DATA BRIEF
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Inequities in Health Insurance Coverage and Access for Black and Hispanic Adults

The Impact of Medicaid Expansion and the Pandemic

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INTRODUCTION

Since its passage in 2010, the Affordable Care Act (ACA) has helped cut the U.S. uninsured rate nearly in half while significantly reducing racial and ethnic disparities in both insurance coverage and access to care — particularly in states that expanded their Medicaid programs.[1]

While much of that progress occurred between 2013 and 2016, federal data show that more than 5 million people gained coverage between 2020 and early 2022, driving the uninsured rate down to a historic low of 8 percent.[2] This recent progress has been driven by federal and state policy actions that increased Medicaid and ACA marketplace coverage, primarily:

- a requirement in the Families First Coronavirus Response Act of 2020 that states keep people with Medicaid coverage continuously enrolled during the COVID-19 public health emergency,[3] in exchange for greater federal funding
- additional states expanding eligibility for their Medicaid programs
- enhanced marketplace premium subsidies.[4]

In this brief, we update our 2020 and 2021 analyses of coverage and access inequities for Black and Hispanic adults in the U.S. using 2013–2021 data from the American Community Survey and the Behavioral Risk Factor Surveillance System. (For more detail, see "How We Conducted This Study.") With a focus on the effects of Medicaid expansion and pandemic-era coverage policies, our update examines trends among and disparities between Black, Hispanic, and white adults across the following measures:

- adults ages 19 to 64 who are uninsured
- adults ages 18 to 64 who went without care in the past 12 months because of cost
- adults ages 18 to 64 who report having a usual health care provider.

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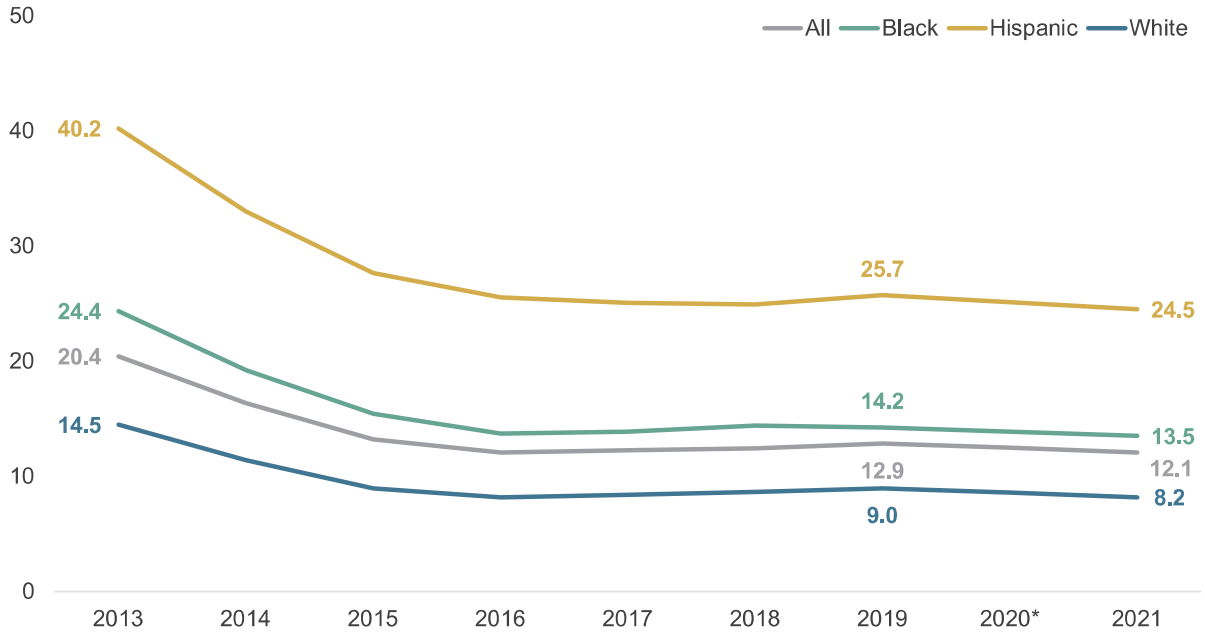
HIGHLIGHTS

- Insurance coverage rates improved for Black, Hispanic, and white adults between 2013 and 2021. The coverage gap between Black and white adults dropped from 9.9 to 5.3 percentage points, while the gap between Hispanic and white adults dropped from 25.7 to 16.3 points.
- Uninsured rates for adults in all three groups improved during the first two years of the COVID-19 pandemic, a finding that held true in states that had expanded Medicaid and those that had not. Black and Hispanic adults experienced larger gains in Medicaid and individual-market coverage than white adults between 2019 and 2021.
- Between 2013 and 2021, states that expanded Medicaid eligibility had higher rates of insurance coverage and health care access, with smaller disparities between racial/ethnic groups and larger improvements, than states that didn't expand Medicaid.
- After Virginia expanded Medicaid in 2019, its uninsured rate for lower-income adults dropped substantially in comparison to neighboring North Carolina, a nonexpansion state, and the disparities between Black and white adults narrowed.
- Compared to lower-income white adults, larger percentages of lower-income Black adults and lower-income Hispanic adults live in states that haven't expanded Medicaid.

Coverage inequities between Black, Hispanic, and white adults have narrowed substantially since 2013. All groups reported improvements between 2019 and 2021.

Percentage of U.S. adults ages 19–64 who are uninsured, by race/ethnicity



* The 2020 ACS PUMS was created using alternative "experimental" sample weights to account for disruptions to data collection resulting from the COVID-19 pandemic. Because the Census Bureau advises against comparing 2020 data to previous years, the 2020 data point has been omitted from this chart.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2021.

Black and Hispanic adults had higher uninsured rates than white adults in 2013, before the ACA took full effect. The disparities reflected lower access to employer-sponsored insurance[5] among people with low incomes, an unregulated and unsubsidized individual insurance market, and lack of Medicaid coverage for adults except for very low income parents in most states.

The ACA attempted to improve coverage rates in several ways, including: 1) by allowing states to expand Medicaid eligibility to everyone below 138 percent of the federal poverty level (in 2023, $20,120 for an individual and $41,400 for a family of four), funded nearly fully by the federal government; and 2) by subsidizing and regulating coverage purchased through the individual market.

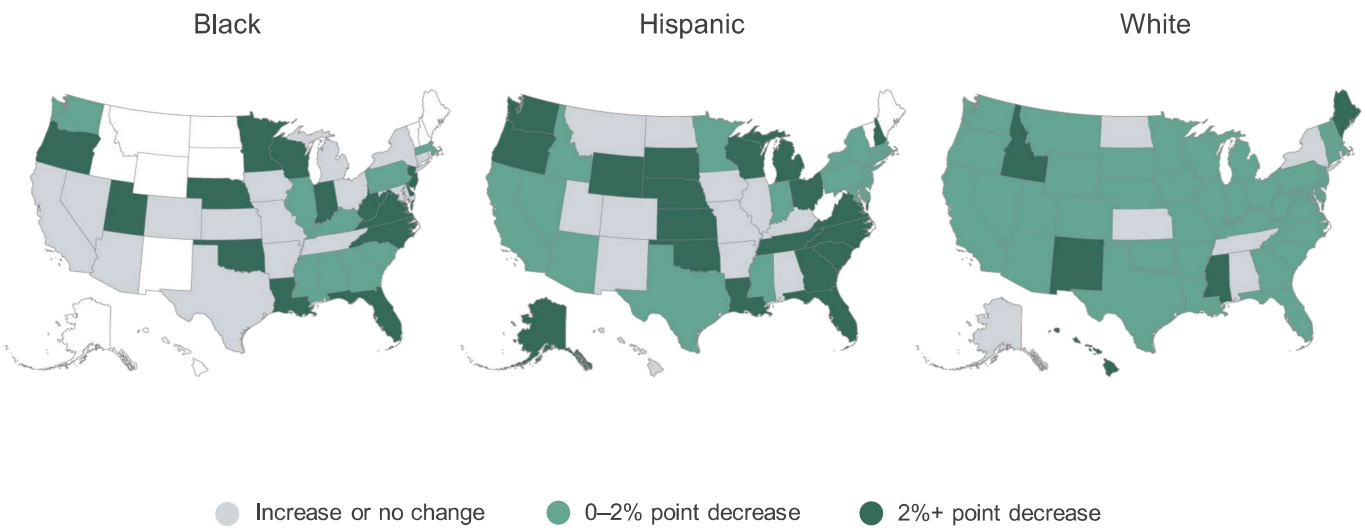
Uninsured rates for adults in each of the three racial/ethnic groups fell after the coverage expansions went into effect in 2014, and Black and Hispanic residents reported the largest gains. Uninsured rates for Hispanic adults fell by 15.7 percentage points between 2013 and 2021. The Black adult uninsured rate dropped by 10.9 points, and the white uninsured rate declined by 6.3 points (Table 1).

These gains reduced coverage disparities considerably. The gap between white and Black adults has dropped from 9.9 percentage points to 5.3 points, and the gap for Hispanic adults has declined from 25.7 to 16.3 points (Table 6).

While the largest coverage gains occurred from 2013 to 2016, adult uninsured rates for these three groups, and for the nation overall, dropped again between 2019 and 2021, as new federal policies aimed at boosting coverage took effect. In fact, they reached historic lows, despite modest declines in employer-based coverage from pandemic-related job losses.

Uninsured rates for Black and Hispanic adults improved considerably in several states between 2019 and 2021, while white adults experienced modest gains in most regions.

Percentage-point change in uninsured rate for U.S. adults ages 19–64 from 2019 to 2021, by state and race/ethnicity



Notes: No shading indicates ACS sample size did not support an estimate for group in that state. An improvement of 2 percentage points (dark green) is considered a high level of improvement, and is greater than or equal to one half (0.5) standard deviations of the state distribution in uninsured rates between the two time periods.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2019 and 2021.

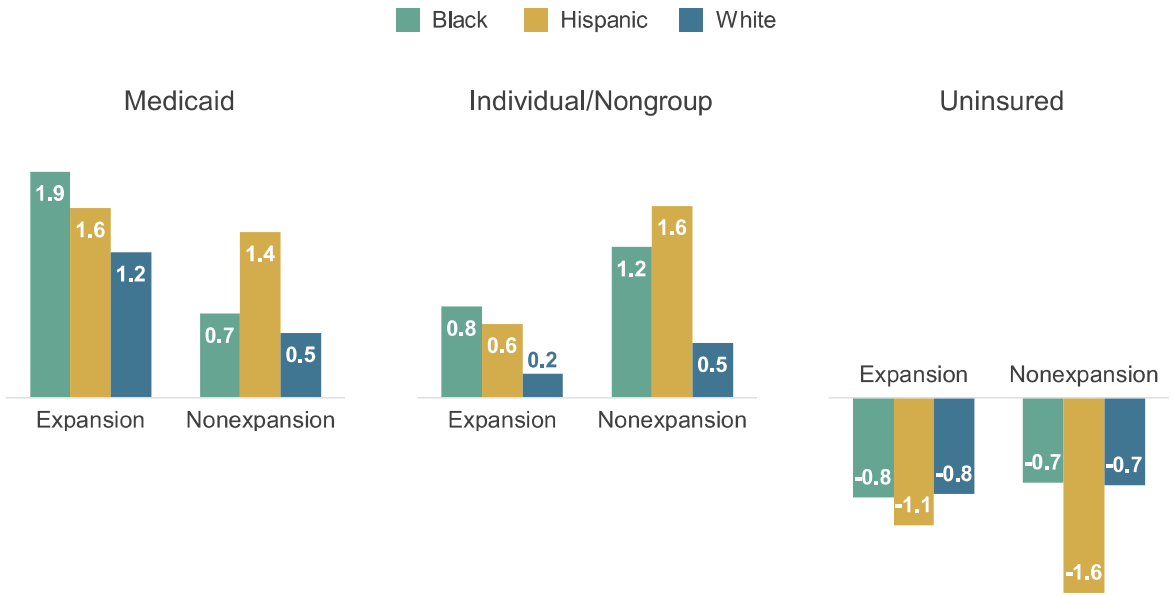
A wide range of states saw coverage gains for Black, Hispanic, and white adults between 2019 and 2021 during the first two years of the pandemic (Table 2).[6] Uninsured rates for Black adults fell at least two percentage points in 14 states, with Nebraska (which expanded Medicaid in 2020) seeing an 11-point improvement. Large coverage gains occurred in several southern states with large Black populations such as Virginia, which expanded Medicaid in 2019, and nonexpansion North Carolina and Florida.

In 19 states, uninsured rates for Hispanic adults declined at least two points as well, with notable progress in Florida as well as California, an expansion state.

White adults experienced modest improvements in coverage in nearly all states.

Medicaid and individual-market coverage gains helped drive lower uninsured rates for each of the three racial and ethnic groups between 2019 and 2021.

Percentage-point change in insurance by coverage source for U.S. adults ages 19–64 between 2019 and 2021, by race/ethnicity and Medicaid expansion status



Notes: Values represent the percentage-point change in the share of a group's total nonelderly adult population that reported having a certain coverage source or no coverage source. Changes in employer-based insurance, Medicare, or other insurance types are not shown. Expansion states are those that expanded Medicaid by January 1, 2021. As of that date, there were 14 states that had not yet expanded Medicaid. Oklahoma and Missouri implemented in mid-to-late 2021 and are considered nonexpansion states for this analysis.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2019 and 2021.

Coverage improvements during the pandemic between 2019 and 2021 have been attributed to several factors:

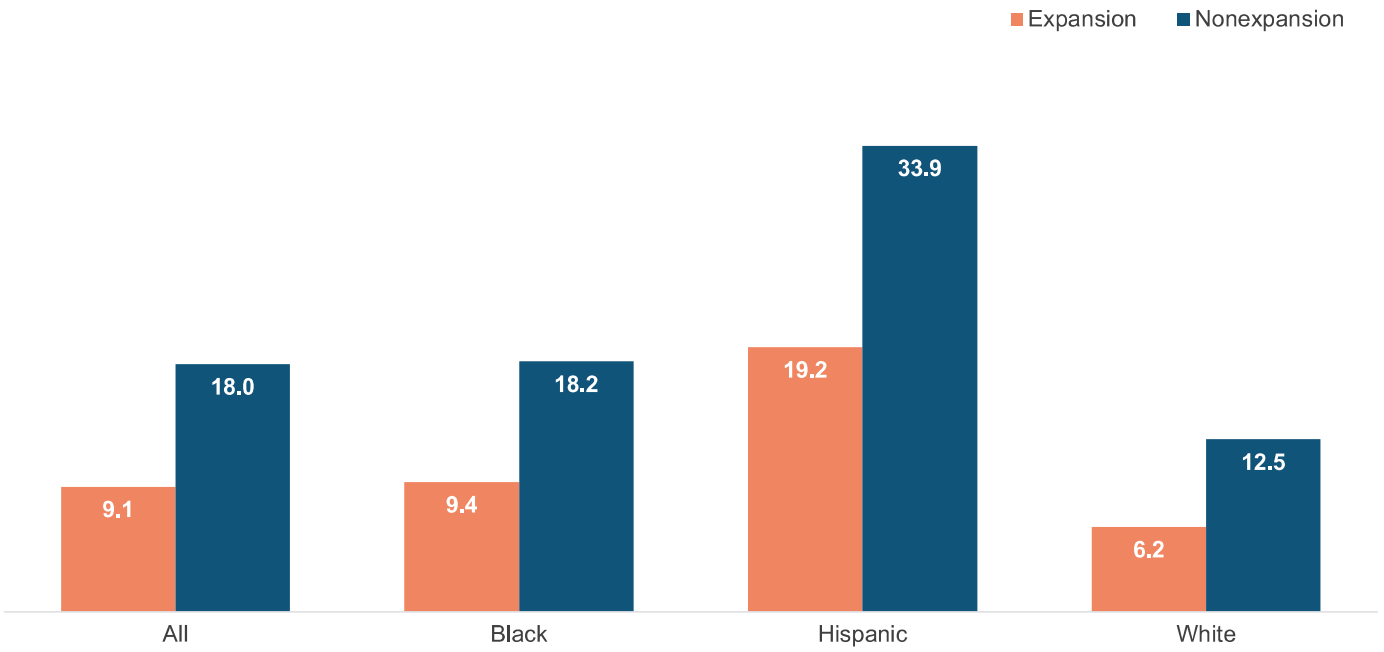
- lower-than-expected declines in employer coverage
- the ACA's coverage expansions, which acted as a safety-net for those who did lose employer coverage
- increased Medicaid coverage, as states implemented the Families First Coronavirus Response Act's continuous enrollment requirement and more states expanded Medicaid[7]
- increased marketplace coverage resulting from the American Rescue Plan Act's enhanced premium tax credits as well as federal and state outreach and enrollment efforts.[8]

We examined how these policies may have affected racial and ethnic groups differently during the 2019–21 period. We also looked for differences between adult residents of states that had expanded eligibility for their Medicaid program under the ACA as of January 1, 2021 (36 states plus the District of Columbia), and residents of the 14 states that had not.

We found that the percentage of adults in both expansion and nonexpansion states who reported having Medicaid or individual market coverage increased between 2019 and 2021, with Black and Hispanic adults seeing the largest coverage gains. Medicaid enrollment for each of the three groups increased the most in expansion states, while individual-market increases were larger in nonexpansion states. These coverage gains helped mitigate the loss of employer health benefits and lower uninsured rates overall in both expansion and nonexpansion states (Tables 1 and 3).[9]

Uninsured rates were lower and racial and ethnic disparities were smaller in states that expanded Medicaid.

Percentage of U.S. adults ages 19–64 who are uninsured, 2021, by race/ethnicity and Medicaid expansion status



Notes: Expansion states are those that expanded Medicaid by January 1, 2021. As of that date, there were 14 states that had not yet expanded Medicaid. Oklahoma and Missouri implemented in mid-to-late 2021 and are considered nonexpansion states for this analysis.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2021.

Recent policies during the pandemic have improved coverage in states that have and have not expanded Medicaid. However, uninsured rates for Black, Hispanic, and white adults continue to be much lower in expansion states — nearly half those for nonexpansion states.

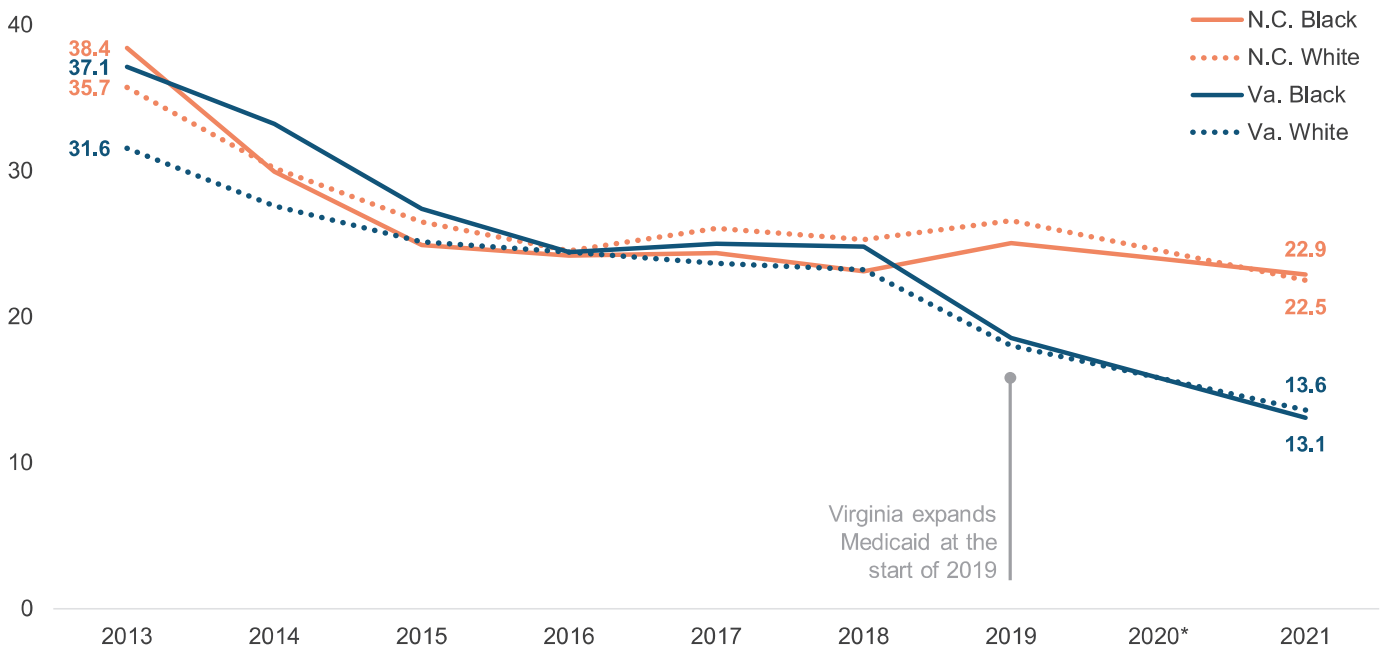
Residents of Medicaid expansion states also have made greater coverage gains since 2013, even though these states already had higher coverage rates than nonexpansion states prior to the ACA's insurance reforms in 2014 (Table 1).

These lower uninsured rates are associated with greater Medicaid coverage. Within each of the three racial/ethnic groups, the percentage of adults enrolled in Medicaid is around two to three times higher in expansion states (Table 3).

Coverage disparities were also much lower in Medicaid expansion states, and they decreased more over the 2013–21 period. For example, the difference between Black and white adult uninsured rates was 3.3 percentage points in Medicaid expansion states but 5.7 points in nonexpansion states. The difference between Hispanic and white adults was 13.1 points in expansion states but 21.4 points in nonexpansion states (Table 6).

After Virginia expanded Medicaid in 2019, uninsured rates for lower-income Black and white adults fell more than they did in nonexpansion North Carolina.

Percentage of U.S. adults ages 19–64 who are uninsured, Virginia and North Carolina, 0–199% FPL, by race/ethnicity



* The 2020 ACS PUMS was created using alternative "experimental" sample weights to account for disruptions to data collection resulting from the COVID-19 pandemic. Because the Census Bureau advises against comparing 2020 data to previous years, the 2020 data point has been omitted from this chart.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2021.

We also examined the effects of expanding Medicaid eligibility by looking at two neighboring states, Virginia and North Carolina. Neither state expanded Medicaid in 2014, when the ACA coverage expansions went into effect. But Virginia opted to expand its program in 2019, while North Carolina had not done so as of January 2021. However, the North Carolina legislature recently reached an agreement to expand, with a vote expected this summer.[10]

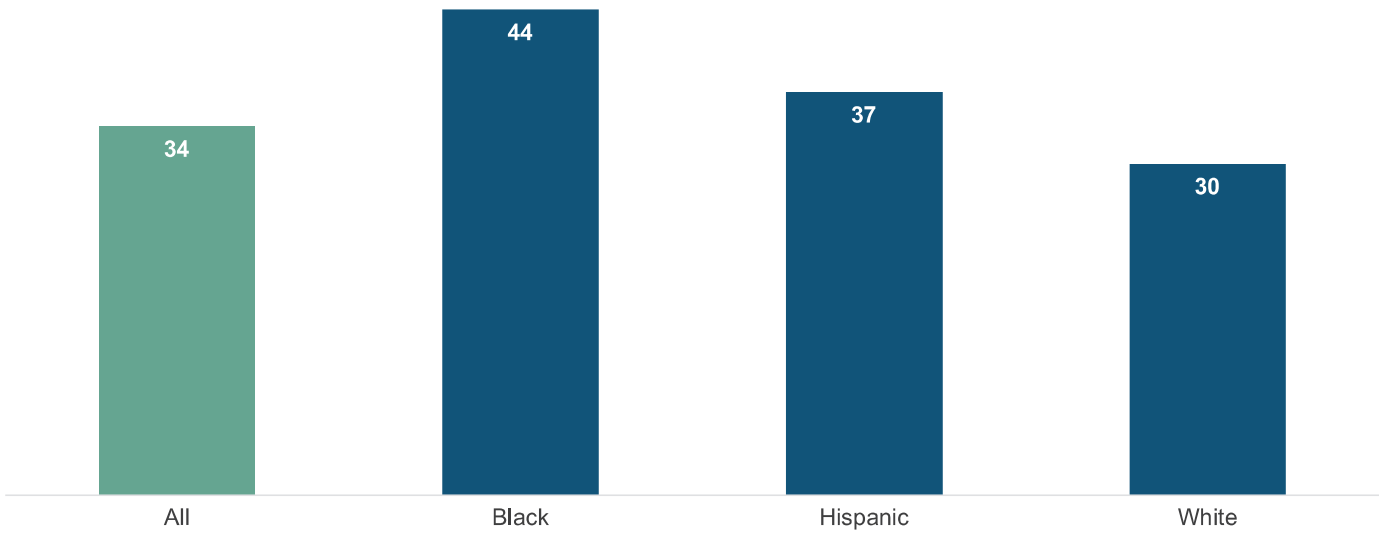
The uninsured rate for Black and white adults with incomes below 200 percent of the federal poverty level (in 2023, $29,160 for an individual and $60,000 for a family of four) declined in both states after 2013 but remained flat beginning in 2016.

After Virginia expanded Medicaid in 2019, uninsured rates for both Black and white lower-income adults dropped another 10 to 11 percentage points. By contrast, rates in North Carolina dipped modestly between 2019 and 2021 reflecting pandemic-related Medicaid and marketplace policy changes.

Because Black Virginians have lower incomes than white residents on average,[11] Medicaid expansion has helped narrow the state's overall Black–white coverage disparity from 6.1 percentage points in 2018 to 2.9 points in 2021 (Table 4).

More than two of five low-income Black adults in the U.S. live in the 12 states that have not expanded Medicaid.

Percentage of low-income U.S. adults (<138% FPL) ages 19–64 who live in Medicaid nonexpansion states, by race/ethnicity



Notes: Calculation based on whether states have expanded Medicaid; currently, 12 states have not yet expanded. FPL = federal poverty level.

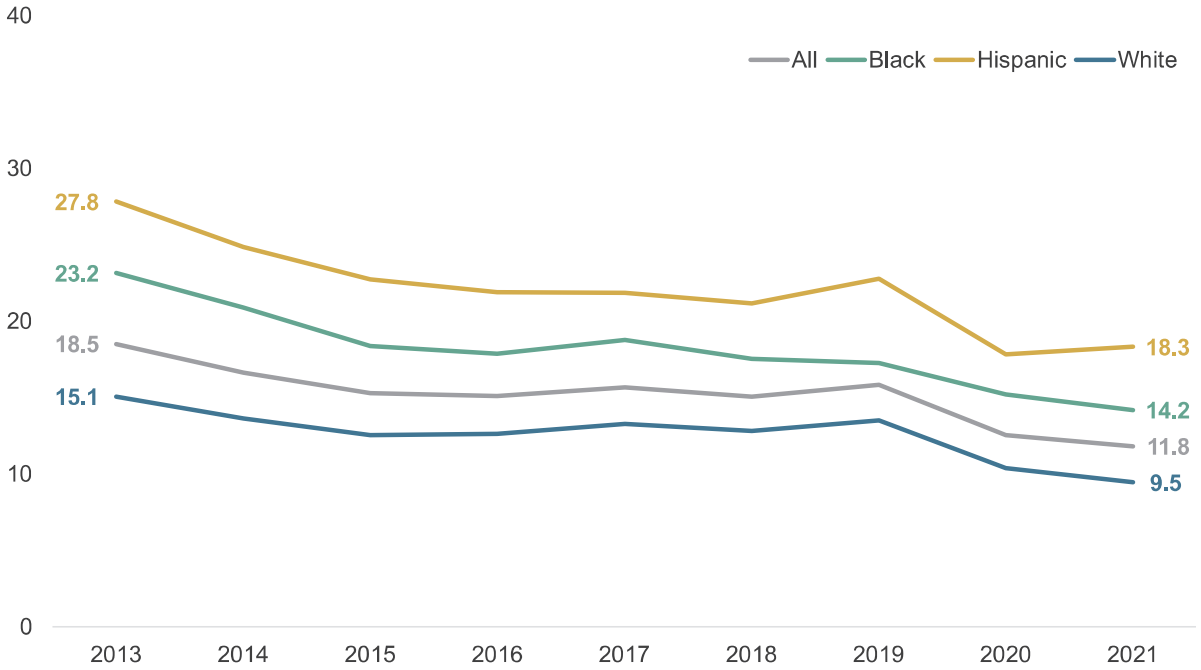
Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2021.

While Medicaid expansion has helped produce greater coverage gains and smaller disparities, the impact of the policy has been unevenly distributed because many states, including some of the most populated in the country, have yet to expand their programs.

Particularly concerning is the fact that a disproportionate share of low-income Black adults — 44 percent — live in the 12 states that had not yet expanded during the study period.[12] This includes four states that have among the highest number of Black residents: Texas, Florida, Georgia, and North Carolina. Thirty percent of low-income white adults live in those 12 states.

Cost-related problems accessing health care declined for working-age adults across racial and ethnic groups since 2013, and disparities between white adults and Black and Hispanic adults narrowed.

Percentage of U.S. adults ages 18–64 who avoided care because of cost in the past 12 months, by race/ethnicity



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2021.

By expanding coverage options and lowering the risk for incurring high out-of-pocket costs, the ACA reduced the financial barriers that previously had prevented many Americans from getting needed health care at the right time.[13]

Black and Hispanic adults have experienced a greater reduction in cost-related access problems than white adults since 2013 (Table 5). Still, since Black and Hispanic adults had much higher rates of cost-related access problems than white adults did in 2013, those improvements have not fully eliminated disparities in access.

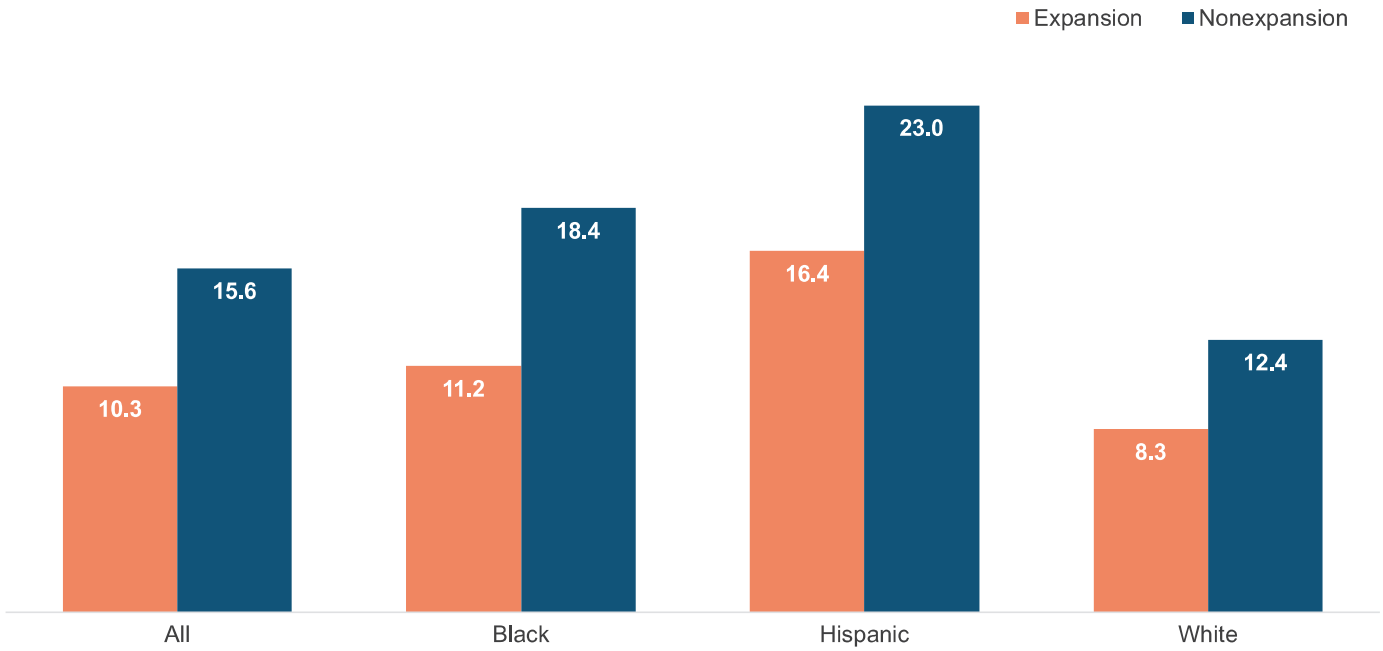
The percentage of Hispanic adults who said they avoided care because of cost dropped by 9.5 percentage points from 2013 to 2021. Cost-related access barriers for Black adults fell by 9.0 points and for white adults by 5.6 points.

While the initial reduction in cost-related access problems occurred between 2013 and 2016, adults within these three groups reported significantly fewer problems after 2019 — perhaps driven by pandemic-related restrictions that deterred people from seeking care altogether.[14]

The reduction in cost barriers has helped narrow disparities in access to care. The Black–white disparity in cost-related access problems dropped from 8.1 to 4.7 percentage points, while the Hispanic–white disparity declined from 12.7 to 8.9 points (Table 6).

Adults living in Medicaid expansion states had lower cost-related access barriers and narrower racial/ethnic disparities in access to care.

Percentage of U.S. adults ages 18–64 who avoided care because of cost in the past 12 months, 2021, by race/ethnicity and Medicaid expansion status



Notes: Expansion states are those that expanded Medicaid by January 1, 2021. As of that date, there were 14 states that had not yet expanded Medicaid. Oklahoma and Missouri implemented in mid-to-late 2021 and are considered nonexpansion states for this analysis.

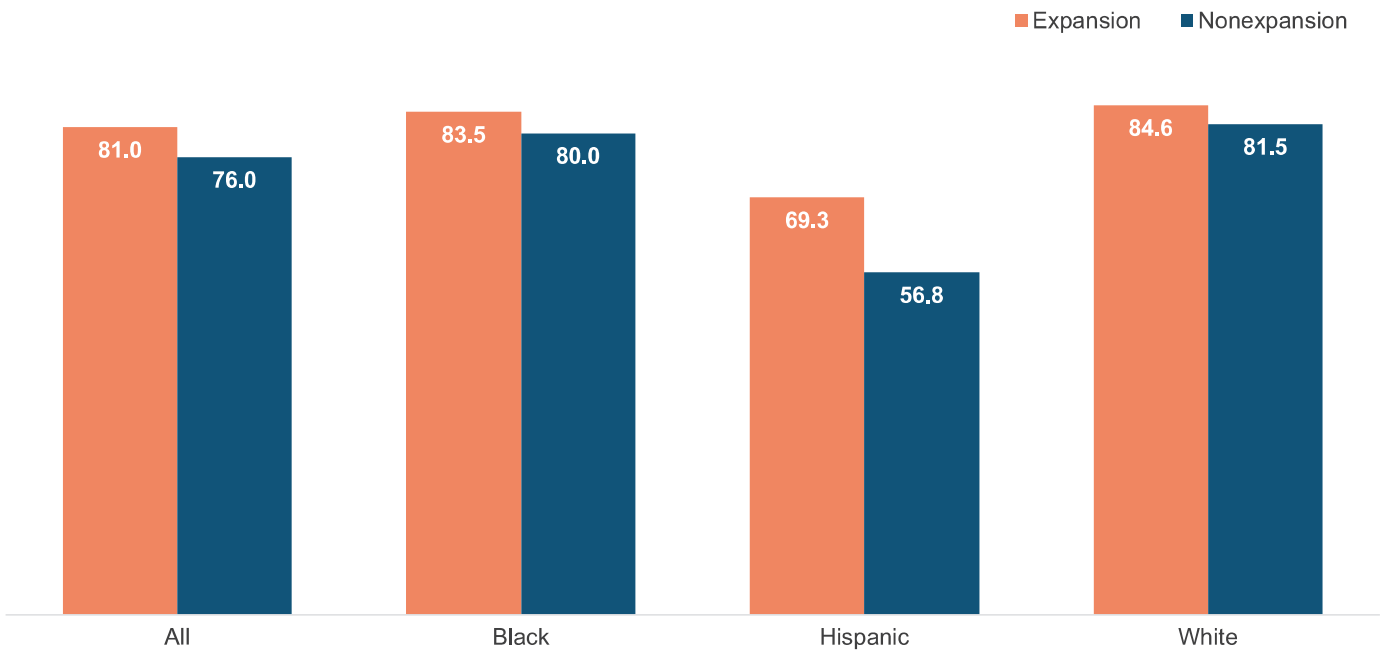
Data: Behavioral Risk Factor Surveillance System (BRFSS), 2021.

Within each of the three racial/ethnic groups, proportionately fewer adults in Medicaid expansion states reported cost-related barriers to getting care, and differences between groups were smaller.

Black and Hispanic adults in Medicaid expansion states have seen cost barriers reduced more since 2013 compared to their counterparts in nonexpansion states, even though they were starting from a baseline of lower access problems (Tables 5 and 6).

Adults living in Medicaid expansion states report having a usual care provider at higher rates along with smaller differences between racial and ethnic groups.

Percentage of U.S. adults ages 18–64 who reported a usual source of care, 2021, by race/ethnicity and Medicaid expansion status



Notes: Expansion states are those that expanded Medicaid by January 1, 2021. As of that date, there were 14 states that had not yet expanded Medicaid. Oklahoma and Missouri implemented in mid-to-late 2021 and are considered nonexpansion states for this analysis.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2021.

Having a usual source of care, like a regular primary care doctor, is also considered a strong indicator of health care access. Being insured makes this more likely.[15]

The gap between Black and white adults who reported having a usual health care provider was fewer than 2 percentage points in 2021 (82.0% vs. 83.7%).[16] In contrast, just 65.7 percent of Hispanic adults, who are uninsured at higher rates, reported having a usual care provider (Table 5).

Across each of these three groups, larger shares of adults living in Medicaid expansion states compared to nonexpansion states reported having a usual source of care (Table 5).

POLICY IMPLICATIONS

The Affordable Care Act has been a powerful force for racial equity in health and health care over the past decade. The expansion in access to affordable coverage has served as the backbone for this progress, helping to remove financial barriers and increase access to primary care clinics and other providers where people can get the care they need to stay healthy.[17] This access has become even more critical during the COVID-19 pandemic.

An important part of these improvements is the law's Medicaid eligibility expansion. As we've shown here, Medicaid expansion continues to be associated with greater coverage gains, better access, and narrower racial/ethnic disparities across states. A growing body of research also points to a wide array of improved clinical outcomes, including mortality.[18]

Seven new states have expanded their Medicaid programs since 2019 (Idaho, Maine, Missouri, Nebraska, Oklahoma, Utah, and Virginia). South Dakota recently passed a ballot initiative to expand Medicaid, while several other states, including North Carolina, Wyoming, and Kansas, are considering legislative action or a ballot initiative.[19]

Medicaid, along with marketplace coverage, has helped maintain and improve coverage levels during the pandemic, in large part because of the continuous enrollment requirement of the Families First Coronavirus Response Act, which has increased enrollment by more than 21 million people.[20] In line with federal data, our analysis points to the critical role of Medicaid in recent coverage gains across both expansion and nonexpansion states, especially for Black and Hispanic adults.[21]

Along with enhanced premium subsidies in the ACA marketplaces (now extended through 2025) and increased federal funding for marketplace outreach and enrollment activities that lifted enrollment to a record 16 million this year, these policies have helped lower-income Americans, particularly people of color, get affordable health insurance and remain enrolled.[22]

Despite this progress, key health outcomes such as life expectancy and maternal mortality have worsened during the pandemic, particularly for people of color.[23] Achieving full equity in insurance coverage is critical to reversing those trends, particularly since certain COVID-19 treatment and testing benefits are scheduled to sunset when the public health emergency ends in May.[24] Protecting progress made and avoiding further coverage gaps will require action on the part of state and federal legislators, including:

- **Filling the Medicaid coverage gap.** Despite increased financial incentives during the pandemic, 11 states have yet to expand Medicaid, including some of the most populous and racially/ethnically diverse states. Congress could create a federal fallback option for Medicaid-eligible people in these states.[25] The Urban Institute estimates that this reform would cover nearly half a million additional Black residents and shrink the Black–white coverage disparity among nonelderly people to a single percentage point.[26]
- **Minimizing coverage loss during Medicaid eligibility redeterminations.** Black and Hispanic people are disproportionately enrolled in Medicaid and thus are especially at risk of losing coverage as states begin to redetermine eligibility on April 1, 2023.[27] The Biden administration has emphasized the need for states to do this slowly, allowing them 14 months to complete the process and requiring them to use up-to-date information to ensure against disenrolling people who remain eligible. While the federal omnibus bill phases down the federal matching funds and gives the federal government leverage to stop disenrollment in states that don't follow federal guidelines, the phase-down is rapid, ending in nine months.[28] This gives states an incentive to move quickly.[29] As many as 15 million people are projected to be disenrolled, nearly half of whom will likely lose coverage because of administrative churn.[30]

- **Allowing longer continuous eligibility within Medicaid.** Disruption in Medicaid coverage because of eligibility changes, administrative errors, and other factors can leave people uninsured and unable to get care. Congress could apply the lessons of the pandemic and give states the option to maintain continuous enrollment eligibility for 12 months without the need to apply for a waiver, just as they have for children in Medicaid and the Children's Health Insurance Program.[31]
- **Permanently extending enhanced marketplace premium subsidies beyond 2025.** The primary reason people give for not enrolling in marketplace plans is the cost of the premium.[32] A permanent extension of the enhanced marketplace subsidies is needed to keep people enrolled in plans and encourage new enrollment in the future.
- **Creating an autoenrollment mechanism.** Research shows that many uninsured people are eligible for Medicaid or subsidized marketplace coverage. Congress could allow people to autoenroll in comprehensive health coverage. The Urban Institute has shown that a comprehensive autoenrollment option has the potential to move the nation to near-universal coverage, and less-comprehensive reforms could still cover millions more.[33]

HOW WE CONDUCTED THIS STUDY

Indicators and Data Sources

- Percentage of uninsured adults and insurance coverage type distribution for ages 19–64: U.S. Census Bureau, American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2021.
- Percentage of adults ages 18–64 who went without care because of cost during the past year and percentage of adults ages 18–64 who had a usual source of care: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2013–2021.

The ACS PUMS and BRFSS are large federal surveys used to track demographic and health characteristics of the U.S. population.

The ACS samples approximately 3.5 million individuals each year, with annual response rates typically above 90 percent. The Census Bureau makes a portion of the ACS response records available to researchers in the Public Use Microdata Sample. Of note, the 2020 ACS PUMS was created using alternative "experimental" sample weights to account for disruptions to data collection resulting from the COVID-19 pandemic; because the Census Bureau advises against comparing 2020 data to previous years, the 2020 data point has been omitted from trend charts in this report.

The Centers for Disease Control and Prevention conducts the BRFSS each year in partnership with implementing agencies in each state. The 2021 BRFSS had a response rate just below 50 percent, with approximately 439,000 completed responses; similar response rates were seen in previous years. Florida did not meet inclusion criteria for the 2021 BRFSS dataset. In the 2021 survey, BRFSS introduced a notable change to its annual question about whether people have a provider that they consider to be their usual source of care by specifying that it could be either one person "or a group of doctors." The change appears to have had a significant impact on survey responses, with respondents much more likely to give an affirmative answer. Because of this impact, we did not include 2013–2020 trend data for the metric within this report.

Analytical Approach

We stratified survey respondents by their self-reported race and ethnicity: Black (non-Hispanic); Hispanic (any race); and white (non-Hispanic). We calculated national and state annual averages from 2013 to 2021 for each of the indicators listed above, stratified by race/ethnicity. We also calculated the average annual rate for Black, Hispanic, and white adults from 2013 to 2021 across two categories of states: the Medicaid expansion group, which included the 36 states that, along with the District of Columbia, had expanded their Medicaid programs under the ACA as of January 1, 2021; and the nonexpansion group, which comprised the 14 states that had not expanded Medicaid as of that time (Oklahoma and Missouri implemented in mid-to-late 2021 and are considered nonexpansion for this analysis). Reported values for expansion/nonexpansion categories are averages among survey respondents, not averages of state rates.

Subpopulation rates based on small samples were suppressed. Estimates derived from ACS PUMS and BRFSS were suppressed if the measures' relative standard error (standard error divided by the estimate) were less than 30 percent.

NOTES

1. Aiden Lee et al., *National Uninsured Rate Reaches All-Time Low in Early 2022* (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Aug. 2022); Jesse C. Baumgartner et al., *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care* (Commonwealth Fund, Jan. 2020); and Munira Z. Gunja et al., *Gap Closed: The Affordable Care Act's Impact on Asian Americans' Health Coverage* (Commonwealth Fund, July 2020).
2. Lee et al., *National Uninsured Rate*, 2022.
3. The recently passed federal omnibus spending bill has changed the provision and now allows states to begin processing Medicaid eligibility redeterminations and resume disenrollments on April 1, 2023. States have one year to initiate the process and two additional months to finish it.
4. 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.
5. Katherine Keisler-Starkey and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2021* (U.S. Census Bureau, Sept. 2022).
6. We follow the Census Bureau's approach from its recent ACS 2021 survey brief and focus on changes between 2019 and 2021 (Douglas Conway and Breauna Branch, *Health Insurance Coverage Status and Type by Geography: 2019 and 2021*, U.S. Census Bureau, Sept. 2022). The 2020 ACS PUMS was created using alternative "experimental" sample weights to account for disruptions to data collection resulting from the COVID-19 pandemic, and the Census Bureau advises against comparing 2020 data to previous years.
7. Collins, "Americans Are on the Brink," 2022.
8. Rachel Schwab, Rachel Swindle, and Justin Giovannelli, *State-Based Marketplace Outreach Strategies for Boosting Health Plan Enrollment of the Uninsured* (Commonwealth Fund, Oct. 2022).
9. The difference between the 2019 and 2021 uninsured rates for Black adults living in nonexpansion states is not statistically significant.
10. Lucille Sherman, "North Carolina Republicans Reach Agreement to Expand Medicaid," *Axios*, Mar. 3, 2023.
11. Authors' analysis of Virginia race/ethnicity and income demographics data from 2021 ACS PUMS.
12. South Dakota is scheduled to implement its Medicaid expansion in July 2023 after passing a ballot initiative in November 2022.
13. Sherry A. Glied, Sara R. Collins, and Saunders Lin, "Did the ACA Lower Americans' Financial Barriers to Health Care?," *Health Affairs* 39, no. 3 (Mar. 2020): 379–86.
14. In the 2021 survey, BRFSS also introduced a small change to its annual question about whether people avoided seeking care in the past year because of cost concerns. Prior to 2021, the question read "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" It was changed in 2021 to focus more explicitly on affordability, "Was there a time in the past 12 months when you needed to see a doctor but could not because you could not afford it?" The difference in rates between 2020 and 2021 is modest — it is unknown if the observed differences resulted from the change in the question's wording, were related to respondents' ability to access care throughout the pandemic, or the result of normal year-to-year survey variation.
15. See "Access to Primary Care," Healthy People 2030, healthypeople.gov.
16. In the 2021 survey, BRFSS introduced a notable change to its annual question about whether people have a provider that they consider to be their usual source of care. The change appears to have had a significant impact on survey responses, with respondents more likely to give an affirmative answer. Because of this change, we do not report trend data for this measure in the report.
17. David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).

18. Sarah Miller, Norman Johnson, and Laura R. Wherry, "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," *Quarterly Journal of Economics* 136, no. 3 (Aug. 2021): 1783–1829.

19. Dan Goldberg, "North Carolina Republicans Announce Deal to Expand Medicaid," *Politico*, Mar. 2, 2023; and Akeiisa Coleman and Sara Federman, "Where Do the States Stand on Medicaid Expansion?," *To the Point* (blog), Commonwealth Fund, Oct. 27, 2022.

20. Center for Medicaid and CHIP Services, *November 2022 Medicaid and CHIP Enrollment Trends Snapshot* (Centers for Medicare and Medicaid Services, Feb. 2023).

21. Keisler-Starkey and Bunch, *Health Insurance Coverage, 2022*; Conway and Branch, *Health Insurance Coverage Status*, 2022; and Lucy Chen et al., *HealthCare.gov Enrollment by Race and Ethnicity, 2015–2022* (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Oct. 2022).

22. Schwab, Swindle, and Giovannelli, *State-Based Marketplace Outreach*, 2022; Akilah Johnson, "Communities of Color Record Big Gains in Health Insurance Coverage," *Washington Post*, Oct. 27, 2022.

23. Elizabeth Arias et al., *Provisional Life Expectancy Estimates for 2021* (National Center for Health Statistics, Aug. 2022); and Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020* (National Center for Health Statistics, Feb. 2022).

24. Dani Blum, "What the End of the COVID Public Health Emergency Could Mean for You," *New York Times*, Feb. 1, 2023.

25. 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.

26. 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).

27. Jamila Taylor, "How CMS Can Improve Health Equity Through the Medicaid and CHIP Programs," The Century Foundation, May 2, 2022; and Patricia M. Boozang and Adam D. Striar, "The End of the COVID-19 PHE and Medicaid Continuous Coverage: Health Equity Implications," *Health Highlights* (newsletter), Manatt Health, Oct. 5, 2021.

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31. Sara R. Collins and Lauren A. Haynes, "Congress Can Give States the Option to Keep Adults Covered in Medicaid," *To the Point* (blog), Commonwealth Fund, Nov. 14, 2022.

32. Sara R. Collins, Lauren A. Haynes, and Relebohile Masitha, *The State of U.S. Health Insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (Commonwealth Fund, Sept. 2022).

33. The approach 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).

TABLE 1

Uninsured Rates by Demographics, 2013–2021 (adults ages 19–64)

	United States					Expansion states					Nonexpansion states				
	2013	2016	2019	2021	Net change (% points)	2013	2016	2019	2021	Net change (% points)	2013	2016	2019	2021	Net change (% points)
TOTAL	20.4	12.1	12.9	12.1	-8.3	18.3	9.4	9.9	9.1	-9.2	24.8	17.4	18.8	18.0	-6.8
Race/Ethnicity															
Black	24.4	13.7	14.2	13.5	-10.9	21.5	10.2	10.3	9.4	-12.1	27.8	17.9	18.9	18.2	-9.6
Hispanic	40.2	25.5	25.7	24.5	-15.7	36.5	20.6	20.3	19.2	-17.3	47.2	34.8	35.5	33.9	-13.4
White	14.5	8.2	9.0	8.2	-6.3	13.1	6.4	7.0	6.2	-7.0	17.5	11.9	13.3	12.5	-4.9
Income															
0–199% FPL	37.9	23.1	23.9	22.5	-15.4	34.7	17.8	17.8	16.3	-18.4	43.6	32.4	34.2	32.8	-10.8
200%–399% FPL	20.0	12.9	15.0	14.2	-5.8	18.8	11.0	12.6	11.6	-7.2	22.4	16.4	19.3	18.7	-3.7
400%+ FPL	6.7	4.1	5.2	5.0	-1.7	6.2	3.4	4.3	4.0	-2.2	8.0	5.7	7.2	7.2	-0.8
Race/Ethnicity, by income															
0–199% FPL															
Black	34.4	20.3	20.6	19.4	-15.0	30.6	14.4	13.6	12.3	-18.3	38.6	26.8	28.0	27.0	-11.6
Hispanic	54.0	36.7	37.8	36.0	-18.0	49.0	29.0	29.0	27.5	-21.6	63.0	50.1	51.8	49.8	-13.3
White	31.2	17.5	18.6	16.9	-14.3	28.8	13.3	13.7	12.0	-16.8	35.9	25.5	27.6	26.1	-9.8
200%–399% FPL															
Black	20.5	11.9	13.9	13.2	-7.3	19.3	10.2	11.0	10.3	-9.0	21.9	13.8	16.8	16.2	-5.7
Hispanic	35.5	23.2	25.3	24.6	-11.0	32.8	19.5	21.2	20.5	-12.3	40.8	30.0	32.5	31.6	-9.2
White	15.3	9.6	11.4	10.5	-4.8	14.5	8.2	9.6	8.5	-6.0	17.0	12.4	14.9	14.2	-2.8
400%+ FPL															
Black	10.2	5.6	6.8	6.8	-3.4	9.7	4.7	5.9	5.7	-4.0	11.1	7.1	8.1	8.4	-2.7
Hispanic	15.0	9.5	11.3	11.2	-3.8	13.9	8.2	9.4	9.3	-4.6	17.3	12.2	15.4	15.2	-2.1
White	5.2	3.1	4.0	3.7	-1.5	4.8	2.6	3.3	3.0	-1.9	6.2	4.4	5.7	5.4	-0.8

NOTES
Expansion states are those that expanded Medicaid by January 1, 2021. As of that date, there were 14 states that had not yet expanded Medicaid. Oklahoma and Missouri implemented in mid-to-late 2021 and are considered nonexpansion for this analysis. FPL = federal poverty level.

DATA
American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2021.

TABLE 2

Uninsured Rates by State and Race/Ethnicity, 2013–2021 (adults ages 19–64)

	All						Black						Hispanic						White					
	2013	2016	2019	2021	Net change (% points)	Remaining uninsured, 2021 (thousands)	2013	2016	2019	2021	Net change (% points)	Remaining uninsured, 2021 (thousands)	2013	2016	2019	2021	Net change (% points)	Remaining uninsured, 2021 (thousands)	2013	2016	2019	2021	Net change (% points)	Remaining uninsured, 2021 (thousands)
United States	**20**	**12**	**13**	**12**	**-8**	**23,544**	**24**	**14**	**14**	**13**	**-11**	**3,138**	**40**	**26**	**26**	**24**	**-16**	**9,049**	**14**	**8**	**9**	**8**	**-6**	**9,218**
Alabama	20	14	15	15	-5	440	24	17	17	16	-8	121	59	43	39	45	-14	57	17	11	13	13	-4	240
* Alaska	24	18	15	14	-10	60	29	–	–	–	–	–	24	17	29	17	-7	5	18	13	10	11	-7	27
* Arizona	24	14	15	15	-9	604	23	11	13	13	-10	25	38	23	25	24	-14	325	16	8	10	9	-7	186
* Arkansas	24	12	13	13	-11	228	28	10	12	13	-15	32	51	34	33	37	-14	52	21	10	11	10	-11	121
* California	24	10	11	10	-14	2,334	21	8	8	8	-13	101	38	18	18	17	-21	1,583	14	5	6	5	-9	392
* Colorado	19	10	10	11	-8	386	20	8	10	11	-9	14	35	23	20	23	-12	173	14	7	8	7	-7	164
* Connecticut	13	7	8	7	-6	158	18	8	8	9	-9	21	29	18	19	18	-11	68	9	4	5	4	-6	51
* Delaware	14	8	10	8	-6	49	14	8	11	8	-6	10	32	24	25	24	-7	14	12	6	7	6	-6	20
* District of Columbia	8	5	4	4	-4	19	11	5	7	6	-5	10	15	14	7	8	-7	4	4	2	2	2	-2	3
Florida	29	18	19	18	-11	2,218	33	19	21	19	-14	363	43	27	26	23	-20	849	22	14	15	14	-7	856
Georgia	26	18	19	18	-8	1,156	28	18	19	18	-10	364	60	47	46	42	-18	259	19	14	15	14	-5	449
* Hawaii	10	5	6	5	-5	41	–	–	–	–	–	–	8	8	7	9	1	7	12	4	7	5	-7	8
* Idaho	23	15	16	12	-11	127	–	–	–	–	–	–	44	35	28	27	-17	39	20	12	14	9	-11	76
* Illinois	18	9	10	10	-8	752	26	10	12	11	-15	109	39	24	22	23	-16	314	12	6	7	6	-5	271
* Indiana	19	11	12	10	-9	396	27	13	14	12	-15	42	41	29	24	22	-19	63	17	9	10	9	-8	263
* Iowa	12	6	7	7	-5	127	21	9	12	14	-6	9	31	21	19	23	-8	26	11	5	6	5	-6	80
Kansas	18	12	13	14	-4	226	24	24	19	20	-4	18	42	30	32	30	-12	62	14	8	10	10	-4	124
* Kentucky	21	7	9	8	-13	204	26	7	11	9	-16	17	53	30	28	31	-21	30	19	6	8	7	-13	144
* Louisiana	25	15	13	11	-14	290	31	17	13	11	-20	91	53	44	39	34	-18	47	19	12	10	9	-10	130
* Maine	16	11	11	8	-8	64	–	–	–	–	–	–	34	22	–	9	-24	2	16	11	11	8	-8	57
* Maryland	14	8	8	8	-6	297	15	8	7	7	-7	80	41	31	30	29	-13	115	9	5	4	4	-4	71
* Massachusetts	5	4	4	3	-2	146	10	6	7	6	-4	16	12	7	8	7	-5	37	4	3	3	2	-2	66
* Michigan	16	8	8	7	-9	431	24	9	9	10	-15	74	30	18	18	16	-14	52	14	6	7	6	-8	269
* Minnesota	11	6	7	6	-5	195	21	10	14	6	-15	14	39	25	21	19	-20	36	8	4	5	5	-4	119
Mississippi	25	18	19	18	-7	295	30	21	22	20	-10	120	50	41	43	43	-7	22	20	15	17	15	-6	135
Missouri	18	13	14	13	-5	474	27	16	17	18	-9	69	40	33	29	29	-11	45	16	11	13	12	-4	319
* Montana	23	12	12	11	-13	67	–	–	–	–	–	–	31	21	16	19	-12	5	20	11	10	9	-11	49
* Nebraska	15	12	11	10	-6	106	30	23	23	11	-19	6	38	32	30	28	-10	36	11	9	8	6	-5	55
* Nevada	27	15	16	15	-12	284	31	12	11	13	-18	21	41	29	27	26	-15	145	20	9	11	9	-11	75
* New Hampshire	16	9	9	7	-9	56	–	–	–	–	–	–	24	11	22	14	-10	5	15	9	8	6	-9	45
* New Jersey	19	11	11	10	-9	563	22	12	12	10	-12	70	41	28	26	25	-16	303	11	5	6	5	-6	130
* New Mexico	28	13	14	14	-14	169	31	10	14	–	–	–	35	15	16	17	-17	104	15	7	9	7	-8	27
* New York	15	9	8	7	-8	874	17	9	8	8	-9	128	29	17	15	14	-15	328	10	5	4	5	-5	284
North Carolina	23	15	17	15	-8	923	27	16	17	15	-12	190	59	44	45	41	-18	245	17	11	12	11	-5	417
* North Dakota	14	9	9	10	-4	43	–	–	–	–	–	–	–	33	18	20	–	4	11	6	6	8	-3	29
* Ohio	16	8	9	9	-7	603	22	10	12	12	-10	95	34	22	22	19	-15	52	14	7	8	8	-6	408
Oklahoma	25	20	22	20	-4	457	27	22	22	19	-8	30	51	42	41	38	-13	95	19	14	17	16	-3	228
* Oregon	21	9	10	9	-13	221	20	8	10	7	-13	3	43	21	24	20	-22	71	18	7	8	7	-12	124
* Pennsylvania	14	8	8	7	-6	556	22	10	9	9	-13	65	28	20	18	18	-11	110	11	6	6	6	-5	333
* Rhode Island	17	6	6	6	-10	41	22	7	7	12	-10	3	43	16	14	13	-30	15	12	4	4	4	-7	19
South Carolina	23	15	16	15	-8	441	27	16	17	15	-11	115	56	47	43	40	-16	74	18	12	13	12	-6	222
South Dakota	17	12	14	13	-5	63	–	24	–	40	–	3	49	28	27	23	-27	4	13	8	10	9	-4	35
Tennessee	20	14	15	15	-5	605	23	15	16	16	-6	104	60	49	51	43	-17	100	17	11	12	12	-5	364
Texas	30	23	24	24	-5	4,228	27	19	20	21	-6	438	47	37	38	38	-9	2,614	17	13	15	14	-3	963
* Utah	18	12	12	11	-6	218	20	–	27	18	-2	4	42	31	29	31	-11	86	14	8	9	8	-6	112
* Vermont	10	5	7	5	-5	19	–	–	–	–	–	–	–	–	–	–	–	–	10	5	6	5	-5	17
* Virginia	17	12	11	9	-8	472	22	13	12	9	-13	83	44	34	33	28	-15	145	12	9	8	6	-6	185
* Washington	20	9	9	9	-11	426	23	9	12	11	-12	20	47	26	28	26	-21	154	16	6	6	6	-9	190
* West Virginia	20	8	10	9	-11	94	21	13	13	8	-13	2	54	22	–	22	-32	4	20	7	10	9	-11	83
Wisconsin	13	7	8	7	-6	249	22	12	12	11	-11	21	35	23	30	23	-12	57	10	5	6	5	-5	146
Wyoming	18	15	17	16	-2	51	–	–	–	–	–	–	28	21	29	22	-6	7	16	14	14	14	-3	37

NOTES

* State had expanded its Medicaid program under the Affordable Care Act as of January 1, 2021.

(–) means there was not sufficient sample size to estimate the rate.

DATA

American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2021.

TABLE 3

Coverage Source Percent Distribution, by Race/Ethnicity, 2013–2021 (adults ages 19–64)

	United States			Expansion states			Nonexpansion states		
	2013	2019	2021	2013	2019	2021	2013	2019	2021
TOTAL (ALL)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer-based	59.7	62.9	62.3	61.4	64.4	63.7	56.1	60.1	59.5
Individual purchase	6.8	8.0	8.4	6.8	7.5	7.8	6.7	8.9	9.7
Medicaid	8.3	11.6	12.8	9.2	14.0	15.4	6.5	6.8	7.5
Medicare	3.1	3.2	3.0	2.9	3.0	2.8	3.5	3.5	3.2
Other	1.7	1.5	1.5	1.4	1.3	1.2	2.3	2.0	2.0
Uninsured	20.4	12.9	12.1	18.3	9.9	9.1	24.8	18.8	18.0
TOTAL (Black)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer-based	49.8	55.2	54.2	50.5	55.2	53.9	48.9	55.3	54.5
Individual purchase	3.4	5.3	6.3	3.3	4.6	5.3	3.7	6.2	7.5
Medicaid	15.3	18.3	19.6	18.2	23.7	25.5	11.8	12.0	12.7
Medicare	4.8	4.8	4.6	4.6	4.7	4.4	5.1	5.0	4.7
Other	2.3	2.1	1.9	2.0	1.7	1.4	2.7	2.5	2.4
Uninsured	24.4	14.2	13.5	21.5	10.3	9.4	27.8	18.9	18.2
TOTAL (Hispanic)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer-based	41.5	49.1	47.9	43.1	50.7	49.6	38.4	46.1	44.9
Individual purchase	3.6	6.4	7.4	3.4	5.3	5.9	3.8	8.5	10.1
Medicaid	11.6	15.6	17.1	14.0	20.8	22.3	6.9	6.4	7.8
Medicare	2.1	2.2	2.1	2.1	2.1	2.1	2.1	2.2	2.0
Other	1.1	1.0	1.0	0.9	0.8	0.8	1.5	1.3	1.4
Uninsured	40.2	25.7	24.5	36.5	20.3	19.2	47.2	35.5	33.9
TOTAL (White)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Employer-based	66.5	68.8	68.6	68.0	70.0	69.7	63.3	66.2	66.2
Individual purchase	8.0	8.6	8.9	7.9	8.2	8.4	8.2	9.4	9.8
Medicaid	6.0	8.8	9.8	6.4	10.4	11.6	5.0	5.4	6.0
Medicare	3.2	3.3	3.1	3.1	3.2	2.9	3.6	3.6	3.3
Other	1.8	1.6	1.5	1.5	1.3	1.2	2.4	2.1	2.1
Uninsured	14.5	9.0	8.2	13.1	7.0	6.2	17.5	13.3	12.5

NOTES
Expansion states are those that expanded Medicaid by January 1, 2021. As of that date, there were 14 states that had not yet expanded Medicaid. Oklahoma and Missouri implemented in mid-to-late 2021; they are considered nonexpansion for this analysis.

DATA
American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2021.

TABLE 4

North Carolina and Virginia Uninsured Rates by Demographics, 2013–2021 (adults ages 19–64)

	North Carolina					Virginia				
	2013	2018	2019	2021	Net change (% points)	2013	2018	2019	2021	Net change (% points)
TOTAL	22.7	15.7	16.5	15.0	-7.7	17.3	12.2	11.1	9.4	-7.9
Race/Ethnicity										
Black	27.0	16.0	17.4	15.3	-11.7	22.2	14.8	12.1	9.1	-13.1
Hispanic	59.4	43.9	45.4	41.5	-17.9	43.7	32.3	33.2	28.2	-15.5
White	16.5	11.8	12.3	11.1	-5.4	12.3	8.7	7.7	6.2	-6.0
Income										
0–199% FPL	42.0	29.9	31.0	27.9	-14.1	38.3	27.8	23.4	18.7	-19.6
200%–399% FPL	18.9	15.5	17.0	16.5	-2.5	18.4	14.3	14.6	12.9	-5.5
400%+ FPL	6.0	5.0	5.8	5.5	-0.4	5.7	4.3	4.4	4.1	-1.6
Race/Ethnicity, by income										
0–199% FPL										
Black	38.4	23.1	25.1	22.9	-15.6	37.1	24.8	18.6	13.1	-24.0
Hispanic	73.2	60.3	60.4	55.9	-17.2	67.0	54.1	52.7	47.5	-19.5
White	35.7	25.3	26.6	22.5	-13.2	31.6	23.2	18.0	13.6	-17.9
200%–399% FPL										
Black	20.4	14.0	16.4	14.4	-6.0	18.0	13.7	13.3	10.2	-7.9
Hispanic	47.2	34.3	39.1	37.6	-9.6	42.6	33.8	37.6	31.2	-11.4
White	14.9	13.4	13.8	13.4	-1.5	14.2	10.7	10.9	9.4	-4.8
400%+ FPL										
Black	10.0	8.0	7.6	6.4	-3.6	8.8	6.9	5.8	5.5	-3.4
Hispanic	16.3	13.5	23.0	18.4	2.1	16.3	11.5	13.7	12.8	-3.5
White	4.8	4.1	4.6	4.6	-0.2	4.0	3.3	3.2	2.7	-1.3

NOTE
FPL = federal poverty level.

DATA
American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2021.

TABLE 5

Rates for Additional Access Indicators by Race/Ethnicity, 2013–2021 (adults ages 18–64)

	United States					Expansion states					Nonexpansion states				
	2013	2016	2019	2021	Net change (% points)	2013	2016	2019	2021	Net change (% points)	2013	2016	2019	2021	Net change (% points)
Care avoided because of cost in previous 12 months															
TOTAL	18.5	15.1	15.9	11.8	-6.7	17.0	13.4	13.9	10.3	-6.8	21.6	18.6	19.6	15.6	-6.0
Race/Ethnicity															
Black	23.2	17.9	17.3	14.2	-9.0	20.9	15.2	14.2	11.2	-9.7	25.9	21.2	20.8	18.4	-7.6
Hispanic	27.8	21.9	22.8	18.3	-9.5	26.3	19.9	20.6	16.4	-9.9	30.7	25.7	26.6	23.0	-7.7
White	15.1	12.7	13.5	9.5	-5.6	14.0	11.3	12.0	8.3	-5.7	17.4	15.5	16.7	12.4	-5.1
Usual source of care															
TOTAL				79.5	N/A				81.0	N/A				76.0	N/A
Race/Ethnicity															
Black				82.0	N/A				83.5	N/A				80.0	N/A
Hispanic				65.7	N/A				69.3	N/A				56.8	N/A
White				83.7	N/A				84.6	N/A				81.5	N/A

NOTES
Expansion states are those that expanded Medicaid by January 1, 2021. As of that date, there were 14 states that had not yet expanded Medicaid. Oklahoma and Missouri implemented in mid-to-late 2021 and are considered nonexpansion for this analysis. In 2021, BRFSS changed the wording to its question on whether a respondent has a usual source of care. This change appears to have had a significant impact on respondent answers and increased the percentage of people who answered "Yes." Because of this change, we did not include 2013–2020 trend data for the metric within this report. Florida did not meet inclusion criteria for the 2021 BRFSS dataset.

DATA
Behavioral Risk Factor Surveillance System (BRFSS), 2013–2021.

TABLE 6

Disparity Trends in Insurance Coverage and Access, 2013–2021

	Black–white disparity (percentage points)			Hispanic–white disparity (percentage points)		
	2013	2021	Net change (% points)	2013	2021	Net change (% points)
Uninsured rates (adults ages 19–64)*						
U.S. average	9.9	5.3	-4.6	25.7	16.3	-9.5
Expansion states	8.4	3.3	-5.2	23.4	13.1	-10.3
Nonexpansion states	10.3	5.7	-4.7	29.8	21.4	-8.4
Care avoided because of cost (adults ages 18–64)**						
U.S. average	8.1	4.7	-3.4	12.7	8.9	-3.9
Expansion states	6.8	2.9	-4.0	12.3	8.1	-4.2
Nonexpansion states	8.5	6.0	-2.5	13.3	10.7	-2.6
Usual source of care (adults ages 18–64)**						
U.S. average		1.7	N/A		18.0	N/A
Expansion states		1.1	N/A		15.3	N/A
Nonexpansion states		1.5	N/A		24.6	N/A

NOTES
Expansion states are those that expanded Medicaid by January 1, 2021. As of that date, there were 14 states that had not yet expanded Medicaid. Oklahoma and Missouri implemented in mid-to-late 2021 and are considered nonexpansion for this analysis. In 2021, BRFSS changed the wording to its question on whether a respondent has a usual source of care. This change appears to have had a significant impact on respondent answers and increased the percentage of people who answered "Yes." Because of this change, we did not include 2013–2020 trend data for the metric within this report. Florida did not meet inclusion criteria for the 2021 BRFSS dataset.

DATA
* American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2021.

** Behavioral Risk Factor Surveillance System (BRFSS), 2013–2021.

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