differences in health care access that persist:

- **Expand Medicaid without restriction in the remaining 15 states.** Medicaid expansion is a proven tool for reducing racial disparities, one that our data show benefits blacks and Hispanics the most. Yet expanded Medicaid eligibility is not available to nearly half of black adults and more than a third of Hispanics, causing an inordinately negative impact on these communities of color. If more states don't choose to expand Medicaid, further reductions in racial disparities may be difficult to attain.

  Our findings on the positive effects of expanding Medicaid also offer a window into the potential impact that current congressional reform bills and proposals could have on disparities. That includes not only "Medicare for all" approaches, but also reforms that seek to eliminate the Medicaid expansion gap and realize the ACA's original intent.[17] Alternatively, Republican proposals to end Medicaid expansion altogether would likely reverse the ACA's historic improvements in racial disparities in health care access.[18]

- **Make marketplace subsidies available to people with incomes under 100 percent of the poverty level or otherwise fill the Medicaid coverage gap.** With significantly lower incomes, black and Hispanic adults in nonexpansion states are at high risk of falling into a coverage gap in which their income is too high for existing Medicaid but not high enough to qualify for marketplace premium subsidies (100%–400% of poverty).[19]

- **Remove the income cap on marketplace subsidy eligibility.** Premium contributions for marketplace plans are capped at a certain percentage of income for people between 100 percent and 400 percent of poverty, with a maximum of 9.78 percent of income. Removing the upper income limit would provide relief to people who are currently spending more than this maximum share of their earnings on health insurance.[20]

- **Enact targeted, state-specific Medicaid expansions beyond the ACA.** For example, California recently expanded its Medicaid program to cover undocumented young adults.[21]

- **Allow undocumented immigrants to shop for coverage in the marketplaces.** This group is currently ineligible for coverage through the ACA insurance exchanges.

All the policies presented here can help make the U.S. health care system more equitable. But they will need to be accompanied by efforts to address drivers of racial inequities in health that extend beyond access to health insurance. Those include inequities in educational opportunity and income[22] and the fact that people of color are often perceived and treated differently by health care providers.[23] A recent survey of Americans' values with regard to health care shows that a majority do not believe that everyone in the U.S. receives equal treatment within the health system.[24] And an overwhelming majority believe that everyone should.

Table 1. U.S. Demographic Estimates, 2018 (base: adults ages 19–64)

	United States		Expansion states		Nonexpansion states		Louisiana		Georgia	
	Total (millions)	%	Total (millions)	%	Total (millions)	%	Total (thousands)	%	Total (thousands)	%
Total	193	100.0%	119	100.0%	74	100.0%	2,695	100.0%	6,245	100.0%
Race/Ethnicity										
White	116	60.1%	72	60.6%	44	59.1%	1,599	59.3%	3,257	52.2%
Black	24	12.5%	12	10.1%	12	16.3%	854	31.7%	1,993	31.9%
Hispanic	35	18.1%	22	18.2%	13	18.0%	134	5.0%	573	9.2%
Income										
0–199% FPL	53	27.5%	31	26.2%	22	29.6%	981	36.6%	1,823	29.5%
200%–399% FPL	56	29.2%	33	27.9%	23	31.2%	737	27.5%	1,855	30.0%
400%+ FPL	83	43.3%	54	45.9%	29	39.2%	959	35.8%	2,498	40.4%
Race/Ethnicity, by income										
White										
0–199% FPL	25	21.7%	15	20.8%	10	23.3%	423	26.6%	743	23.0%
200%–399% FPL	32	27.5%	19	26.2%	13	29.7%	445	28.0%	903	28.0%
400%+ FPL	58	50.8%	38	53.1%	20	47.0%	721	45.4%	1,581	49.0%
Black										
0–199% FPL	9	39.5%	5	38.7%	5	40.3%	454	53.6%	716	36.4%
200%–399% FPL	8	31.6%	4	29.7%	4	33.5%	223	26.4%	644	32.8%
400%+ FPL	7	28.9%	4	31.6%	3	26.1%	170	20.1%	607	30.9%
Hispanic										
0–199% FPL	14	38.9%	8	37.8%	5	40.6%	61	46.3%	249	43.8%
200%–399% FPL	12	34.7%	7	34.5%	5	35.0%	38	28.4%	194	34.2%
400%+ FPL	9	26.4%	6	27.7%	3	24.4%	33	25.2%	125	22.1%

NOTES

Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

FPL = federal poverty level.

DATA

American Community Survey Public Use Microdata Sample (ACS PUMS), 2018.

Table 2. Uninsured Rates by Demographics, 2013–2018 (base: adults ages 19–64)

	United States					Expansion states					Nonexpansion states				
	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)
Total	20.4	12.1	12.2	12.4	–8.0	18.4	9.2	9.1	9.2	–9.1	23.9	16.8	17.3	17.6	–6.3
Race/Ethnicity															
White	14.5	8.2	8.4	8.6	–5.9	13.1	6.1	6.2	6.4	–6.7	16.9	11.6	12.1	12.3	–4.5
Black	24.4	13.7	13.9	14.4	–9.9	21.5	9.9	9.5	10.1	–11.4	27.3	17.5	18.3	18.7	–8.6
Hispanic	40.2	25.5	25.1	24.9	–15.3	36.3	20.0	19.3	19.1	–17.2	46.9	34.7	34.5	34.3	–12.6
Income															
0–199% FPL	37.9	23.1	23.1	23.2	–14.7	34.6	17.1	16.6	16.6	–18.0	42.8	31.8	32.2	32.4	–10.4
200%–399% FPL	20.0	12.9	13.4	13.9	–6.1	18.9	10.8	10.9	11.3	–7.7	21.7	15.9	16.9	17.7	–4.0
400%+ FPL	6.7	4.1	4.5	4.8	–1.9	6.3	3.4	3.6	3.9	–2.4	7.7	5.4	6.1	6.6	–1.1
Race/Ethnicity, by income															
0–199% FPL															
White	31.2	17.5	17.8	18.0	–13.2	28.7	12.4	12.3	12.5	–16.1	35.0	25.1	25.8	25.9	–9.0
Black	34.4	20.3	20.5	20.8	–13.6	30.1	13.7	13.1	13.6	–16.5	38.5	26.7	27.5	27.7	–10.8
Hispanic	54.0	36.7	36.1	36.0	–18.0	48.5	28.1	27.3	26.9	–21.6	63.0	50.2	49.6	49.6	–13.4
200%–399% FPL															
White	15.3	9.6	10.2	10.6	–4.7	14.5	8.0	8.3	8.5	–6.0	16.5	12.0	12.9	13.5	–3.0
Black	20.5	11.9	12.3	13.3	–7.2	19.3	10.0	9.6	10.3	–9.0	21.6	13.7	14.7	15.9	–5.7
Hispanic	35.5	23.2	23.1	23.7	–11.8	32.7	19.1	18.6	19.1	–13.6	40.4	30.0	30.5	31.0	–9.3
400%+ FPL															
White	5.2	3.1	3.4	3.7	–1.5	4.8	2.6	2.8	3.0	–1.9	6.0	4.2	4.6	5.0	–1.0
Black	10.2	5.6	6.1	7.1	–3.2	9.8	4.7	4.9	5.6	–4.2	10.8	6.8	7.6	8.9	–2.0
Hispanic	15.0	9.5	10.4	10.7	–4.3	13.9	8.0	8.4	8.7	–5.1	17.0	12.1	14.1	14.1	–2.9

NOTES

Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Net change is percentage-point change between 2013 and 2018.

FPL = federal poverty level.

DATA

American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

Table 3. Trends in Black–White and Hispanic–White Disparities in Insurance Coverage and Access, 2013–2018

	Black–White disparity (percentage points)			Hispanic–White disparity (percentage points)		
	2013	2018	Net change (% points)	2013	2018	Net change (% points)
Uninsured rates (base: adults ages 19–64)*						
U.S. average	9.9	5.8	–4.1	25.7	16.3	–9.4
Expansion states	8.4	3.7	–4.7	23.2	12.7	–10.5
Nonexpansion states	10.4	6.4	–4.0	30.0	22.0	–8.0
Care avoided because of cost (base: adults ages 18–64)**						
U.S. average	8.1	4.7	–3.4	12.7	8.3	–4.4
Expansion states	6.8	3.1	–3.7	12.1	8.3	–3.8
Nonexpansion states	8.6	5.2	–3.5	13.8	8.3	–5.5
Usual source of care (base: adults ages 18–64)**						
U.S. average	6.5	2.8	–3.7	22.4	18.7	–3.6
Expansion states	5.6	1.9	–3.7	20.9	17.8	–3.1
Nonexpansion states	6.3	2.3	–4.1	24.8	20.2	–4.6

NOTES

Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

DATA

* American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

** Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

Table 4. Rates for Access Indicators by Race/Ethnicity, 2013–2018 (base: adults ages 18–64)

	United States					Expansion states					Nonexpansion states				
	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)
Care Avoided Because of Cost in Previous 12 Months															
Total	18.5	15.1	15.7	15.1	–3.4	17.0	13.3	13.7	13.2	–3.9	21.0	18.1	18.9	18.2	–2.8
Race/Ethnicity															
White	15.1	12.7	13.3	12.9	–2.2	14.0	11.2	11.6	11.1	–2.9	16.9	15.1	16.0	15.7	–1.3
Black	23.2	17.9	18.8	17.6	–5.6	20.8	14.8	15.9	14.3	–6.6	25.5	21.0	21.7	20.8	–4.7
Hispanic	27.8	21.9	21.9	21.2	–6.7	26.2	19.6	19.7	19.5	–6.7	30.7	25.7	25.3	23.9	–6.7
Usual Source of Care															
Total	72.0	73.8	73.1	72.6	0.6	73.9	76.4	75.7	75.0	1.0	68.9	69.6	68.9	68.8	0.0
Race/Ethnicity															
White	77.6	78.6	77.5	77.0	–0.6	79.1	80.6	79.6	79.1	0.0	75.0	75.4	74.1	73.4	–1.6
Black	71.1	74.7	74.4	74.1	3.0	73.5	78.1	78.6	77.2	3.7	68.7	71.4	70.3	71.2	2.5
Hispanic	55.3	58.2	58.1	58.2	3.0	58.2	63.0	62.4	61.3	3.1	50.2	50.6	51.3	53.2	3.0

NOTES

Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Net change is percentage-point change between 2013 and 2018.

DATA

Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

Table 5. Louisiana/Georgia Uninsured Rates by Demographics, 2013–2018 (base: adults ages 19–64)

	Louisiana					Georgia				
	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)
Total	24.7	15.4	12.5	11.8	–12.9	26.0	18.1	18.7	19.1	–6.9
Race/Ethnicity										
White	18.9	11.8	9.7	9.5	–9.4	19.1	13.9	14.1	14.9	–4.2
Black	31.3	17.3	13.0	11.3	–19.9	28.4	18.0	19.0	19.2	–9.2
Hispanic	52.7	43.8	38.0	39.6	–13.2	60.1	46.8	45.3	45.5	–14.6
Income										
0–199% FPL	41.8	25.9	19.7	17.8	–24.0	46.3	35.0	35.5	35.9	–10.4
200%–399% FPL	21.3	14.4	11.9	11.6	–9.7	21.9	16.4	17.6	18.8	–3.1
400%+ FPL	9.7	5.5	5.5	5.9	–3.8	8.1	5.6	6.5	7.3	–0.8
Race/Ethnicity, by income										
0–199% FPL										
White	37.7	24.3	18.0	16.5	–21.2	40.9	32.3	32.2	33.1	–7.9
Black	42.0	22.8	16.6	14.0	–27.9	41.4	29.4	30.1	30.4	–11.0
Hispanic	70.7	58.5	51.8	54.0	–16.7	75.5	62.6	62.7	63.4	–12.1
200%–399% FPL										
White	19.0	12.0	10.6	10.9	–8.1	17.9	13.7	14.9	16.4	–1.5
Black	22.5	14.3	10.3	8.7	–13.8	21.0	14.1	14.9	16.4	–4.6
Hispanic	45.3	38.4	33.6	34.8	–10.5	50.0	40.4	38.9	40.7	–9.3
400%+ FPL										
White	7.4	4.5	4.2	4.6	–2.7	5.9	4.5	5.1	5.7	–0.3
Black	14.6	6.4	7.5	8.0	–6.6	12.4	6.5	7.9	9.3	–3.0
Hispanic	31.4	20.0	20.3	20.4	–11.0	21.3	16.2	17.1	18.6	–2.6

NOTES

Net change is percentage-point change between 2013 and 2018.

FPL = federal poverty level.

DATA

American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

NOTES

1. Ajay Chaudry, Adlan Jackson, and Sherry A. Glied, *Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?* (Commonwealth Fund, Aug. 2019).

2. Eric C. Schneider et al., *Health Care in America: The Values and Experiences That Could Shape Health Reform* (Commonwealth Fund, Dec. 2019).

3. See U.S. Census Bureau, "American Community Survey — Response Rates," n.d.

4. See Centers for Disease Control and Prevention, "BRFSS Combined Landline and Cell Phone Weighted Response Rates by State, 2018," n.d.

5. Chaudry, Jackson, and Glied, *Did the Affordable Care Act,* 2019.

6. Estimates of the rate vary slightly across federal surveys, depending on the age group, question, and methodology.

7. Munira Z. Gunja, Sara R. Collins, and Herman K. Bhupal, *Is the Affordable Care Act Helping Consumers Get Health Care?* (Commonwealth Fund, Dec. 2017).

8. David C. Radley, Sara R. Collins, and Susan L. Hayes, *2019 Scorecard on State Health System Performance* (Commonwealth Fund, June 2019).

9. See "Access to Health Services," *Healthy People 2020,* healthypeople.gov.

10. Cathy Schoen et al., *Health Care in the Two Americas: Findings from the Scorecard on State Health System Performance for Low-Income Populations* (Commonwealth Fund, Sept. 2013), Exhibit 27, p. 57.

11. Difference is not statistically significant.

12. Improvement for Hispanics and blacks in nonexpansion states was not statistically significant.

13. Radley, Collins, and Hayes, *2019 Scorecard on State,* 2019.

14. Based on Medicaid expansion status as of publication date, with Virginia, Maine, Idaho, and Utah included as expansion states; authors' analysis of U.S. Census Bureau, 2018 1-Year American Community Survey, Public Use Microdata Sample (ACS PUMS).

15. As of 2016, there were an estimated 8.4 million undocumented immigrants from Latin America living in the United States. Jeffrey S. Passel and D'Vera Cohn, *U.S. Unauthorized Immigrant Total Dips to Lowest Level in a Decade* (Pew Research Center, Nov. 2018).

16. Sara Rosenbaum, "The New 'Public Charge' Rule Affecting Immigrants Has Major Implications for Medicaid and Entire Communities," *To the Point* (blog), Commonwealth Fund, Aug. 15, 2019.

17. Senator Bernie Sanders, "The Medicare for All Act of 2019" (S. 1129); and Senator Elizabeth Warren, "Ending the Stranglehold of Health Care Costs on American Families," Nov. 1, 2019; and Vice President Joe Biden, "The Biden Plan to Protect and Build on the Affordable Care Act," n.d.; and Mayor Pete Buttigieg, "Medicare for All Who Want It: Putting Every American in Charge of Their Health Care with Affordable Choice for All," n.d.

18. Republican Study Committee, *A Framework for Personalized, Affordable Care,* n.d.

19. Rachel Garfield, Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid* (Henry J. Kaiser Family Foundation, Mar. 2019).

20. Jodi Liu and Christine Eibner, *Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market* (Commonwealth Fund, Aug. 2018).

21. Alexei Koseff, "California Will Give Health Coverage to Undocumented Young Adults," *San Francisco Chronicle,* June 10, 2019.

22. Sandro Galea et al, "Estimated Deaths Attributable to Social Factors in the United States," *American Journal of Public Health* 101, no. 8 (Aug. 2011): 1456–65.

23. Laurie Zephyrin, "Pregnancy-Related Deaths Reflect How Implicit Bias Harms Women. We Need to Fix That.," *STAT,* July 10, 2019; Kevin A. Schulman et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," *New England Journal of Medicine* 340, no. 8 (Feb. 1999): 618–26; and William L. Schpero et al., "For Selected Services, Blacks and Hispanics More Likely to Receive Low-Value Care Than Whites," *Health Affairs* 36, no. 6 (June 2017): 1065–69.

24. Schneider et al., *Health Care in America,* 2019.

ABOUT THE AUTHORS

Jesse C. Baumgartner is a research associate in the Health Care Coverage, Access, and Tracking program at the Commonwealth Fund. Before joining the Fund, he worked as a technology development/licensing manager at Memorial Sloan Kettering Cancer Center, a life sciences consultant at Stern Investor Relations, and earlier in his career as a reporter for the *Lewiston Tribune* in Idaho. Mr. Baumgartner earned his B.A. in journalism and history from the University of North Carolina at Chapel Hill, where he was elected *Phi Beta Kappa,* and is currently pursuing his M.P.H. at the CUNY Graduate School of Public Health and Health Policy. He is also a CFA® charterholder.

Sara R. Collins, Ph.D., is vice president for Health Care Coverage, Access, and Tracking at the Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, she has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine. Earlier in her career, she was an associate editor at *U.S. News & World Report,* a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. Dr. Collins holds a Ph.D. in economics from George Washington University.

David C. Radley, Ph.D., M.P.H., is senior scientist for the Commonwealth Fund's Health Care Coverage, Access, and Tracking program, working on the Scorecard project. Dr. Radley develops national, state, and substate regional analyses on health care system performance and related insurance and care system market structure analyses. He is also a senior study director at Westat, a research firm that supports the Scorecard project. Previously, he was associate in domestic health policy for Abt Associates, with responsibility for a number of projects related to measuring long-term care quality and evaluating health information technology initiatives. Dr. Radley received his Ph.D. in health policy from the Dartmouth Institute for Health Policy and Clinical Practice, and holds a B.A. from Syracuse University and an M.P.H. from Yale University.

Susan L. Hayes, M.P.A., is a Ph.D. candidate in Health Services Research at Brown University. She is a former senior researcher for the Commonwealth Fund's Health Care Coverage, Access, and Tracking program. Ms. Hayes holds an M.P.A. from New York University's Wagner School of Public Service and an A.B. in English from Dartmouth College. She has been a journalist, a freelance health writer, a contributing editor to *Parent & Child* magazine, and cowrote a book on raising bilingual children with a pediatrician at Tufts Medical Center.

ACKNOWLEDGMENTS

At the Commonwealth Fund, the authors thank David Blumenthal, Elizabeth Fowler, Eric Schneider, and Barry Scholl for helpful comments; Chris Hollander, Deborah Lorber, Paul Frame, and Jen Wilson for editing and design; and Munira Gunja and Gabriella Aboulafia for research support.

Editorial support was provided by Christopher Hollander.

For more information about this brief, please contact:
Jesse C. Baumgartner
Research Associate, Health Care Coverage, Access, and Tracking
The Commonwealth Fund
jb@cmwf.org

The Commonwealth Fund

Affordable, quality health care. For everyone.

About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.