DATA BRIEF
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Gap Closed: The Affordable Care Act's Impact on Asian Americans' Health Coverage

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INTRODUCTION

Eliminating racial inequities in insurance coverage was one of the main goals of the Affordable Care Act (ACA). Prior to the law, people of color were uninsured at significantly higher rates than whites. Recent research has indicated that these gaps have narrowed,[1] although remaining disparities within the Black, Latino, Native American/Alaska Native communities have been starkly exposed during the COVID-19 pandemic.[2]

Asian Americans are the fastest-growing racial or ethnic group in the United States.[3] Surveys and research analyses often group Asian Americans with other races or ethnicities, limiting what we know about the way this group experiences health care. Asian Americans are composed of more than 50 distinct ethnicities with significant socioeconomic diversity. Chinese, Indian, and Filipino Americans are the three largest groups.

After implementation of the ACA, the uninsured rate declined among all races and ethnicities through 2016. Prior research has reported on the reduction and elimination of coverage disparities between Asian American and white adults, including significant gains among the lower-income population.[4] In this brief, we build on those previous findings by extending the analysis of different Asian American ethnicities through 2018 and exploring the reduction in disparities by income, insurance type, and Medicaid expansion. Specifically, we use two-year rolling averages to review:

- Insurance coverage rates for Asian Americans compared to other races and ethnicities, as well as rates for specific Asian American ethnicities and subpopulations.
- Coverage trends among different income groups and those living in Medicaid expansion states to better understand specific effects of ACA provisions on the Asian American population.

Understanding the effects of the ACA on Asian American coverage can provide important insights for eliminating remaining coverage inequities for Black, Latino, and other racial and ethnic communities — at a moment when racial injustice has been laid bare. It also can help us identify remaining coverage challenges for different Asian American populations moving forward.

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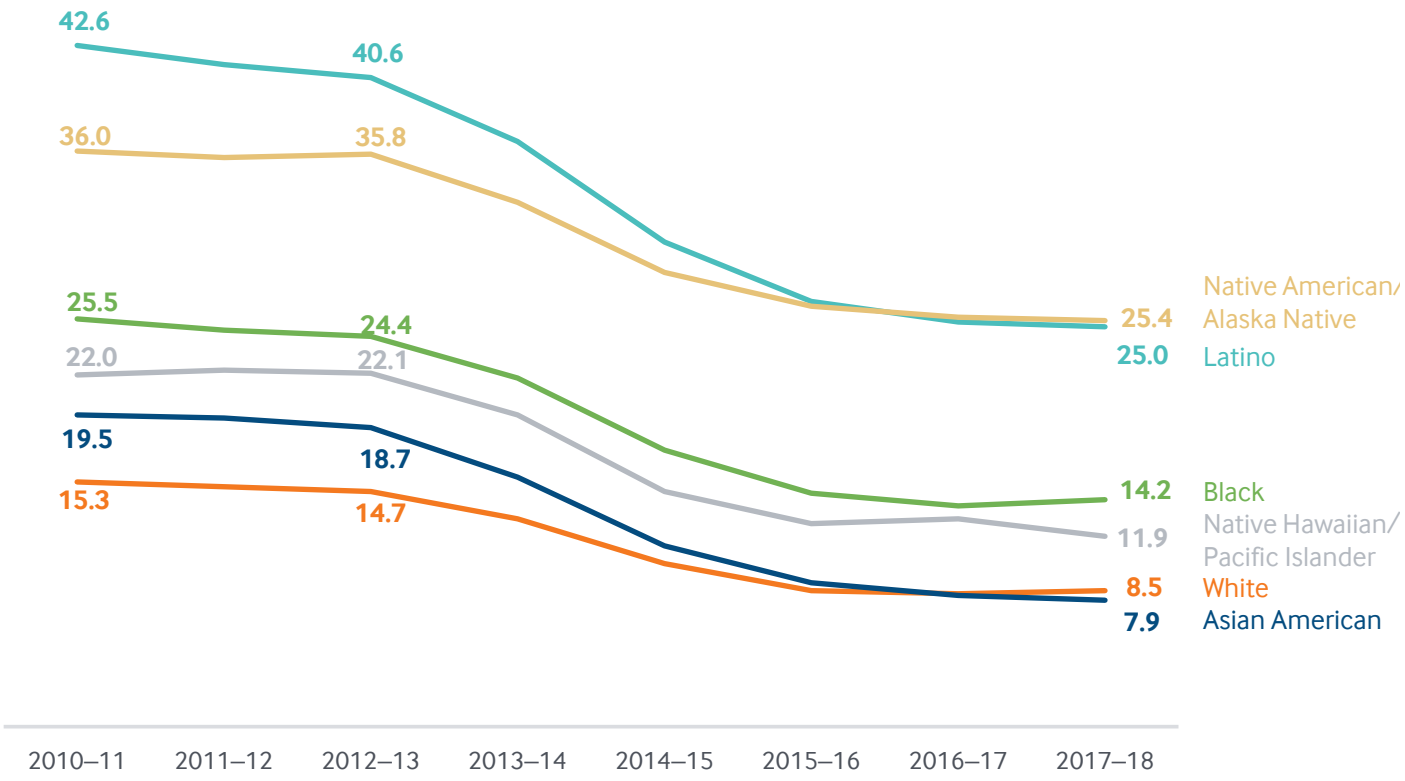
KEY HIGHLIGHTS

- The ACA helped eliminate the coverage gap between Asian American and white adults. In 2010–2011, Asian Americans were significantly more likely to be uninsured compared to whites. By 2017–2018, Asian Americans had the lowest uninsured rate of any racial or ethnic group in the U.S. Uninsured rates have fallen among all Asian American subgroups since the passage of the ACA, but not uniformly. Korean, Vietnamese, and other Asian Americans were significantly more likely to be uninsured in 2017–2018, compared to Indian, Chinese, and Filipino Americans.
- Since the passage of the ACA, the coverage disparity between Asian Americans and whites was eliminated across all income categories through coverage gains within Medicaid, the individual and ACA marketplaces, and employer-based insurance. The largest reduction in disparities occurred within the subgroup of adults earning between 138 percent and 399 percent of the federal poverty level ($16,753 to $48,439 for an individual in 2018).
- The vast majority of Asian Americans live in Medicaid expansion states, which has helped to drive down their overall uninsured rate. But since the passage of the law, the coverage gap has been eliminated between Asian Americans and white adults in both expansion and nonexpansion states.

The ACA eliminated the insurance coverage gap between Asian Americans and whites.

Percent of adults ages 19–64 who were uninsured



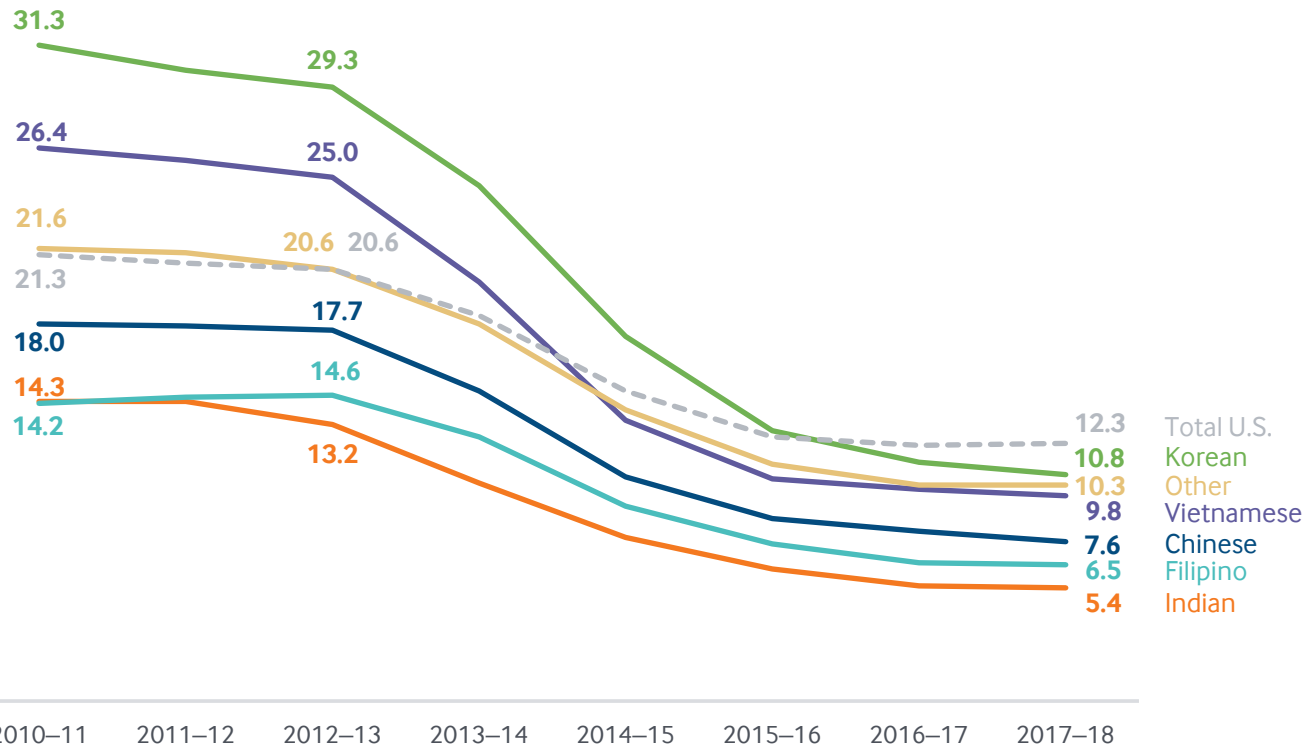
Data: Commonwealth Fund analysis of the American Community Survey (2010–2018).

In 2010–2011, prior to the ACA's coverage expansions, working-age Asian Americans were more likely to be uninsured compared to whites, and had the second-lowest uninsured rate compared to all other races and ethnicities, including Black and Latino adults. The coverage disparity between Asian Americans and whites stood at 4.2 percentage points, with 19.5 percent of Asian Americans uninsured compared to 15.3 percent of whites. By 2017–2018, the gap had disappeared. The uninsured rate among Asian Americans improved by more than 11 percentage points, dropping their overall uninsured rate to 7.9 percent, the lowest rate of any racial or ethnic group, including whites.

For the full period, Native Hawaiians/Pacific Islanders and Native Americans/Alaska Natives had significantly higher uninsured rates than Asian Americans. These two groups are often grouped with Asian Americans for purposes of survey research.

Uninsured rates across all Asian American subpopulations dropped, with Indian Americans the least likely to be uninsured by 2017–2018.

Percent of adults ages 19–64 who were uninsured



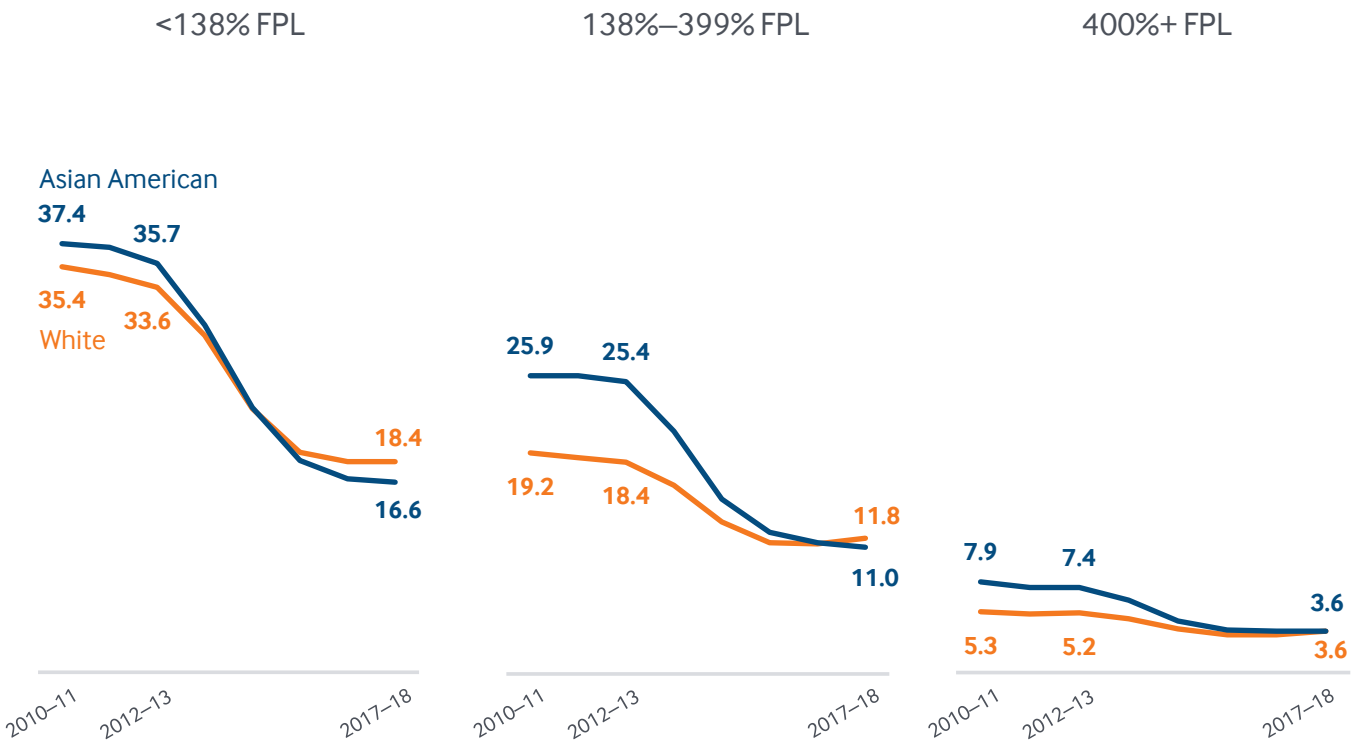
Data: Commonwealth Fund analysis of the American Community Survey (2010–2018).

We examined Asian Americans by six different subgroups: Indian, Chinese, Filipino, Korean, Vietnamese, and other Asian Americans, which include over 15 additional ethnicities. All these populations experienced at least a 7 percentage-point decline in the uninsured rate since 2010–2011, but gains varied. Koreans experienced a 20.5-point drop in their uninsured rate, compared to a 7.7-point drop among Filipinos.

Although coverage gains occurred across all subgroups, Korean, Vietnamese, and other Asian Americans were still significantly more likely to be uninsured in 2017–2018 compared to Indian, Chinese, and Filipino Americans.

The Asian American–white coverage disparity had been eliminated across all poverty categories by 2017–2018.

Percent of adults ages 19–64 who were uninsured



We compared uninsured rates of Asian Americans and whites across different income brackets to better highlight the impact of specific ACA provisions. Disparities that existed before the ACA was implemented have closed within each income group, though the size of the coverage gains varied across the levels.

Note: FPL = federal poverty level.

Data: Commonwealth Fund analysis of the American Community Survey (2010–2018).

Less than 138 percent of the poverty level. Adults who earn less than 138 percent of the federal poverty level ($16,753 for an individual and $34,638 for a family of four in 2018) may be eligible for different forms of coverage depending on their state of residence and immigration status.[5]

Adults within this income range who are lawfully present and live in states that expanded Medicaid under the ACA are eligible to enroll in their state's Medicaid program.[6] As of 2018, 77 percent of the Asian American population lived in states that had expanded Medicaid.[7] Adults in nonexpansion states are eligible for subsidies through the ACA marketplaces if they earn more than 100 percent of poverty and do not have an affordable offer of employer coverage. Importantly, lawfully present immigrants who are in the five-year waiting period for Medicaid are eligible for marketplace subsidies even if they earn below 100 percent of poverty.[8]

In 2010–2011, Asian Americans in this income group were more likely to be uninsured compared to whites (37.4% to 35.4%). However, by 2017–2018, the gap between Asian Americans and whites reversed, with whites more likely to be uninsured than Asian Americans.

138 percent to 399 percent of the poverty level. Adults who earn between 100 percent and 399 percent of poverty ($12,140–$48,439 for an individual and $25,100–$100,149 for a family of four in 2018) and are legally present in the United States may be eligible for subsidized health insurance through the ACA marketplaces. This group also may include lawfully present adults with incomes under 138 percent of poverty who are in the five-year waiting period to enroll in Medicaid and are eligible to enroll in subsidized coverage through the marketplace.[9]

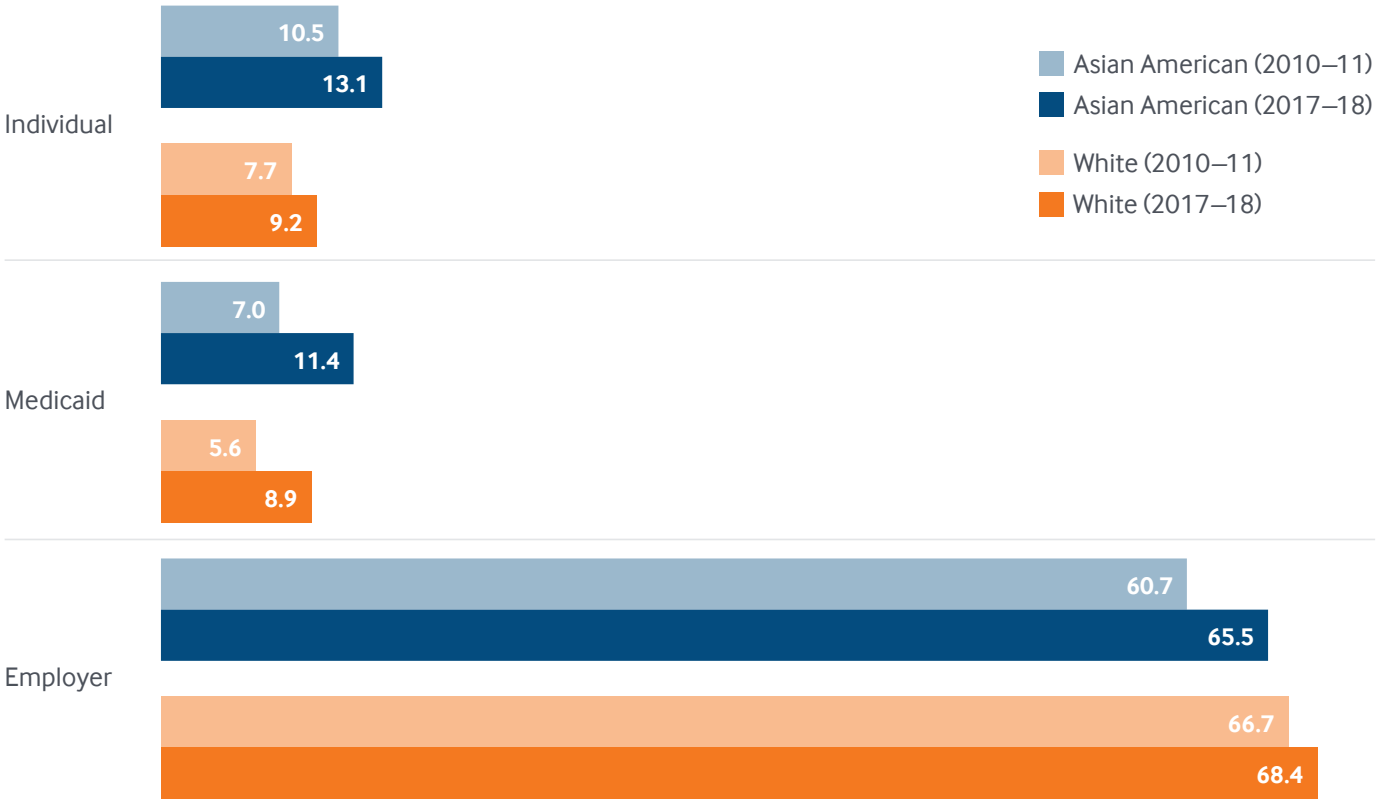
The Asian American–white coverage disparity within this income group started at 6.7 percentage points in 2010–2011; but by 2017–2018, the gap had closed, and Asian Americans were no more likely to be uninsured than whites.

400 percent or more of the poverty level. Adults who earn 400 percent or more of poverty can enroll in coverage through the marketplaces, but they are not eligible for subsidies. The ACA made coverage more accessible and comprehensive even for those not eligible for subsidies through the ban on preexisting condition exclusions, community ratings, and other insurance market reforms. Even prior to the implementation of the ACA, uninsured rates had consistently been lower for this income group across all races and ethnicities (data not shown).

The Asian American–white coverage disparity within this income group was 2.6 percentage points in 2010–2011. By 2017–2018, the disparity had been eliminated and the uninsured rate for whites and Asian Americans was the same.

Asian Americans eliminated the coverage gap through improvements in the private market and Medicaid.

Percent of adults ages 19–64 with different forms of insurance coverage, 2010–2011 vs. 2017–2018



Data: Commonwealth Fund analysis of the American Community Survey (2010–2018).

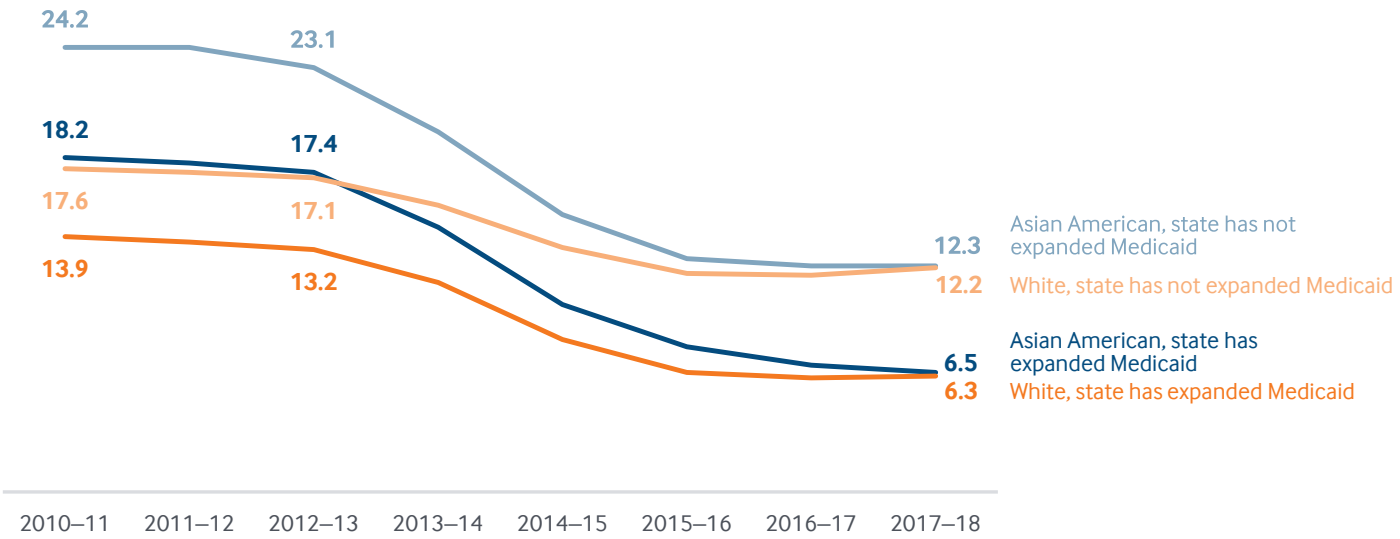
Asian American adults eliminated the coverage gap with white adults through gains in the individual market, Medicaid, and employer-sponsored insurance. These improvements were larger than those reported by whites.

The share of Asian Americans in these forms of coverage increased between 2010–2011 and 2017–2018. These data are consistent with other research showing that Asian Americans are geographically concentrated within Medicaid expansion states and are effectively accessing the Medicaid and individual insurance markets — two of the ACA's main strategies for increasing coverage.[10]

Increases in employer-sponsored insurance can be linked to ACA coverage requirements for individuals and employers, as well as overall improvements in the economy through 2018, which spurred employment growth.

In states that expanded Medicaid eligibility as well as states that did not, Asian Americans experienced greater gains in health insurance coverage compared to whites.

Percent of adults ages 19–64 who were uninsured



Data: Commonwealth Fund analysis of the American Community Survey (2010–2018).

In Medicaid expansion states as well as nonexpansion states, Asian Americans had larger coverage gains compared to whites in both relative and absolute terms. As a result, the coverage disparity between the two groups has been eliminated across both groups of states. Still, whites and Asian Americans in states that haven't expanded Medicaid are uninsured at higher rates than those in states that have expanded.

POLICY IMPLICATIONS

The Affordable Care Act's coverage expansions have improved health insurance coverage for Asian Americans and all racial and ethnic groups. However, notable disparities remain, particularly among Blacks, Hispanics, Native Americans/Alaska Natives, and Native Hawaiians/Pacific Islanders. Asian American adults entered 2010 with relatively low uninsured rates — the second-lowest behind whites. Benefiting from the ACA's coverage expansions, by 2018 Asian Americans had the lowest uninsured rate of any racial or ethnic group. However, the coverage disruptions from COVID-19 may affect coverage in this community; the unemployment rate for Asian Americans soared to 15 percent in May. In addition, over half of minority-owned businesses are owned by Asian Americans, which may put this group at increased risk of losing their businesses and coverage in the pandemic-driven recession.[11]

The Asian American progress has been driven by gains across both public and private insurance plans, with nearly identical coverage improvements in Medicaid expansion and nonexpansion states (although uninsured rates are much higher in nonexpansion states among all groups, including Asian Americans). Even though the coverage gap between white and Asian American adults has been eliminated since the ACA, coverage gains vary among the numerous distinct Asian American subpopulations, and many Asian Americans remain without health insurance coverage.

Coverage gains for all Americans have generally stalled since 2016 for four distinct reasons:

- Lack of Medicaid expansion in 14 states.[12]
- Affordability barriers in private insurance and particularly for people whose income exceeds the eligibility threshold for marketplace subsidies (400% of poverty).
- Congressional and executive branch actions, including immigration policies that have reduced enrollment in both Medicaid and marketplace plans.
- The fact that undocumented immigrants are ineligible for Medicaid or marketplace coverage; [13] an estimated 1.7 million Asian Americans are undocumented.[14]

With Black, Latino, and other communities still facing significant gaps, there are numerous policy options for covering more people and achieving equity within insurance coverage:

Expand Medicaid without work requirements or other restrictions in the remaining nonexpansion states. Research shows that 81 percent of Asian American nonelderly adults currently live in states that have expanded Medicaid, compared to 66 percent of the overall adult population, meaning that these communities have disproportionately benefited from this key ACA coverage provision.[15] In contrast, only 54 percent of Black adults live in these states, which has limited the equity effects of the ACA for the Black community.

The expansion of Medicaid in additional states without barriers such as work requirements could improve coverage even more, as would congressional proposals that seek to eliminate the Medicaid expansion gap with a federal solution.[16] This is particularly true in states with substantial Asian American (and Black) populations, such as Texas, Florida, and Georgia. Targeted Medicaid expansions to include undocumented populations, such as California's recent legislation, also could have a dramatic impact for Asian Americans in certain states.[17]

Extend and enhance marketplace subsidies. Premium contributions for marketplace plans are capped at 2.1 percent to 9.78 percent of income for people between 100 percent and 400 percent of poverty ($26,200 to $104,800 for a family of four in 2020). However, affordability continues to be the most often-cited reason why people don't enroll in coverage through the marketplaces.[18] Those who earn above 400 percent of poverty are not eligible for tax credits and may spend well beyond 9.78 percent of their income on premiums. Extending the upper income limit beyond 400 percent of poverty and enhancing subsidies for those under 400 percent of poverty would provide relief to people who find their coverage unaffordable.[19]

Provide funding and support for community-based outreach and marketplace navigation assistance in all states. Previous research has found that investing in effective community-based outreach and navigation efforts with cultural and language-specific strategies likely increases enrollment in Medicaid and the ACA marketplaces.[20] The Trump administration has dramatically reduced funding for marketplace navigators and advertising since 2017, potentially limiting the reach of these groups to enroll underrepresented populations.[21] If funding continues to be limited, state policymakers could fund local groups that serve Asian Americans and other targeted racial and ethnic communities.

Continue to collect and analyze Asian American subpopulation data. Section 4302 of the ACA requires federal data collection efforts to collect information on people's race, ethnicity, and other demographics, with the aim of reducing U.S. health disparities.[22] Our analysis shows that there is significant heterogeneity in insurance coverage rates among different subgroups within the broader Asian American population. Collecting and analyzing subpopulation data has been noted as an important goal in the past and continues to be critically important to informing policymaking.[23]

HOW WE CONDUCTED THIS STUDY

This study uses 2010–2018 data from the American Community Survey (ACS) to look at the percentage of uninsured adults ages 19–64.

The ACS is a large federal survey conducted by the U.S. Census Bureau that is used to track demographic characteristics of the U.S. population, including respondents' insurance coverage status and their primary type of health insurance coverage (for example, employer-based, Medicaid). The ACS samples approximately 3.5 million individuals each year, with annual response rates over 90 percent. The Census Bureau makes approximately two-thirds of ACS response records available to researchers in the Public Use Microdata Sample (ACS PUMS).

Analytical Approach

We stratified survey respondents by their self-reported race or ethnicity: white (non-Hispanic), Black (non-Hispanic), Hispanic (any race), Asian American, American Indian/Alaska Native, and Native Hawaiian or Pacific Islander. We also stratified by income categories and specific Asian American ethnicities: Indian, Chinese, Korean, Filipino, Vietnamese, and other. (Note: A small number of respondents self-identified as having multiple Asian ethnicities. These individuals are included in estimates for all Asian Americans, but are not included in exhibits that separate each ethnicity.) We calculated national rolling two-year averages for the uninsured rate from 2010–2011 to 2017–2018 to ensure sufficient sample size, stratified by race and ethnicity. We also calculated the average annual uninsured rate for Asian American and white adults from 2010–2011 to 2017–2018 across two categories of states:

- The Medicaid expansion group included the 31 states that, along with the District of Columbia, had expanded their Medicaid programs under the ACA as of January 1, 2018.
- The nonexpansion group comprised the 19 states that had not expanded Medicaid as of January 1, 2018. Maine and Virginia are considered nonexpansion states in this analysis because they both implemented their Medicaid expansions in 2019.

Reported values for expansion/nonexpansion categories are averages across survey respondents, not averages of state rates.

Estimates derived from the ACS PUMS were suppressed if unweighted cell counts had a relative standard error greater than 30 percent.

NOTES

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5 For premium tax credit eligibility in a given year, the federal poverty guidelines from the prior year are applied.

6 Since the start of 2018, Maine, Virginia, Idaho, and Utah have expanded their Medicaid programs.

7 Authors' analysis of U.S. Census Bureau, 2018 1-Year American Community Survey, Public Use Microdata Sample (ACS PUMS). In this analysis, expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

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9 CMS, "Coverage for Lawfully," n.d.

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13 Munira Z. Gunja and Sara R. Collins, *Who Are the Remaining Uninsured and Why Do They Lack Coverage? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018* (Commonwealth Fund, Aug. 2019); and Randy Capps et al., Gauging the Impact of DHS' Proposed Public-Charge Rule on U.S. Immigration (Migration Policy Institute, Nov. 2018).

14 Karthick Ramakrishnan and Sono Shah, One "Out of Every 7 Asian Immigrants Is Undocumented," *Data Bits* (blog), APPI Data, updated Sept. 8, 2017.

15 Based on Medicaid expansion status as of publication date, with Virginia, Maine, Idaho, and Utah included as expansion states; authors' analysis of U.S. Census Bureau, 2018 1-Year American Community Survey, Public Use Microdata Sample (ACS PUMS). Although Nebraska and Oklahoma have passed ballot initiatives expanding Medicaid, the expansions have not yet taken effect; therefore, for this calculation they are considered to be nonexpansion states.

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