REPORT

A Complicated Maze: How Workers Navigate the US Health Care System

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By Emma Curchin, John Schmitt

CEPR CENTER FOR ECONOMIC AND POLICY RESEARCH

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Summary

As we have documented in earlier research, 16 million US workers (about one of every 10 workers in the economy) have no health insurance. In this report, we examine the current sources of health coverage for those workers who do have some form of health insurance.

The most important source of health insurance for workers are employer-based policies, which cover seven of every 10 workers (70.7 percent).

Medicaid is the second most important source of coverage for workers, insuring one of every 10 workers in the country (10.3 percent).

Individual policies purchased through the Affordable Care Act (ACA) cover just under five percent of workers (4.6 percent). Less-regulated private insurance policies issued outside of the ACA insure a smaller share of workers (3.7 percent).

Military-related health insurance through the Veterans Administration and other sources provide insurance for a smaller share of workers (2.9 percent).

But, as we document here, coverage arrangements vary substantially by workers' individual demographics (such as race and ethnicity, gender, and age) and by the characteristics of the jobs they hold (public versus private sector, unionization, and pay levels).

Employer-based policies cover a much smaller share of Hispanic (53.1 percent) and Black (65.9 percent) workers than they do white (77.1 percent) or Asian (74.0 percent) workers.

Medicaid is an important source of health insurance for women workers: 11.5 percent, compared to 9.2 percent for men. This is especially true for Hispanic (18.1 percent) and Black (17.5 percent) women who work.

Two looming changes to health insurance policy threaten the current coverage of millions of workers.

The first is a legislative proposal to rescind the ACA’s subsidies to states to support their large and successful “Medicaid expansion” programs, which we estimate here could lead to as many as 12.8 million workers losing their Medicaid coverage.

The second immediate threat is the scheduled termination at the end of this year of temporary COVID-19-related expanded subsidies for low- and middle-income households who purchase health insurance through the ACA exchanges. We estimate, conservatively, that ending these subsidies could result in more than 1.1 million workers losing their current coverage.

Acknowledgements

We are grateful to Dean Baker and Julie Cai for their very helpful feedback on this report and an earlier related report.

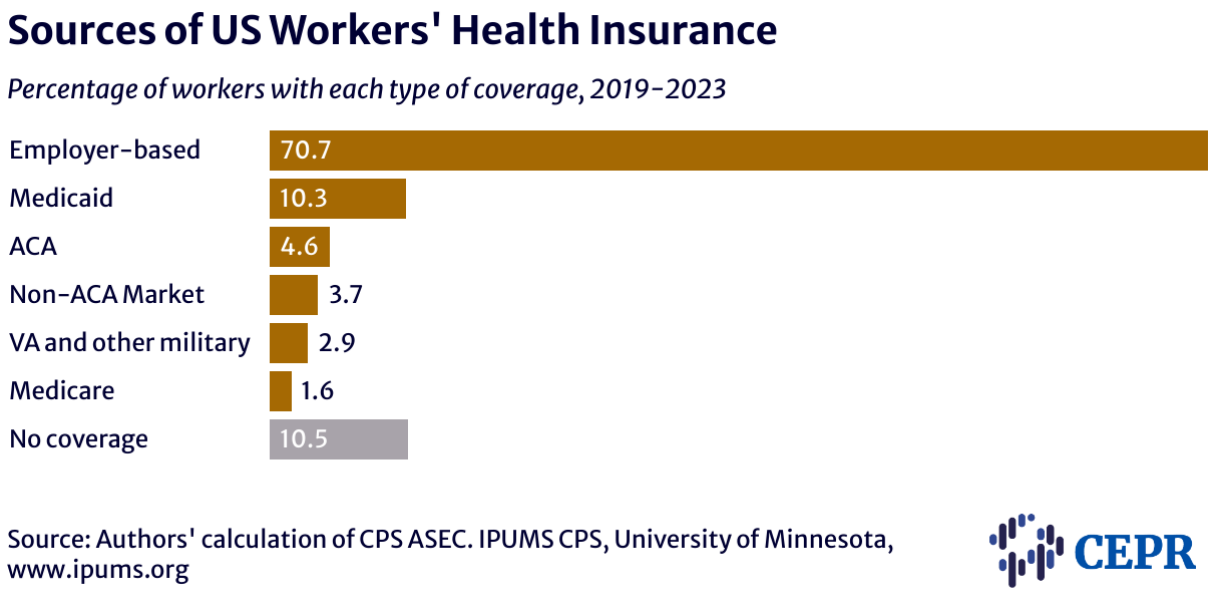
Introduction

In a recent report, we documented that almost 16 million workers in the United States between the ages of 18 and 64 had no private or public health insurance.[1] This figure includes 10 million full-time workers who held jobs throughout the entire year.[2] In this report, we examine how workers who do have coverage obtain the coverage they have.

Workers seeking health insurance for themselves and their families must navigate a complicated and often confusing system. Access to coverage depends on their employer, their household income, family size, age, veteran status, the state they live in, whether or not they are covered by a union contract, and other factors. As we documented in our earlier report, this system has consistently left just over 10 percent of the workforce without any form of health insurance.

As **Figure 1** shows, the most important source of health insurance for workers 18 to 64 years old who do have coverage are employer-based policies, which cover seven of every 10 workers (70.7 percent).[3] The next most important source of coverage for workers is the Medicaid program, which insures one of every 10 workers in the country (10.3 percent). Individual policies purchased through the Affordable Care Act (ACA) cover just under five percent of workers (4.6 percent).[4] Less-regulated private insurance policies issued outside of the ACA insure a smaller share of workers (3.7 percent). Military-related health insurance through the Veterans Administration and other sources provide insurance for a smaller share of workers (2.9 percent).[5] A small share of workers in the 18 to 64 year age range are covered by Medicare (1.6 percent), the health insurance program that focuses primarily on the population 65 and older. These younger workers generally qualify for Medicare because they have long-term disabilities.[6] But despite this array of coverage options, the currently available sources of health insurance leave more than one in 10 workers without any form of health insurance (10.5 percent).

Figure 1



The coverage arrangements summarized for all workers in Figure 1, however, vary substantially by workers' individual demographics (gender, race and ethnicity, age, and others) and by the characteristics of the jobs they hold (public

versus private sector, union coverage, state, and others). In this report, we use data from the six most recent years of available data from the Annual Social and Economic Supplement (ASEC) of the Census Bureau's monthly Current Population Survey (CPS)[7] to document the ways that workers obtain health insurance coverage and how their choice of coverage varies by their personal characteristics and the jobs they hold.

Sources of Health Insurance Coverage Vary Widely by Workers' Demographics

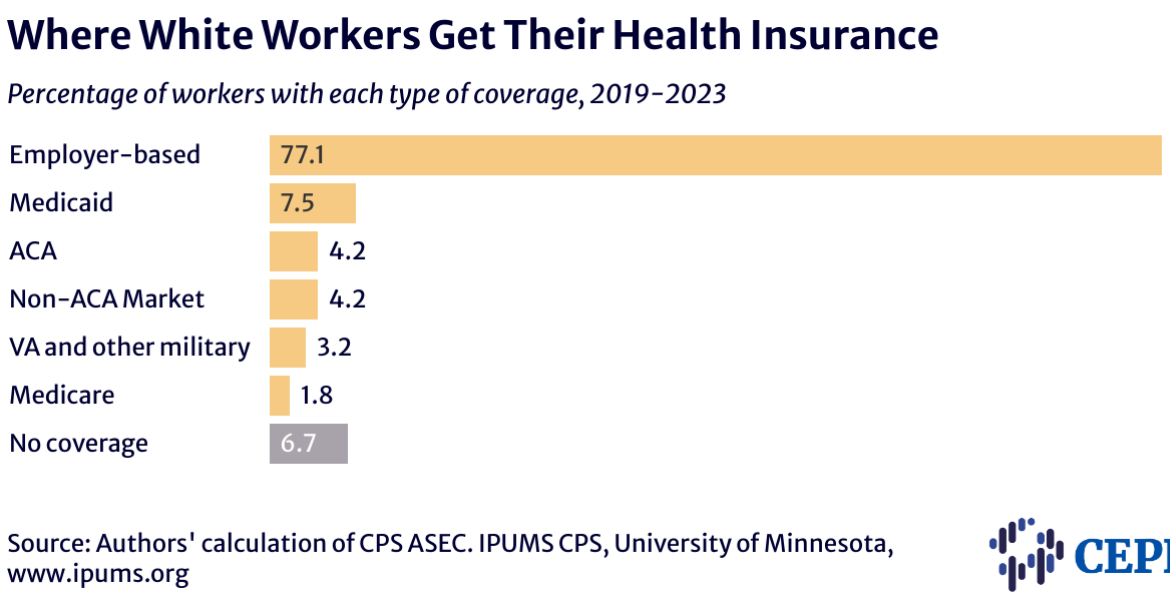
The pattern of health insurance coverage in Figure 1 holds for the workforce as a whole, but sources of coverage vary substantially by worker demographics. **Table 1A** summarizes how the types of coverage differ across workers' gender, race or ethnicity, age, marital status, the presence of children in their household, formal educational attainment, citizenship status and nativity, their 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.

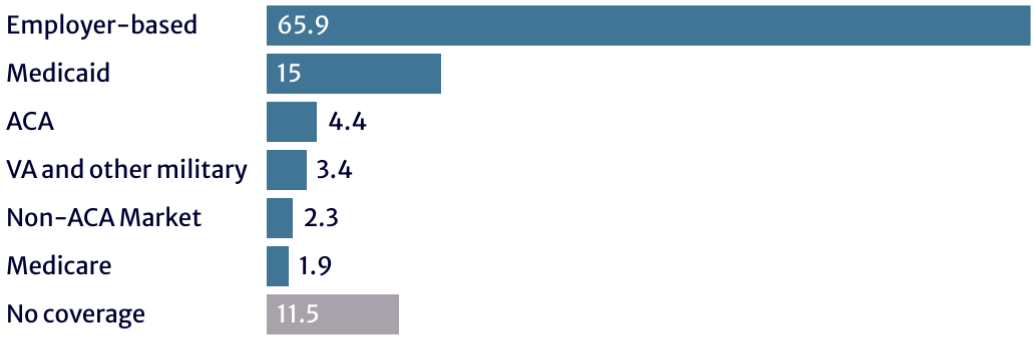
White workers are the least likely to lack coverage entirely (6.7 percent), primarily the result of having the highest coverage through employer-based insurance plans (77.1 percent). White workers are the least likely to use Medicaid, but about one in 14 white workers (7.5 percent) are insured through 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 2



Where Black Workers Get Their Health Insurance

Percentage of workers with each type of coverage, 2019-2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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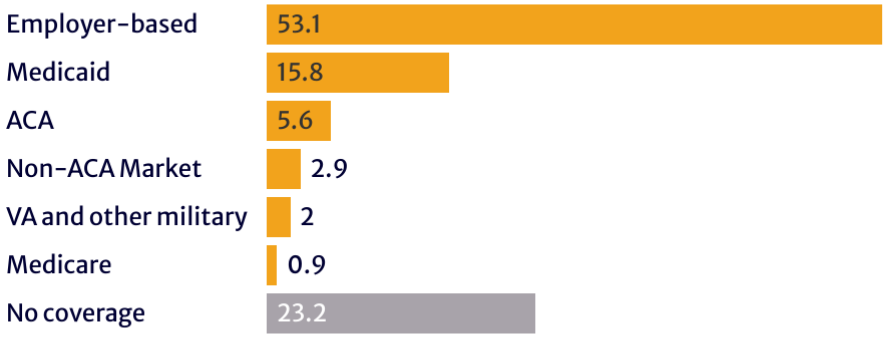
Where Hispanic Workers Get Their Health Insurance

Percentage of workers with each type of coverage, 2019-2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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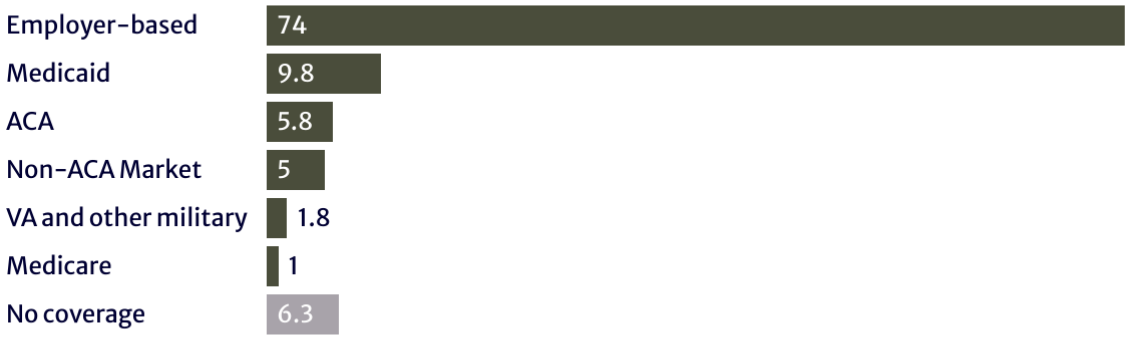
Where Asian Workers Get Their Health Insurance

Percentage of workers with each type of coverage, 2019-2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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Almost one of every four Hispanic workers (23.2 percent) lack any form of health insurance – the highest rate of the groups in Figure 2. Hispanic workers are the least likely to have coverage through their employer (53.1 percent) and the most likely to be enrolled in Medicaid (15.8 percent). They make slightly more use than average of the ACA (5.6 percent versus 4.6 percent on average). But Hispanic workers are less likely than average to use private non-ACA policies (2.9 percent versus the 3.7 percent average), military-related policies (2.0 percent versus 2.9 percent), or Medicare (0.9 percent versus 1.6 percent).

Black workers are more likely than the average to lack insurance (11.5 percent versus a 10.5 percent on average). Most Black workers have insurance through their employer (65.9 percent) but they are still far less likely than white workers (77.1 percent) to have an employer-sponsored plan. Medicaid is the next most important source of insurance for Black workers (15.0 percent). Black workers also have the highest share of coverage from military sources (3.4 percent versus 3.2 percent for white workers, who have the second highest share). The share with ACA policies was very close to the overall average, but the share of Black workers with private non-ACA plans was the lowest for the four groups in Figure 2. Just under two percent of Black workers between 18 and 64 are covered by Medicare.

Asian workers are, by a small margin, the least likely to lack insurance (6.3 percent versus 6.7 percent for white workers), an outcome that reflects a high share with employer-based coverage (74.0 percent) and the highest rates of ACA coverage (5.8 percent) and non-ACA market coverage (5.0 percent). Insurance through Medicaid (9.8 percent) lies between Black and Hispanic rates (both about 15 percent) and white rates (7.5 percent). Asian workers are the group least reliant on military-related coverage (1.8 percent) and only one percent of Asian workers are insured through Medicare.

Educational Attainment

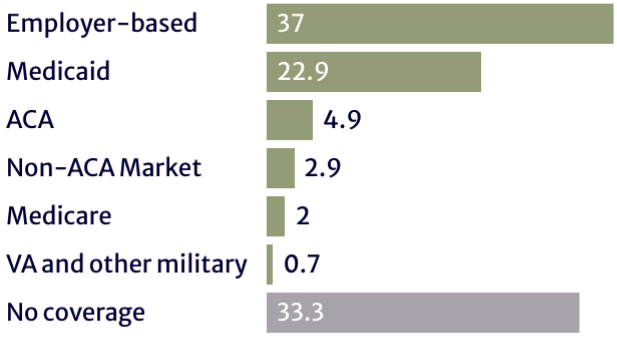
Differences in health insurance coverage are even larger by educational attainment (**Figure 3**).

One third (33.3 percent) of workers with less than a high school degree have no health insurance from any source, and only slightly more (37.0 percent) have insurance through an employer (their own or another family member's). Among the demographic groups analyzed here, workers with less than a high school degree are the demographic group that relies most heavily on Medicaid (22.9 percent). They also are somewhat more likely than workers with more education to use subsidized ACA plans (3.9 percent) and Medicare (2.0 percent), but the differences are small and they are also less likely to use unsubsidized ACA plans (only 1.0 percent). Workers who have not completed high school are the least likely to pay for non-ACA private insurance (2.9 percent) or to have coverage through military-related plans (0.7 percent).

Figure 3

Health Insurance of Workers with Less Than a High School Degree

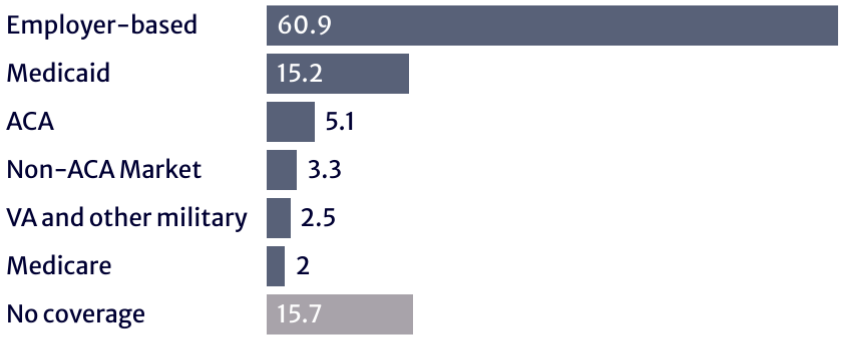
Percentage of workers with each type of coverage, 2019-2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

Health Insurance of Workers with a High School Degree

Percentage of workers with each type of coverage, 2019-2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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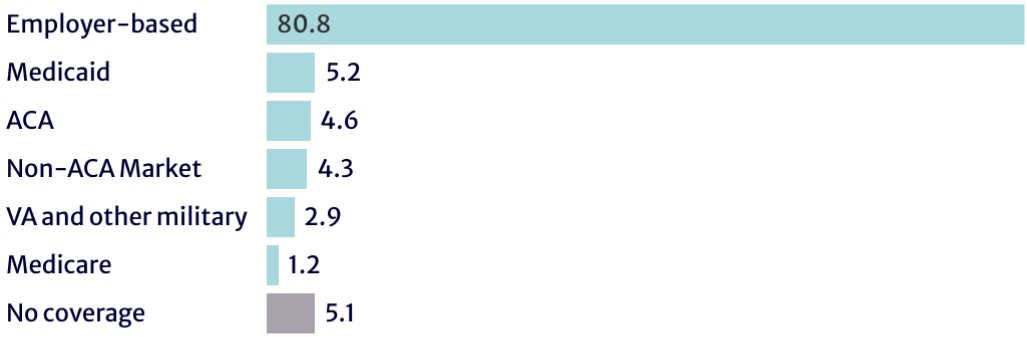
Health Insurance of College Graduates

Percentage of workers with each type of coverage, 2019-2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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Health Insurance of Workers with Advanced Degrees

Percentage of workers with each type of coverage, 2019-2023

Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

A large share of workers with only a high school degree also lack health insurance of any kind (15.7 percent). High school graduates are far less likely than average to have employer-based coverage (60.9 percent) and substantially more likely than average to use Medicaid (15.2 percent). Almost one of every 20 high school graduates has policies through the ACA (5.1 percent, where 3.9 percentage points are subsidized ACA plans). Non-ACA plans cover 3.3 percent, military-related policies cover another 2.5 percent, and 2.0 percent use Medicare.

Workers with some college, but not a four-year degree, are generally better off than those with only a high school degree, but still face major challenges. Almost one in 10 workers without a four-year college degree (9.4 percent) have no health insurance from any source. At 70.4 percent, employer-based coverage is their most important source of coverage, almost identical to the 70.7 percent average for the workforce as a whole. Workers with some college are somewhat more likely than average to rely on Medicaid (11.2 percent, versus 10.3 percent for all workers). Workers with some college are also the most dependent on military-related policies (3.9 percent). Medicare covers 1.7 percent of the group.

About one in 20 workers with a four-year college degree lack any form of health insurance (5.1 percent). The large majority of college graduates (80.8 percent) rely heavily on employer-based plans. While graduates make substantially less use of Medicaid (5.2 percent), the program still insures two million workers with a four-year college degree.[8] Private plans through the ACA (4.6 percent) and private plans outside of the ACA (4.3 percent) together cover about one in 12 college graduates, while military-related plans insure 2.9 percent. College graduates are the least likely to be enrolled in Medicare (1.2 percent).

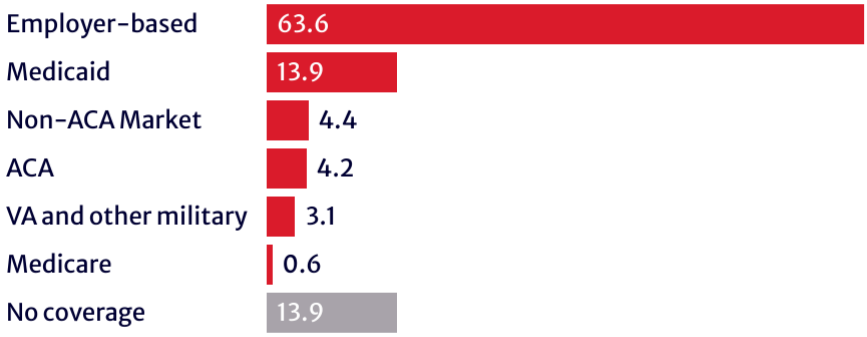
Only a relatively small share of workers with advanced degrees (those with more than a four-year college degree) lack any form of health insurance (2.9 percent). This group makes the highest use of employer-based plans (86.7 percent) and lowest use of Medicaid (3.0 percent), ACA plans (3.3 percent), and Medicare (1.2 percent) with the remainder in non-ACA market (4.0 percent) and military-related (3.1 percent) plans.

Age

Figure 4

Young Workers' (18-25) Health Insurance

Percentage of workers with each type of coverage, 2019-2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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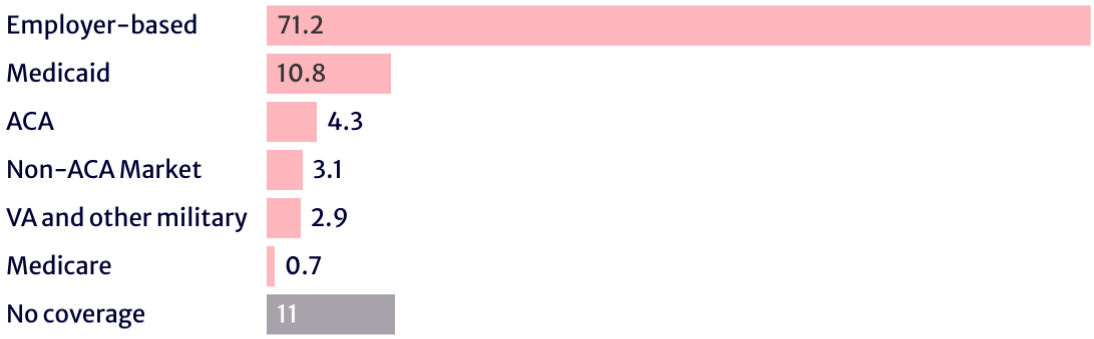
Where Workers Aged 26-50 Get Their Health Insurance

Percentage of workers with each type of coverage, 2019-2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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Young workers are more likely than older workers to go without health insurance. In recent years, the uninsured rate for 18-to-25 year-olds has averaged 13.9 percent, compared to 11.0 percent for those 26 to 50, and 7.5 percent for those 51 to 64 (**Figure 4**). (We have chosen the first age cut-off because the ACA allowed children to remain on their parents' employer-based coverage until age 26.)

Younger workers are less likely than older workers to have employer-based coverage (63.6 percent for 18-to-25 year-olds, versus over 70 percent for the two older age categories, and these figures include employer-based coverage through a parental plan). Younger workers are also more likely than older workers to be insured through Medicaid (13.9 percent for 18-to-25 year olds, compared to 10.8 percent for 26-to-50 year-olds and 6.9 percent for 51-to-64 year-olds).[9] Young workers are the least likely to rely on Medicare (0.6 percent), likely because Medicare eligibility for those under 65 is generally linked to long-term disability.

Nativity and citizenship

Where workers were born and whether or not they have US citizenship is another major influence on whether or not workers have health insurance and, if so, what type of coverage they have (**Figure 5**).

Figure 5

Health Insurance Status of Workers Born in the US

Percentage of workers with each type of coverage

Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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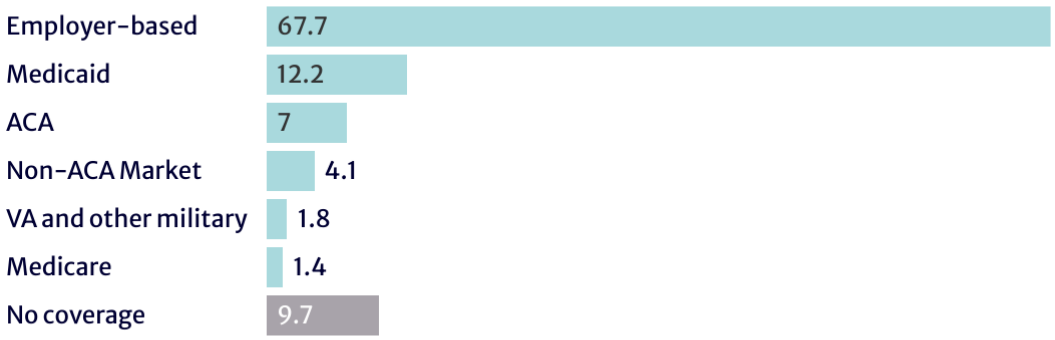
Health Insurance Status of Foreign-Born US Citizen Workers

Percentage of workers with each type of coverage



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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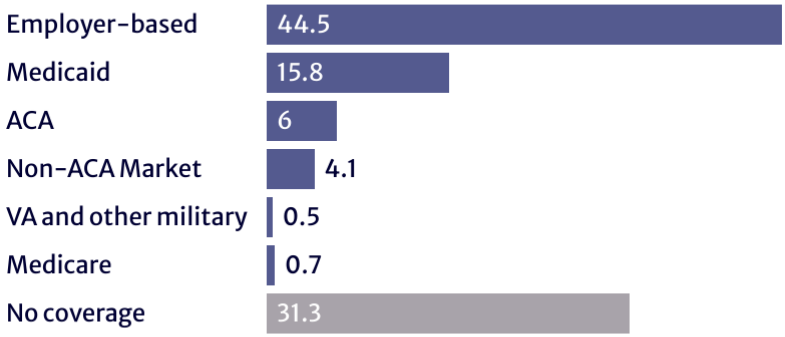
Health Insurance Status of Foreign-Born Workers Without Citizenship

Percentage of workers with each type of coverage



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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Workers born in the United States, who as of this writing have a constitutional guarantee of US citizenship, are more likely than foreign-born US citizens and foreign-born noncitizens to have some form of health insurance. About 8.2 percent of workers who are US citizens lack health insurance, compared to 9.7 percent of foreign-born citizens, and 31.3 percent of foreign-born noncitizens.

US-born workers are more likely (74.1 percent) than foreign-born citizens (67.7 percent) – and far more likely than foreign-born noncitizens (44.5 percent) – to have employer-based coverage.

Differences in coverage through Medicaid close some of this gap: 9.4 percent of the US-born, compared to 12.2 percent of foreign-born US citizens and 15.8 percent of foreign-born noncitizens. Insurance through the ACA is also somewhat more important for foreign-born workers: 4.1 percent for the US-born versus 7.0 percent for foreign-born US citizens and 6.0 percent for foreign-born noncitizens. Foreign-born US citizens (1.4 percent) and foreign-born noncitizes (0.7 percent) are less likely than US-born citizens (1.7 percent) to be covered by Medicare.

Marital status and the presence of children in the household

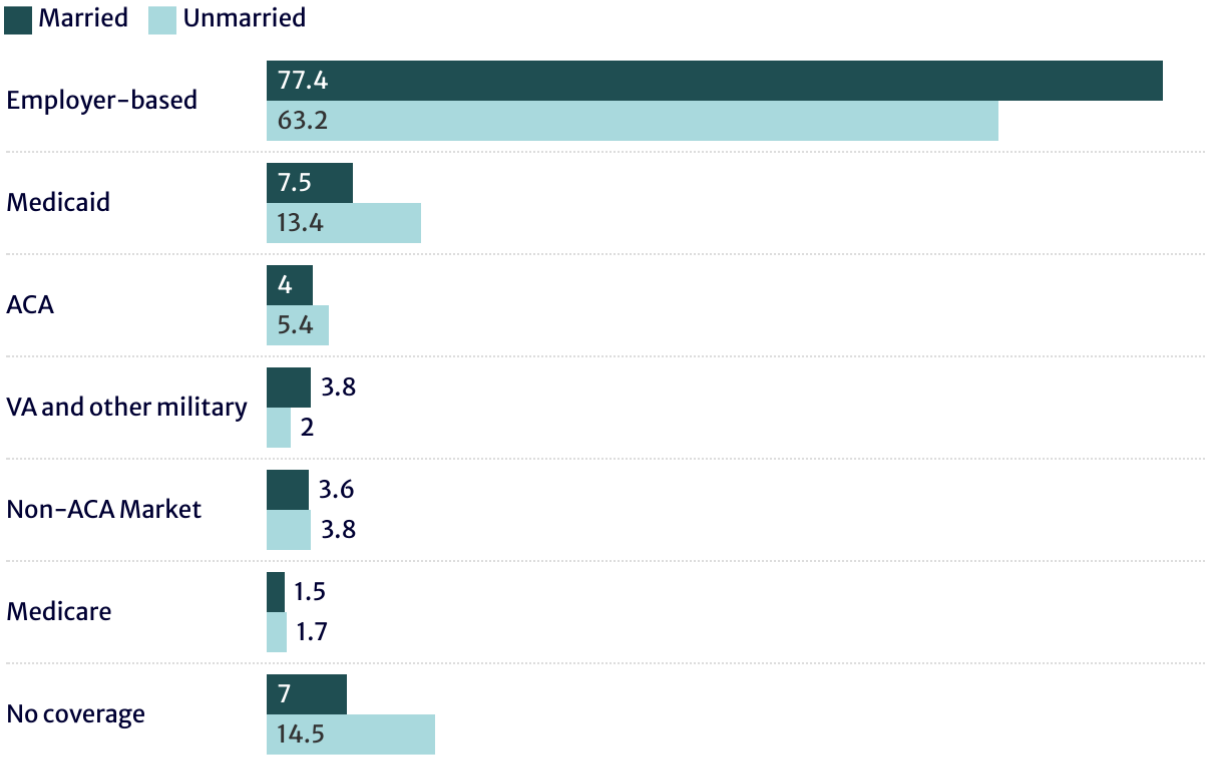
Workers who are married are much less likely to lack coverage (7.0 percent) than those who are not (14.5 percent).

In a mechanical sense, the most important reason for this difference is the large gap in employer-based coverage (**Figure 6**). About 77 percent of married workers have employer-based coverage, compared to only about 63 percent of unmarried workers. This likely reflects an important feature of the US health insurance system, which is that employer-based plans typically allow workers (usually at additional cost to the worker) to include married spouses and children on their employer-sponsored plan. In all of the data presented here, a worker's coverage through an employer-based plan may be through their own employer or an employer's plan where another member of the household, such as a spouse or parent, is employed.

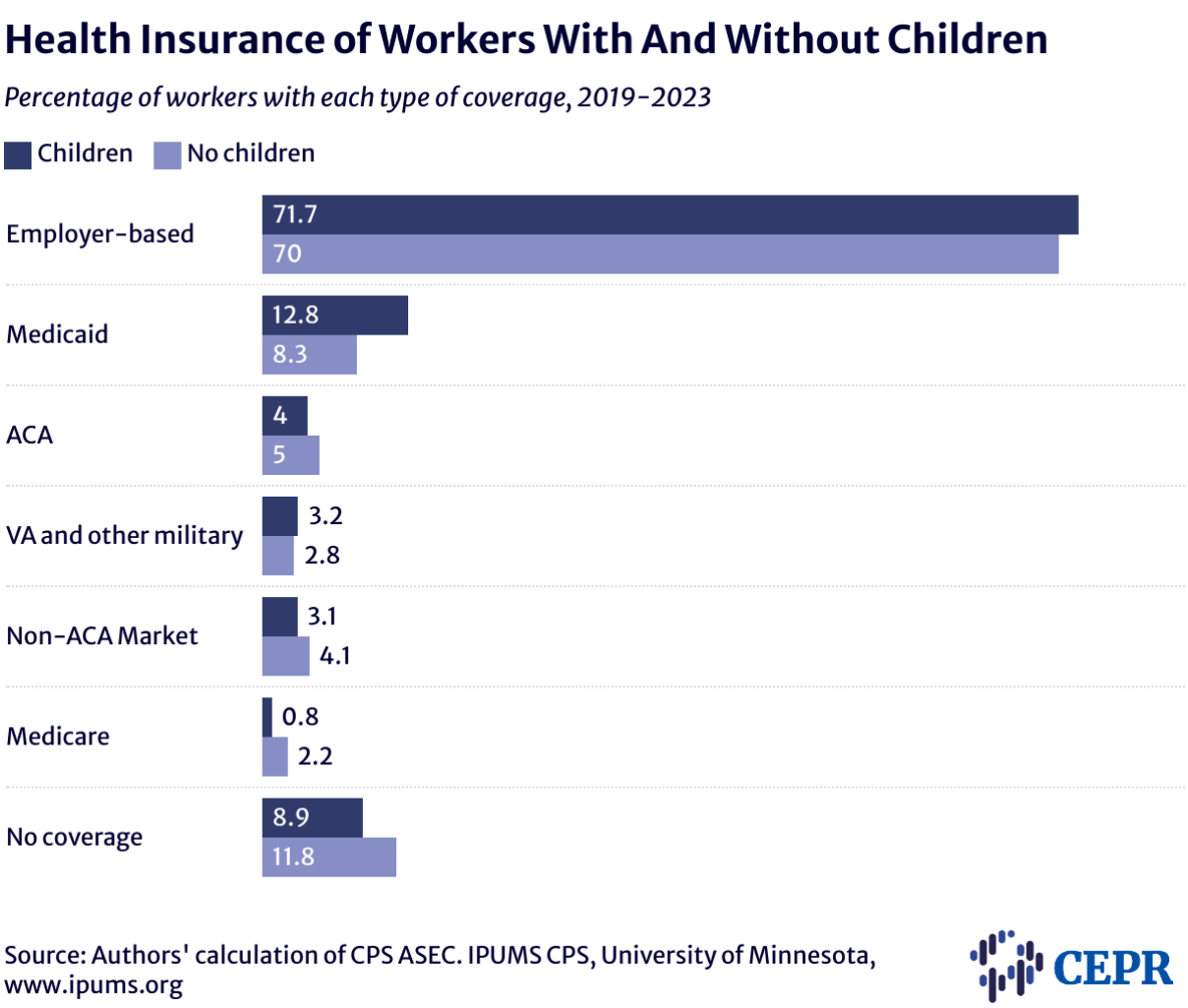
Figure 6

Married and Unmarried Workers Health Insurance

Percentage of workers with each type of coverage, 2019–2023



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org



At the same time, unmarried workers are much more likely than married workers to have insurance through Medicaid (13.4 percent versus 7.5 percent). As with employer-based coverage, this disparity likely reflects legal differences in eligibility. Medicaid is means-tested and limited to low-income households, and – importantly – income limits are adjusted for family size. If two low-income workers have identical incomes, one may qualify for Medicaid if there is also a child present in the household, while the other may be above the household-size-adjusted income cutoff if the worker has no other members in their household.

In a similar vein, while households with children have very similar likelihoods of being covered by employer-based plans (71.7 percent of households with children and 70.0 percent of households without children), households with children are much more likely to have insurance through Medicaid (12.8 percent) than households without children (8.3 percent).

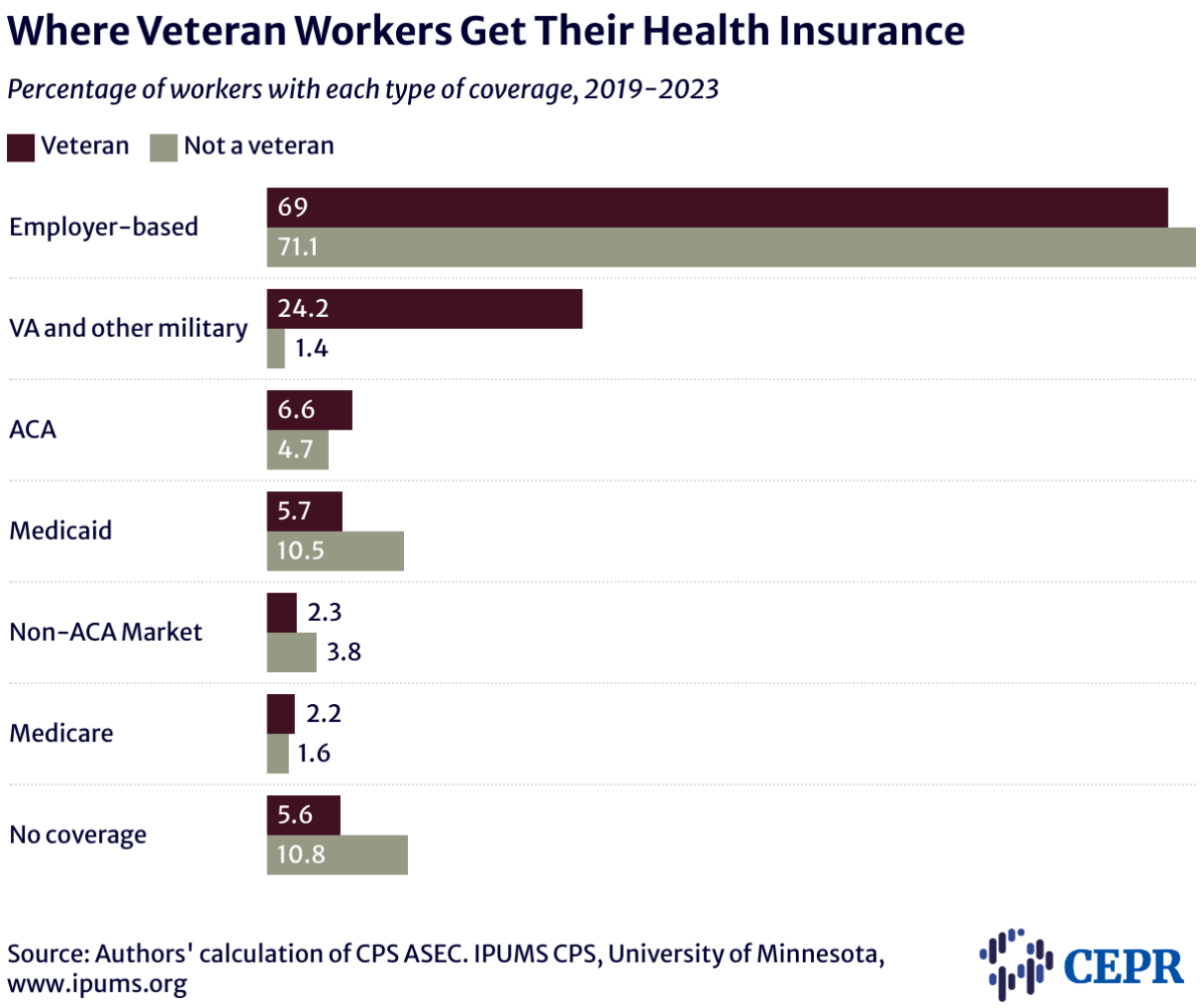
Medicaid appears to be particularly important for working households raising children. As Table 1B shows, this is especially the case for working women. About 14.8 percent of working women with children and about 16.4 percent of unmarried working women obtain their insurance through Medicaid.

Veteran status

Veterans are substantially less likely to lack health insurance coverage than non-veterans (a 5.6 percent uninsured rate for veterans versus a 10.8 percent rate for non-veterans, see **Figure 7**). While veterans and non-veterans have roughly

similar rates for employer-based insurance (69.0 percent for veterans and 71.1 percent for non-veterans), veterans have a very large share of coverage through military-related plans (24.2 percent). A small share of non-veterans (1.4 percent) have military-related coverage through spouses or parents who are veterans.

Figure 7

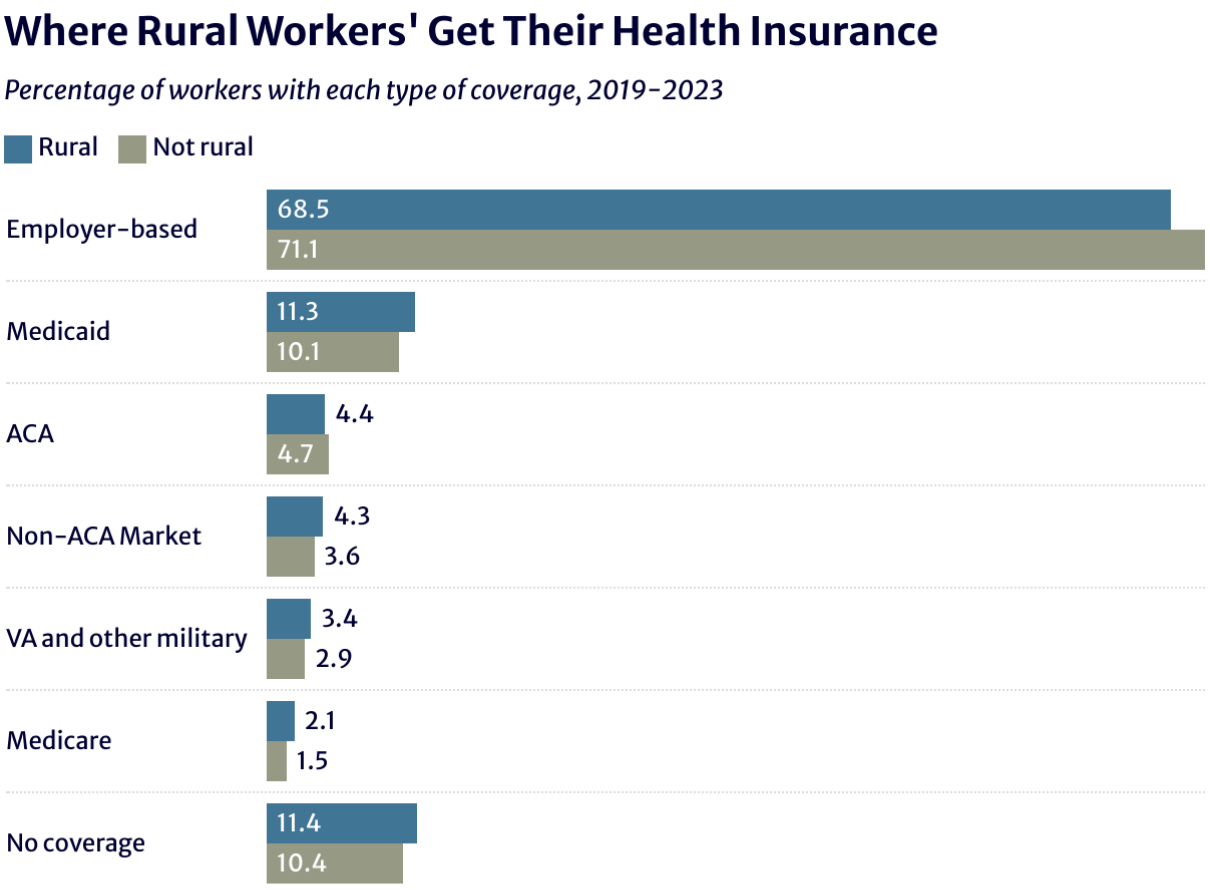


Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

Rural and non-rural

Rural versus non-rural[10] residence appears to make relatively little difference in overall coverage rates or the composition of coverage (**Figure 8**). Workers living in rural areas are somewhat more likely to lack coverage (11.4 percent) than workers in non-rural areas (10.4 percent). The fairly small difference in employer-based coverage (68.5 percent in rural areas, compared to 71.1 percent in non-rural areas) is partially offset by a slightly higher rate of utilization of Medicaid (11.3 percent versus 10.1 percent) and Medicare (2.1 percent versus 1.5 percent).

Figure 8

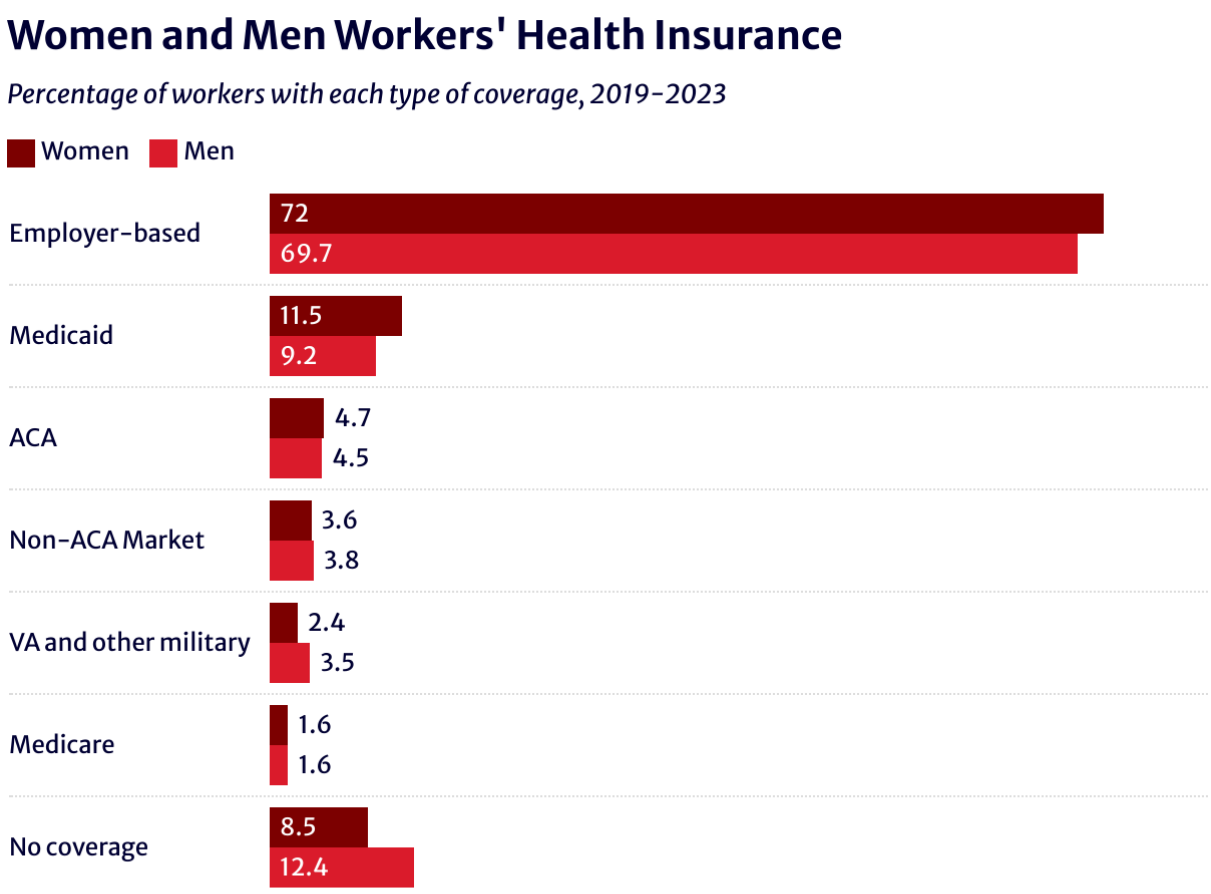


Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

Gender

By gender (**Figure 9**), the biggest gap is in the share of workers who lack health insurance. About one in eight men in the workforce (12.4 percent) lack health insurance, compared to about one in 12 women (8.5 percent). The main difference in coverage patterns is that women are somewhat more likely than men to have coverage through an employer or through Medicaid (2.3 percentage points higher in both cases, in part for reasons just discussed) and less likely than men to have a military-related plan (a 1.1 percentage point difference).

Figure 9



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

Tables 1B and **1C** present the same data on coverage rates by worker demographics as in Table 1A (and Figures 1 through 8), but separately for women (Table 1B) and men (Table 1C). This allows us to note any differences in coverage rates by gender, *within* the other categories we've seen so far. The most striking feature of this separate breakdown by gender is how similar the coverage patterns are across these two genders, except with respect to coverage through Medicaid and employer-based insurance, where women are more likely to be covered, and with respect to military-related insurance, where women are less likely than men to be covered.

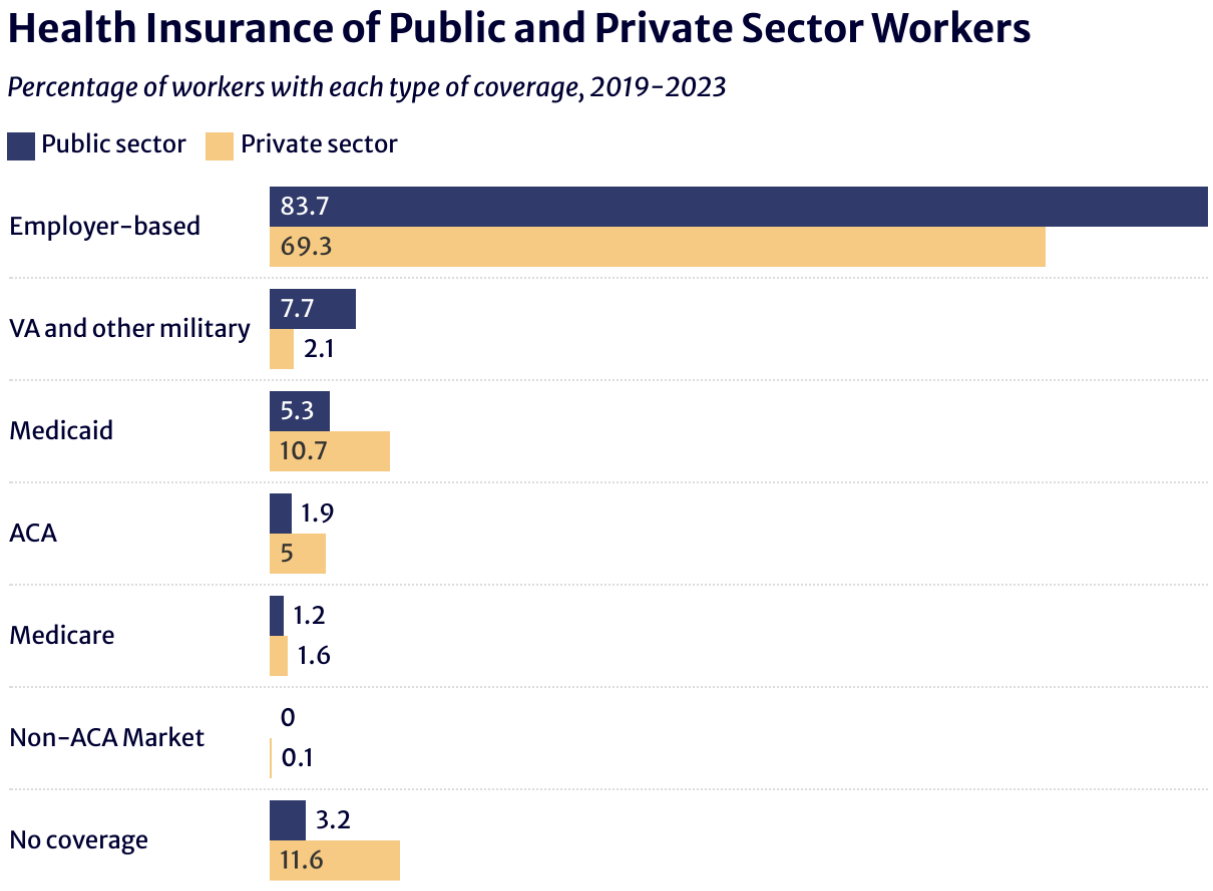
Coverage Also Varies Widely by Job Characteristics

So far, we have examined how the use of different kinds of health insurance varies by worker demographics. We can also look at how characteristics of the jobs that workers hold affect the kinds of health insurance they have. **Table 2A** shows the type of coverage workers hold along four dimensions: whether they work in the public or private sector; whether or not they are covered by a union; whether or not they are in a state that has expanded Medicaid coverage (where state laws can affect health insurance availability); and how well their job pays relative to other workers.

Public or private sector

Workers in public sector jobs are far less likely to lack health insurance (3.2 percent) than their counterparts in the private sector (11.6 percent) (**Figure 10**). This primarily reflects much higher rates of employer-based coverage in the public sector (83.7 percent, compared to 69.3 percent in the private sector) and, to a lesser degree, the higher share of public sector workers with military-related coverage (7.7 percent, versus 2.1 percent in the private sector).[11]

Figure 10



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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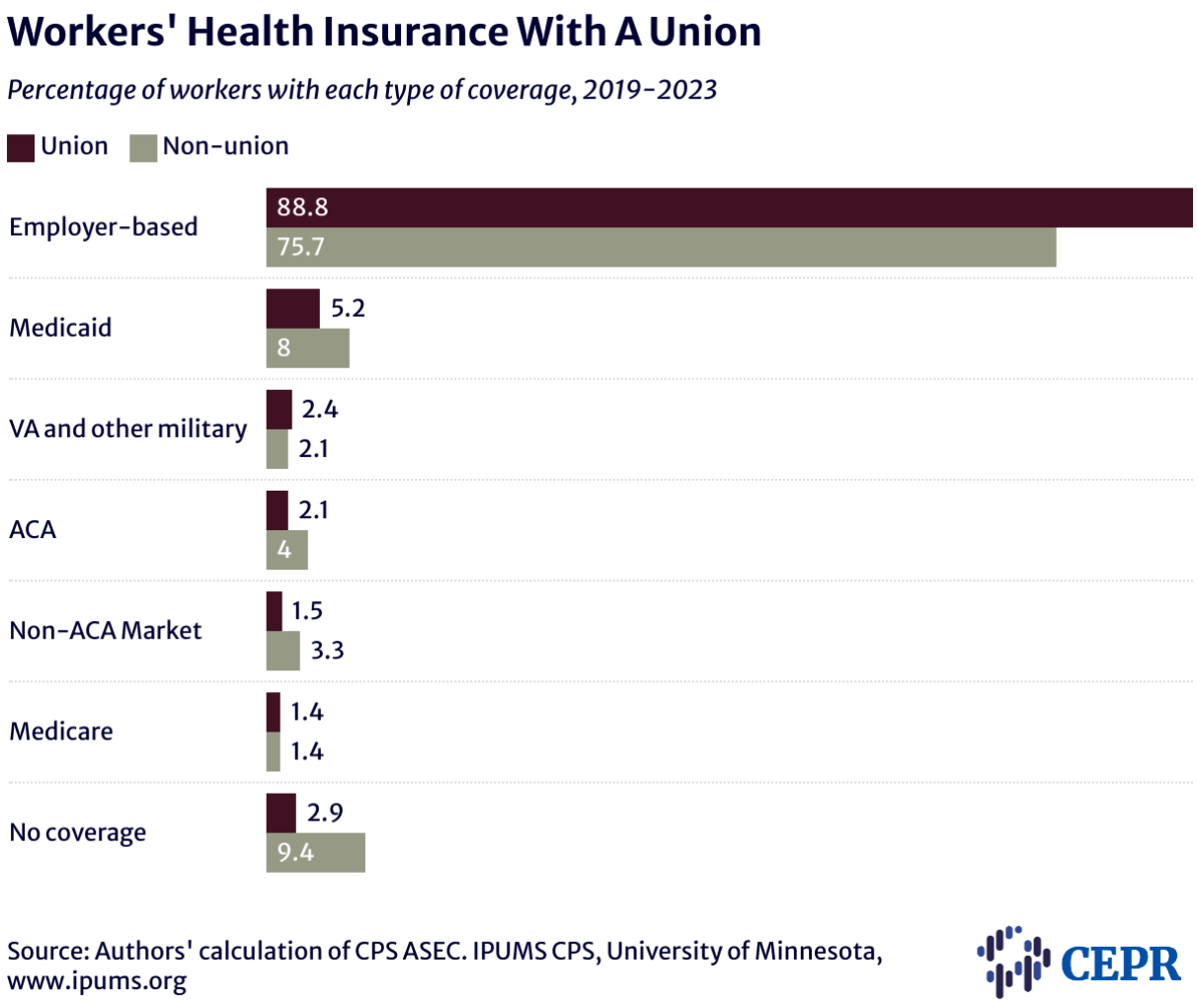
Private sector workers make greater use of Medicaid (10.7 percent, compared to

5.3 percent for the public sector), ACA policies (5.0 percent versus 1.9 percent), and non-ACA private plans (4.0 percent versus 2.0 percent).

Union status

Only 3.0 percent of workers covered by a union contract lack some form of health coverage. The uninsured rate for non-union workers, at 9.8 percent, is more than three times higher (**Figure 11**). The main driver of this difference is the substantially higher rate of employer-based coverage for union workers (89.0 percent) relative to non-union workers (75.2 percent). Union workers also make less use of Medicaid (5.6 percent versus 8.6 percent for non-union), ACA policies (1.9 percent versus 2.6 percent for non-union), and non-ACA policies (1.4 percent versus 3.1 percent).

Figure 11



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

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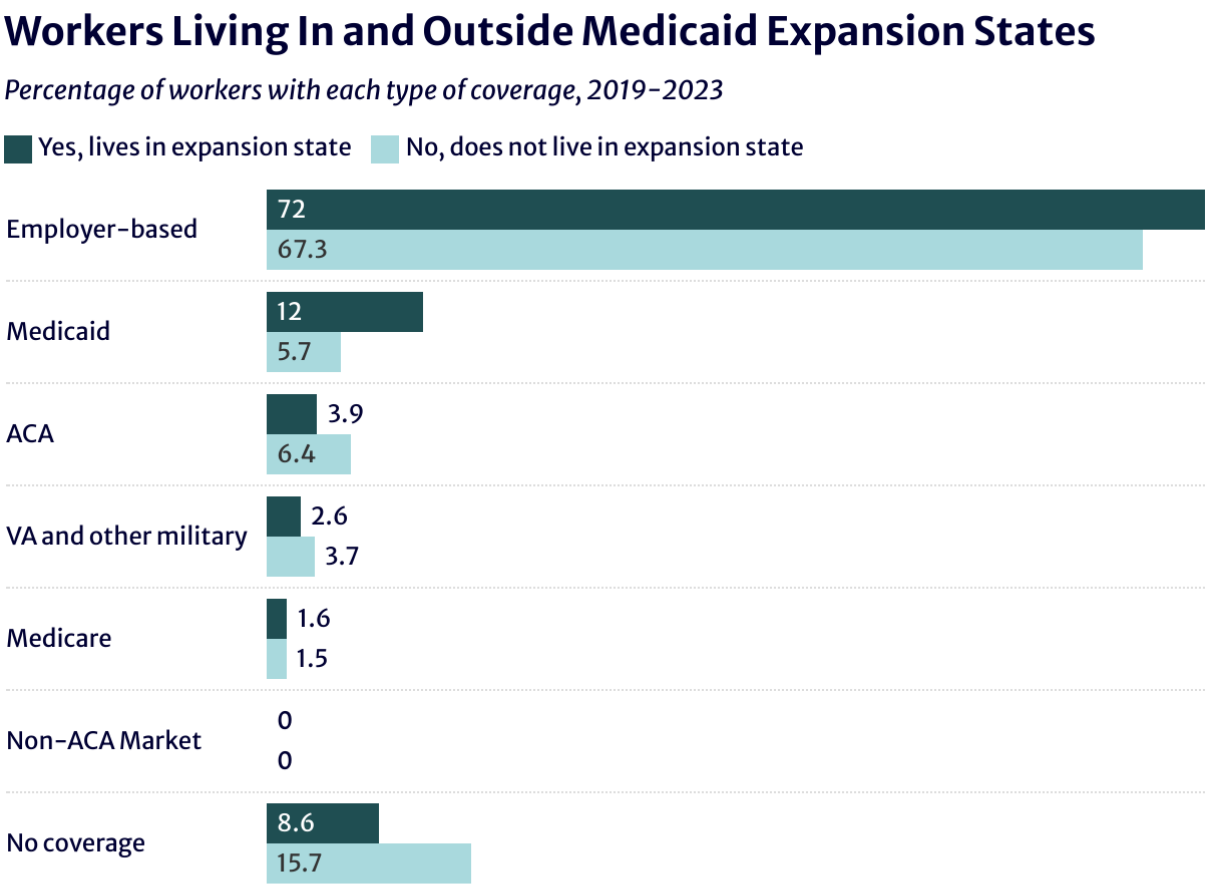
Medicaid expansion states

Workers who live (and generally work) in states that participate in the ACA expansion have a much lower uninsured rate (8.6 percent) than those in states that have declined to participate (15.7 percent, see **Figure 12**). Medicaid coverage for workers in expansion states is significantly higher (12.0 percent) than in non-expansion states (5.7 percent). Employer-based coverage is also higher in expansion states – 72.0 percent versus 67.3 percent in states that have not participated in the ACA-related expansion.

Figure 12



Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

CEPR

Wage level

Health insurance coverage varies systematically with workers' wages (**Figure 13**). In the bottom 40 percent of the wage distribution, 16.8 percent of workers lack any kind of health coverage; in the top 20 percent, the uninsured rate falls to 2.9 percent. The biggest reason for this difference in coverage rates is the much higher likelihood of having employer-based coverage in higher-paying jobs (87.7 percent at the top, more than 30-percentage-points higher than for the bottom 40 percent). This gap is only partially offset by higher shares of coverage through Medicaid and the ACA for lower-wage workers.

Figure 13

Source: Authors' calculation of CPS ASEC. IPUMS CPS, University of Minnesota, www.ipums.org

Tables 2B and **2C** present the same data on coverage rates by job characteristics as in Table 2A separately for women (Table 2B) and men (Table 2C). As with the earlier demographic analysis, men in the workforce are, on average and across job types, consistently more likely to be uninsured. As was the case with worker demographics, the biggest differences in coverage types by gender are limited almost entirely to coverage by employer-based plans and Medicaid, where women are in almost every case more likely to be insured than men. Men are more likely to have military-related insurance, but both the difference in take-up rates and the number of workers eligible for veteran-related policies is small.

Some Policy Considerations

The complicated maze that is the US health insurance system leaves one in 10 US workers without insurance. Employer-based health insurance is the central pillar of the current system and covers 70 percent of the workforce, but employer-based coverage systematically fails low- and middle-wage workers, workers of color, younger workers, and immigrant workers. The remaining private and public forms of insurance jointly fall far short of filling the gap.

But the coverage data do not tell the whole story. Two looming changes to the health insurance system threaten to greatly increase the share of workers without coverage.

The first threat is a legislative proposal that would eliminate the long-standing ACA subsidy to states that raise the income ceiling for Medicaid eligibility. Under the ACA, the federal government pays nearly all of the state costs involved in increasing the upper limit for Medicaid eligibility from 100 percent of the federal poverty level to 138 percent of the federal poverty line. According to estimates by KFF and the Center on Budget and Policy Priorities, this subsidy has allowed more than 20 million people in households just above the poverty line to obtain coverage through Medicaid.[12] A separate KFF study found that 64 percent of those covered by the Medicaid expansion were working either full-time (44 percent) or part-time (20 percent). Taken together, these figures suggest that elimination of the Medicaid expansion could lead to as many as 12.8 million workers losing their Medicaid coverage (64 percent of the 20 million total covered through Medicaid expansion).

The second immediate threat to coverage is the scheduled termination of the COVID-19-related expansion of subsidies to low- and middle-income households who purchase health insurance through the ACA exchanges.[13] These subsidies triggered a large increase in ACA enrollment; after holding steady between 2015 and 2020 in the range of 11 to 12 million total enrollees per year, ACA marketplace coverage more than doubled between 2020 and 2025 to the current total of over 24 million enrollees.[14]

The temporary subsidies driving this doubling in ACA coverage, however, are set to expire at the end of 2025. A recent analysis by the Urban Institute predicts that if these subsidies are not renewed, “four million people could become uninsured.”[15] The Urban Institute estimate refers to all beneficiaries of the enhanced subsidies, not just the workers we analyze here. But these numbers allow us to make a rough, if conservative, estimate of the impact on workers alone. The Urban Institute projects that 4 million people (workers, non-workers, and other family members) could lose their coverage. This figure of 4 million people is out of a total number of enrollees in 2024 (the final year of the Urban Institute analysis) of 21.4 million, or about 19 percent of the total. If we assume a proportional impact on the subgroup of subsidized ACA participants who were workers in 2024, which was 5.8 million,[16] this would suggest that more than 1.1 million workers could lose their coverage if the enhanced subsidies expire at the end of this year. This is likely a conservative estimate of coverage losses for workers because the COVID-19 subsidies provided relief to families with higher incomes than in the past — meaning that low- and middle-wage workers who previously made too much to qualify for the standard subsidies became eligible, and would be the most affected by the rescission of these subsidies.

While the ACA has undeniably made significant improvements in the scope of coverage and the quality of care, the US health insurance system remains a bewildering challenge for people trying to access healthcare. Unfortunately, the main lines of the current policy debate are focused almost exclusively on measures that would undermine the progress made under the ACA.

Despite the narrow focus of the current policy debate, there are alternatives to the current US health insurance system. A full discussion of the alternatives is beyond the scope of this report, but we can sketch some possible ways forward that would greatly expand workers' coverage rates and provide continuity of their coverage as they move through the labor market — while maintaining and likely improving the quality of care received.

Possibly the simplest step in the direction of universal quality coverage would be to allow employers and individuals of all ages to "buy in" to the existing Medicare program, currently restricted to those 65 and older.[17] This approach would build incrementally on three institutions of the existing health insurance system: Medicare, employer-provided health insurance, and the ACA Marketplace. An employer seeking to provide health insurance to its workforce could offer coverage through Medicare at a cost that is likely substantially below comparable private coverage. An individual without employer-based or other coverage could use existing subsidies to enroll in Medicare through the ACA Marketplace, where Medicare would compete on price and quality with private insurers that are also offering coverage.

Another option would be to gradually lower the eligibility age for Medicare, a program that already offers almost universal coverage to the population 65 and older.[18] A plan to reduce the Medicare eligibility age by one year every year (or along some other schedule) could reduce coverage gaps for older workers and, if continued for a sufficiently long period, build a parallel public health insurance system available to the entire workforce, independent of their employer.

Beyond these more intentionally incremental approaches, the US could move more quickly to adopt a "single-payer" system. In single-payer systems, the government finances (almost) all healthcare costs for all residents, but the care is typically delivered by a mix of private and public entities.[19]

In the US context, proposals for a single-payer system are often referred to as "Medicare For All." A US single-payer system would replace the current "multi-payer" system where individuals, employers, and the government pay for health insurance provided through a mix of private or public entities – with all the complexity seen in the data presented earlier. In the best version of a single-payer system, all US residents would be covered for all medically necessary services, including doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug, and medical supply costs.

Canada's Medicare program provides a useful, nearby point of reference for something close to a single-payer system. Their system is a decentralized, universal, publicly-funded single-payer health system called Canadian Medicare.[20] All Canadian citizens are eligible for free, basic medical services. Services such as prescriptions, dental care, and private hospital rooms are often covered by private insurance. A common feature, in practice, of single-payer systems is that they have a small private insurance market that offers private coverage for some services not included in the single-payer system.[21]

The US spends 16.7 percent of its GDP on healthcare, which is 5.7 percentage points higher than the average of comparable countries. In 2023, US health spending per capita was $13,432, approaching double the $7,393 average per capita spending in comparable OECD countries.[22] A recent, careful comparison by The Commonwealth Fund of health care expenditures in the United States and OECD countries concluded: “More than half of excess US health spending was associated with factors likely reflected in higher prices, including more spending on: administrative costs of insurance (~15% of the excess), administrative costs borne by providers (~15%), prescription drugs (~10%), wages for physicians (~10%) and registered nurses (~5%), and medical machinery and equipment (less than 5%).” The mix of private and public financing and provision of healthcare in the United States appears to be linked to higher rather than lower prices in the United States, relative to the systems in other countries where the private sector plays a much smaller role.[23] These large differences in spending suggest that the US could, like our peer countries, feasibly provide high-quality universal coverage at a savings of multiple percentage points of GDP. In the short term, these savings could support a transition to a new system while addressing any longer term concerns about the scope and quality of care. In short, given how much we already spend, we *could* have a universal system with high quality care for all.[24]

Table 1A

Workers' Health Insurance Coverage, By Worker Characteristics and Type of Coverage, 2019–2023

Percent of workers with each type of coverage

	Private		ACA		Public			
	Employer-based	Non-ACA Market	No subsidy	Subsidized	Medicaid	Medicare	VA and other military	No coverage
All	70.7	3.7	1.5	3.1	10.3	1.6	2.9	10.5
Women	72.0	3.6	1.4	3.3	11.5	1.6	2.4	8.5
Men	69.7	3.8	1.5	3.0	9.2	1.6	3.5	12.4
White	77.1	4.2	1.5	2.7	7.5	1.8	3.2	6.7
Black	65.9	2.3	1.3	3.1	15.0	1.9	3.4	11.5
Hispanic	53.1	2.9	1.3	4.3	15.8	0.9	2.0	23.2
Asian	74.0	5.0	1.8	4.0	9.8	1.0	1.8	6.3
18–25	63.6	4.4	1.3	2.9	13.9	0.6	3.1	13.9
26–50	71.2	3.1	1.4	2.9	10.8	0.7	2.9	11.0
51–64	74.3	4.7	1.6	3.9	6.9	4.1	2.9	7.5
Married	77.4	3.6	1.4	2.6	7.5	1.5	3.8	7.0
Unmarried	63.2	3.8	1.6	3.8	13.4	1.7	2.0	14.5
Children	71.7	3.1	1.2	2.8	12.8	0.8	3.2	8.9
No children	70.0	4.1	1.6	3.4	8.3	2.2	2.8	11.8
Less than HS	37.0	2.9	1.0	3.9	22.9	2.0	0.7	33.3
HS degree	60.9	3.3	1.4	3.7	15.2	2.0	2.5	15.7
Some college	70.4	3.7	1.4	3.3	11.2	1.7	3.9	9.4
College	80.8	4.3	1.7	2.9	5.2	1.2	2.9	5.1
Advanced	86.7	4.0	1.5	1.8	3.0	1.2	3.1	2.9
US born	74.1	3.6	1.4	2.7	9.4	1.7	3.3	8.2
Foreign-born, citizen	67.7	4.1	1.8	5.2	12.2	1.4	1.8	9.7
Foreign-born, non-citizen	44.5	4.1	1.4	4.6	15.8	0.7	0.5	31.3
Veteran	69.0	2.3	0.9	1.5	5.7	2.2	24.2	5.6
Not a veteran	71.1	3.8	1.5	3.2	10.5	1.6	1.4	10.8
Rural	68.5	4.3	1.4	3.0	11.3	2.1	3.4	11.4
Not rural	71.1	3.6	1.5	3.2	10.1	1.5	2.9	10.4

Source: Authors' analysis of 2019–2024 ASEC. Rows do not sum to 100.0 because a small number of workers report more than one type of insurance.

Table 1B

Women Workers' Health Insurance Coverage, By Worker Characteristics and Type of Coverage, 2019–2023

Percent of workers with each type of coverage

	Private		ACA		Public			
	Employer-based	Non-ACA Market	No subsidy	Subsidized	Medicaid	Medicare	VA and other military	No coverage
All women	72.0	3.6	1.4	3.3	11.5	1.6	2.4	8.5
White	78.0	4.1	1.5	2.8	8.3	1.8	2.5	5.7
Black	66.2	2.3	1.2	3.4	17.5	1.8	2.6	9.2
Hispanic	55.6	3.0	1.3	4.6	18.1	1.0	1.8	18.2
Asian	74.6	4.9	1.6	4.1	9.8	1.1	1.8	5.7
18–25	64.1	4.4	1.3	3.1	15.9	0.6	2.7	11.8
26–50	72.8	2.9	1.4	3.0	12.2	0.7	2.3	8.5
51–64	75.1	4.7	1.7	4.1	7.2	4.3	2.3	6.3
Married	79.3	3.6	1.4	2.6	6.9	1.5	3.3	5.8
Unmarried	64.1	3.7	1.5	4.0	16.4	1.7	1.4	11.4
Children	71.2	3.0	1.2	3.0	14.8	0.9	2.5	7.8
No children	72.6	4.2	1.7	3.6	8.6	2.3	2.2	9.0
Less than HS	36.6	2.8	1.0	4.3	28.4	2.2	0.8	27.5
HS degree	59.7	3.4	1.3	4.1	18.6	2.2	1.9	13.4
Some college	69.6	3.6	1.5	3.6	13.6	1.8	2.7	8.6
College	81.2	4.1	1.7	3.0	5.7	1.2	2.5	4.5
Advanced	87.8	3.7	1.4	1.9	3.0	1.2	2.5	2.6
US born	74.7	3.5	1.4	2.9	10.9	1.7	2.6	6.9
Foreign-born, citizen	68.7	4.2	1.8	5.4	12.4	1.5	1.7	7.9
Foreign-born, non-citizen	46.7	4.3	1.6	5.5	17.1	0.7	0.7	26.2
Veteran	64.1	2.5	0.7	1.6	6.3	2.4	30.0	4.7
Not a veteran	72.1	3.7	1.5	3.3	11.6	1.6	1.9	8.5
Rural	69.5	4.2	1.4	3.3	12.9	2.1	2.7	9.2
Not rural	72.3	3.6	1.4	3.3	11.3	1.6	2.3	8.3

Source: Authors' analysis of 2019–2024 ASEC. Rows do not sum to 100.0 because a small number of workers report more than one type of insurance.

Table 1C

Men Workers' Health Insurance Coverage, by Worker Characteristics and Type of Coverage, 2019–2023

Percent of workers with each type of coverage

	Private		ACA		Public			
	Employer-based	Non-ACA Market	No subsidy	Subsidized	Medicaid	Medicare	VA and other military	No coverage
All men	69.7	3.8	1.5	3.0	9.2	1.6	3.5	12.4
White	76.3	4.3	1.5	2.6	6.8	1.8	3.9	7.7
Black	65.6	2.3	1.3	2.8	12.2	2.1	4.3	14.2
Hispanic	51.2	2.8	1.2	4.0	14.1	0.9	2.2	27.2
Asian	73.5	5.1	2.0	3.8	9.9	1.0	1.8	6.8
18–25	63.2	4.4	1.3	2.7	12.1	0.7	3.5	15.9
26–50	69.7	3.2	1.5	2.8	9.5	0.8	3.5	13.1
51–64	73.5	4.7	1.6	3.6	6.6	3.9	3.4	8.5
Married	75.8	3.6	1.4	2.6	8.1	1.5	4.3	8.0
Unmarried	62.4	3.9	1.6	3.5	10.5	1.7	2.5	17.5
Children	72.1	3.3	1.3	2.7	10.8	0.8	3.9	10.0
No children	67.9	4.1	1.6	3.2	8.1	2.1	3.2	14.1
Less than HS	37.3	2.9	1.0	3.7	19.9	1.9	0.6	36.6
HS degree	61.6	3.2	1.4	3.5	12.9	1.9	2.9	17.2
Some college	71.2	3.8	1.4	3.0	8.9	1.5	5.0	10.3
College	80.4	4.4	1.7	2.8	4.6	1.2	3.3	5.6
Advanced	85.3	4.5	1.6	1.8	3.0	1.3	3.8	3.2
US born	73.6	3.7	1.5	2.6	8.1	1.7	4.0	9.5
Foreign-born, citizen	66.8	3.9	1.9	4.9	11.9	1.4	1.9	11.4
Foreign-born, non-citizen	43.0	3.9	1.4	4.0	15.0	0.7	0.4	34.6
Veteran	69.8	2.2	1.0	1.4	5.6	2.2	23.2	5.7
Not a veteran	70.2	3.9	1.5	3.1	9.5	1.5	1.0	13.0
Rural	67.6	4.3	1.4	2.7	9.9	2.2	4.1	13.3
Not rural	70.0	3.7	1.5	3.0	9.1	1.5	3.4	12.2

Source: Authors' analysis of 2019–2024 ASEC. Rows do not sum to 100.0 because a small number of workers report more than one type of insurance.

Table 2A

Workers' Health Insurance Coverage, by Job Characteristics and Type of Coverage, 2018–2023

Percent of workers with each type of coverage

	Private		ACA		Public			
	Employer-based	Non-ACA Market	No subsidy	Subsidized	Medicaid	Medicare	VA and other military	No coverage
All	70.7	3.7	1.5	3.1	10.3	1.6	2.9	10.5
Public sector	83.7	2.0	0.7	1.2	5.3	1.2	7.7	3.2
Private sector	69.3	4.0	1.6	3.4	10.7	1.6	2.1	11.6
Union	88.8	1.5	0.6	1.5	5.2	1.4	2.4	2.9
Non-union	75.7	3.3	1.3	2.7	8.0	1.4	2.1	9.4
Medicaid expansion								
Yes	72.0	3.8	1.3	2.6	12.0	1.6	2.6	8.6
No	67.3	3.5	1.9	4.5	5.7	1.5	3.7	15.7
Wage quintile								
Lowest	49.1	3.8	1.5	4.9	20.7	2.3	2.5	20.0
Second	65.6	3.2	1.4	3.9	12.9	1.5	2.8	13.5
Middle	77.5	3.0	1.3	2.6	7.7	1.2	3.1	8.1
Fourth	84.9	3.1	1.2	1.6	4.1	1.2	3.5	4.5
Highest	87.7	3.8	1.4	1.3	2.8	1.2	3.0	2.9

Source: Authors' analysis of 2019–2024 ASEC. Union coverage is based on only one-fourth of the ASEC sample in each year, excludes the self-employed, and are not directly comparable with other groups. Union values are based on the one-quarter subsample of ASEC that also participate in the Outgoing Rotation Group. Rows do not sum to 100.0 because a small number of workers report more than one type of insurance.

Table 2B

Women Workers' Health Insurance Coverage, by Job Characteristics and Type of Coverage, 2018–2023

Percent of workers with each type of coverage

	Private		ACA		Public			
	Employer-based	Non-ACA Market	No subsidy	Subsidized	Medicaid	Medicare	VA and other military	No coverage
All women	72.0	3.6	1.4	3.3	11.5	1.6	2.4	8.5
Public sector	85.5	2.0	0.8	1.4	6.2	1.3	3.8	3.3
Private sector	69.9	3.9	1.6	3.7	12.2	1.6	2.0	9.3
Union	89.1	1.9	0.6	1.8	6.0	1.3	2.0	2.1
Non-union	76.6	3.2	1.3	2.9	8.8	1.5	1.9	7.6
Medicaid expansion								
Yes	73.1	3.7	1.3	2.8	13.3	1.7	2.1	6.7
No	68.8	3.6	1.9	4.8	6.7	1.5	3.1	13.3
Wage quintile								
Lowest	51.5	3.8	1.5	5.2	22.3	2.2	2.2	16.2
Second	69.4	3.2	1.4	3.8	13.5	1.5	2.4	9.6
Middle	80.7	3.0	1.3	2.5	7.6	1.2	2.4	5.5
Fourth	86.9	2.9	1.2	1.5	4.0	1.3	2.5	3.4
Highest	87.9	3.8	1.3	1.5	3.3	1.2	2.3	2.6

Source: Authors' analysis of 2019–2024 ASEC. Union coverage is based on only one-fourth of the ASEC sample in each year, excludes the self-employed, and are not directly comparable with other groups. Union values are based on the one-quarter subsample of ASEC that also participate in the Outgoing Rotation Group. Rows do not sum to 100.0 because a small number of workers report more than one type of insurance.

Table 2C

Men Workers' Health Insurance Coverage, by Job Characteristics and Type of Coverage, 2018–2023

Percent of workers with each type of coverage

	Private		ACA		Public			
	Employer-based	Non-ACA Market	No subsidy	Subsidized	Medicaid	Medicare	VA and other military	No coverage
All men	69.7	3.8	1.5	3.0	9.2	1.6	3.5	12.4
Public sector	81.3	2.0	0.6	0.9	4.0	1.1	12.8	3.0
Private sector	68.8	4.0	1.6	3.2	9.5	1.5	2.2	13.4
Union	88.6	1.1	0.6	1.3	4.5	1.4	2.8	3.6
Non-union	74.8	3.3	1.2	2.4	7.2	1.4	2.4	11.2
Medicaid expansion								
Yes	71.0	3.9	1.3	2.5	10.8	1.6	3.2	10.4
No	66.0	3.5	1.9	4.2	4.7	1.5	4.3	17.8
Wage quintile								
Lowest	46.2	3.7	1.5	4.4	18.7	2.4	3.0	24.7
Second	61.4	3.1	1.4	4.0	12.3	1.5	3.3	17.8
Middle	74.6	3.0	1.4	2.7	7.7	1.2	3.8	10.5
Fourth	83.3	3.3	1.2	1.6	4.2	1.1	4.3	5.4
Highest	87.5	3.8	1.4	1.2	2.4	1.1	3.4	3.1

Source: Authors' analysis of 2019–2024 ASEC. Union coverage is based on only one-fourth of the ASEC sample in each year, excludes the self-employed, and are not directly comparable with other groups. Union values are based on the one-quarter subsample of ASEC that also participate in the Outgoing Rotation Group. Rows do not sum to 100.0 because a small number of workers report more than one type of insurance.

APPENDIX Data and Definitions

We use nationally representative data from Annual Social and Economic Supplement (ASEC), which is conducted annually by the Census Bureau as part of the monthly Current Population Survey (CPS).[25] The ASEC collects information from approximately 60,000 households on demographics, incomes, work status, and other characteristics, including detailed information on health insurance coverage. While the data are gathered primarily in March, most of the supplement's questions focus on the household's experience in the preceding calendar year. We focus here on the workers' demographics, work status, and health insurance coverage throughout the calendar year preceding their March interview. A household's answers provided in March of 2024 (currently, the most recent survey), for example, refer to their employment situation and health insurance coverage throughout 2023.

The ASEC offers several methods to measure an individual's health insurance coverage in the calendar year before their interview. Throughout this report, we follow the Census Bureau practice of referring to individuals as "uninsured" if they "did not have health insurance coverage for the entire calendar year" prior to their March interview.[26] This produces a conservative estimate of the number of workers without health insurance because it excludes workers who had health insurance at some point in the year, but lacked coverage in one or more months of the year.

We limit our sample to workers between the ages of 18 and 64. Workers 65 and older are overwhelmingly eligible for the federal Medicare program, which provides nearly universal coverage to the elderly, regardless of their income or employment status. Workers under 18 make up only a small portion of the workforce and their health insurance coverage generally comes through their parents (many of whom are in the workforce).[27] Our main interest here is to document the sources of the health insurance coverage that workers have and to explore how these sources vary by workers' demographic characteristics and work situation.

With respect to demographics, the ASEC data allow us to identify workers by age, gender, race/ethnicity, marital status, presence or absence of a child in the household, and education level. The ASEC assigns two gender categories, male and female. We use detailed ASEC responses to define five mutually exclusive race and ethnicity categories: White, Black, Hispanic, Asian, and Other, where the Other category includes racial and ethnic groups with only small numbers of observations, even in the pooled multi-year data we use here. For simplicity, we limit marital status to two categories: currently married and not currently married (which includes single, divorced, and widowed). We distinguish between five mutually exclusive levels of formal education: less than high school, high school degree, some college but not a four-year degree, college graduate, and advanced degree.

To capture differences in employment status, we divide workers into three mutually exclusive categories that together cover all working-age adults who participated in work at some point in the calendar year: full-time, full-year workers; part-time or part-year workers; and workers who experienced at least one spell of unemployment of at least one week in duration. Full-time, full-year workers were employed in a job or jobs for at least 50 weeks in the year for at least 35 hours per week. Part-time or part-year workers were employed between

one and 49 weeks in the year, or for fewer than 35 hours per week, or both. Our "unemployed" category includes survey respondents who had at least one spell of unemployment during the year, regardless of their full-time or part-time status when not unemployed.

Within each survey year, we also divide workers into five pay bands by first ordering all workers from the lowest to the highest hourly rates of pay, and then dividing them into five equally sized groups.[28] We define these wage quintiles across the entire wage distribution, grouping men and women together. This means that the wage quintiles we show below generally contain different numbers of men and women in each quintile. Importantly, women are overrepresented in lower quintiles and men are overrepresented in higher quintiles.

In order to increase the precision of the analysis for smaller demographic groups, we have pooled together the last six years of ASEC data. These surveys were fielded every March from 2019 through 2024, and refer to calendar years 2018 through 2023. Each year's data are weighted to be representative of the population within each year. We include the March 2020 CPS, which was fielded just as the COVID-19 pandemic was declared. Excluding the March 2020 survey does not meaningfully alter any of our qualitative or quantitative findings.[29]

Appendix Table 1

Number of workers, by worker characteristics and type of coverage, March 2024

Thousands of workers

	Private		ACA		Public			
	Employer-based	Non-ACA Market	No subsidy	Subsidized	Medicaid	Medicare	VA and other military	No coverage
All	107,319,000	4,659,000	2,298,000	5,806,000	15,890,000	1,400,000	2,451,000	16,819,000
Women	51,642,000	2,199,000	1,011,000	2,964,000	8,101,000	664,000	1,179,000	6,483,000
Men	55,677,000	2,460,000	1,287,000	2,842,000	7,789,000	736,000	1,272,000	10,336,000
White	68,075,000	3,037,000	1,434,000	2,826,000	6,658,000	839,000	1,536,000	6,132,000
Black	13,352,000	378,000	277,000	805,000	2,919,000	244,000	389,000	2,388,000
Hispanic	15,995,000	791,000	369,000	1,598,000	4,855,000	190,000	320,000	7,233,000
Asian	7,830,000	404,000	175,000	475,000	1,084,000	96,000	124,000	676,000
Other Races	2,067,000	50,000	42,000	101,000	375,000	31,000	82,000	391,000
18-25	13,922,000	915,000	276,000	735,000	3,421,000	151,000	384,000	3,502,000
26-50	63,287,000	2,249,000	1,364,000	3,225,000	9,664,000	640,000	1,261,000	10,273,000
51-64	30,110,000	1,495,000	658,000	1,846,000	2,805,000	609,000	805,000	3,044,000
Married	61,345,000	2,227,000	1,136,000	2,476,000	5,919,000	527,000	1,737,000	5,813,000
Unmarried	45,974,000	2,433,000	1,162,000	3,330,000	9,971,000	873,000	713,000	11,007,000
Children	47,607,000	1,746,000	909,000	2,403,000	8,252,000	349,000	1,114,000	6,078,000
No children	59,711,000	2,913,000	1,389,000	3,402,000	7,638,000	1,051,000	1,336,000	10,741,000
Less than HS	3,924,000	331,000	102,000	438,000	2,358,000	140,000	71,000	3,378,000
HS degree	24,037,000	1,207,000	569,000	1,846,000	6,402,000	517,000	457,000	6,834,000
Some college	27,591,000	1,212,000	627,000	1,639,000	4,497,000	424,000	806,000	3,794,000
College	32,177,000	1,282,000	665,000	1,395,000	1,956,000	218,000	662,000	2,149,000
Advanced	19,589,000	628,000	335,000	488,000	677,000	100,000	454,000	664,000
US born	91,016,000	3,697,000	1,824,000	4,153,000	11,695,000	1,213,000	2,221,000	10,360,000
Foreign-born, citizen	9,543,000	418,000	258,000	824,000	1,638,000	102,000	180,000	1,308,000
Foreign-born, non-citizen	6,760,000	544,000	215,000	829,000	2,558,000	85,000	50,000	5,152,000
Veteran	4,414,000	109,000	68,000	106,000	279,000	60,000	949,000	311,000
Not a veteran	102,904,000	4,551,000	2,230,000	5,700,000	15,611,000	1,340,000	1,502,000	16,509,000
Rural	11,769,000	640,000	205,000	694,000	1,806,000	176,000	289,000	2,078,000
Not rural	94,883,000	3,985,000	2,070,000	5,070,000	13,988,000	1,220,000	2,131,000	14,573,000
Public sector	17,431,000	296,000	125,000	349,000	1,130,000	121,000	665,000	692,000
Private sector	89,706,000	4,330,000	2,159,000	5,436,000	14,600,000	1,255,000	1,773,000	16,005,000
Medicaid expansion								
Yes	78,823,000	3,529,000	1,447,000	3,262,000	13,756,000	977,000	1,594,000	10,464,000
No	28,496,000	1,130,000	851,000	2,544,000	2,135,000	423,000	857,000	6,355,000

Source: Authors' analysis of March 2024 ASEC. Some groupings do not sum to total because of a small number of missing values in the ASEC data.

Footnotes

[1] We limit our analysis to workers 18 to 64 because Medicare provides nearly universal health insurance coverage for the population age 65 and older.

[2] See, Emma Curchin and John Schmitt, *Chronic Condition: Working Without Health Insurance*, Center for Economic and Policy Research, January 10, 2025. These numbers refer to 2023, the most recent year for which full-year data are available in the Census Bureau's Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC).

[3] See data description below for definitions and details.

[4] The coverage percentages shown in the main tables in this report are the averages over the six calendar years 2018 through 2023, the most recent full-year data currently available in the CPS ASEC. Pooling multiple years of data allows us to get a more accurate picture of coverage rates for smaller demographic groups and less common forms of health insurance. Using data before and after the worst years of the Covid-19 pandemic also reduces any distortions related to the pandemic as well as policy responses to the pandemic, including substantial but temporary Covid-19-related subsidies to insurance purchased through ACA marketplaces.

[5] Military coverage includes TRICARE, CHAMPUS, and other forms of insurance available to veterans and their families as a result of military service.

[6] Most importantly, workers 18 to 64 are eligible for Medicare if they have been receiving Social Security Disability Income for two or more years. See, for example, Social Security Administration, “Medicare Information,” https://www.ssa.gov/disabilityresearch/wi/medicare.htm and HealthCare.gov “People with Disabilities,“ https://www.healthcare.gov/people-with-disabilities/ssdi-and-medicare/.

[7] We are grateful to IPUMS for their work creating and maintaining a harmonized, publicly available extract of the CPS ASEC. See: Steven Ruggles, Sarah Flood, Matthew Sobek, Daniel Backman, Grace Cooper, Julia A. Rivera Drew, Stephanie Richards, Renae Rogers, Jonathan Schroeder, and Kari C.W. Williams. IPUMS USA: Version 16.0 [dataset]. Minneapolis, MN: IPUMS, 2025. https://doi.org/10.18128/D010.V16.0

[8] See Appendix Table 1A for numbers of workers in each category in Table 1A.

[9] As mentioned earlier, we exclude workers 65 and older from our analysis because they have close to universal coverage, primarily as a result of the Medicare program.

[10] The non-rural areas are a mix of urban and suburban areas, so we are reluctant to refer to rural and "urban" areas.

[11] The data analyzed here are limited to the civilian workforce and exclude active-duty members of the military. Those workers who report military-related health insurance coverage are either veterans, relatives of veterans, or relatives of active-duty members of the military.

[12] Jessica Mathers, Jennifer Tolbert, Priya Chidambaram, and Sammy Cervantes. "5 Key Facts About Medicaid Expansion," KFF, April 25, 2025. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/;
and Jennifer Sullivan, Allison Orris, and Gideon Lukens, "Entering Their Second Decade, Affordable Care Act Coverage Expansions Have Helped Millions, Provide the Basis for Further Progress," Center on Budget and Policy Priorities, March 25, 2024, https://www.cbpp.org/research/health/entering-their-second-decade-affordable-care-act-coverage-expansions-have-helped.

[13] These subsidies were initially included in the 2021 American Rescue Plan Act (ARPA) and extended in the 2025 Inflation Reduction Act (IRA).

[14] Jared Ortaliza, Justin Lo, and Cynthia Cox. “Enrollment Growth in the ACA Marketplaces,” KFF, April 2, 2025. https://www.kff.org/policy-watch/enrollment-growth-in-the-aca-marketplaces/.

[15] See Jessica Banthin, Matthew Buettgens, Michael Simpson, Jason Levitis, “Who Benefits from Enhanced Premium Tax Credits in the Marketplace?” Urban Institute, June 17, 2024. https://www.urban.org/research/publication/who-benefits-enhanced-premium-tax-credits-marketplace. Note that these numbers refer to all enrollees, not just the subset of enrollees who are also working full-time, part-time, or all temporarily unemployed.

[16] Authors’ analysis of the CPS data for March 2024.

[17] Dean Baker. “Getting to Medicare for All, Eventually.” Center for Economic and Policy Research. *Beat The Press* (blog), April 2, 2020. https://cepr.net/publications/getting-to-medicare-for-all-eventually/.

[18] John Holahan et al., “Lowering the Age of Medicare Eligibility to 60,” Urban Institute, June 2022, https://www.rwjf.org/content/rwjf-web/us/en/insights/our-research/2022/06/lowering-the-age-of-medicare-eligibility-to-60.html.

[19] See, for example, the discussion here: Physicians for a National Health Program (PNHP), "About Single Payer," accessed May 5, 2025, https://pnhp.org/what-is-single-payer/.
[20] Roosa Tikkanen et al., "International Health Care System Profiles: Canada," The Commonwealth Fund, June 5, 2020, https://www.commonwealthfund.org/international-health-policy-center/countries/canada.
[21] The United Kingdom also has a single-payer system, but differs from Canada in that it also has a single-provider system, meaning the government pays for and provides healthcare.
[22] Emma Wager et al., "How Does Health Spending in the U.S. Compare to Other Countries?" (Peterson-KFF Health System Tracker, April 9, 2025), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#Health%20expenditures%20per%20capita,%20U.S.%20dollars,%202023%20(current%20prices%20and%20PPP%20adjusted); See also, OECD, Health at a Glance 2023, Figure 7.1, p. 155. https://www.oecd.org/content/dam/oecd/en/publications/reports/2023/11/health-at-a-glance-2023_e04f8239/7a7afb35-en.pdf.
[23] Ani Turner, George Miller, and Elise Lowry, "High U.S. Health Care Spending: Where Is It All Going?" The Commonwealth Fund, October 4, 2023, https://doi.org/10.26099/r6j5-6e66; "The Role Of Administrative Waste In Excess US Health Spending," *Health Affairs Research Brief*, October 6, 2022, https://doi.org/10.1377/hpb20220909.830296.
[24] "PNHP Research: The Case for a National Health Program," Physicians for a National Health Program (PNHP), https://pnhp.org/resource/pnhp-research-the-case-for-a-national-health-program/, accessed May 5, 2025.
[25] We use the ASEC extract prepared by IPUMS (which formerly stood for the Integrated Public Use Microdata Series) prepared, maintained, and available online at the University of Minnesota: Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Megan Schouweiler, and Michael Westberry. IPUMS CPS: Version 12.0 [dataset]. Minneapolis, MN: IPUMS, 2024. https://doi.org/10.18128/D030.V12.0.
[26] See, for example, Katherine Keisler-Starkey and Lisa N. Bunch (2024), "Health Insurance Coverage in the United States: 2023," P60-284, Current Population Reports, U.S. Census Bureau, p. 19.
[27] Given that the ASEC is primarily administered in March but refers to the preceding calendar year, we follow standard practice and limit our sample to respondents between the ages of 19 and 65 at the time the survey is administered. About three-fourths of the 19 year olds in March were 18 in the preceding calendar year; a similar share of the 65 year olds in March were 64 in the preceding calendar year.
[28] For workers who experienced unemployment at some point during the year, we calculate their hourly wage using their pay in the weeks they were employed. In practice, this means that a small number of workers who were unemployed during the entire calendar year are excluded from the sample for this variable.
[29] See Table 5 and the related discussion in Curchin and Schmitt (2025).