DATA BRIEF
SEPTEMBER 2022

The State of U.S. Health Insurance in 2022

Findings from the Commonwealth Fund Biennial Health Insurance Survey

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The number and percentage of Americans lacking health insurance is falling to historic lows, thanks to policy changes aimed at helping people get and stay covered during the COVID-19 pandemic, as well as the recent decision by several states to expand Medicaid eligibility under the Affordable Care Act. Still, a large number of people in the United States remain uninsured or inadequately covered, a situation that will worsen when some temporary pandemic measures expire.

In this data brief, we present findings from the Commonwealth Fund Biennial Health Insurance Survey to describe the state of Americans' health insurance coverage in 2022. We answer the following questions:

- How many people experience gaps in their coverage, and how long are those gaps?
- How many people have insurance but are underinsured?
- Are health care costs affecting people's decision to get needed care?
- Are these costs leaving people with medical bills they cannot pay?

For the survey, SSRS interviewed a nationally representative sample of 8,022 adults age 19 and older between March 28 and July 4, 2022. This analysis focuses on 6,301 respondents under age 65. Note that because the 2022 edition of the Biennial Health Insurance Survey employed a new sampling method and was conducted mostly online rather than by telephone, as in the past, we are unable to present data on trends in responses over the years. To learn more about our survey, including the revised sampling method, see "How We Conducted This Survey."

The Commonwealth Fund

SURVEY HIGHLIGHTS

- Forty-three percent of working-age adults were inadequately insured in 2022. These individuals were uninsured (9%), had a gap in coverage over the past year (11%), or were insured all year but were underinsured, meaning that their coverage didn't provide them with affordable access to health care (23%).
- Twenty-nine percent of people with employer coverage and 44 percent of those with coverage purchased through the individual market and marketplaces were underinsured.
- Forty-six percent of respondents said they had skipped or delayed care because of the cost, and 42 percent said they had problems paying medical bills or were paying off medical debt.
- Half (49%) said they would be unable to pay for an unexpected $1,000 medical bill within 30 days, including 68 percent of adults with low income, 69 percent of Black adults, and 63 percent of Latinx/Hispanic adults.
- Sixty-eight percent of Democrats, 55 percent of Independents, and 46 percent of Republicans said President Biden and Congress should make health care costs a top priority in the coming year.

WHO IS UNDERINSURED?

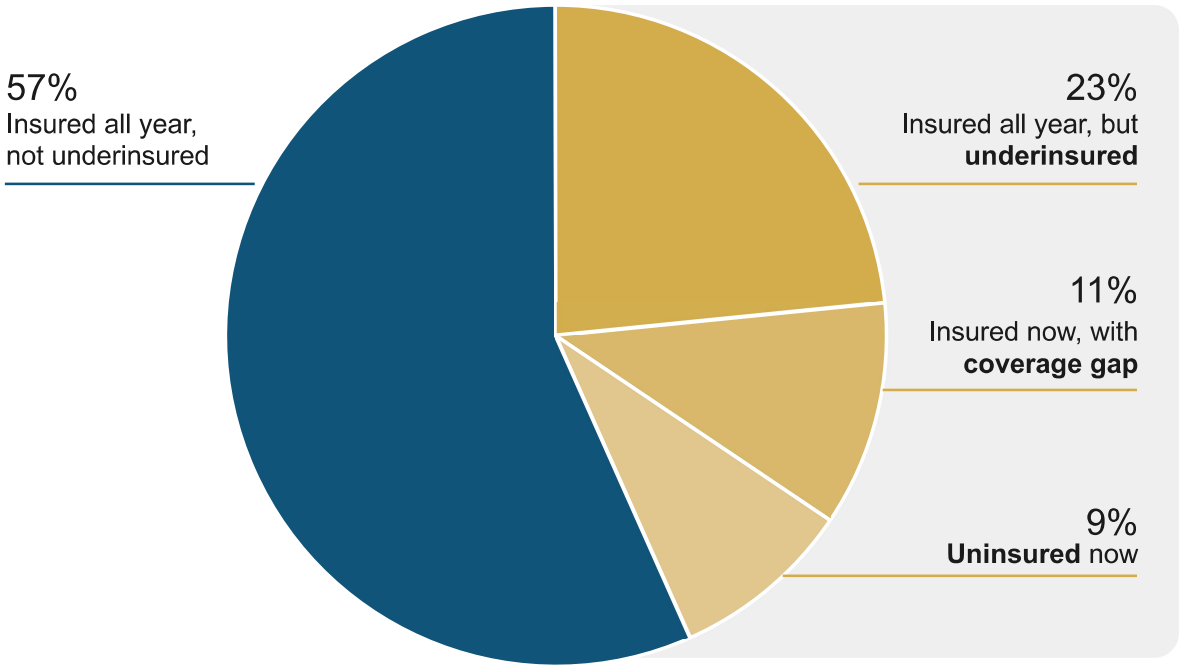
For our analysis, people who are insured all year are considered to be underinsured if their coverage doesn't enable affordable access to health care. That means at least one of the following statements applies:

- Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 10 percent or more of household income.
- Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 5 percent or more of household income for individuals living under 200 percent of the federal poverty level ($27,180 for an individual or $55,500 for a family of four in 2022).
- The deductible constituted 5 percent or more of household income.

Because out-of-pocket costs occur only if a person uses their insurance to obtain health care, we also consider the deductible when determining whether someone is underinsured. The deductible is an indicator of the financial protection that a health plan offers as well as the risk of incurring costs before a person gets health care. We do not, however, consider the risk of incurring high costs owing to an insurance plan's other design features, such as out-of-pocket maximums, copayments, or uncovered services, since we do not ask about these features in the survey.

More than two of five working-age adults are inadequately insured.

Percentage of adults ages 19–64, by insurance coverage status within the past 12 months



Notes: "Insured all year, but underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of household income; out-of-pocket costs, excluding premiums, equaled 5% or more of household income if low-income (<200% of poverty); or deductibles equaled 5% or more of household income. "Insured now, with coverage gap" refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

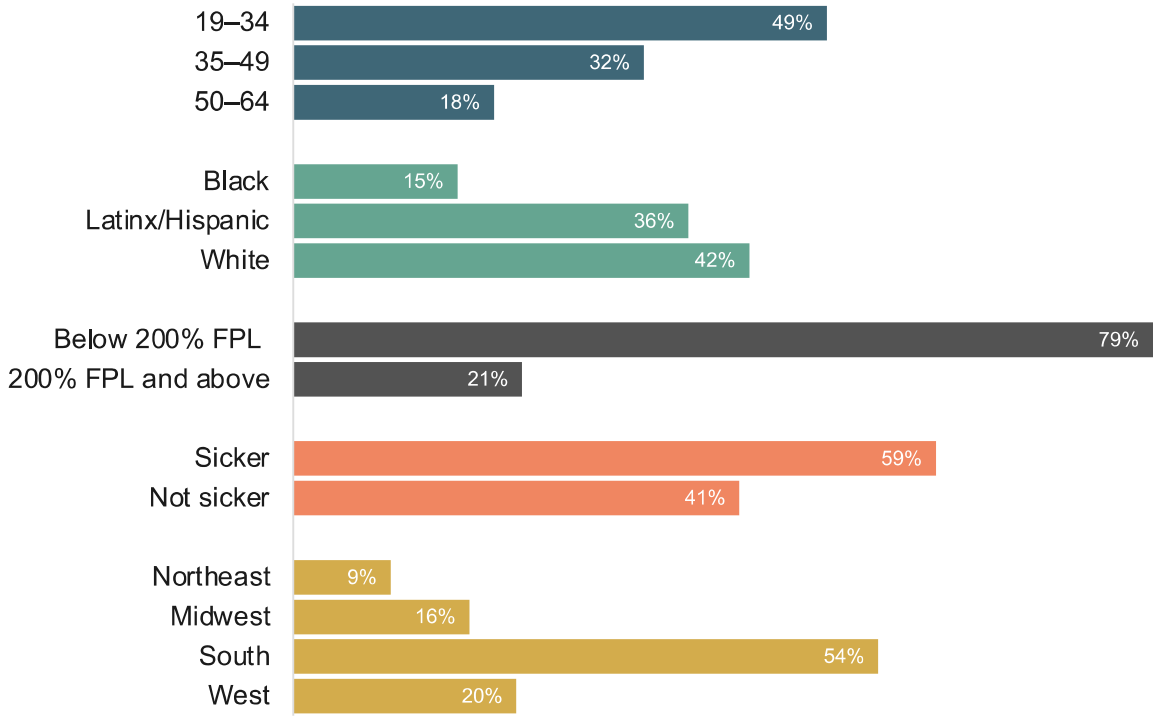
Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

By mid-2022, 43 percent of adults ages 19 to 64 had inadequate insurance coverage, meaning they were uninsured at the time of the survey (9%), had coverage when surveyed but experienced a time without coverage in the past year (11%), or had continuous coverage over the past year but were underinsured (23%) (see the box, "Who Is Underinsured?") (Table 1).

Our uninsured estimate is lower than the rate reported by the Centers for Disease Control and Prevention for this age group in the first quarter of 2022 (11.8%, with a confidence interval of 10.3% to 13.3%) and recently by the U.S. Census Bureau for all of 2021 (11.6%, with a confidence interval of 11.3% to 11.9%). (See "Estimates of U.S. Uninsured Rates" for detail.) U.S. uninsured rates have been declining as a result of historically high enrollment in Medicaid and in marketplace plans, driven primarily by pandemic-related policy changes.[1] Our survey estimate may indicate further gains through the first half of 2022. But while smaller surveys like ours can provide leading indications of the overall direction of U.S. uninsured rates, federal surveys, given their large sample sizes, will always provide the most reliable point estimates. It's important to note that because our estimated uninsured rate has a margin of error of +/– .9 percent, the true estimate falls between 8 percent and 9.9 percent

People who were uninsured for a year or longer were disproportionately young, Latinx/Hispanic, poor, sicker, and living in the South.

*Percentage distribution of adults ages 19–64 who were uninsured for one or more years, by age, race, income, health status, and region^*



^ Base: Adults ages 19–64 who were insured but had a gap in coverage in the past year or were uninsured at the time of the survey.

Notes: FPL = federal poverty level. "Sicker" includes respondents with fair or poor health status, or at least one of the following chronic health conditions: hypertension or high blood pressure; heart failure or heart attack; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

Among the world's high-income countries, the U.S. stands alone for the complexity of its health insurance system. Americans are eligible for different types of coverage depending on whether their employer offers it, what their income level is, and what their age and health care needs are. There is no national autoenrollment mechanism for people who don't have employer coverage; they must know which program they are eligible for and then sign up for coverage. Consequently, people can experience insurance gaps at different points in their lives, like when they lose a job.

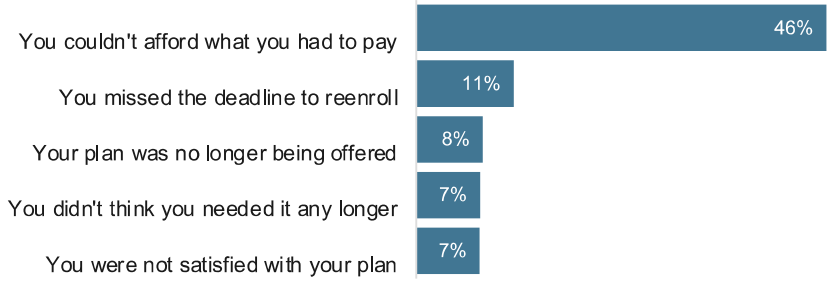
In the survey, 20 percent of respondents either were uninsured at the time of the survey or were insured but reported a coverage gap in the prior year. The majority who were insured when surveyed but had had a coverage gap reported a gap of relatively short duration (data not shown). But the vast majority (79%) of people who were uninsured when surveyed had been without any coverage for a year or longer (Table 2). Across both groups, people who lacked coverage for a year or more were disproportionately poor, young, and Latinx/Hispanic; in fair or poor health or living with a chronic health problem; and/or living in the South.

The Affordable Care Act (ACA) plugged holes in the system through its insurance market reforms, including a ban on excluding people from coverage because of a preexisting health condition; its subsidies for marketplace plans; and its expansion of Medicaid eligibility. But because the law was built on the existing insurance system, people can still experience coverage gaps. In addition, many people experience chronic, structural uninsurance: these include people who fall into the Medicaid coverage gap in the 12 states that have yet to expand Medicaid as well as undocumented immigrants, who are not eligible for federally subsidized coverage. These individuals still have no access to affordable coverage.

Premium costs are the main reason people give for not buying marketplace or individual market coverage or for dropping their coverage.

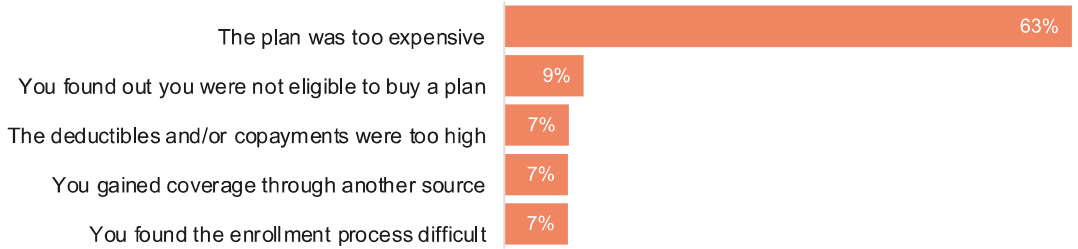
What was the MAIN reason you lost or dropped coverage?

BASE: *Percentage of adults ages 19–64 who were uninsured at the time of the survey or who were insured but had a gap in coverage in the past 12 months, and previously had marketplace coverage*



What was the MAIN reason you did not buy a plan?

BASE: *Percentage of adults ages 19–64 who tried to buy a plan in the individual market or marketplaces in the past three years but never bought a plan*



Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

To find out if they are eligible for one of the ACA's subsidized marketplace plans or for Medicaid, at any time of year Americans can go to the federal website, HealthCare.gov, enter their income and address, and see what their coverage options are. But some people who are uninsured or have experienced a coverage gap do not sign up for either Medicaid or marketplace plan. In addition, some people who search for individual-market coverage or marketplace plan never end up enrolling in one.

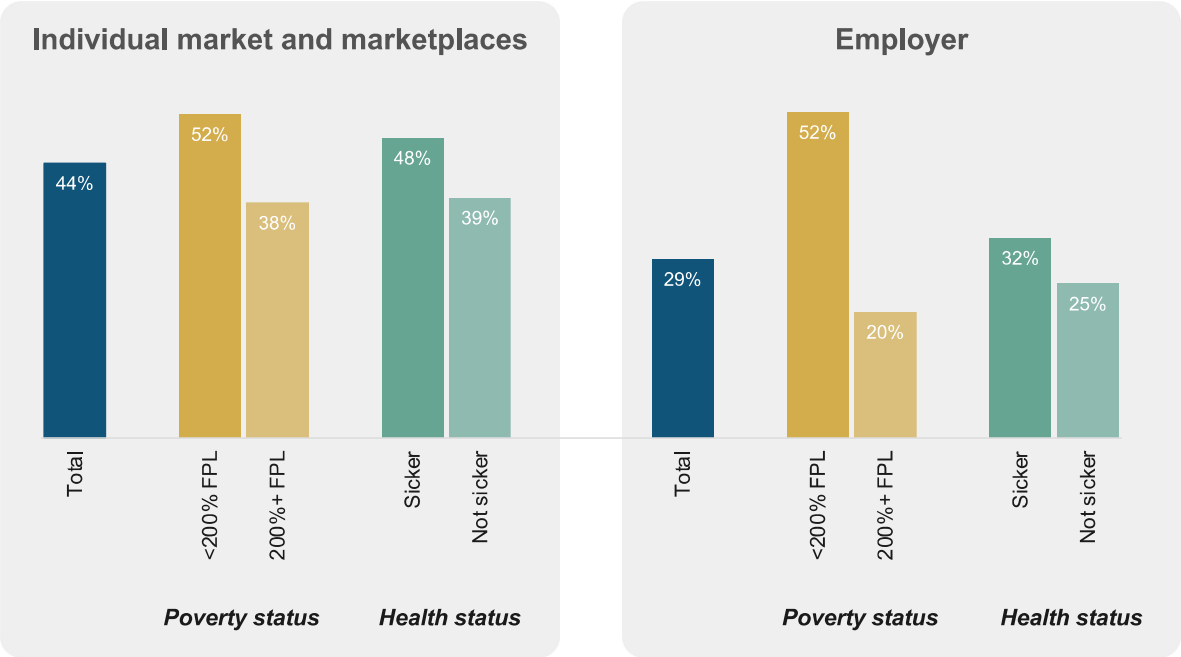
According to our survey, not being able to afford plan premiums was the reason most often cited for not enrolling in individual market or marketplace coverage or losing such coverage.

Among uninsured people or those with a coverage gap who previously had Medicaid, loss of eligibility was the main reason most often cited (data not shown).

Open enrollment through the marketplaces lasts from November 1 through January 15, but people who lose their insurance, from any source, are generally eligible for a special enrollment period outside those dates. We asked people who had coverage through an employer whether they were aware they were eligible to enroll in a marketplace plan at any time if they lost their coverage. Fifty-six percent of people with employer coverage who had spent some time uninsured during the year were not aware of this enrollment flexibility (data not shown).

Two of five people enrolled in individual-market or marketplace plans and three of 10 in employer plans were underinsured; people with low income and health problems were most at risk.

*Percentage of adults ages 19–64 insured all year who were underinsured^*



^ Base: Adults ages 19–64 who were insured all year and had individual market coverage (including marketplace plans) or employer-sponsored insurance at the time of the survey.

Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of household income; out-of-pocket costs, excluding premiums, equaled 5% or more of household income if low-income (<200% of poverty); or deductibles equaled 5% or more of household income. Coverage type given at time of survey; respondent was insured all year but may not have had same insurance for full year. FPL = federal poverty level. "Sicker" includes respondents with fair or poor health status, or at least one of the following chronic health conditions: hypertension or high blood pressure; heart failure or heart attack; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

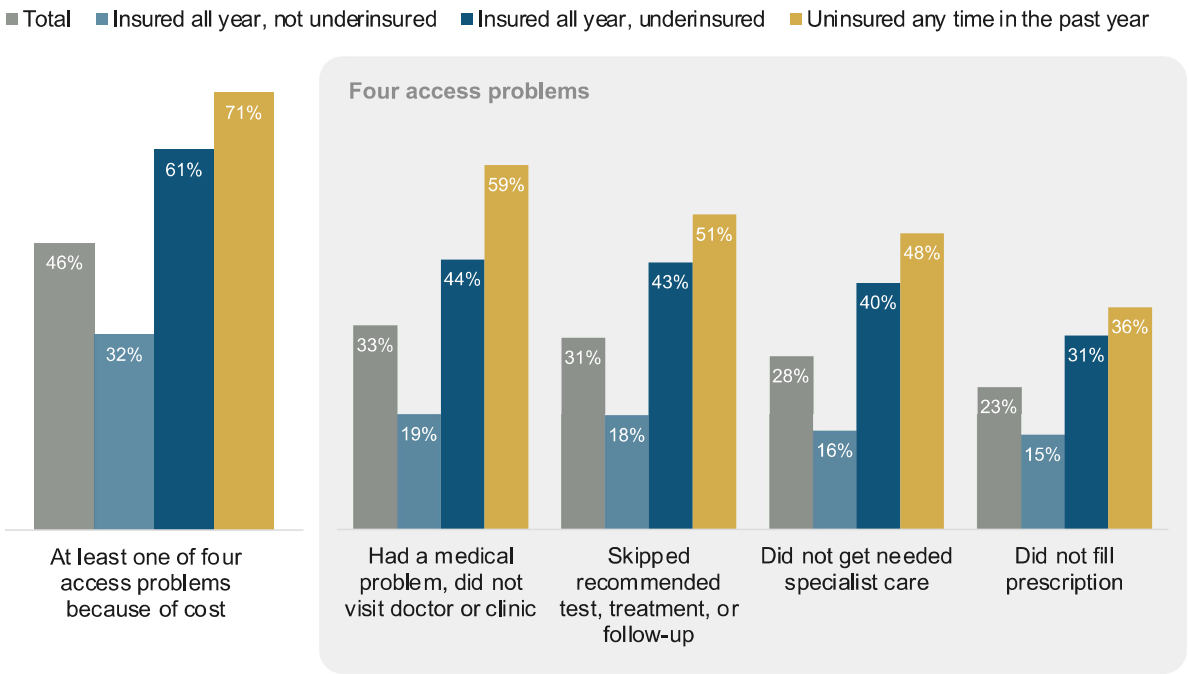
Among people who were insured all year in private health plans, 29 percent of those with coverage through an employer and 44 percent with individual market or marketplace coverage were underinsured. This means that their coverage wasn't enough to enable affordable access to health care: either because their reported out-of-pocket costs, excluding premiums, and/or deductibles were high relative to their income (see the box, "Who Is Underinsured?").

People with low income, whether covered by employer insurance or by an individual-market or marketplace plan, were underinsured at higher rates than people with higher income (Table 3). Enrollees with health problems also were at higher risk of being underinsured than healthier people, though differences were not significant for those covered in the individual market and marketplaces.

The high cost sharing people face in many employer, individual-market, and marketplace plans is primarily driven by the prices that providers, especially hospitals, charge to commercial insurers and employers. These prices are the highest in the world.[2] And consumers bear the burden, in the cost of their insurance, the size of their deductibles, their out-of-pocket maximums, and their copayments.

Cost-related problems getting needed care were reported at the highest rates by adults who were underinsured or lacked continuous coverage.

Percentage of adults ages 19–64 who in the past year had any of four problems accessing care because of cost



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of household income; out-of-pocket costs, excluding premiums, equaled 5% or more of household income if low-income (<200% of poverty); or deductibles equaled 5% or more of household income. "Uninsured any time in the past year" refers to adults who were either uninsured at the time of the survey or were insured but spent some time uninsured in the past year.

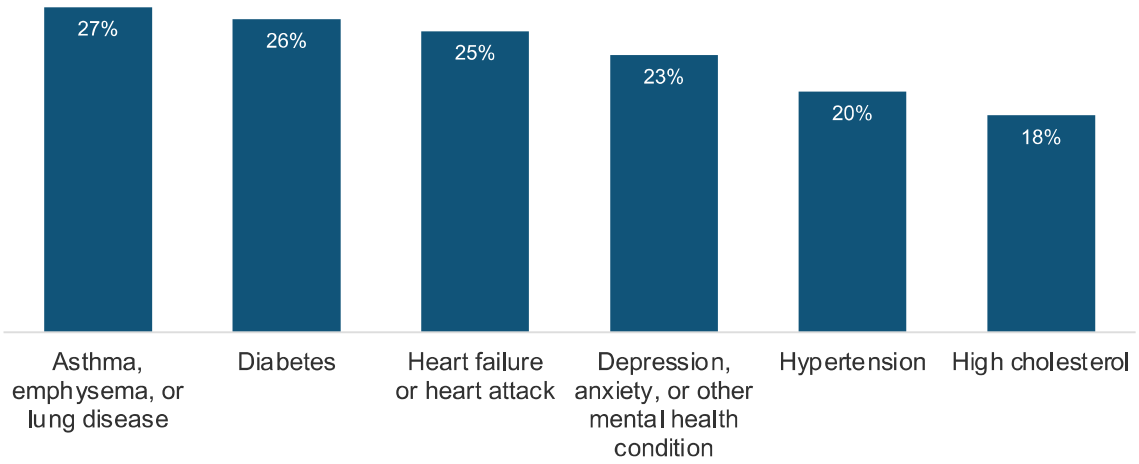
Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

Lack of good health insurance is a barrier to people's ability to get timely health care. Sixty-one percent of working-age adults who were underinsured and 71 percent of those who lacked continuous coverage said they had avoided getting needed health care because of the cost of that care. This included not going to the doctor when sick, skipping a recommended follow-up visit or test, not seeing a specialist when recommended, or not filling a prescription (Table 4).

While survey respondents reported delaying health care for treatment of new health conditions and for ongoing health problems — and sometimes both — somewhat more people said that the care they avoided was related to ongoing health problems (Table 4).

Up to one-quarter of people with chronic health problems said they had not filled a prescription in the past year for their health condition because of the cost.

*Percentage of adults ages 19–64 with a chronic health condition who skipped or didn't fill a prescription in the past year because of the cost^*



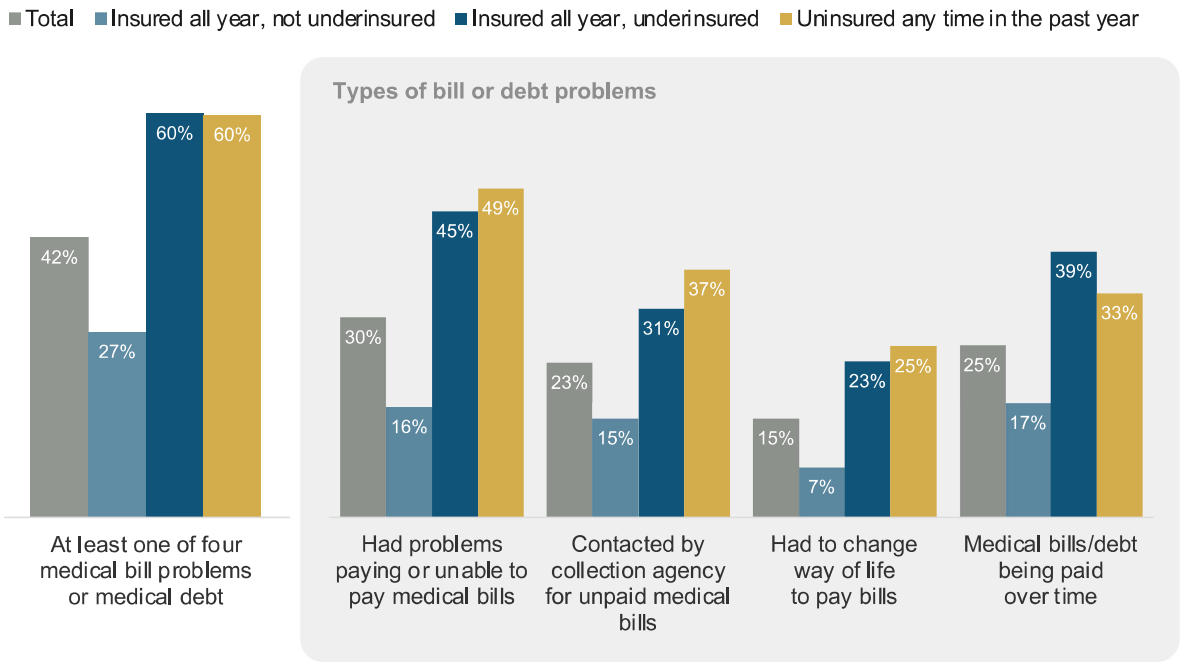
As much as a quarter of people with chronic health problems like diabetes said that out-of-pocket costs for prescription drugs to treat those problems had caused them to skip doses or not fill a prescription for the condition(s) they indicated.

^ Base: Adults ages 19–64 with a chronic health condition.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

Medical bill problems or debt were reported at the highest rates by adults who were underinsured or lacked continuous coverage.

Percentage of adults ages 19–64 who had medical bill or debt problems in the past year



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of household income; out-of-pocket costs, excluding premiums, equaled 5% or more of household income if low-income (<200% of poverty); or deductibles equaled 5% or more of household income. "Uninsured any time in the past year" refers to adults who were either uninsured at the time of the survey or were insured but spent some time uninsured in the past year.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

Americans have amassed billions of dollars in medical debt as a consequence of inadequate insurance coverage. There is an estimated $88 billion of medical debt on consumer credit records, accounting for 58 percent of all debt-collection entries on credit reports — by far the largest single source of debt in collections.[3] This estimate does not include debt people owe directly to providers.

In our survey, 30 percent of working-age adults reported that they had problems paying medical bills over the past year, and one-quarter said that they were paying off medical debt over time. The share of those with medical debt rose to more than one-third among people who were underinsured or lacked continuous coverage. Of people reporting medical debt, more than half (56%) said the amount was $2,000 or more (Table 5).

We also found out that more than 30 percent of adults who were underinsured or who lacked continuous coverage said they had been contacted by a collection agency about unpaid medical bills. While the majority of adults said that the bills in collection were those they could not afford to pay, one-quarter (24%) said the bills had been the result of a billing mistake.

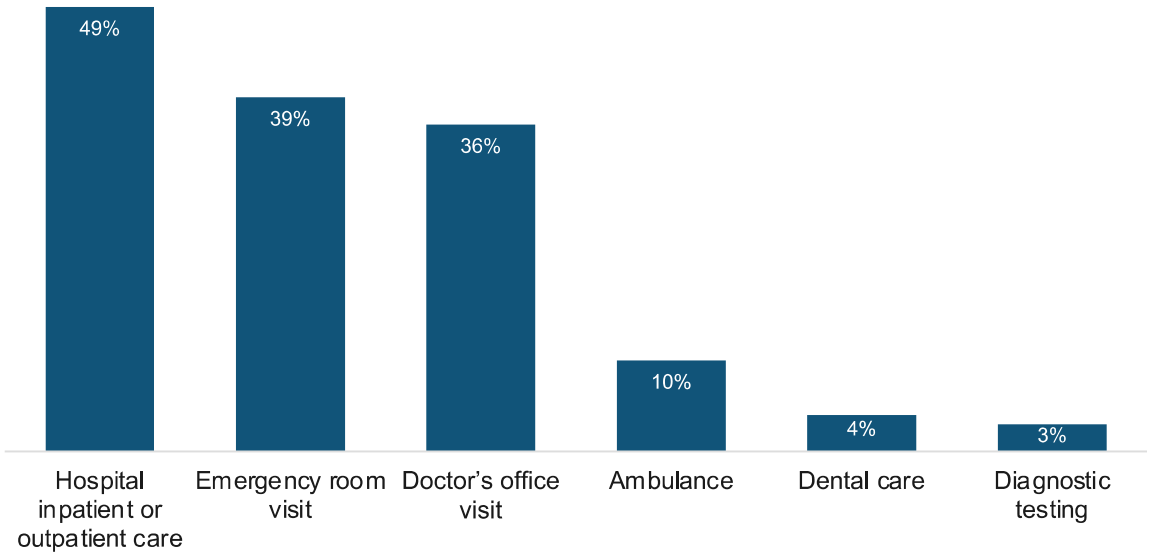
About one-quarter of adults who were underinsured or lacked continuous coverage said they had to change their way of life to pay their medical bills.

Nearly half of adults with any medical bill problem or with medical debt said their issue was related to a surprise bill: they received care at an in-network hospital but were billed by a doctor there who was not in their plan's network (Table 5). The No Surprises Act has outlawed surprise bills such as these, but the timeframe covered by the survey's questions included the period before the law went into effect in January 2022.[4]

Hospital inpatient and outpatient care were the primary source of people's medical bill problems.

*Percentage of adults ages 19–64 who had medical bill or debt problems^*

What type of care were your bills for?



^ Base: Respondents who reported at least one of the following medical bill problems in the past 12 months: had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt.

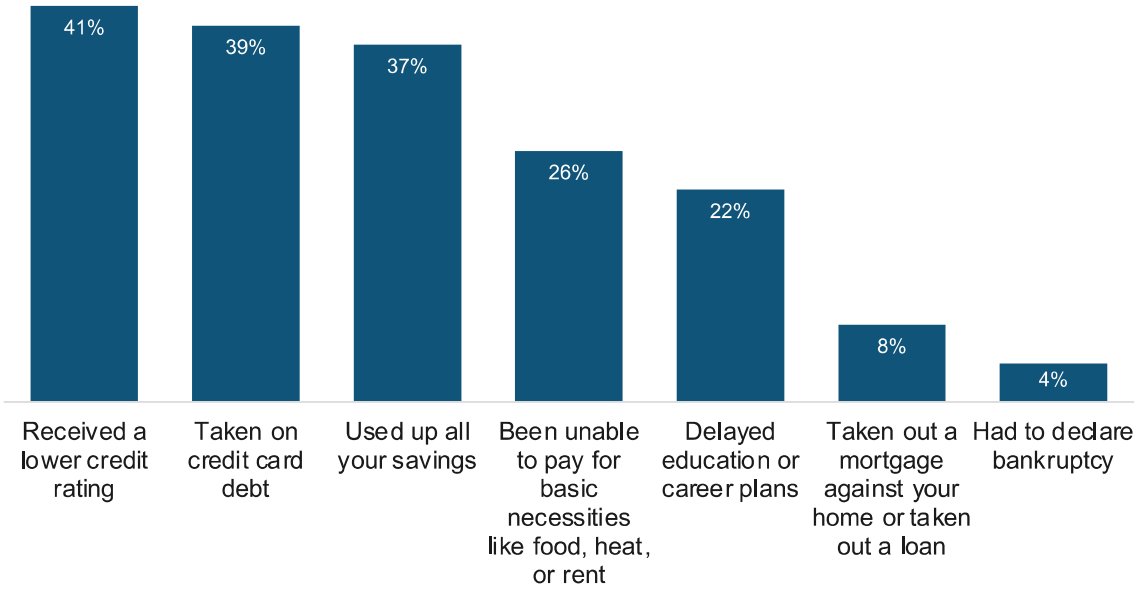
Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

Problems with paying medical bills and debt stemmed most frequently from inpatient or outpatient hospital visits. The care people received that resulted in bill problems was split equally among treatment for new health conditions and for ongoing conditions (Table 5).

People who had problems paying medical bills or were paying off medical debt experienced long-term financial consequences.

*Percentage of adults ages 19–64 who had medical bill or debt problems^*

Have any of the following happened in the past two years because of medical bills?



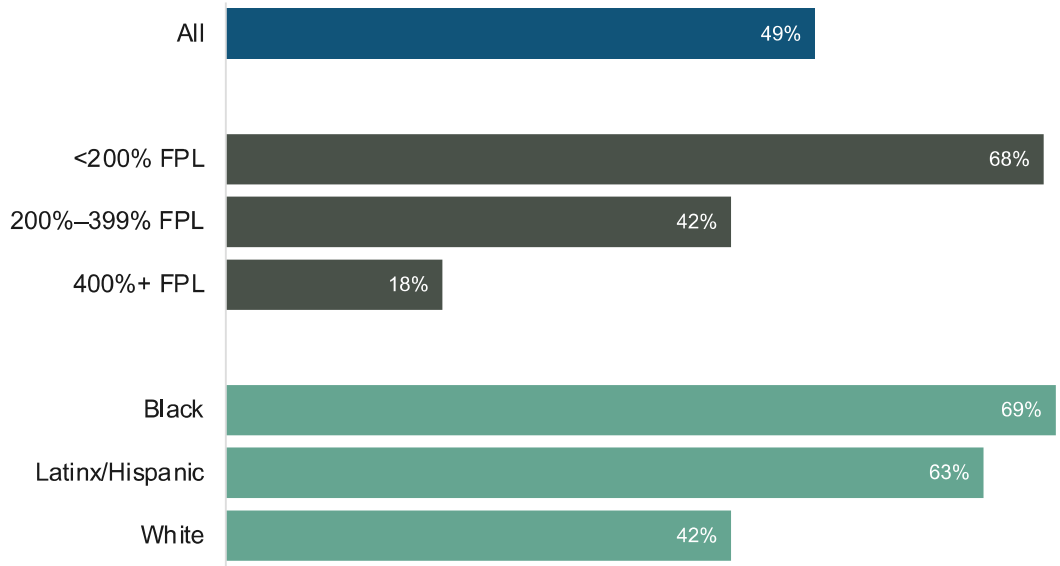
^ Base: Respondents who reported at least one of the following medical bill problems in the past 12 months: had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

People experienced both short- and long-term financial consequences from medical bill problems or medical debt. About two of five adults who reported any medical bill problem or medical debt received a lower credit rating because of problems paying these bills, took on credit card debt to pay them, and/or used up all their savings to pay them.

Half of adults would not be able to cover an unexpected $1,000 medical bill within 30 days; people of color and people with low income were the least likely to have funds.

Percentage of adults ages 19–64 who said they would be unable to pay an unexpected medical bill of $1,000 within 30 days, by income and race/ethnicity



Note: FPL = federal poverty level.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

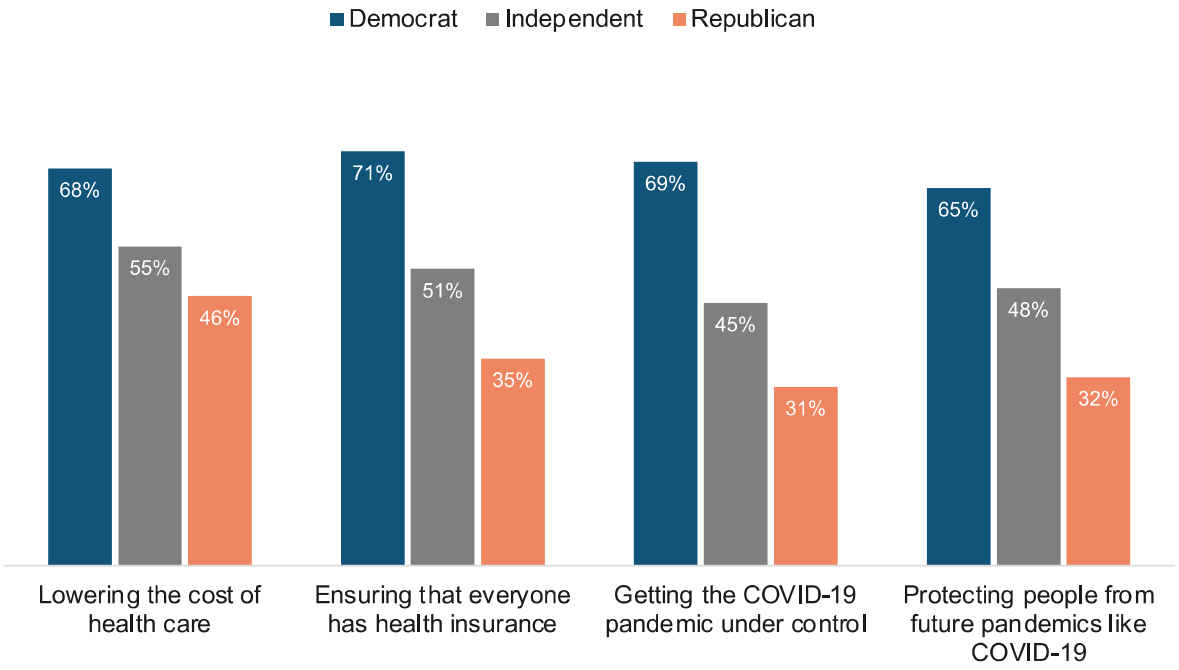
The average insurance deductible for employer health plans with single coverage is more than $1,000 ($1,434 for all covered workers in 2021), and it's more than $2,000 ($2,825) for HealthCare.gov marketplace plans.[5] Out-of-pocket maximums average $4,272 for single coverage in employer plans and range up to $8,700 in marketplace plans.[6] These plan features leave people with considerable cost exposure in case of a sudden illness or accident.

Half of survey respondents said that they would not have the money to cover an unexpected $1,000 medical bill within 30 days. Rates were even higher for specific groups: 68 percent for people with low income, 69 percent for Black adults, and 63 percent for Latinx/Hispanic adults.

The public is divided along partisan lines on what should be the top health care priorities for the president and Congress, but there is more agreement on lowering health care costs.

Percentage of adults ages 19–64 who said each health care issue should be a top priority

Over the next 12 months, how much of a priority should each of the following be for the president and Congress?



When asked about their top health care policy priorities for the president and Congress, survey respondents were divided along partisan lines. The closest Democrats, Republicans, and Independents came to agreement was on the need to lower the cost of health care. Ensuring everyone has coverage, controlling COVID-19, and preparing for future pandemics were viewed as top priorities among a large majority of Democrats but fewer Independents and Republicans.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

CONCLUSION AND POLICY RECOMMENDATIONS

The number of uninsured people in the U.S. has fallen by nearly half since the ACA was signed into law.[7] Coverage gains over the past two years have been achieved through the American Rescue Plan Act's enhanced marketplace subsidies and through the Families First Coronavirus Response Act's requirement that states keep people enrolled in Medicaid until the end of the public health emergency in exchange for enhanced federal matching funds.[8] Both provisions, coupled with increased outreach and advertising as well as state and federal extensions of open enrollment periods, drove enrollment in the marketplaces and Medicaid to record highs.

But the end of the public health emergency, expected in 2023, will trigger a massive effort by states to redetermine Medicaid enrollees' eligibility, a process that could leave many uninsured. The findings of this survey point to two areas of policy change needed to protect and build on recent coverage gains and improve the quality of coverage. Below are some options for policymakers to consider.

Covering All Americans, and Keeping Them Covered

- The Inflation Reduction Act of 2022 extended the enhanced marketplace plan subsidies for three years. Congress can make them permanent. Our survey shows just how much consumers weigh the cost of premiums when deciding whether to enroll and stay enrolled in marketplace plans.
- Congress could require that states conduct Medicaid eligibility redeterminations gradually, and it could phase down enhanced Medicaid matching funds rather than eliminate them immediately at the end of the public health emergency. This would help states transition people to new coverage and prevent erroneous terminations of Medicaid coverage.
- Congress could provide a federal fallback option for Medicaid-eligible people in states that have yet to expand their program; this could reduce the number of uninsured people in those states by an estimated 1.9 million.[9] The Urban Institute estimates that in those states, Black residents would see the biggest gains, with their uninsured rates falling by 27 percent.
- Congress could make it easier for adults to stay on Medicaid by allowing states to maintain continuous eligibility, without the need to apply for a federal waiver. States currently have this option for children enrolled in Medicaid and CHIP; those implementing it have lowered their child uninsured rates.[10]
- The Biden administration's enhanced outreach and enrollment efforts during the pandemic could be maintained and expanded.[11]
- Congress could allow people to autoenroll in comprehensive health coverage, a strategy that has the potential to move the nation to near-universal coverage.[12]

Improving Insurance Design and Protecting Consumers from Medical Debt

- The Biden administration or Congress could place limits on or ban short-term insurance plans and other coverage that doesn't comply with ACA benefit requirements. Consumers who enroll in these skimpy policies are often exposed to catastrophic medical costs.[13] By drawing healthier people out of the individual market and the marketplaces, these policies also have increased premiums for people who remain.[14]
- Congress could rein in deductibles and out-of-pocket costs in marketplace plans by enhancing cost-sharing reduction subsidies and

changing the benchmark plan in the ACA marketplaces from silver to gold, which offers better financial protection.[15] Not only would these policies reduce the number of Americans who are underinsured, but these improvements could lower the number of people without insurance by 1.5 million.[16]

- States, which regulate their fully insured employer markets, could use rate regulation to limit growth in premiums and cost sharing, as Rhode Island has.[17] They could also explore other policy options to improve employer coverage, just as many states did prior to the ACA's passage in requiring coverage of young adults on their parent's plans.[18]
- The Biden administration recently launched new actions to protect consumers from being financially harmed by medical debt, including scrutinizing providers' bill collection practices.[19] Congress could reinforce those actions by requiring providers to allow debt repayment grace periods following illness or during appeals processes; banning egregious hospital practices such as suing patients, garnishing their wages, or placing liens on homes; and a ban or limits on charging interest.[20]
- Federal and state policymakers could address the high health care prices driving up premiums and deductibles, such as by creating new public insurance options.[21]

The primary purpose of health insurance is to help people get health care in a timely fashion and protect them from catastrophic costs in the event of serious illness. Insurance fills these needs when coverage is continuous and comprehensive. While the ACA helped the U.S. make great strides toward better health coverage, the job is not done.

HOW WE CONDUCTED THIS SURVEY

With this year's survey, the Commonwealth Fund introduces a new baseline. Historically, the Commonwealth Fund Biennial Health Insurance Survey was conducted exclusively using phone administration via stratified random-digit dial (RDD) phone sample. This year, however, we shifted to a hybrid sample design that utilized stratified address-based sample (ABS), combined with SSRS Opinion Panel, and prepaid cell phone sample. Other changes include expanding the survey to include all adults age 19 and older and making refinements to how we calculate poverty status and determine underinsurance for borderline cases. Collectively, these changes affect year-to-year differences in our trend questions. For that reason, this year's brief does not report on trends.

The Commonwealth Fund Biennial Health Insurance Survey, 2022, was conducted by SSRS from March 28 through July 4, 2022. The survey consisted of telephone and online interviews in English and Spanish and was conducted among a random, nationally representative sample of 8,022 adults age 19 and older living in the continental United States. A combination of address-based, SSRS Opinion Panel, and prepaid cell phone samples were used to reach people. In all, 3,716 interviews were conducted online or on the phone via ABS, 3,656 were conducted online via the SSRS Opinion Panel, and 650 were conducted on prepaid cell phones.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses from low-income households. Statistical results were weighted in stages to compensate for sample designs and patterns of nonresponse that might bias results. The first stage involved applying a base weight to account for different selection probabilities and response rates across sample strata. In the second stage, sample demographics were poststratified to match population parameters. The data are weighted to the U.S. adult population by sex, age, education, geographic region, family size, race/ethnicity, population density, civic engagement, and frequency of internet use, using the 2019 and 2021 U.S. Census Bureau's Current Population Survey (CPS), the 2015–2019 American Community Survey (ACS) 5-Year Estimates, and Pew Research Center's 2021 National Public Opinion Reference Survey (NPORS).[22]

The resulting weighted sample is representative of the approximately 254 million U.S. adults age 19 and older. The survey has an overall maximum margin of sampling error of +/– 1.5 percentage points at the 95 percent confidence level. As estimates get further from 50 percent, the margin

of sampling error decreases. The ABS portion of the survey achieved an 11.4 percent response rate, the SSRS Opinion Panel portion achieved a 2 percent response rate, and the prepaid cell portion achieved a 2.9 percent response rate.

This brief focuses on adults under age 65. The resulting weighted sample is representative of approximately 196.7 million U.S. adults ages 19 to 64. The survey has a maximum margin of sampling error of +/– 1.7 percentage points at the 95 percent confidence level for this age group.

Refinements to Poverty Status

A respondent's household size and income are used to determine poverty status.

Previously, household size was determined by combining information about marital status and the presence of dependents under age 25 in the household, which resulted in a maximum possible household size of four persons. This year, we used a new survey question where respondents provided an open-ended numeric response. This allowed us to use the full U.S. Federal Poverty Guidelines up to 14 household members.

To create a fully populated income variable, we used hot deck imputation to populate income ranges for respondents that did not answer income questions. We then generated random exact incomes for each respondent. Respondent incomes within each income range were assumed to be uniformly distributed and were assigned using a standard increment between each income based on the size of the income range and the number of respondents with incomes in the range.

The more precise household size and random exact incomes were used to determine poverty status for all respondents according to the 2021 U.S. Federal Poverty Guidelines.

Refinements to Underinsurance Components

Underinsured adults are individuals who are insured all year but report at least one of three indicators of financial exposure relative to income: 1) out-of-pocket costs, excluding premiums, are equal to 10 percent or more of household income; or 2) out-pocket-costs, excluding premiums, are equal to 5 percent or more of household income (if living under 200 percent of the federal poverty level); or 3) their deductible is 5 percent or more of household income.

For each of the three underinsurance component measures, there are borderline cases for which the income ranges provided are too imprecise to categorize the respondent into "less than" or "more than" the stated underinsurance component. Previously, the Fund redistributed borderline cases for each component by conducting a 50/50 split into the "less than" and "more than" categories. This year we leveraged the imputed income ranges and random exact incomes generated to determine poverty status to categorize borderline cases.

Additionally, for those respondents who provided deductibles, we duplicated the methodology used to determine random exact incomes to compute random exact deductibles. These exact deductibles were compared to exact incomes to categorize borderline cases for the component of underinsurance that relates deductible to income.

Estimates of U.S. Uninsured Rates

Survey	Current uninsured rate [confidence interval]	Population	Time frame of survey	Time frame of reference	Sample frame
Commonwealth Fund Biennial Health Insurance Survey[23]	8.9 [8.0, 9.9]	U.S. adults ages 19–64	March–July 2022	At the time of interview	Address-based probability sample supplemented with SSRS probability panel, prepaid cell phone probability sample; online and telephone interviews
National Health Interview Survey (NHIS)[24]	11.8 [10.3, 13.3]	U.S. adults ages 18–64	January–March 2022	At the time of interview	Multistage area probability design; personal household interviews[25]
Current Population Survey (CPS)[26]	11.6 [11.3, 11.9]	U.S. adults ages 19–64	February–April 2022	Previous calendar year	Probability-selected sample; personal and telephone interviews[27]

NOTES

1 Sara R. Collins, "Americans Are on the Brink of Experiencing Premium Pain and Health Insurance Loss," *To the Point* (blog), Commonwealth Fund, July 13, 2022.

2 Sara R. Collins, *Status of U.S. Health Insurance and Policy Levers to Expand Coverage and Lower Consumer Costs*, invited testimony, U.S. House of Representatives Committee on Oversight and Reform, Hearing on "Examining Pathways to Universal Health Coverage," Mar. 29, 2022.

3 Consumer Financial Protection Bureau, *Medical Debt Burden in the United States* (CFPB, Feb. 2022).

4 Jack Hoadley, Madeline O'Brien, and Kevin Lucia, *No Surprises Act: A Federal–State Partnership to Protect Consumers from Surprise Medical Bills* (Commonwealth Fund, forthcoming).

5 D. Keith Branham et al., *Health Insurance Deductibles Among HealthCare.Gov Enrollees, 2017–2021*, HSS/ASPE issue brief no. HP-2022-02 (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Jan. 13, 2022).

6 Gary Claxton et al., *Employer Health Benefits 2021 Annual Survey* (Henry J. Kaiser Family Foundation, Nov. 2021); and Jesse C. Baumgartner, Munira Z. Gunja, and Sara R. Collins, *The New Gold Standard: How Changing the Marketplace Coverage Benchmark Could Impact Affordability* (Commonwealth Fund, Sept. 2022).

7 Robin A. Cohen and Amy E. Cha, *Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2021–March 2022* (National Center for Health Statistics, July 2022).

8 Sara R. Collins, "Americans Are on the Brink," 2022.

9 John Holahan and Michael Simpson, *Next Steps in Expanding Health Coverage and Affordability: What Policymakers Can Do Beyond the Inflation Reduction Act* (Commonwealth Fund, Sept. 2022); Sara Rosenbaum, "Expanding Health Coverage to the Poorest Residents of States That Have Not Expanded Medicaid," *To the Point* (blog), Commonwealth Fund, Feb. 1, 2022; and John Holahan et al., *Filling the Gap in States That Have Not Expanded Medicaid Eligibility* (Commonwealth Fund, June 2021, updated Oct. 5, 2021).

10 Sarah Sugar et al., *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic*, HHS/ASPE issue brief no. HP-2021-10 (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Apr. 2021).

11 Rachel Schwab, Rachel Swindle, and Justin Giovannelli, *Record Enrollment Underscores Importance of Marketplace Outreach to Promote More Affordable Plans* (Commonwealth Fund, forthcoming).

12 Even a less comprehensive, more narrowly targeted autoenrollment mechanism could significantly reduce the number of people without insurance. Under this approach, the federal government would treat all legal residents as insured, 12 months a year, regardless of whether they actively enrolled in a health plan. Income-related premiums would be collected through the tax system. See Linda J. Blumberg, John Holahan, and Jason Levitis, *How ^^ Auto-Enrollment Can Achieve Near-Universal Coverage: Policy and Implementation Issues* (Commonwealth Fund, June 2021).

13 Emily Curran et al., "In the Age of COVID-19, Short-Term Plans Fall Short for Consumers," *To the Point* (blog), Commonwealth Fund, May 12, 2020.

14 Mark A. Hall and Michael J. McCue, "Short-Term Health Insurance and the ACA Market," *To the Point* (blog), Commonwealth Fund, Mar. 16, 2022.

15 A bill introduced by Senator Jeanne Shaheen (D–N.H.) would raise the cost-protection of the marketplace benchmark plan and make more people eligible for cost-sharing subsidies (Improving Health Insurance Affordability Act of 2021, S. 499, 117th Cong. (2021), S. Doc. 1–6). This could eliminate deductibles for some people and reduce them for others by as much as $1,650 a year. See Linda J. Blumberg et al., *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Urban Institute, Oct. 2019); and Baumgartner et al., A New Gold Standard, 2022.

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17 Christopher F. Koller, "Health Care Costs — Mapping the Forest and Finding a Path," *View from Here* (blog), Milbank Memorial Fund, Feb. 21, 2019.

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21 Choose Medicare Act, H.R. 5011, 117th Cong. (2021), H.R. Doc. 1–32; Medicare-X Choice Act of 2021, H.R. 1227, 117th Cong. (2021), H.R. Doc. 1–24; Medicare-X Choice Act of 2021, S. 386, 117th Cong. (2021), S. Doc. 1–25; State Public Option Act, H.R. 4974, 117th Cong. (2021), H.R. Doc. 1–27; State Public Option Act, S. 2639, 117th Cong. (2021), S. Doc. 1–27; Public Option Deficit Reduction Act, H.R. 2010, 117th Cong. (2021), H.R. Doc. 1–17; CHOICE Act, S. 983, 117th Cong. (2021), S. Doc. 1–12; Health Care Improvement Act of 2021, S. 352, 117th Cong. (2021), S. Doc. 1–75; State-Based Universal Health Care Act of 2021, H.R. 3775, 117th Cong. (2021), H.R. Doc. 1–30; Christine H. Monahan, Justin Giovannelli, and Kevin Lucia, "HHS Approves Nation's First Section 1332 Waiver for a Public Option–Style Health Care Plan in Colorado," *To the Point* (blog), Commonwealth Fund, July 12, 2022; Christine H. Monahan, Justin Giovannelli, and Kevin Lucia, "Update on State Public Option–Style Laws: Getting to More Affordable Coverage," *To the Point* (blog), Commonwealth Fund, Mar. 29, 2022; and Ann Hwang et al., *State Strategies for Slowing Health Care Cost Growth in the Commercial Market* (Commonwealth Fund, Feb. 2022).

22 Weights for sex, age, education, geographic region, family size, and race/ethnicity were determined using the 2021 Annual Social and Economic Supplement for the CPS; population density using the 2015–2019 ACS 5-Year Estimates; civic engagement using the 2019 Volunteering and Civic Life Supplement of the CPS; and frequency of internet use using Pew Research Center's 2021 NPORS.

23 Commonwealth Fund Biennial Health Insurance Survey, 2022.

24 Cohen and Cha, *Health Insurance Coverage: Early Release,* 2022.

25 National Center for Health Statistics, "About the National Health Interview Survey," updated Jan. 16, 2019.

26 Katherine Keisler-Starkey and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2021* (U.S. Census Bureau, Sept. 2022).

27 Bureau of Labor Statistics, *Design and Methodology: Current Population Survey — America's Source for Labor Force Data*, Technical Paper 77 (U.S. Census Bureau, Oct. 2019).

TABLE 1

Insurance Status by Demographics, 2022 (base: adults ages 19–64)

	Total (19–64)	Insured all year		Insured all year				Uninsured any time in the past year		Uninsured any time in the past year			
				Insured all year, not underinsured		Insured all year, underinsured				Insured now, had a gap		Uninsured now	
		Point estimate	CI	Point estimate	CI	Point estimate	CI	Point estimate	CI	Point estimate	CI	Point estimate	CI
Percent distribution	100%	80.1%	78.7%, 81.4%	56.6%	55.0%, 58.3%	23.4%	22.0%, 24.9%	19.9%	18.6%, 21.3%	11.0%	10.0%, 12.1%	8.9%	8.0%, 9.9%
Unweighted n	6,301	5,091		3,657		1,434		1,210		723		487	
Gender													
Male	48	78		59		20		22		11		11	
Female	51	82		55		27		18		11		8	
Age													
19–34	36	71		48		23		29		17		12	
35–49	32	81		61		20		19		10		9	
50–64	32	89		62		27		11		6		5	
Race/Ethnicity													
Non-Hispanic White	58	85		58		26		15		9		7	
Non-Hispanic Black	13	74		58		16		26		17		9	
Hispanic	19	68		47		21		32		15		17	
Hispanic, U.S.-born	13	75		53		22		25		15		10	
Hispanic, Foreign-born	6	53		35		18		47		15		32	
Asian/Pacific Islander	7	85		62		23		15		10		5	
Other/Mixed	2	81		58		23		19		13		7	
Poverty status													
Below 133% poverty	36	68		42		26		32		17		15	
133%–249%	22	77		45		32		23		11		11	
250%–399%	17	87		63		24		13		7		5	
400% poverty or more	25	94		83		11		6		4		1	
Under 200% poverty	50	70		43		28		30		16		14	
200% poverty or more	50	90		71		19		10		6		4	
Fair/Poor health status, or any chronic condition*													
No	41	80		59		20		20		11		10	
Yes	59	80		55		26		20		11		8	
Adult work status													
Not working	32	78		53		25		22		12		10	
Full-time	56	83		61		22		17		10		7	
Part-time	11	72		46		26		28		14		14	
Employer size**													
1–19 employees	22	70		46		24		30		13		17	
20–49 employees	10	72		49		22		28		15		14	
50–99 employees	7	76		53		23		24		15		10	
100 or more employees	60	88		65		22		12		8		4	
Medicaid expansion													
Did not expand Medicaid	32	74		47		27		26		11		15	
Expanded Medicaid	68	83		61		22		17		11		6	
U.S. Census region													
Northeast	17	85		63		23		15		10		5	
Midwest	20	84		58		26		16		10		6	
South	38	75		50		25		25		12		13	
West	24	81		62		19		19		11		8	

NOTES

CI = confidence interval. The survey has an overall maximum margin of sampling error of +/– 1.7 percentage points at the 95 percent confidence level (CI). As estimates get further from 50 percent, the margin of sampling error decreases. "Insured all year" refers to adults who were insured for the full year up to and on the survey field date; "Underinsured" is defined as insured all year but experienced one of the following: out-of-pocket expenses, excluding premiums, equaled 10% or more of household income; out-of-pocket expenses, excluding premiums, equaled 5% or more of household income if low income (<200% of poverty); or deductibles equaled 5% or more of household income; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to adults who reported being uninsured at the time of the survey.

* At least one of the following health problems: hypertension or high blood pressure; heart failure or heart attack; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

** Base: Full- and part-time employed adults ages 19–64.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2022).

TABLE 2

Duration of Gap in Coverage by Demographics, 2022 (base: adults ages 19–64)

		Uninsured any time in the past year				Uninsured now	
	Uninsured any time in the past year	3 months or less	4–11 months	1 year or more	Uninsured now	11 months or less	1 year or more
Percent distribution	100%	20%	23%	55%	100%	20%	79%
Unweighted n	1,210	280	305	612	487	118	364
Gender							
Male	51	49	45	55	56	50	57
Female	47	50	52	44	43	50	43
Age							
19–34	52	57	58	49	50	52	49
35–49	30	29	27	32	32	37	32
50–64	17	14	14	18	18	11	19
Race/Ethnicity							
Non-Hispanic White	44	49	45	42	43	45	43
Non-Hispanic Black	17	17	21	15	13	18	12
Hispanic	31	20	27	36	37	28	39
Hispanic, U.S.-born	16	15	17	17	15	15	15
Hispanic, Foreign-born	15	5	10	19	22	12	24
Asian/Pacific Islander	6	12	5	4	4	8	3
Other/Mixed	2	3	3	2	2	0	2
Poverty status							
Below 133% poverty	57	47	55	61	59	49	61
133%–249%	25	24	26	26	28	31	27
250%–399%	11	12	14	8	10	15	9
400% poverty or more	7	16	5	4	3	6	3
Under 200% poverty	74	64	71	79	76	66	78
200% poverty or more	26	36	29	21	24	34	22
Fair/Poor health status, or any chronic condition*							
No	42	42	46	41	44	51	43
Yes	58	58	54	59	56	49	57
Adult work status							
Not working	36	36	30	37	37	34	37
Full-time	49	52	49	47	46	39	48
Part-time	16	11	21	15	17	26	15
Employer size**							
1–19 employees	35	22	25	44	44	–	48
20–49 employees	15	15	13	16	16	–	17
50–99 employees	10	10	14	8	9	–	7
100 or more employees	40	53	47	31	30	–	27
Medicaid expansion							
Did not expand Medicaid	41	27	35	50	52	50	53
Expanded Medicaid	58	73	64	50	48	50	46
U.S. Census region							
Northeast	12	17	17	9	9	8	10
Midwest	16	16	16	16	14	14	13
South	47	39	41	54	55	53	56
West	24	27	26	20	22	25	20

NOTES

"Uninsured any time in the past year" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date or who reported being uninsured at the time of the survey. There were 13 respondents who were uninsured any time in the past year who did not provide a duration of time without coverage. "Uninsured now" refers to adults who reported being uninsured at the time of the survey. There were five respondents who were uninsured at the time of the survey who did not provide a duration of time without coverage.

* At least one of the following health problems: hypertension or high blood pressure; heart failure or heart attack; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

** Base: Full- and part-time employed adults ages 19–64.

– Sample size too small to report results.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2022).

TABLE 3

Underinsured Indicators, 2022 (base: adults insured all year, ages 19–64)

	Unweighted n (Insured all year)	Out-of-pocket medical expenses equal 10% or more of household income	Out-of-pocket medical expenses equal 5% or more of household income if low income*	Either out-of-pocket indicator	Deductible equals 5% or more of household income	Underinsured rate
Percent distribution	*100%*	14%	14%	19%	18%	29%
Base for rates above:	*5,091*	5,091	5,091	5,091	5,091	5,091
Gender						
Male	*2,004*	11	10	14	16	25
Female	*3,041*	17	17	23	19	33
Age						
19–34	*1,536*	16	17	21	20	32
35–49	*1,773*	12	12	16	13	25
50–64	*1,772*	16	12	19	19	30
Race/Ethnicity						
Non-Hispanic White	*2,310*	15	13	19	19	31
Non-Hispanic Black	*996*	12	14	16	10	22
Hispanic	*1,179*	16	19	22	16	30
Hispanic, US-born	*899*	14	18	21	16	29
Hispanic, Foreign-born	*280*	21	22	26	16	33
Asian/Pacific Islander	*367*	11	10	15	19	27
Other/Mixed	*208*	17	19	23	16	29
Poverty status						
Below 133% poverty	*1,316*	22	32	32	18	38
133%–249%	*1,100*	17	18	25	27	42
250%–399%	*986*	13	–	13	21	28
400% poverty or more	*1,689*	5	–	5	8	12
Under 200% poverty	*1,968*	21	31	31	20	39
200% poverty or more	*3,123*	10	–	10	16	21
Fair/Poor health status, or any chronic condition**						
No	*2,078*	11	11	15	17	25
Yes	*3,013*	17	16	22	18	32
Adult work status						
Not working	*1,435*	19	20	25	17	32
Full-time	*3,178*	11	9	14	18	26
Part-time	*473*	19	23	28	20	36
Employer size***						
1–19 employees	*605*	15	13	19	21	34
20–49 employees	*286*	15	18	22	21	31
50–99 employees	*270*	13	13	18	19	30
100 or more employees	*2,480*	11	9	15	16	25
Medicaid expansion						
Did not expand Medicaid	*1,580*	19	18	24	23	37
Expanded Medicaid	*3,499*	13	12	17	15	26
U.S. Census region						
Northeast	*899*	14	13	18	15	27
Midwest	*1,021*	14	12	19	21	31
South	*1,913*	17	16	22	20	33
West	*1,246*	11	12	16	13	23
Insurance type******						
Employer	*3,415*	13	10	17	19	29
Medicare	*340*	19	24	25	12	32
Medicaid	*751*	16	23	24	5	26
Individual (including Marketplace)	*375*	17	17	23	36	44
Other	*210*	12	10	14	12	20

NOTES

"Insured all year" refers to adults who were insured for the full year up to and on the survey field date. "Underinsured" is defined as insured all year but experienced one of the following: out-of-pocket expenses, excluding premiums, equaled 10% or more of household income; out-of-pocket expenses, excluding premiums, equaled 5% or more of household income if low income (<200% of poverty); or deductibles equaled 5% or more of household income.

* "Low income" defined as <200% of the federal poverty level.

** At least one of the following health problems: hypertension or high blood pressure; heart failure or heart attack; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

*** Base: Full- and part-time employed adults ages 19–64.

**** Insurance type at time of survey.

– No data. Analysis restricted to respondents with incomes below 200% of poverty.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2022).

TABLE 4

Access Problems, by Insurance Continuity, Insurance Adequacy, and Demographics, 2022 (base: adults ages 19–64)

			Insured all year		Uninsured at any time in the past 12 months	Uninsured at any time in the past 12 months		Race/Ethnicity			Poverty status	
	Total (19–64)	Insured all year	Insured all year, not underinsured	Insured all year, underinsured*		Insured now, had a gap	Uninsured now	Non-Hispanic White	Non-Hispanic Black	Hispanic	Under 200% FPL	200% FPL or more
Percent distribution	**100%**	**80%**	**57%**	**23%**	**20%**	**11%**	**9%**	**58%**	**13%**	**19%**	**50%**	**50%**
Unweighted n	*6,301*	*5,091*	*3,657*	*1,434*	*1,210*	*723*	*487*	*2,714*	*1,253*	*1,613*	*2,769*	*3,532*
Access problems in past year												
Went without needed care in past year because of costs:												
Did not fill prescription	23	20	15	31	36	39	33	22	25	27	27	19
Skipped recommended test, treatment, or follow-up	31	26	18	43	51	49	53	30	28	35	33	28
Had a medical problem, did not visit doctor or clinic	33	26	19	44	59	56	63	32	27	37	37	28
Did not get needed specialist care	28	23	16	40	48	47	49	28	23	30	31	24
At least one of four access problems because of cost	46	40	32	61	71	70	71	46	44	52	51	41
Dental care	43	38	32	53	65	62	69	42	43	52	52	35
Reason for skipped or delayed medical care because of cost**												
New health condition	30	32	33	30	26	24	28	30	26	29	28	32
Ongoing health condition	39	40	41	40	36	39	33	39	44	37	38	40
New and ongoing health conditions	30	27	25	30	37	37	37	31	28	33	32	28
Preventive care												
Regular source of care	88	93	92	93	68	82	51	89	91	84	85	90
Blood pressure checked in past two years¥	86	90	90	89	72	77	66	89	88	79	82	91
Received mammogram in past two years (females age 40+)	66	70	72	65	38	43	31	65	73	63	58	72
Received pap test in past three years (females ages 21–64)	64	68	71	63	46	52	39	63	66	65	58	70
Received colon cancer screening in past five years (age 50+)	64	67	68	65	39	49	28	64	69	62	60	67
Cholesterol checked in past five years¥¥	66	72	71	74	42	48	35	68	64	62	56	76
Seasonal flu shot in past 12 months	49	55	55	54	26	31	20	50	41	46	42	56
At least one dose of COVID vaccine	76	80	80	79	61	65	57	74	73	77	68	84
Access problems for people with health problems												
Unweighted n	*4,242*	*3,457*	*2,408*	*1,049*	*785*	*495*	*290*	*1,890*	*891*	*1,035*	*1,940*	*2,302*
Skipped does or not filled prescription for medications for the health problem(s)^ . . . because of the cost of the medicines?	19	15	10	27	36	35	37	17	22	23	24	14

NOTES

* "Underinsured" is defined as insured all year but experienced one of the following: out-of-pocket expenses, excluding premiums, equaled 10% or more of household income; out-of-pocket expenses, excluding premiums, equaled 5% or more of household income if low income (<200% of poverty); or deductibles equaled 5% or more of household income.

** Base: Respondents with any cost-related access problem, defined as did not fill a prescription for medcine because of cost, skipped a medical test, treatment or follow-up recommended by a doctor because of cost, had a medical problem but did not go to a doctor or clinic because of cost, or did not see a specialist when they or their doctor thought they needed one because of cost.

¥ In past year if respondent has hypertension or high blood pressure.

¥¥ In past year if respondent has hypertension or high blood pressure, heart disease, or high cholesterol.

^ Base: Respondens with at least one of the following health problems: hypertension or high blood pressure; heart failure or heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol; or depression, anxiety, or other mental health problem.

FPL = federal poverty level.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2022).

TABLE 5

Medical Bill Problems by Insurance Continuity, Insurance Adequacy, and Demographics, 2022 (base: adults ages 19–64)

			Insured all year		Uninsured at any time in the past 12 months	Uninsured at any time in the past 12 months		Race/Ethnicity			Poverty status	
	Total (19–64)	Insured all year	Insured all year, not underinsured	Insured all year, underinsured*	Uninsured at any time in the past 12 months	Insured now, had a gap	Uninsured now	Non-Hispanic White	Non-Hispanic Black	Hispanic	Under 200% FPL	200% FPL or more
Percent distribution	**100%**	**80%**	**57%**	**23%**	**20%**	**11%**	**9%**	**58%**	**13%**	**19%**	**50%**	**50%**
Unweighted n	*6,301*	*5,091*	*3,657*	*1,434*	*1,210*	*723*	*487*	*2,714*	*1,253*	*1,613*	*2,769*	*3,532*
Medical bill problems in past year												
Had problems paying or unable to pay medical bills	30	25	16	45	49	50	48	28	34	36	36	23
Contacted by collection agency for unpaid medical bills	23	19	15	31	37	38	35	21	33	27	29	17
Bill sent to collection agency because of billing mistake ¥	24	30	34	25	13	17	8	27	17	21	19	34
Bill sent to collection agency because unable to pay the bill ¥	75	70	66	75	87	83	92	73	81	78	81	66
Had to change way of life to pay bills	15	12	7	23	25	26	24	12	17	21	19	11
Any of above three bill problems	36	32	23	53	55	57	53	33	46	43	44	29
Medical bills/debt being paid off over time	25	24	17	39	33	36	30	25	30	27	27	24
Any bill problem or medical debt	42	37	27	60	60	62	57	39	51	48	48	35
Base: Any bill problem or medical debt												
Unweighted n	*2,749*	*2,012*	*1,126*	*886*	*737*	*453*	*284*	*1,054*	*658*	*791*	*1,430*	*1,319*
How much are the medical bills that are being paid off over time?												
Less than $2,000	43	44	52	36	42	39	47	41	51	45	45	42
$2,000 to less than $4,000	28	29	28	31	25	27	21	29	25	29	26	30
$4,000 to less than $8,000	16	16	12	20	17	21	11	17	13	14	15	18
$8,000 to less than $10,000	6	5	4	7	8	6	11	7	5	5	6	6
$10,000 or more	6	6	5	7	7	5	10	6	5	6	7	5
Was this for care received in the past year or earlier?												
Past year	47	47	49	46	45	47	43	48	44	43	41	54
Earlier year	32	33	37	29	30	32	28	30	34	39	36	27
Both	21	20	14	25	24	21	29	22	22	17	23	19
What type of care was this for?**												
Hospital inpatient or outpatient care	49	50	45	57	44	47	40	51	49	43	46	53
Doctor's office visit	36	36	33	40	36	36	35	36	41	33	36	37
Emergency room visit	39	34	33	36	49	48	50	36	47	39	44	32
Ambulance	10	10	9	11	12	14	8	11	12	8	12	8
Dental	4	5	4	5	3	2	4	5	2	4	4	4
Diagnostic testing	3	3	3	3	2	3	2	3	2	3	3	3

NOTES

* "Underinsured" is defined as insured all year but experienced one of the following: out-of-pocket expenses, excluding premiums, equaled 10% or more of household income; out-of-pocket expenses, excluding premiums, equaled 5% or more of household income if low income (<200% of poverty); or deductibles equaled 5% or more of household income.

** Respondents could select more than one type of care.

¥ Base: Adults ages 19–64 who indicated they were contacted by a collection agency for unpaid medical bills.

FPL = federal poverty level.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2022).

TABLE 5 (CONTINUED)

Medical Bill Problems by Insurance Continuity, Insurance Adequacy, and Demographics, 2022 (base: adults ages 19–64)

			Insured all year		Uninsured at any time in the past 12 months	Uninsured at any time in the past 12 months		Race/Ethnicity			Poverty status	
	Total (19–64)	Insured all year	Insured all year, not underinsured	Insured all year, underinsured*	Uninsured at any time in the past 12 months	Insured now, had a gap	Uninsured now	Non-Hispanic White	Non-Hispanic Black	Hispanic	Under 200% FPL	200% FPL or more
Percent distribution	**100%**	**80%**	**57%**	**23%**	**20%**	**11%**	**9%**	**58%**	**13%**	**19%**	**50%**	**50%**
Unweighted n	*6,301*	*5,091*	*3,657*	*1,434*	*1,210*	*723*	*487*	*2,714*	*1,253*	*1,613*	*2,769*	*3,532*
Base: Any bill problem or medical debt												
Unweighted n	*2,749*	*2,012*	*1,126*	*886*	*737*	*453*	*284*	*1,054*	*658*	*791*	*1,430*	*1,319*
Was this for a new or ongoing health condition?												
New condition	36	35	40	29	37	35	40	37	34	33	32	40
Ongoing condition	34	36	36	36	29	30	28	32	37	36	34	35
Both new and ongoing conditions	28	27	22	33	32	33	30	29	26	29	31	24
Insurance status of a person/s at time care was provided												
Insured at time care was provided	66	81	82	80	28	37	17	71	58	54	52	84
Uninsured at time care was provided	22	10	11	9	52	40	68	18	28	31	32	9
More than one person with medical bill problems and one person uninsured and the other insured	4	3	2	4	5	6	4	3	4	4	5	2
Medical bills from both insured and uninsured time periods	8	5	4	7	13	15	11	7	8	9	9	5
Were some or all medical bills the result of a surprise bill?												
Yes	48	48	48	48	47	54	38	46	50	46	48	47
No	52	52	52	52	52	46	60	54	50	53	51	53
Percent reporting that the following happened in the past two years because of medical bills:												
Unable to pay for basic necessities (food, heat, or rent)	26	22	16	28	36	36	36	21	24	36	34	15
Used up all savings	37	36	26	46	40	40	40	38	32	36	41	32
Took out a mortgage against your home or took out a loan	8	7	4	10	10	11	8	6	6	10	9	6
Took on credit card debt	39	40	32	48	37	39	34	41	30	37	35	45
Had to declare bankruptcy	4	4	3	5	6	6	7	4	3	6	6	3
Delayed education or career plans	22	18	15	23	30	29	32	20	18	25	26	16
Received a lower credit rating	41	39	37	41	47	47	48	44	46	36	45	36
Any financial problems resulting from medical debt	72	69	63	77	78	76	80	73	70	72	75	68

NOTES

* "Underinsured" is defined as insured all year but experienced one of the following: out-of-pocket expenses, excluding premiums, equaled 10% or more of household income; out-of-pocket expenses, excluding premiums, equaled 5% or more of household income if low income (<200% of poverty); or deductibles equaled 5% or more of household income.

FPL = federal poverty level.

DATA

Commonwealth Fund Biennial Health Insurance Survey (2022)

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