Preface

The Health-Care Crisis

While many people disagree about the nature of the problem, and there is very little agreement about the solution, one thing that Americans tend to agree on is that health care is a problem.

In the US system, wealth equates to health-care access. Wealthy Americans are therefore, predictably, not as worried about health care as an issue. For working-class Americans, health-care costs top lists of national concerns. In a 2025 review of the issue by Gallup, 29 percent of Americans, nearly 1 in 3, saw health-care cost as the most urgent national health problem, and a record 23 percent saw the US health-care system as in crisis. A record low of 16 percent was satisfied with the cost of health care (though satisfaction was much higher for those at higher-income levels). This holds true across party lines. The 2025 polling data indicated that 64 percent of Republicans, 66 percent of Independents, and 81 percent of Democrats believed that the health-care system was either in a state of crisis or had serious problems. A full 64 percent of American adults believed that the government should ensure that all Americans had health-care coverage.[1]

Emma Wager, of the Kaiser Family Foundation (KFF), speaking about the latest Gallup results said that this increased concern, especially about costs, makes sense because "health care is something that people can't choose how much they're going to buy, or how much they can really price-shop in most circumstances. It's an expense that is unpredictable and that we all face." Wager went on to explain that the ageing population, and inflation are other factors impacting this debate. As consumers have less disposable income, medical costs or potential medical costs become a more important issue for many consumers.[2]

These concerns are mirrored in global analyses of health care and costs. The US health-care system is the most expensive in the world, and yet the United States routinely ranks last in high-income nations in terms of overall performance, access, equity, and health outcomes.[3] Defenders of the status quo argue that America's high costs and competitive health insurance system improve outcomes. Studies indicate, for instance, that the United States offers faster access to specialists and specialized equipment, but critics argue that these advantages do not compensate for the lower-overall quality of care, the lack of patient equity, and the other major problems tied to the for-profit medical system.

A Preponderance of Issues

The first and most often discussed problem with US health care is affordability. Out-of-pocket costs and health insurance premiums have risen far faster than rel-

ative income, meaning that for many Americans, the cost of having health care and utilizing health care has risen as a percentage of their annual cost of living, while wages have not kept pace. From 2022 to 2026, for instance, wage growth fell by more than 3 percent, while health insurance costs rose by around 6 percent. This represents a real loss in affordability for all Americans, but especially for those who are working class or middle class. A Liberty Street Economics study, from 2026, looked at how rising health-care costs were also increasing the cost of labor for employers that provide health coverage and discourages employer-linked coverage.[4]

Affordability is, of course, closely linked to income level, but also to whether or not states chose to expand Medicaid coverage, which makes lower-cost options available for underemployed Americans, by shifting the perception of income. Studies have found that those living near the Medicaid level, but making too much to quality, are among the most vulnerable to suffering economic problems due to medical costs, and also more likely to be negatively impacted by medical debt. Studies like this show how insufficient it is to base federal support on income, wherever the dividing line is drawn, creates a group just beyond that line that is most vulnerable to rising costs and still insufficiently wealthy to easily absorb major health-care costs.[5]

While affordability ranks highest in terms of American health-care concerns, there are many other problems that impact the quality of American health care. For one, patients frequently complain that the US health-care system is too difficult to comprehend. A proliferation of health insurance providers and plans, and difficulty perceiving the differences between them, lead to a situation where American consumers are left without the power to effectively evaluate their choices. When medical needs require them to seek treatment outside of their provider network, or when treatments or tests involve unforeseen costs and bills, this contributes to unexpected medical debt and economic disruption.

The complexity of the US health-care system is a direct result of trying to operate health care as a for-profit system. Complexity results from having overlapping billing and claim management systems, from having to navigate multiple providers and coverage systems, etc. Essentially, because the US system is one in which consumers are forced to go through intermediary companies (insurance) before providing payment to providers, Americans pay more for health care and find the system more difficult to use.[6]

The complexity of the system, and the need to work through intermediary companies that are set up to maximize profit (meaning to reduce spending per patient) impact access to health care, but access is also related to other factors, like availability. Despite high average wages for health-care professionals compared to other countries, the United States still faces a primary care shortage, one that has become increasingly severe and is likewise impacted by a drive to limit the migration of foreign physicians to work in the United States. Studies of the health-care field indicate that the physician shortage could be as severe as 86,000 by 2036,

and that this will predominantly impact rural communities, the working class, and patients seeking primary care.[7]

Beyond affordability and access problems, the US health-care system also suffers from fundamental and foundational structural dysfunctions. For one thing, the fact that health care, for many Americans, is tied to employment is a problem that decreases overall health-care coverage, giving an advantage to large businesses over small businesses, and results in medical debt compounding job losses or changes in employment, while also tying individuals to specific jobs and limiting the capability of workers to seek education or other job opportunities. This is not only a problem for workers, but also for companies seeking to provide insurance coverage. As premiums rise, this increases the burden on insurers providing insurance for their workers, and this ultimately discourages growth and expansion. This is not the case for large corporations, but has a significant impact on small- and mid-sized businesses large enough to need to provide insurance assistance according to federal regulations.[8]

Solutions and Perceptions

The question of how to deal with America's health insurance problems stimulates intense disagreement among politicians and the public. Much of this debate, in the twenty-first century, has centered around the Affordable Care Act (ACA), the most transformative piece of health-care reform legislation passed since the 1960s. The ACA, also known as "Obamacare," initially to critics but now also to supporters, dramatically reduced the uninsured population in the United States by centralizing medical insurance marketing, forcing companies to offer cheaper plans for lower-income Americans, and expanding Medicaid.

Opponents of the ACA have long complained about aspects of the bill that imposed fines for uninsured individuals or for companies that failed to provide insurance benefits, but a majority of Americans support the ACA and believe it has had a positive impact on society. The Republican Party has repeatedly fought against efforts to expand the ACA and Medicaid, and has promised to repeal the law and to replace it with a different health-care package. Republicans have not created a functional alternative program, and have merely used the promise of repeal as a marketing strategy. The Republican Party has also taken steps to limit the number of Americans covered by the program, in furtherance of measures to limit corporate and federal spending on health care. The current debate includes an argument over whether or not to extend ACA subsidies needed by many Americans, without which costs will again increase for millions of families.[9]

Some proponents believe that expanding the ACA is the most effective way to address health-care reform, but increasingly Progressives are demonstrating interest in a far more aggressive kind of reform, establishing a nationalized, single-payer health-care system in which the federal government covers basic care, greatly reducing the for-profit insurance industry. The idea for a nationalized health insurance service has been around since the 1940s, but has repeatedly failed to gain enough political support to pass through the legislature. This failure

Accessing Care

When discussing health care in America, the high cost of medical insurance is one of the primary talking points. Analysts and citizens alike have debated the cost of prescription drugs, the high cost of co-pays and deductibles, and basic medical care, but beyond costs, there are other obstacles that lessen the effectiveness of the American health-care system. Some of these problems can be linked together under the broad issue of “access,” meaning how well insured and uninsured patients, can access the care that they require.

Studies indicate that around 91 percent of American adults have health insurance, but many people attempting to access care face hurtles. Problems ranging from difficulty understanding coverage, to changing requirements for coverage and authorization, to hidden costs, limit the effectiveness of health care for many Americans.

An Opaque System

Writing in the *Journal of the American Medical Association* in 2023, physicians Larry Levitt and Drew Altman stated simply,

> Lack of insurance coverage, high costs, and poor outcomes are well-documented problems in the US health care system, and policies to address them have been hotly debated for decades. However, complexity is another underappreciated problem that hinders access and affordability and is more difficult to quantify.[1]

Levitt and Altman are talking about one of the less-covered difficulties with the health-care system, which is complexity, meaning the complex systems that both insured and uninsured persons must navigate when trying to access care. Polling data showed that 6 in 10 people who had insurance reported problems utilizing their health insurance. More strikingly, 75 percent of insured people reported difficulties accessing mental health services through their insurance plan. Studies also indicate that 80 percent of people who use the health-care system the most reported problems accessing health care.

In the study, Levitt and Altman discuss several ways in which users had difficulty accessing care, from being unable to get appointments with in-network physicians, to being denied prior authorization for care recommended by their physician, to having health-care claims denied. Part of this problem is opacity. Surveys revealed that half of health insurance subscribers did not understand at least some aspect of their coverage, and more than 30 percent didn’t understand what costs were covered by their plan and what they would owe. This complexity extended to difficulties with signing up for care, and these included persons purchasing private insurance, but was more prominent for patients utilizing Medicare, Medicaid, and the Affordable Care Act (ACA).

Why is the insurance system so complicated? The primary problem comes down to commercial interests. Visitors to the ACA have more than 100 options, and Medicare enrollees have an average of forty-three Medicare Advantage Plans to choose from. The diffi-

U.S. Health Care Is Broken: Here Are 3 Ways It's Getting Worse

By Maria Aspan
All Things Considered (NPR), December 4, 2025

One year after UnitedHealthcare's CEO was shot and killed, the crisis in U.S. health care has gotten even worse—in ways both obvious and hidden.

People increasingly can't afford health insurance. The costs of both Obamacare and employer-sponsored insurance plans are set to skyrocket next year, in a country where health care is already the most expensive in the developed world.

Yet even as costs surge, the companies and the investors who profit from this business are also struggling financially. Shares in UnitedHealth Group, the giant conglomerate that owns UnitedHealthcare and that plays a key role in the larger stock market, have plunged 44% from a year earlier. (It was even worse before a rally in UnitedHealth shares on Wednesday.)

"UnitedHealth's reputation in the investment community, before December 4 last year, was [as] a safe place to put your money. And that basically got all blown up," says Julie Utterback, a senior equity analyst who covers health care companies for Morningstar.

Then, on Dec. 4, 2024, UnitedHealthcare CEO Brian Thompson was shot on a Manhattan street on his way to an investor event. The shocking act of violence sparked a widespread consumer outcry over U.S. health care costs and denied claims, and plunged UnitedHealth Group into a public relations disaster.

But that was only the start of the business woes for the company and its entire industry—which are facing regulatory scrutiny, tightening margins, and investor skepticism. Many of UnitedHealth's top competitors have also seen their shares suffer in the past year, at a time when the stock market in general has been hitting tech-driven record highs. The S&P 500's healthcare index has lagged the larger market. And some Wall Street analysts are bracing for another rocky year in the business of health care.

"Near term, there's a lot more volatility to come," says Michael Ha, a senior equity research analyst who covers health care companies for investment bank Baird.

December 4 Started to Reveal Depth of U.S. Health Care Problems

This wide-ranging crisis for both consumers and businesses underline the brokenness of the U.S. health care system: When neither the people it's supposed to serve nor the people making money from it are happy, does it work at all?

"We're really at an inflection point," says Katherine Hempstead, a senior policy officer at the Robert Wood Johnson Foundation and the author of a book about the insurance industry.

"Every segment of the health insurance business right now is stressed," she adds.

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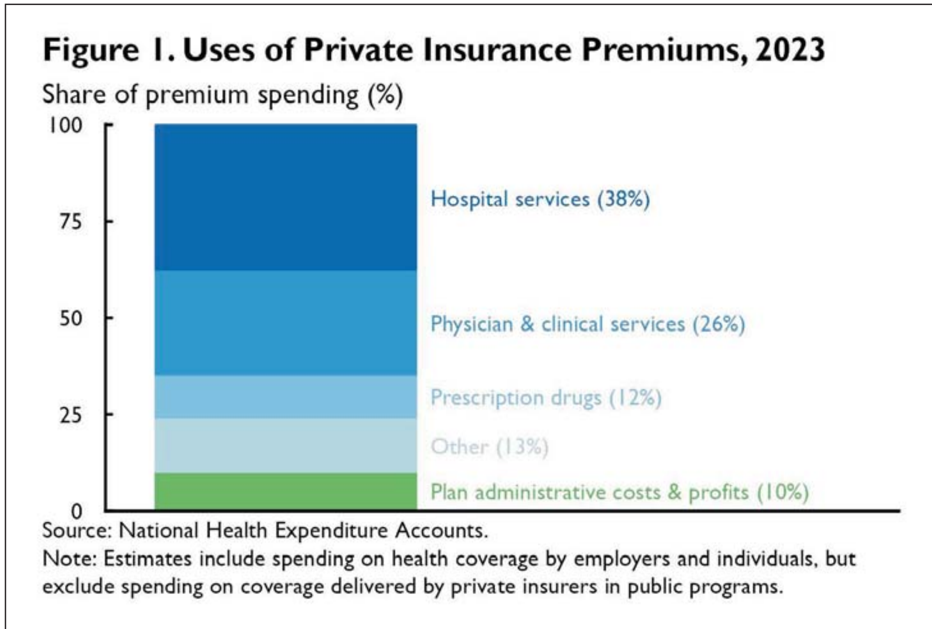
fall by 92%. To even partly protect the enrollee, the pre-subsidy premium would need to fall below the $2,067 per year that the enrollee would pay without the enhanced credits, a more than 72% decline.

To be clear, steps to reduce underlying insurance premiums would have other important benefits. They could directly reduce costs for people who get coverage from an employer. They would also reduce the federal cost of subsidizing both Marketplace and employer coverage, savings that policymakers could use to offset the roughly $30 billion annual cost of extending the enhanced credits. But they would not, in themselves, meaningfully address the near-term cost increases that are facing Marketplace enrollees.

The remainder of my testimony examines each of these points in greater detail.

Strategies for Reducing Private Health Insurance Premiums

To understand the options for reducing health insurance premiums, it is useful to first examine where premium dollars go today.[2] Figure 1 uses data from the National Health Expenditure Accounts to break down how the dollars that individuals and employers spent on private health insurance during 2023 (the most recent year for which data are available) were ultimately used.



The figure shows that 90% of the dollars spent on private health insurance in 2023 were ultimately spent on health care, with only 10% accounted for by insurer administrative costs and profits. An important takeaway is that, while there are surely opportunities to squeeze insurer profit margins and reduce administrative costs, substantially reducing premiums (at least without excluding high-cost enrollees from coverage or shifting costs onto enrollees by increasing cost-sharing or narrowing benefits) is likely to require reduc-

US Health Care Is Rife with High Costs and Deep Inequities, and That's No Accident—A Public Health Historian Explains How the System Was Shaped to Serve Profit and Politicians

By Zachary Schulz
The Conversation, June 6, 2025

A few years ago, a student in my history of public health course asked why her mother couldn't afford insulin without insurance, despite having a full-time job. I told her what I've come to believe: The U.S. health care system was deliberately built this way.

People often hear that health care in America is dysfunctional—too expensive, too complex and too inequitable. But dysfunction implies failure. What if the real problem is that the system is functioning exactly as it was designed to? Understanding this legacy is key to explaining not only why reform has failed repeatedly, but why change remains so difficult.

I am a historian of public health with experience researching oral health access and health care disparities in the Deep South. My work focuses on how historical policy choices continue to shape the systems we rely on today.

By tracing the roots of today's system and all its problems, it's easier to understand why American health care looks the way it does and what it will take to reform it into a system that provides high-quality, affordable care for all. Only by confronting how profit, politics and prejudice have shaped the current system can Americans imagine and demand something different.

Decades of Compromise

My research and that of many others show that today's high costs, deep inequities and fragmented care are predictable features developed from decades of policy choices that prioritized profit over people, entrenched racial and regional hierarchies and treated health care as a commodity rather than a public good.

Over the past century, U.S. health care developed not from a shared vision of universal care, but from compromises that prioritized private markets, protected racial hierarchies and elevated individual responsibility over collective well-being.

Employer-based insurance emerged in the 1940s, not from a commitment to worker health but from a tax policy workaround during wartime wage freezes. The federal government allowed employers to offer health benefits tax-free, incentivizing coverage while sidestepping nationalized care. This decision bound health access to employment status, a

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Why Affordability Will Be a Key Issue in the 2026 Midterm Elections

By William A. Galston
Brookings, March 25, 2026

Since the pandemic, Americans have ranked the cost of living (often labeled "affordability") as the top problem they want America's leaders to address. The typical household budget has many different components, of course. Some of them, such as health care, have been pressuring families for several decades. Problems in other areas, such as housing, have become acute only in recent years. But the rapid rise in overall prices since the beginning of the pandemic has merged these areas into a broader public concern. Although average hourly wages have risen by 30.8% since then,[1] costs for many core elements of household budgets have risen even more, and most Americans feel that they are at best running in place.[2] Because the rate of price increases remains well above the Federal Reserve Board's target of 2%, this concern shows no sign of abating, and the effects of the war with Iran will make matters worse.

Health Care

Between 1999 and 2024, health care rose from 13% to 18% as a share of GDP, an increase that has serious consequences for family budgets. While wages rose by 119% during this period, workers' contributions to family health care insurance premiums surged by 308%, almost three times the pace of wages. This increase was not the result of employers shifting the burden of health insurance to workers; the overall cost of insurance premiums rose even faster, by 342%—more than five times as much as the economy-wide rate of inflation. Since the pandemic began, the burden on average families has accelerated: Out- of-pocket expenses per person rose by nearly one-third, from $1,239 to $1,652, in just five years.

Against this backdrop, it is not surprising that health care has risen to the top of Americans' concerns about affordability. A recent survey found that 32% of respondents were "very worried" about health care costs, compared to 24% for food and groceries, 23% for rent or mortgage payments, 22% for utilities, and 17% for gas and other transportation.

Because the problems of health care in the U.S. are structural and deeply rooted, the prospects for quick relief are not bright.

Housing

Unlike health care, the housing affordability crisis mostly began with the pandemic. Since early 2020, the cost of median-priced housing has risen by 28%, from $317,000 to $405,000, while mortgage interest rates surged from 3.45% to 6.11%.

These increases have disrupted the long-established balance between housing prices and household incomes. Until 2020, a median-income household could afford mortgages to buy median-priced homes. Now, households need incomes of $120,000 to qualify for

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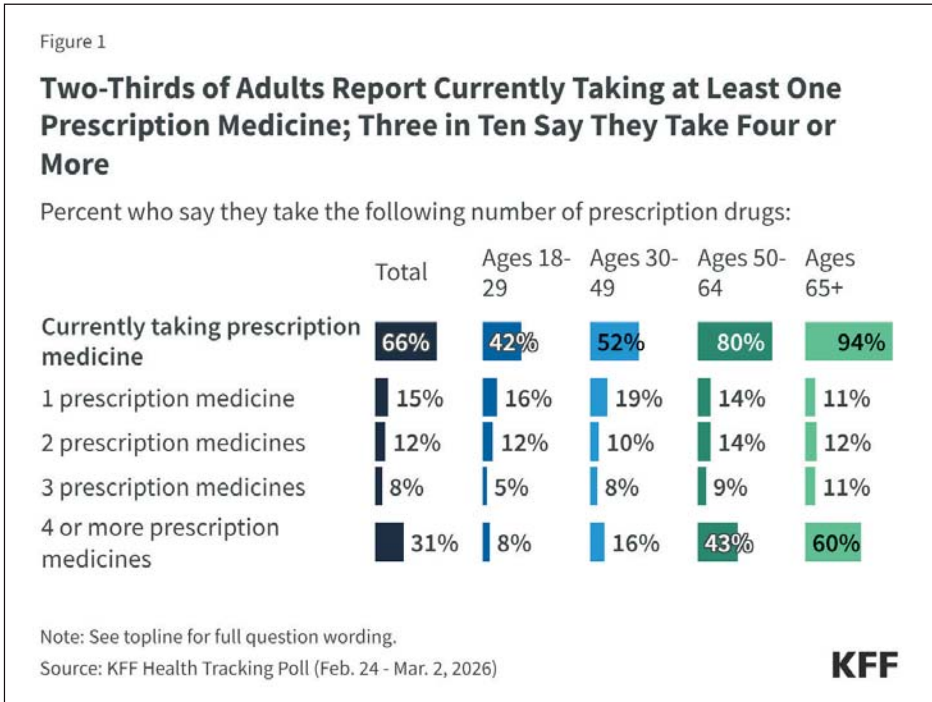
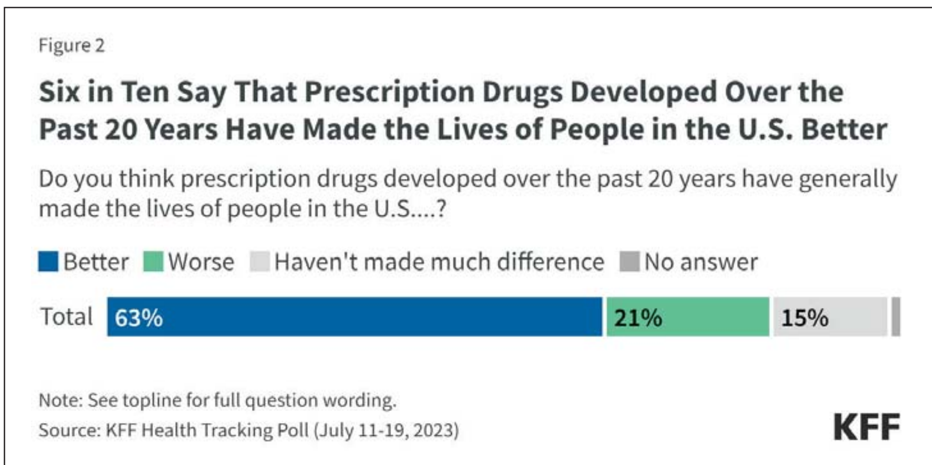
The Public's Experiences with and Views of Prescription Drugs

Prescription drugs touch the lives of most people in the U.S. in some way, and the public broadly recognizes their benefits. About two-thirds (66%) of adults say they are currently taking at least one prescription drug, and three in ten (31%) say they currently take four or more prescription medications. While many adults across age groups take prescription medications, older adults are much more likely to report taking 4 or more medications.

Six in ten adults ages 65 and older report taking four or more prescription medications, compared to fewer than half of younger adults.





Doctor's Bills Often Come with Sticker Shock for Patients—But Health Insurance Could Be Reinvented to Provide Costs Upfront

By Michal Horný
The Conversation, November 11, 2024

You have scheduled an appointment with a health care provider, but no matter how hard you try, no one seems to be able to reliably tell you how much that visit will cost you. Will you have to pay US$20, $1,000—or even more?

Patients are increasingly on the hook for health care costs through deductibles, co-pays and other fees. As a result, patients are demanding credible cost information before appointments to choose where they seek care and control their budget.

Yet, in spite of recent legislation and regulations, upfront information on patient out-of-pocket costs is still difficult to obtain from both health care providers and insurers.

Predicting Out-of-Pocket Costs

Why is it so difficult to tell patients in advance how much their care is going to cost?

This is a question health economists like me try to answer. Although the fundamental reason is simply the unpredictable nature of health care, the fact that it translates to unpredictable out-of-pocket costs for patients is a policy choice.

Health insurance plans in the U.S. such as Medicare and Medicare Advantage, as well as most individual and group plans, leave a percentage of the cost of care for patients to settle out of pocket. These include deductibles—the amount patients have to pay for a service before their insurance kicks in—or coinsurance, a percentage of the cost of care that patients must pay after they have met their deductible.

Understandably, most patients want to know their out-of-pocket costs before a doctor's office visit or a trip to the hospital. However, the cost of care—and thus the percentage of the cost patients will pay—often isn't available until after care has been delivered. This is because of the way health care providers are paid for their work.

Health care providers typically seek payments for each patient retrospectively, based on the volume and intensity of services they have delivered. But both are hard to predict. A physician usually needs to see a patient before deciding how to address their health care needs. Sometimes, an extra test or imaging scan is needed to confirm a diagnosis or plan treatment.

Crucially, a variety of unexpected complications can occur even during routine procedures. Addressing these unforeseen complications often requires providing unanticipated

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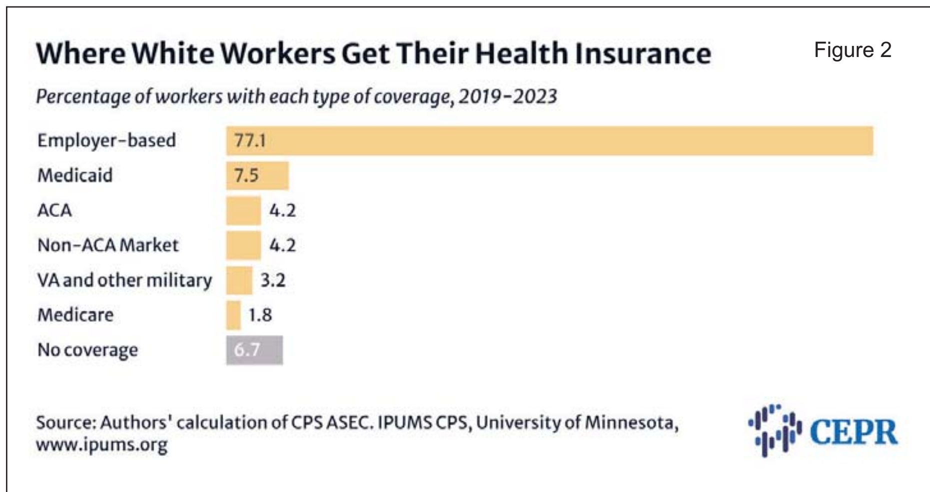
Sources of Health Insurance Coverage Vary Widely by Workers' Demographics

The pattern of health insurance coverage in Figure 1 holds for the workforce as a whole, but sources of coverage vary substantially by worker demographics. Table 1A summarizes how the types of coverage differ across workers' gender, race or ethnicity, age, marital status, the presence of children in their household, formal educational attainment, citizenship status and nativity, veteran status, and whether or not they live in a rural area.

Race and Ethnicity

Figure 2 compares the types of coverage workers obtain by their race and ethnicity.

White workers are the least likely to lack coverage entirely (6.7 percent), primarily the result of having the highest coverage through employer-based insurance plans (77.1 percent). White workers are the least likely to use Medicaid, but about one in 14 white workers (7.5 percent) are insured through the program. Smaller shares of white workers use non-ACA private plans (4.2 percent) and ACA marketplace policies (4.2 percent). About three percent of white workers have insurance through a military-related policy and just under two percent are covered by Medicare.



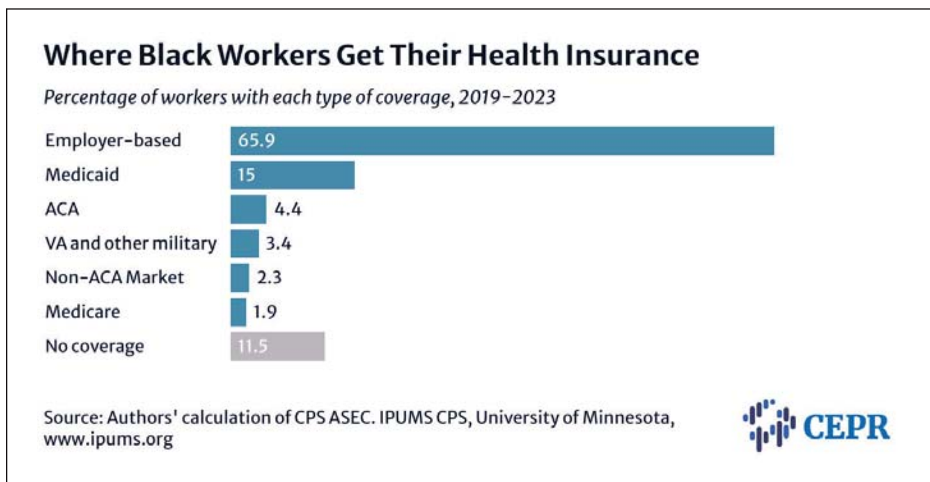


Figure 1

Status of State Action on the Medicaid Expansion Decision, as of February 2025

Click on a Medicaid non-expansion state to view the characteristics of individuals in the coverage gap.

Adopted and implemented (41 states including DC) Not adopted (10 states)

Note: Wisconsin provides Medicaid eligibility to adults up the poverty level under a Medicaid waiver. As a result, there is no one in the coverage gap in Wisconsin. Estimate for individuals ages 19–34 in Wyoming does not meet minimum standards for statistical reliability.

Source: KFF Status of State Medicaid Expansion Decisions Tracker; KFF analysis based on 2024 Medicaid eligibility levels and 2023 American Community Survey, 1-Year Estimate.

KFF

2025, 41 states, including the District of Columbia, have adopted Medicaid expansion (Figure 1).

In the ten states that have not adopted Medicaid expansion, an estimated 1.4 million individuals remain in the coverage gap. These adults have incomes above their state's Medicaid eligibility threshold but below the poverty level, making them ineligible for ACA Marketplace subsidies (Figure 2). Because the Medicaid expansion was expected to be mandatory for states, the ACA did not provide eligibility for subsidies in the Marketplaces for people below poverty.

Medicaid eligibility remains limited in states that have not expanded their programs. All non-expansion states, except Wisconsin (which provides coverage through a waiver), do not offer Medicaid to adults without children, regardless of their income (Figure 3). As a result, 80% of the individuals in the coverage group are adults without dependent children.

Uninsured rates in states without Medicaid expansion are nearly twice as high as those in expansion states (14.1% vs. 7.6%). People without insurance have more difficulty

New in 2026: More Plans Now Work with Health Savings Accounts

US Department of Health & Human Services, 2026

As a result of the Working Families Tax Cuts legislation signed into law by President Trump, more 2026 Marketplace plans—including all Bronze and Catastrophic health plans—now work with Health Savings Accounts to help you pay your share of costs for health care.

You can contribute to a Health Savings Account when you're enrolled in an eligible High-Deductible Health Plan, like a Bronze or Catastrophic plan.

- Setting aside money in a Health Savings Account for health care costs, like deductibles, copayments, and coinsurance, helps save you money and lowers your taxable income and what you might owe when you file taxes.
- You decide how much to contribute to your Health Savings Account based on your budget. There's no minimum amount (but there's a yearly limit).
- The amount in your Health Savings Account rolls over year to year and can earn interest, putting more money in your account to cover your health care needs.

To save money on health care costs through a Health Savings Account, you must enroll in a plan that is specifically eligible to be used with a Health Savings Account, like any Bronze or Catastrophic plan or another Marketplace plan that's designated as eligible for a Health Savings Account.

When to Consider Bronze & Catastrophic Plans

For 2026, all Bronze and Catastrophic plans now work with Health Savings Accounts. If you're thinking about these plan types, here's what you need to know:

- Bronze plans generally have the lowest monthly premiums but higher out-of-pocket costs when you need care. Many cover services while you're paying the deductible. They can be a good choice if you usually use a few medical services and mostly want protection from very high costs if you get seriously sick or injured. Learn more about Bronze plans.
- Catastrophic plans have lower monthly premiums but the highest out-of-pocket costs and cover at least 3 primary care visits per year before you finish paying the deductible. They help protect you if something serious happens, like a major accident or unexpected illness. These plans are available to people under 30 or those over 30 who qualify for hardship or affordability exemptions. Learn more about Catastrophic health plans and what they cover.

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Regression-adjusted relative probabilities of being uninsured, by worker characteristics, pooled data for 2018-2023

Table 5

	All workers		Full-time full-year	Part-time part-year	Experienced Unemployment
	(1)	(2)	(3)	(4)	(5)
Part-time part-year	--	0.020	--	--	--
Experienced unemployment	--	0.050	--	--	--
Black	0.005	0.005	-0.001 N	0.017	0.025
Hispanic	0.056	0.056	0.047	0.074	0.074
Asian	-0.044	-0.044	-0.041	-0.051	-0.047
Other races	0.051	0.050	0.044	0.056	0.078
Male	0.027	0.030	0.029	0.028	0.049
Age 18-25	0.004	-0.001 N	0.019	-0.028 N	-0.028 N
Age 26-50	0.022	0.022	0.017	0.037	0.039
Unmarried	0.047	0.045	0.040	0.058	0.069
No children	0.012	0.012	0.007	0.024	0.046
Less than HS	0.149	0.145	0.135	0.164	0.169
High School	0.058	0.056	0.044	0.079	0.093
Some college	0.023	0.021	0.015	0.040	0.044
College	0.006	0.005	0.002 N	0.021	0.005 N
Wage quintile					
Lowest	0.094	0.091	0.119	0.044	0.058
Second	0.046	0.046	0.053	0.031	0.043
Middle	0.015	0.017	0.020	0.012	0.012 N
Fourth	0.000 N	0.002 N	0.003 *	0.006 N	0.005 N
Foreign born, US citizen	0.018	0.018	0.019	0.019	0.006 N
Foreign born, not US citizen	0.159	0.158	0.150	0.174	0.173
Year					
2019	-0.003 *	-0.003 *	-0.004 *	0.003 N	-0.011 N
2020	0.005	0.002 N	-0.002 N	0.016	-0.002 N
2021	-0.002 N	-0.002 #	-0.003 #	-0.004 N	-0.001 N
2022	-0.010	-0.009	-0.010	-0.010 *	-0.013 N
2023	-0.007	-0.007	-0.005	-0.011	-0.026
Constant	0.013 N	0.006	0.004 #	0.032	0.054
Sample size	407,221	407,221	300,477	76,857	29,887
Population weighted average rate	0.105	0.105	0.088	0.130	0.187

Notes: Unless otherwise indicated, all coefficients are statistically significant the 1% level; * indicates the 5% level; # indicates significance at the 10% level; "N" indicates not statistically significant at at least the 10% level. Those without health insurance reported having no health insurance from any source during the entire calendar year. Unemployed group composed of those who experienced any spell of unemployment during the calendar year, regardless of full-time or full-year status when employed.
Source: Authors' analysis of IPUMS extract of the Current Population Survey's Annual Social and Economic supplement, 2019-2024.

results, however, can help us to understand some of the underlying factors that make particular communities and individuals more or less vulnerable, and thereby assist in the process of identifying strategies for how to improve the coverage rates.

Numbers of Uninsured Workers

Table 6 provides estimates by demographic group of the number of workers who were without health insurance for the entire year in 2023. Prior tables pooled the data for the

have experienced a problem using their health insurance, including denied claims. Four in ten (39%) of those who reported having trouble paying medical bills said that denied claims contributed to their problem.

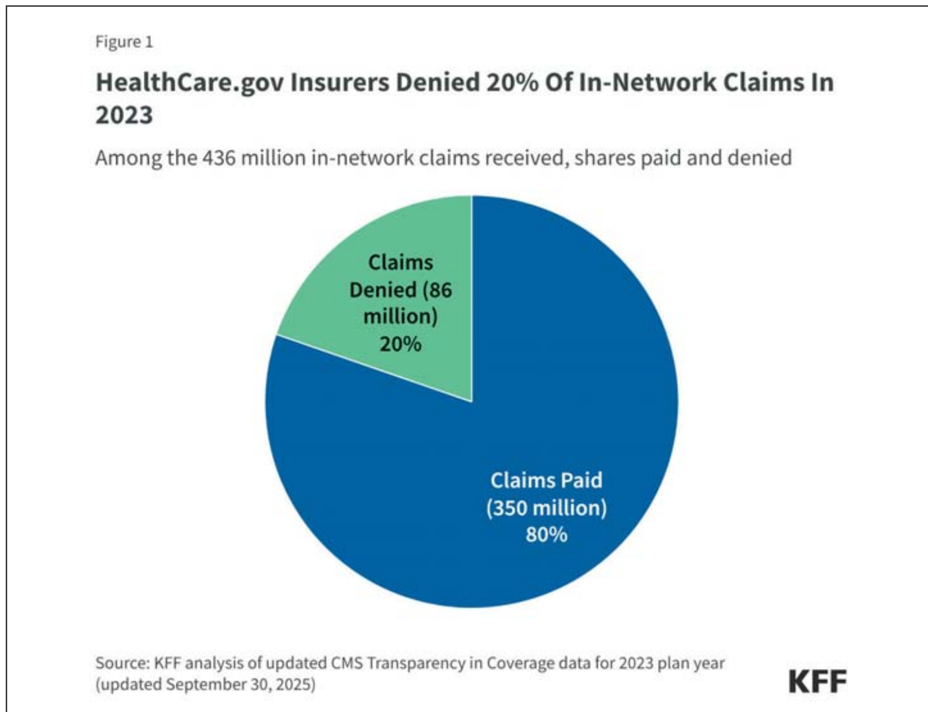
As a part of the annual QHP certification process, issuers (referred to as insurers in this brief) must report certain denied claims information to CMS for plans that were offered in the previous year that they want to offer in the upcoming year. Data does not include information about denied requests for prior authorization (a claim decision made before a service is provided). The dataset only includes information about claims for benefits (medical and prescription drugs combined) made after a service was provided (post-service claims).

Insurers participating in the Marketplace in 2025 reported aggregated data on all HealthCare.gov QHPs they offered in 2023. Additionally, plan-level data from 2023 are reported for plans returning in 2025, including the number of in- and out-of-network claims submitted and denied, and reasons for claims denials. Among insurers participating in HealthCare.gov states in 2023, 43 are not participating in 2025 so they did not provide claims denial information. Among returning insurers, such denial information was only reported for 68% of their claims (the share of claims attributable to returning plans), as not all plans offered in 2025 were also offered in 2023. Additionally, only 55% of plans in the dataset were offered in 2023 and are included in the plan-level reporting for denial reasons. See the Methods and Data Limitations section for more details.

Claims Denials and Appeals in 2023

Insurer-level Claims Denials Data

Insurers reported receiving 471 million claims in 2023, with 93% (436 million claims) filed for in-network services. Of these in-network claims, 86 million were ultimately de-



Websites

Brookings Institution
Brookings.edu

The Brookings Institution is a nonprofit think tank based in Washington, DC, that conducts research and provides public education on economic issues. The Brookings Center on Health Policy produces original research and research analysis of issues involving health care and affordability. Most of the organization's research is available for free to the public, students, and researchers.

Center for American Progress (CAP)
Americanprogress.org

The Center for American Progress (CAP) is a nonprofit research and public advocacy organization that funds and supports research on economics and policy. The CAP is known for presenting arguments in favor of Progressive policies including in the realm of health care. CAP's "Strengthening Health" is a subdivision within the organization that covers and researches issues relating to health coverage, health insurance, and chronic health issues.

The Commonwealth Fund
Commonwealthfund.org

The Commonwealth Fund, founded in 1918 in New York City is a private foundation studying and reporting on the health-care industry and advocating for policies meant to improve the quality of health care and to improve health-care access for the uninsured, people of color, and people marginalized. The Commonwealth Fund funds and produces a variety of research, polling studies, and other studies focused on various aspects of the health-care debate, including chronic illness, health insurance, affordability, and access.

Economic Policy Institute (EPI)
Epi.org

The Economic Policy Institute is a nonprofit based in Washington, DC, that works on research focused on economic policies and the impact of those policies on labor and the quality of live around the world. The EPI conducts research on the health-care system, focusing on how low- and middle-income families are impacted by health-care affordability. The EPI has produced analyses of health economics, health-insurance industry profit and distribution, and how health-care affordability impacts other measures of economic stability.