Guide to Equity for the Uninsured

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ABOUT THIS GUIDE

This guide equips advocates and other changemakers with key information about health care for the uninsured, including an overview of the system's inequities, and highlights the policy and accountability levers that can advance equity.

This guide is part of a larger project on inequities and policy levers in the US health care system. For the complete guide, visit urbn.is/4054rNQ.

The other topics covered include the following:

- behavioral health care system
- Children's Health Insurance Program
- Indian Health Service
- Marketplace insurance
- Medicaid
- Medicare
- Medicaid-Medicare
- pharmacy services
- Veterans' Affairs

OVERVIEW

Health care is very expensive in the United States, and health insurance is designed to make health care affordable and accessible. Research demonstrates that health insurance coverage improves access to health care services, health outcomes, and the financial well-being of individuals and families. However, about 25 million Americans were uninsured in 2023, many because they simply cannot afford to buy coverage or they are not eligible for public health insurance options due to immigration status. People from racial and ethnic minority groups are more likely to be uninsured than white people. Eliminating uninsurance could improve access to health care and health outcomes and reduce racial and ethnic health disparities.

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POPULATION

The Affordable Care Act (ACA) of 2010 improved access to health insurance coverage by providing states with an option to increase income eligibility for Medicaid, establishing federally subsidized health insurance Marketplace programs where individuals and small businesses can purchase affordable coverage, and banning insurers from denying coverage to people with preexisting health conditions. Since the passage of the ACA, the rate of uninsurance in the US fell considerably from about 18 percent of the population (46.5 million people) to the most recent estimates of 7.7 percent of the population, or 25.3 million people, in early 2023.

Based on 2022 data, key geographic and demographic characteristics of the uninsured population are as follows:

- The national average uninsurance rate is 9.6 percent, ranging from 2.8 percent of Massachusetts residents to 18.9 percent of Texas residents. Uninsurance rates are nearly twice as high in states that did not adopt the ACA's Medicaid expansion compared with expansion states (14.1 percent versus 7.5 percent).
- Nonelderly adults (ages 19–64) are more likely to be uninsured than children; 11.3 percent of nonelderly adults were uninsured as compared with 5.1 percent of children, likely because income limits for public insurance programs, such as Medicaid, tend to be higher for children than for adults.
- Uninsured people are disproportionately people of color; racial and ethnic composition of the uninsured is as follows: 19.1 percent are American Indian/Alaska Native, 18 percent are Hispanic/Latinx, 12.7 percent are Native Hawaiian and other Pacific Islanders, 10 percent are African American/Black, 6.6 percent are white, and 6 percent are Asian Americans.
- Three-quarters of uninsured individuals are US citizens (75.6 percent), while the remainder are noncitizens (24.4 percent).

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PROVIDERS AND SERVICE DELIVERY

Certain community-based outpatient providers, such as community health centers, rural health clinics, migrant health clinics, and health care facilities for those facing homelessness are required by law to see a patient regardless of ability to pay or immigration status. These "safety net" providers are often located in underresourced communities and offer comprehensive primary care and preventive services to uninsured populations for free or on a sliding fee basis. Some private providers will see patients on a self-pay basis.

All hospitals must comply with the Emergency Medical Treatment and Labor Act, which requires hospitals to provide emergency services regardless of a patient's insurance status or ability to pay. Some hospitals serve as safety nets or essential hospitals; they tend to be located in underserved communities, both urban and rural, and provide high-quality care to a large share of uninsured and underinsured patients and those with public health coverage.

Several new entrants in the health care market also will see patients on a self-pay basis. These include urgent care and walk-in clinics that are a part of drug stores like CVS and Walgreens.

For More Information

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FINANCING

When uninsured people access health care but cannot pay for it, health care providers can absorb the cost of the care as bad debt or get compensated from various federal, state, or local public programs designed to offset the cost of medical care provided to the uninsured. In 2017, public funding for uninsured care was estimated at $33.6 billion, covering about 80 percent of medical expenses for uninsured care, with the remainder covered by private sources. Major funding sources for health care for the uninsured include the following:

- **federal programs** such as Veteran's Health Administration, Medicaid, Indian Health Services, and community health center grants
- **state and local programs,** which include state and local funding for Medicaid, indigent care, and medical assistance programs
- **private sources,** which include donations from philanthropic organizations, hospital charity care, and crowdfunding efforts to pay for medical bills, although private financial assistance may be limited and insufficient to ensure continuity of care for chronic lifelong health conditions, such as diabetes

For More Information

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BARRIERS TO OBTAINING HEALTH INSURANCE

The US is the only high-income country without universal health insurance. Without guaranteed access to health coverage, many Americans rely on private employer-sponsored health coverage or public insurance programs such as Medicaid, Children's Health Insurance Program (CHIP), and Medicare. Insured individuals are often responsible for paying a share of monthly premiums and health care costs, such as deductibles and copays for doctor's visits and medications. Key barriers to accessing health insurance include the following:

- **Lack of employer insurance**: Small businesses with fewer than 50 workers are not required to offer health insurance. Self-employed workers, those with seasonal or part-time jobs, and gig workers also often lack access to affordable employer coverage.
- **Limited Medicaid expansion and income limits**: States that have expanded Medicaid under the ACA offer coverage for people with incomes up to 138 percent of the federal poverty level (FPL), or about $41,400 for a family of four in 2023. In contrast, nonexpansion states may set limits as low as 18 percent of FPL, or about $5,400 a year for the same family size. As of December 2023, 10 states have not adopted Medicaid expansion, leaving about 1.9 million people without access to affordable health coverage.
- **Enrollment barriers**: Many uninsured people are eligible for Medicaid or other public programs but may remain uninsured or experience gaps in continuous insurance due to a lack of awareness or challenges meeting administrative requirements such as filling out enrollment forms and submitting required documentation.

- **Immigration status**: Most lawfully present immigrants who meet public program requirements, such as income and state residency, cannot enroll in Medicaid until they have been in the United States with qualified status for over five years. Anti-immigration policies proposed or enacted by federal, state, and local governments have heightened fears among immigrant families about using public benefits, including health insurance programs.
- **Affordability:** Surveys of the American public suggest that the most common reason for being uninsured is simply being unable to afford monthly premiums and other cost-sharing requirements.

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BARRIERS TO ACCESSING HEALTH CARE SERVICES

Key barriers to accessing care for the uninsured include:

- **Cost of care**: Uninsured nonelderly adults are four times more likely than adults with private insurance to forgo needed health care because of the cost. The uninsured may be charged more for services than people with insurance and are also far more likely than people with insurance to incur high medical debt.
- **Limited safety net capacity:** Safety net providers that can offer free or discounted care often have limited capacity to serve everyone in need, including because of unstable and declining federal and state funding and low Medicaid payment rates. Operating hospitals and health care facilities in underserved communities with large shares of uninsured and publicly insured patients is financially challenging, and even leads to hospital closures.

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- **Impacts of uncompensated care on safety net providers**: "Two New Reports Suggest Federal Funding Delays Threaten Community Health Center Operations and Future Growth," George Washington University Milken Institute School of Public Health, November 14, 2023; and Khullar, Dhruv, Zirui Song, and Dave A. Chokshi, "Safety-Net Health Systems at Risk: Who Bears the Burden of Uncompensated Care?" *Health Affairs Forefront*, May 18, 2018.

How Health Care Access Barriers Affect Uninsured Patients

[An] 18-year-old boy has a history of testicular cancer and had the first testicle removed. He goes to see the doctor because he now has a lump on his other testicle. He has only been in the country for three years and is not eligible for insurance. The primary care provider refers him to an oncologist because it is likely the lump is cancerous. He is provided one visit with the oncologist to confirm this is cancer but receives no follow-up because his family cannot afford subsequent visits, surgery, or chemotherapy.

DISPARITIES

The uninsured are disproportionately poor, and people of color are more likely to have worse access to health care and poor health than people with insurance:

- Uninsured adults and children are much more likely to live in poverty than their insured counterparts despite the majority living in working families. Nearly half of uninsured people lived in families with annual incomes below 200 percent of FPL, which was $30,000 for a family of four in 2023.
- People from racial and ethnic minority groups are more likely to be uninsured than white people. For example, nearly 1 in 5 American Indians and Alaska Natives (19.1 percent) and Latinx/Hispanic individuals (18.0 percent) are uninsured compared to less than 1 in 10 white Americans (6.6 percent).
- The uninsured are more likely than those with insurance to skip primary care and preventative screenings and avoid or delay care for chronic health conditions, which contributes to poor health status.

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OVERSIGHT AND ACCOUNTABILITY

The federal and state governments oversee programs that provide free or reduced-cost care to the uninsured.

- **Centers for Medicare and Medicaid Services (CMS):** CMS oversees and guides Medicaid programs under the US Department of Health and Human Services (HHS). Under federal law, state Medicaid programs must make disproportionate share hospital payments to safety-net hospitals that serve many uninsured people and/or covered by Medicaid.
- **Health Resources and Services Administration (HRSA):** HRSA's Bureau of Primary Health Care, under HHS, is responsible for oversight of community health centers, ensuring that health centers follow program requirements as well as other federal rules, laws, and regulations.
- **US Department of Veterans Affairs (VA):** The VA manages and oversees the Veterans Health Administration, the largest source of federal funding for uninsured care in 2017.
- **Indian Health Services (IHS):** IHS, within HHS, spent an estimated $2.3 billion on uninsured care in 2017.
- **State and local governments:** Some states operate financial assistance programs for the uninsured and/or provide Medicaid coverage for immigrants without documentation.
- **Advocacy:** Many national and state organizations advocate for policies and programs to improve access to affordable health insurance and health care, including consumer advocacy groups such as Community Catalyst and Families USA, medical professional associations such as the American Medical Association, American Academy of Pediatrics, and American Hospital Association, and many others.

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POLICIES AND ACTIONS THAT COULD LESSEN BARRIERS AND DISPARITIES

Health insurance coverage is associated with improved access to and utilization of health care, better health outcomes, and improved financial security of families and health care providers. Universal health insurance that makes health care free and accessible to everyone could advance health equity. The Medicaid expansion, for example, contributed to reductions in racial and ethnic disparities in health insurance coverage and access to care, but disparities are not fully eliminated. The following actions and policies could improve access to health insurance:

Expanding Access to Medicaid in All States and Territories

- An estimated 3.5 million people would gain access to coverage if all states expanded Medicaid. In addition, about one in four uninsured recently pregnant women would likely gain coverage if all states provided 12 months of Medicaid postpartum coverage for pregnant and parenting people.
- All states could opt for Medicaid access for lawfully residing immigrants without a five-year waiting period and create state-sponsored coverage options for immigrants without documentation. States that expanded Medicaid coverage for immigrants saw reduced uninsurance rates, increased use of health care services, and improved health outcomes of immigrant populations.
- States could adopt policies and procedures to make enrolling and maintaining enrollment in Medicaid and CHIP easier.

Increasing Accountability and Funding for Public Health Care Programs

- Federal investments and technical assistance resources could be devoted to improving data systems in state and federal health care programs. Requirements for public reporting on health insurance coverage, access, utilization, and outcomes of all residents by demographic and geographic characteristics such as race, ethnicity, and rurality could lead to greater transparency and accountability for equitable outcomes.
- Meaningful community engagement could inform effective policymaking, such as working with diverse uninsured populations to understand and address barriers to health insurance access and developing, implementing, and evaluating programs to improve coverage, access, and patient experiences with health care.
- Greater federal investments in public health care programs such as Medicaid, CHIP, Veterans Health Administration, and IHS, as well as health insurance navigator programs, community health centers, and essential hospitals could improve access and quality of care for millions of Americans and promote health equity.

Expanding Access to Comprehensive and Affordable Employer-Sponsored Health Insurance

- About 11 million full-time workers were uninsured in 2021. Requiring all employers, regardless of size, to offer health insurance and providing subsidies or tax benefits for small businesses to lower the cost of premiums could improve access to comprehensive coverage for more working individuals and families.

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GLOSSARY

Accountability is an assurance that an individual or organization is evaluated on its performance or behavior related to something for which it is responsible.

The **Affordable Care Act** (sometimes known as ACA, PPACA, or "Obamacare") is a comprehensive health care reform law enacted in March 2010. The primary goals of the ACA are to make health insurance more affordable by providing financial assistance (also known as subsidies) to people to purchase health insurance and expand the Medicaid program to cover more people with low incomes.

A **coverage gap** results from state decisions not to expand Medicaid, meaning their income was above Medicaid eligibility but below the lower limit for Marketplace premium tax credits.

An **expansion state** is a state that, as of March 23, 2010, offered health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of FPL.

The **federal poverty level** is a measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance and Medicaid and CHIP coverage.

Federal subsidies are cash assistance available to purchase health coverage at reduced or no cost for people with incomes below certain levels. Marketplace insurance plans with premium tax credits are sometimes known as subsidized coverage.

Health disparities are preventable differences in disease, health status, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

The **Marketplace** is a shopping and enrollment service for medical insurance created by the ACA in 2010. In some states, the federal government runs the Marketplace (sometimes called the "exchange") for individuals and families.

Nonexpansion states are states that have not adopted the Medicaid expansion.

Quality measures are tools that help assess or quantify health care processes, outcomes, patient experiences, and organizational structures and/or systems associated with providing high-quality health care.

Safety net hospitals tend to serve large populations of racial and ethnic minorities and face unique challenges in providing high-quality care in resource-constrained environments.

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