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Health Coverage by Race and Ethnicity: Changes Under the ACA

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Key Takeaways

People of color historically have been more likely to be uninsured and to face more barriers accessing care than Whites. The Affordable Care Act (ACA) health coverage expansions provided an opportunity to help reduce these disparities. This brief examines changes in health coverage under the ACA by race and ethnicity and discusses the implications for health coverage disparities. Based on Kaiser Family Foundation analysis of Current Population Survey data for the nonelderly population, it finds:

- People of color have had larger gains in coverage compared to Whites since implementation of the ACA, helping to narrow racial and ethnic disparities in coverage.** All racial and ethnic groups had coverage gains. Gains were largest for nonelderly Hispanics, whose uninsured rate decreased from 26% to 17%, reducing the number of uninsured by 4.0 million. The number of nonelderly uninsured Asians fell by 0.9 million, and their uninsured rate decreased by almost half from 15% to 8%. Among nonelderly Blacks, the number of uninsured fell by 1.8 million and the uninsured rate decreased from 17% to 12%. Nonelderly Whites had a smaller change in their uninsured rate, which fell from 12% to 8%, but the largest decrease in the number of uninsured (6.7 million), reflecting their larger overall population size.
- Despite larger coverage gains for people of color, disparities in coverage persist, particularly for Hispanics.** Medicaid plays a key role helping to fill gaps in private coverage for nonelderly Hispanics and Blacks, but they remain more likely to be uninsured than Whites. Hispanics are at the highest risk of being uninsured, with nonelderly adult Hispanics nearly two and half times as likely to be uninsured than nonelderly adult Whites (22% vs. 9%). Uninsured rates for children are lower than rates for adults, but Hispanic children are still twice as likely a White children to be uninsured (8% vs. 4%).
- Opportunities remain to increase coverage through enrollment of eligible but uninsured individuals in Medicaid or subsidized Marketplace coverage, but eligibility for coverage varies by race and ethnicity.** Nonelderly uninsured Blacks are more likely than nonelderly uninsured Whites to be ineligible for coverage because they fall into the coverage gap in states that have not implemented the Medicaid expansion. Nonelderly uninsured Asians and Hispanics have lower eligibility rates because they include higher shares of noncitizens, and some are ineligible due to immigration status.
- Progress reducing coverage disparities could be eroded by recent cuts to outreach funding, changes to Medicaid, and repeal of the individual mandate.** These changes could limit enrollment of eligible people and lead to coverage losses that would disproportionately affect people of color.

Introduction

Despite improvements in population health and continued efforts to reduce disparities in health and health care, people of color remain more likely to be uninsured and to face increased barriers accessing care compared to Whites.¹ People of color also have lower utilization of care compared to Whites and have worse measures of health status and health outcomes.² As the United States population becomes more racially and ethnically diverse, with people of color projected to constitute over half of the population in 2045,³ disparities have growing implications for the nation. The Affordable Care Act (ACA) coverage expansions offered an opportunity to increase coverage among people of color and address the longstanding racial and ethnic disparities in health coverage. This brief examines changes in health coverage by race and ethnicity under the ACA and discusses the implications for health coverage disparities.

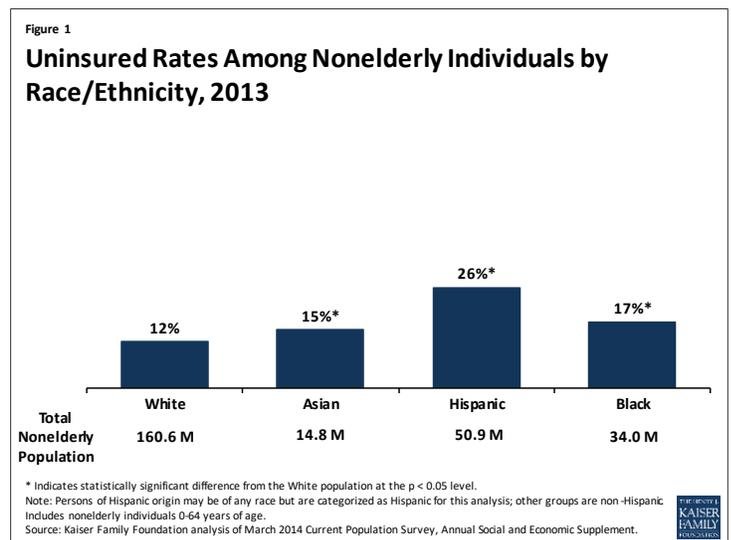
The ACA Health Coverage Expansions

The ACA established new coverage options for low- and moderate-income individuals. The ACA included an expansion of Medicaid to low-income adults with incomes up to 138% of the federal poverty level (FPL) (\$28,676 for a family of three in 2018).⁴ The ACA also established health insurance Marketplaces through which individuals can purchase insurance coverage and provides tax credits to individuals with incomes between 100% and 400% FPL (\$20,780 to \$83,120 for a family of three in 2018).⁵

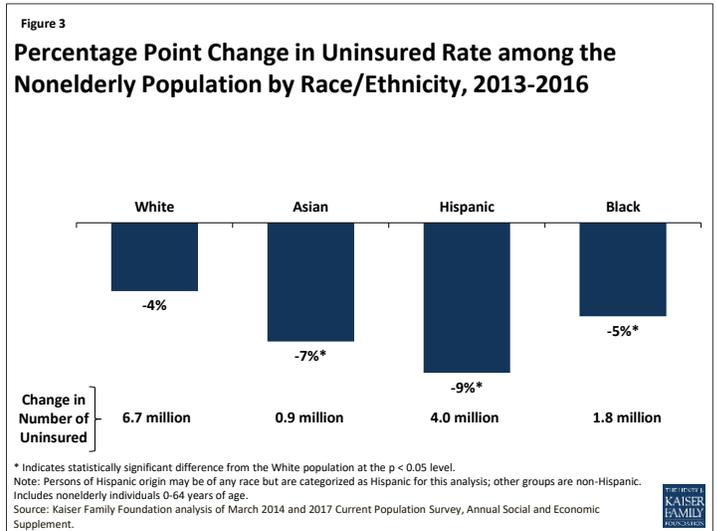
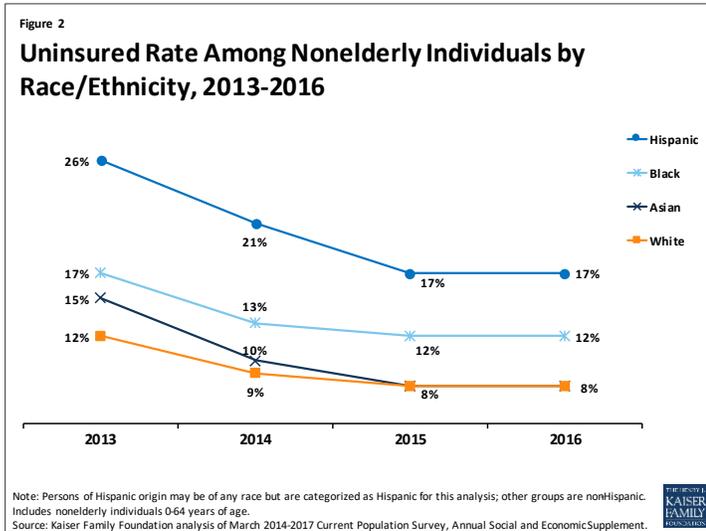
Under the ACA, these expansions became effective as of January 2014. As enacted, the Medicaid expansion to low-income adults was to be implemented nationwide; however, it was effectively made a state option by the 2012 Supreme Court ruling on the ACA. As of January 2018, 33 states, including the District of Columbia, had adopted the expansion, although it had not yet been implemented in Maine. In the 19 states that have not implemented the expansion, an estimated 2.4 million poor adults fall into a coverage gap.⁶ These adults did not gain access to an affordable coverage option because they earn too much to qualify for Medicaid but not enough to receive tax credits for Marketplace coverage, which become available at 100% FPL.

Changes in Health Coverage by Race/Ethnicity under the ACA

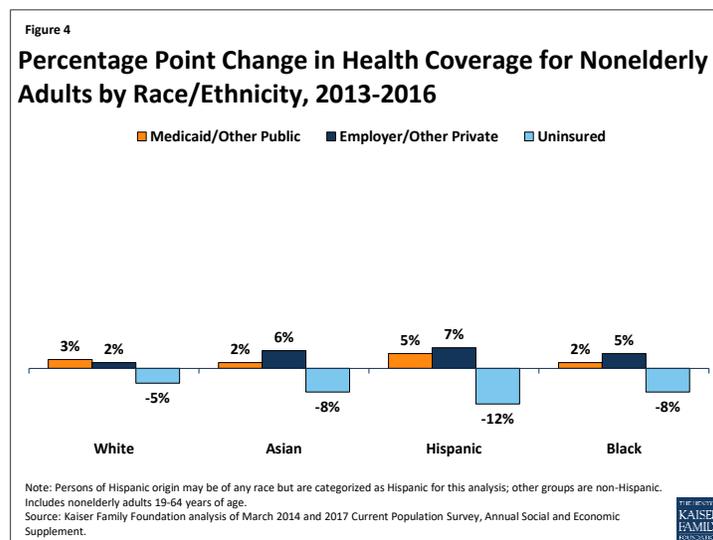
Prior to the ACA, people of color were more likely to be uninsured than Whites. As of 2013, a total of 41.1 million nonelderly individuals were uninsured, including 18.7 million Whites, 2.2 million Asians, 13.1 million Hispanics, and 5.8 million Blacks. While nearly half of the uninsured were Whites (46%)⁷, people of color had a higher risk of being uninsured than Whites (Figure 1). Hispanics were at the highest risk of being uninsured with over one in four lacking coverage.



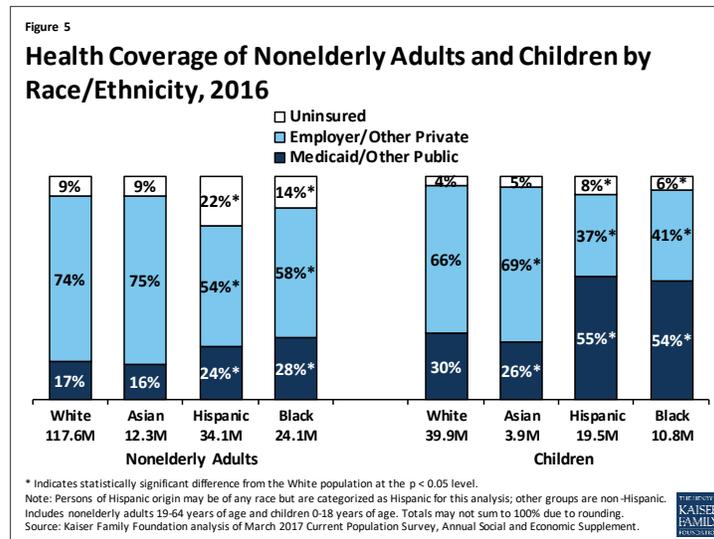
People of color have experienced larger gains in coverage compared to Whites since ACA implementation. All racial and ethnic groups experienced reductions in their uninsured rate between 2013 and 2016, with coverage remaining largely steady between 2015 and 2016 (Figure 2). Decreases in the uninsured rate were larger among communities of color compared to Whites, which helped narrow disparities in coverage (Figure 3). Coverage gains were particularly large for Hispanics, who experienced a 4.0 million decline in the number of uninsured and a 9 point decline in their uninsured rate over the period. Asians and Blacks also had larger percentage point reductions in their uninsured rate compared to Whites, resulting in the numbers of uninsured Asians and Blacks decreasing by 0.9 and 1.8 million, respectively. Though Whites had a smaller change in their uninsured rate, they had the largest decrease in the number of uninsured over the period (6.7 million), reflecting their larger overall population size.



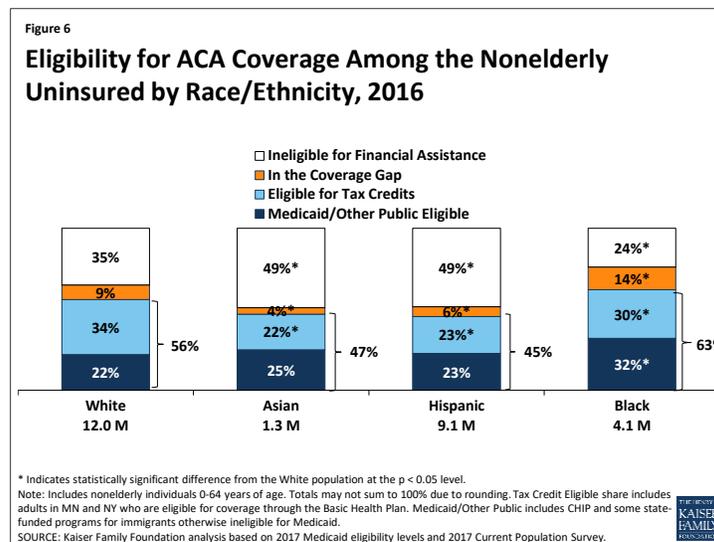
Coverage gains for adults were driven by increases in both Medicaid and private coverage. Medicaid and private coverage increased for White, Hispanic, and Black nonelderly adults between 2013 and 2016, which led to the drops in their uninsured rates, while gains in private coverage drove most of the decline in the uninsured rate for nonelderly adult Asians (Figure 4). Coverage changes for children were smaller over the period. Private coverage for Asian, Hispanic, and Black children increased and there was a small increase in Medicaid coverage for White children (data not shown).



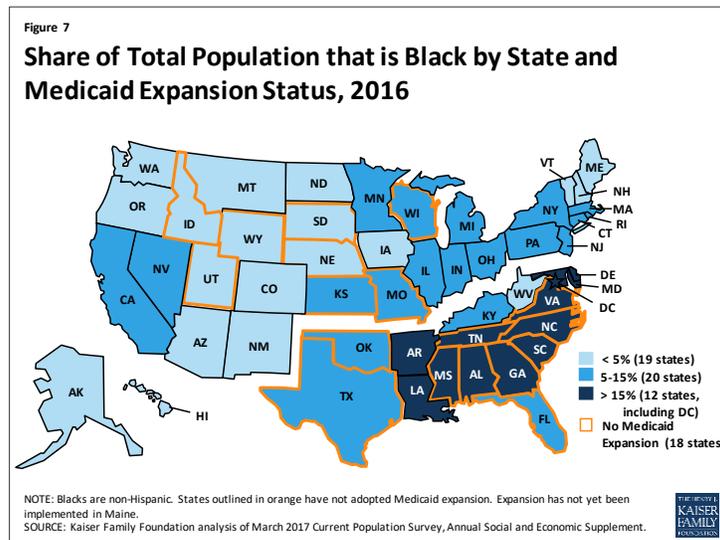
Racial and ethnic disparities in coverage persist despite recent coverage gains and Medicaid’s role filling gaps in private coverage for adults and children of color. Even with the recent gains coverage, Hispanic and Black nonelderly adults and children remain significantly less likely to have private coverage compared to Whites. Medicaid helps fill these gaps in coverage, covering over one in four Hispanic and Black nonelderly adults and over half of Hispanic and Black children. However, it does not fully offset the difference, leaving Hispanics and Blacks at higher risk of being uninsured. Hispanics are at the highest risk of being uninsured, with nonelderly adult Hispanics nearly two and half times as likely to be uninsured than nonelderly adult Whites (22% vs. 9%). Uninsured rates for children are lower than rates for adults, but Hispanic children are still twice as likely a White children to be uninsured (8% vs. 4%).



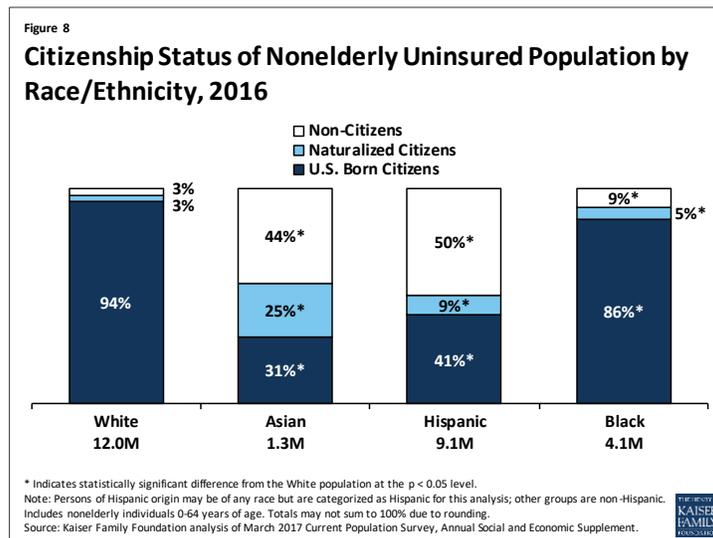
Opportunities remain to increase coverage through enrollment of eligible but uninsured individuals in Medicaid or subsidized Marketplace coverage, but eligibility for coverage varies by race and ethnicity. In 2016, 27.5 million nonelderly people lacked health insurance. Overall, an estimated 53% of this population is eligible for financial assistance for coverage.⁸ This includes one in four (25%) who are eligible for Medicaid and nearly a third (29%) who are eligible for premium tax credits to purchase coverage through the Marketplaces.⁹ However, eligibility for financial assistance for coverage among the uninsured varies substantially across racial and ethnic groups (Figure 6).



Uninsured nonelderly Blacks are more likely than Whites to fall in the coverage gap because a greater share live in states that have not implemented the Medicaid expansion. While over 6 in 10 (63%) uninsured nonelderly Blacks are eligible for Medicaid or subsidies for Marketplace coverage, they are more likely than uninsured nonelderly Whites to be ineligible for assistance because they fall into the coverage gap in states that did not expand Medicaid (14% vs. 9%). This finding reflects that Blacks make up a greater share of the population in the South, where most states have not expanded Medicaid (Figure 7).



Uninsured nonelderly Asians and Hispanics are less likely than Whites to be eligible for financial assistance for coverage, because they include larger shares of noncitizens and some do not qualify due to immigration status. Less than half nonelderly uninsured Asians (47%) and Hispanics (45%) are eligible for financial assistance for coverage compared to over half of uninsured Whites (56%). This, in part, reflects that noncitizens account for higher shares of nonelderly uninsured Asians and Hispanics compared to Whites (Figure 8), and some of those noncitizens remain ineligible for assistance due to their immigration status.



Discussion

These findings show that the ACA has contributed to large coverage gains among people of color, which have narrowed coverage disparities and will likely lead to improved access to care and utilization. The coverage gains have helped reduce longstanding disparities in coverage faced by people of color, particularly for Hispanics. These coverage gains are expected to reduce disparities in access to and use of health care as well as health outcomes over the long-term. Research shows that health insurance makes a key difference in whether, when, and where people get medical care and ultimately how healthy they are.¹⁰

Although the ACA coverage expansions have helped narrow disparities in health coverage for people of color, disparities persist. Hispanics adults and children, in particular, remain at higher risk of being uninsured. These ongoing coverage disparities contribute to greater barriers to accessing care and at risk for unaffordable medical bills that could lead to medical debt and financial instability.

Opportunities remain to increase coverage and further reduce coverage disparities by enrolling individuals who are eligible for financial assistance for coverage but remain uninsured.

However, the extent to which enrollment can increase coverage varies by race/ethnicity since eligibility for coverage among the remaining uninsured varies substantially across racial and ethnic groups. Some uninsured individuals remain ineligible for assistance for coverage because they fall into the coverage gap in states that did not expand Medicaid or do not qualify based on immigration status. Further, recent [cuts in funding to Navigator programs](#) that conduct outreach and provide enrollment assistance and a shorter open enrollment period may limit progress reaching the remaining eligible but uninsured population.

Recent progress reducing coverage disparities could be eroded by changes to Medicaid and repeal of the individual mandate. Although efforts to repeal and replace the ACA and cut federal financing for Medicaid failed last year, in 2018, there may be changes in Medicaid through waivers to impose work requirements and other restrictions and proposals to reduce federal Medicaid funding may reemerge. Reductions or limits in Medicaid would disproportionately affect people of color and widen coverage disparities. The repeal and replace debate and elimination of the individual mandate may also contribute to coverage losses that would widen disparities. In fact, recent data from other survey data point to increases in the uninsured rate during 2017, with larger increases for Blacks and Hispanics compared to Whites.¹¹

Data and Methods

This brief is based on Kaiser Family Foundation analysis of Current Population Survey data for the nonelderly population between ages 0-64. See, "[Estimates of Eligibility for ACA Coverage among the Uninsured in 2016](#)," for more information on methods used to estimate eligibility for coverage among the uninsured. Throughout the brief, individuals of Hispanic origin may be any race but are classified as Hispanic for this analysis; all other groups are limited to non-Hispanic individuals. Due to sample size limitations data could not be reported for American Indians and Alaska Natives or Native Hawaiians and Other Pacific Islanders. (See the following infographics based on American Community Survey data for information for [American Indians and Alaska Natives](#) and [Native Hawaiians and Pacific Islanders](#).)

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Endnotes

¹ Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity*, (Washington, DC: Kaiser Family Foundation, June 2016), <http://files.kff.org/attachment/Chartpack-Key-Facts-on-Health-and-Health-Care-by-Race-and-Ethnicity>.

² Ibid.

³ “Projections of the Population by Sex, Hispanic Origin, and Race for the United States 2015 to 2060,” U.S. Census Bureau, accessed November 10, 2017, <https://www.census.gov/data/tables/2014/demo/popproj/2014-summary-tables.html>.

⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2017 Poverty Guidelines. Available at: <https://aspe.hhs.gov/poverty-guidelines>.

⁵ Ibid.

⁶ Rachel Garfield and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, (Washington, DC: Kaiser Family Foundation, November 2017), <http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

⁷ Kaiser Family Foundation, *Key Facts about the Uninsured Population* (Washington, DC: Kaiser Family Foundation, September 2017), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

⁸ Rachel Garfield, et al., *Estimates of Eligibility for ACA Coverage among the Uninsured in 2016*, (Washington, DC: Kaiser Family Foundation, October 2017), <http://kff.org/uninsured/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/>.

⁹ Ibid.

¹⁰ Kaiser Commission on Medicaid and the Uninsured, *Key Facts About the Uninsured Population*, (Washington, DC: Kaiser Family Foundation, September 2016), <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

¹¹ Zac Auter, “U.S. Uninsured Rate Steady at 12.2% in Fourth Quarter of 2017,” *Gallup News* (January 16, 2018), <http://news.gallup.com/poll/225383/uninsured-rate-steady-fourth-quarter-2017.aspx>