



A Stubborn Problem: Unaffordable Health Costs Continue to Strain Californians' Finances

INTRODUCTION

Uninsurance rates in both the U.S. and California have dropped significantly since the Affordable Care Act's (ACA) health insurance coverage expansions were implemented in 2014.¹ Despite this increase in coverage, many people continue to report spending large shares of their income on health insurance and health care. These high health care and coverage costs, burdens themselves, can also impose other tangible hardships, such as causing people to rely on credit cards to pay medical bills (increasing credit card debt), and making it difficult to afford other basic needs, such as food and housing.²

In previous publications, we have explored the [impact of the ACA](#) and [the pandemic](#) on health care affordability in California. In both cases, we found that ACA-related reforms and pandemic-era policy interventions had positive impacts on the ability of Californians to afford health care, but, notably, that disparities persisted by race, income, and coverage status.

For this brief, we sought to improve our understanding of whether and how health care affordability changed between 2019 and 2024. This timeframe allows us to compare pre-pandemic experiences to what Californians reported in 2024, after some of the economic impacts of the pandemic subsided and several policies at the state and federal levels were implemented to address health care costs (see sidebar). Overall, we found that measures of affordability mostly improved or held steady during this time period, though there were notable disparities across demographic subgroups and regions of the state. However, we also found a significant increase in the share of Californians with large deductibles, mostly driven by growing deductibles for people with employer-sponsored coverage. High deductibles expose a rising number of people to potentially large out-of-pocket health care costs if they become sick or injured.

This analysis also provides an important baseline in advance of historic federal policy changes. These include changes to Medicaid under H.R. 1, which is expected to reduce Medicaid enrollment and increase uninsurance by millions of people nationally, as well as reduce federal spending for Medicaid by hundreds of billions of dollars over the next decade.³ In addition, Congress allowed the expiration of enhanced federal subsidies at the end of 2025 for millions of people across the U.S. who purchased coverage on ACA health insurance marketplaces, which has increased premiums and could result in lost coverage for millions of people.⁴ These policy changes are estimated to reduce coverage and increase the cost of health care for millions of Californians.^{5,6}

¹ Enhanced federal subsidies ended on December 31, 2025; at the time of writing, Congress had not acted to extend them.

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State and Federal Policies Impacting Health Care Affordability 2019–2024

During the pandemic, a series of laws passed by the U.S. Congress included provisions designed to support access to health insurance and health care. For instance, the American Rescue Plan Act (ARP) and Inflation Reduction Act (IRA) significantly increased and extended enhanced premium tax credits for Marketplace plans, resulting in lower health insurance premiums for almost two million people in California.^{7,8} And the Families First Coronavirus Response Act (FFCRA) offered states increased federal funding for Medicaid if they allowed enrollees to keep their Medicaid coverage through the duration of the public health emergency. Policies such as these helped make health care and insurance coverage more affordable for individuals and families.

California also implemented several additional policies to expand coverage and help people with the cost of health care between 2019 and 2024, including:

- Adopting an individual mandate requiring people to obtain health insurance.
- Enacting multiple phased Medi-Cal expansions to provide coverage to all income-eligible residents regardless of immigration status. The final phase expanding coverage to adults 26–49 was implemented in 2024.⁹ California is now scaling back this expansion in response to budgetary pressures; the state will maintain coverage for existing enrollees but paused new enrollment for adults in January of 2026.¹⁰
- Supplementing federal premium tax subsidies through Covered California to include residents with incomes up to 600% of FPG.
- Eliminating deductibles and reducing copays for enrollees in Covered California with incomes up to 250% FPL, using revenue from the state's individual mandate penalty.¹¹

To understand issues of health care and insurance affordability in California, we studied several measures of affordability from the California Health Insurance Survey (CHIS), which asks people from throughout the state a variety of questions about health insurance and health care, including about coverage and care costs as well as challenges of affordability. We also examined high burden spending in California and the U.S. using the Current Population Survey (CPS), which is a federal data source that includes information on both income and health care costs for all 50 states and D.C. We tested for statistically significant changes over time and between certain demographic groups and regions for the following measures:

◆ **Health Insurance Deductibles**

- What shares of Californians report having health insurance deductibles of at least \$2,000?

◆ **Medical Bills**

- What proportions of Californians say they have trouble paying medical bills?
- How large are the medical bills that Californians have trouble paying?

◆ **Impacts of Medical Bills**

- What shares of Californians report entering credit card debt to finance medical bills?
- What shares of Californians report that trouble paying medical bills causes them difficulties in affording basic necessities, such as food and housing?

◆ **High Burden Spending (Current Population Survey or CPS)**

- How does California compare to the U.S. on the share of people who report spending 10% or more of income on premiums and other health care costs, such as co-pays, deductibles, and co-insurance?

Overall, the share of Californians who reported having problems paying medical bills declined from 13.3% in 2019 to 11.8% in 2024. Statewide, medical bill impacts such as trouble paying for basic necessities, having bills larger than \$4,000, or taking out credit card debt to finance medical bills largely held steady from 2019 to 2024, with no statistically significant shifts in any of those reported experiences. However, during this same time period, the percentage of people reporting large deductibles (over \$2,000) increased from 34.8% to 37.8%; this shift was driven primarily by people with employer-sponsored coverage facing larger deductibles. This is a sign that employer-sponsored insurance, long the backbone of health coverage for working-age adults across the U.S., is becoming less generous and exposing people to higher potential for out-of-pocket health care spending. In addition, disparities persist by income, race/ethnicity, coverage type, and region across measures. Finally, we found that high burden spending has declined in both the U.S. and California in recent years, and that rates of high burden spending in California are consistently lower than rates nationwide. However, there are disparities by income both nationally and in California.

DEDUCTIBLES OF MORE THAN \$2,000

Deductibles are an important concept in understanding the affordability of health insurance and health care. A [health insurance deductible](#) is the amount of out-of-pocket costs that beneficiaries must pay before the insurer begins to pay claims. For instance, if a person with a \$2,000 deductible were hospitalized for an injury or illness, they would need to pay the first \$2,000 in bills before their insurer begins to pay any of its share.

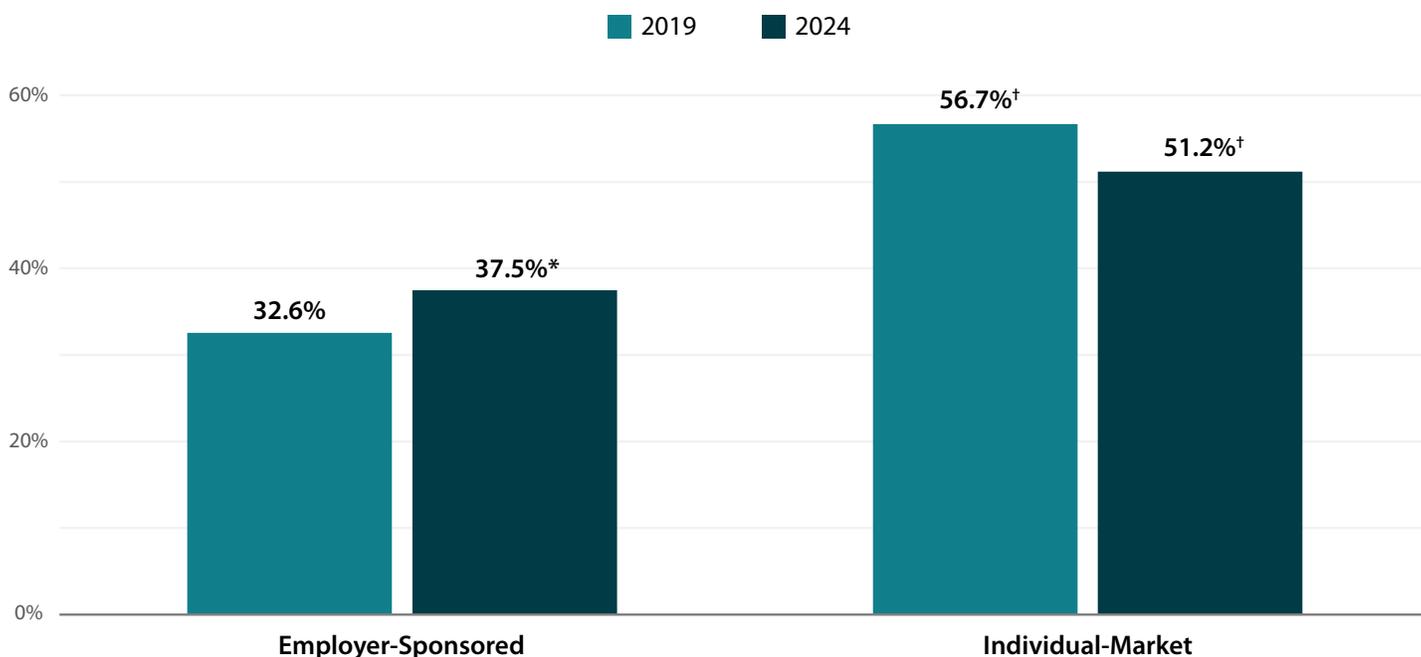
Health insurance deductibles raise particular concerns when they exceed the ability for beneficiaries to readily pay them, such as in the case of “high deductibles”; this can be especially problematic when facing a sudden injury, illness, or chronic condition, as the entire high deductible generally must be paid before there is any coverage from the insurer, meaning that someone could suddenly owe thousands of dollars even with insurance coverage. Even modest deductibles can be difficult to afford for those with lower incomes. When deductibles are unaffordable, people may go without needed medical care or may experience downstream financial impacts, such as trouble paying for other necessities, which we examine later in this brief.

Growing Share of Californians Have Large Deductibles

While there are different definitions for what makes a “large,” “high,” or “unaffordable” deductible, this study focuses on a measure from the CHIS on rates of Californians who said they had a deductible of more than \$2,000. For the overall population of California with private insurance (i.e., Californians with employer-sponsored insurance [ESI] or individual-market coverage), we found that 37.8% of people reported a deductible of more than \$2,000 in 2024, which is a statistically significant increase from 34.8% in 2019 (Appendix Table 1). This continues an upward trend in California and nationally since implementation of the ACA. As we reported in a previous brief, the share of Californians with high deductibles nearly doubled from 16% in 2013 to 31% in 2018.¹²

The increase in large deductibles between 2019 and 2024 was concentrated in certain groups: People with employment-based insurance (ESI), White Californians, urban Californians, and people with income above 400% FPG all reported statistically significant increases in high deductibles between 2019 and 2024. It is also important to note that although there was no statistically significant increase in high deductibles for people with individual-market coverage between 2019 and 2024, the share reporting deductibles over \$2000 (51.2%) is considerably larger than for those with employment-based insurance (Figure 1).

Figure 1. Californians with Private Insurance with Deductibles Over \$2,000 by Coverage Type, 2019 vs. 2024



Source: SHADAC analysis of CHIS data.

* Statistically significant difference from 2019 at the 95% level.

† Statistically significant difference from employer-sponsored at the 95% level.

TROUBLE PAYING MEDICAL BILLS

Another important measure for affordability of health care is whether people have trouble paying medical bills, which can occur for people without health insurance and even for those with health insurance, particularly when plans leave beneficiaries responsible for substantial portions of their health care bills (e.g., high deductibles, lack of coverage for certain services, etc.).

For this measure, we analyzed data from the CHIS on people who reported that they have had difficulty paying medical bills in the past twelve months.

Fewer Californians Report Trouble Paying Medical Bills in 2024

In 2024, 11.8% of Californians reported having trouble paying medical bills, which was a statistically significant improvement from 13.3% in 2019. The largest improvements were seen among people with individual-market coverage and people with incomes of 250–399% FPG, suggesting enhanced subsidies through Covered California may have been key drivers of this change (Table 1). Urban Californians and those in the San Joaquin Valley experienced a statistically significant improvement on this measure between 2019 and 2024, as well. There were no significant changes over time for other coverage types, income groups, or by race/ethnicity.

Table 1. Californians Reporting Trouble Paying Medical Bills in the Past Twelve Months, 2019 vs. 2024

Population	2019 Rate	2024 Rate	2019–2024 Difference in Rates (percentage point change)	2024 Subgroup vs. Reference (percentage point difference)
Total	13.3%	11.8%	-1.5% *	N/A
Coverage Type (Reference: Employment-Based)	—	—	—	—
Uninsured	17.4%	16.5%	-0.9%	6.0% #
Medi-Cal	12.8%	12.1%	-0.6%	1.6% #
Employment-Based	11.7%	10.6%	-1.1%	REF
Individual-Market	19.0%	14.3%	-4.7% *	3.7% #
Income, % FPG (Reference: 400%+)	—	—	—	—
0–138%	15.7%	15.0%	-0.6%	6.9% #
139–249%	18.1%	16.6%	-1.5%	8.4% #
250–399%	17.6%	13.1%	-4.5% *	5.0% #
400%+	8.9%	8.1%	-0.7%	REF
Race/Ethnicity (Reference: White, Non-Latino/x)	—	—	—	—
Latino/x	15.3%	13.5%	-1.8%	2.0% #
American Indian/Alaskan Native, Non-Latino/x	17.3%	15.3%	-2.0%	0.0%
Asian/Native Hawaiian/Pacific Islander, Non-Latino/x	6.0%	6.9%	1.0%	-4.6% #
Black, Non-Latino/x	17.5%	15.1%	-2.4%	3.6%
White, Non-Latino/x	12.7%	11.5%	-1.2%	REF
Other/Two or More Races, Non-Latino/x	15.6%	14.5%	-1.1%	3.0%
Geography (Reference: Urban)	—	—	—	—
Urban	13.0%	11.5%	-1.5% *	REF
Rural	16.2%	14.7%	-1.5%	3.2% #
Region (Reference: Total)	—	—	—	—
Northern/Sierra Counties	18.6%	19.8%	1.2%	8.0% #
Bay Area Counties	10.1%	8.5%	-1.6%	-3.3% #
Sacramento Area Counties	12.5%	11.7%	-0.8%	-0.1%
San Joaquin Valley	19.6%	15.2%	-4.4% *	3.4% #
Central Coast Counties	22.1%	16.1%	-6.0%	4.3% #
Los Angeles County	11.8%	11.7%	-0.1%	-0.1%
Other Southern California Counties	12.9%	11.4%	-1.5%	-0.4%

Source: SHADAC analysis of CHIS data. Regional estimates from AskCHIS.

* Statistically significant difference from 2019 at the 95% level.

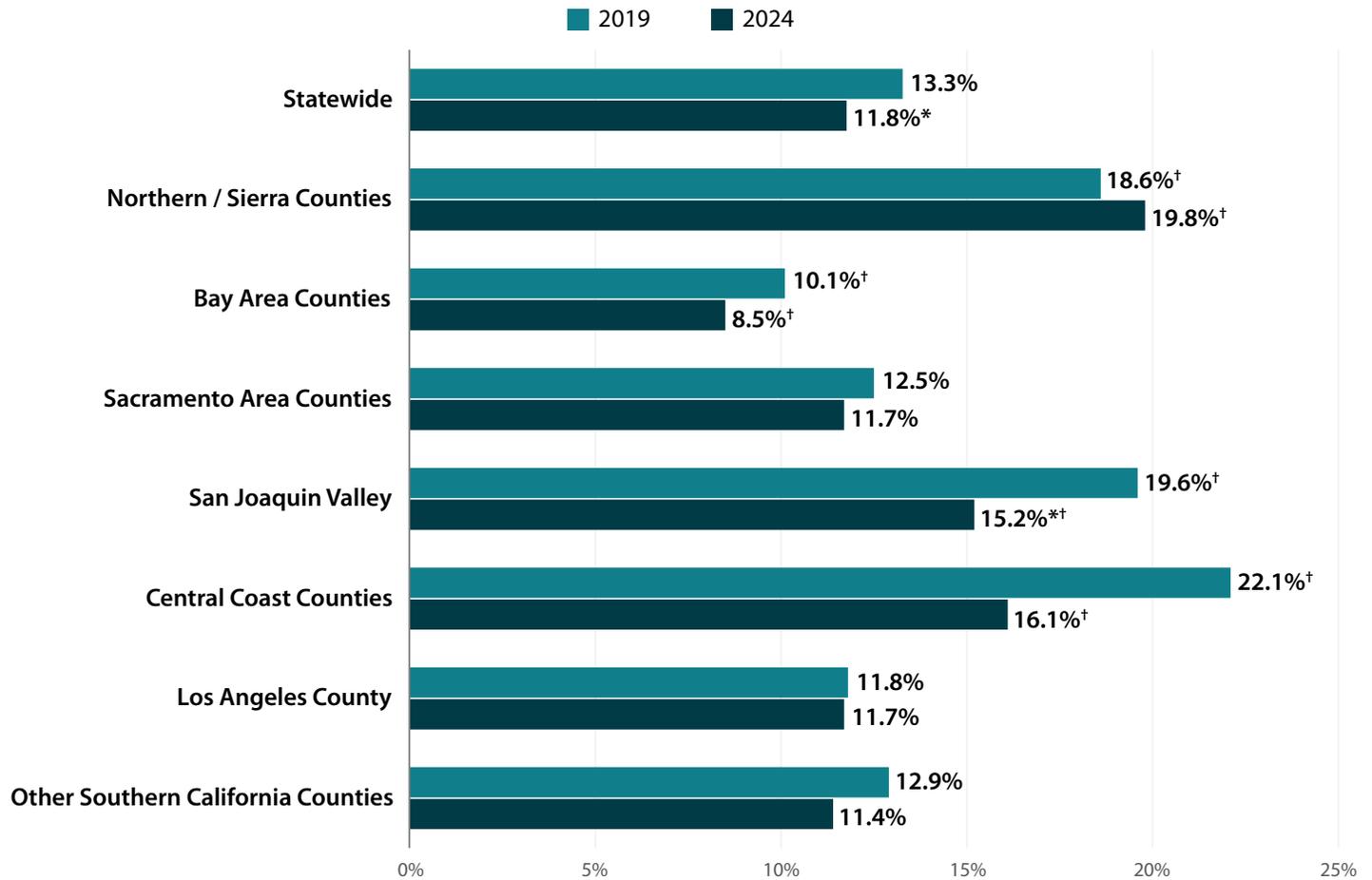
Statistically significant difference from reference group at the 95% level.

Significant Disparities Persist Across Regions and Demographic Groups

Despite improvements between 2019 and 2024 statewide and for certain groups, there are still significant disparities in who faces trouble paying medical bills in California. For example, people with incomes below 138% FPG report trouble paying medical bills at nearly twice the rate (15.0% vs. 8.1%) of those with incomes above 400% FPG. Middle income groups (139–249% and 250–399% FPG) are also more likely to report trouble paying medical bills than Californians with incomes above 400% FPG. The share of Latino/x Californians reporting trouble paying medical bills was also higher than that for White Californians (13.5% vs. 11.5%, respectively), and the rate among Asian/Native Hawaiian/Pacific Islander Californians was substantially lower (6.9%) than for White Californians. There were also differences across coverage types, with the uninsured, people on Medi-Cal, and those with individual-market coverage all being more likely to report difficulty paying medical bills than those with employer-sponsored coverage.

There was also significant variation across regions for this measure, ranging from a low of 8.5% in the Bay Area to a high of 19.8% in Northern/Sierra Counties. Residents of the San Joaquin and Central Coast Counties were also more likely (15.2% and 16.1%, respectively) to report trouble paying medical bills than the statewide average. These regional patterns in 2024 are similar to differences across regions in 2019 (Figure 2).

Figure 2. Californians Reporting Trouble Paying Medical Bills by Region, 2019 vs. 2024



Source: SHADAC analysis of output from AskCHIS.
 * Statistically significant difference from 2019 at the 95% level.
 † Statistically significant difference from total at the 95% level.

FINANCIAL CONSEQUENCES OF MEDICAL BILLS

Below we discuss three potential consequences of having trouble paying medical bills, including:

1. The share of people with accumulated medical bills over \$4,000;
2. The share of those using credit cards/credit card debt to finance medical bills; and,
3. Those who report difficulties affording basic needs, such as food and housing, due to medical bills.

These CHIS measures were only asked of the 11.8% of people who reported trouble paying medical bills, rather than all Californians.

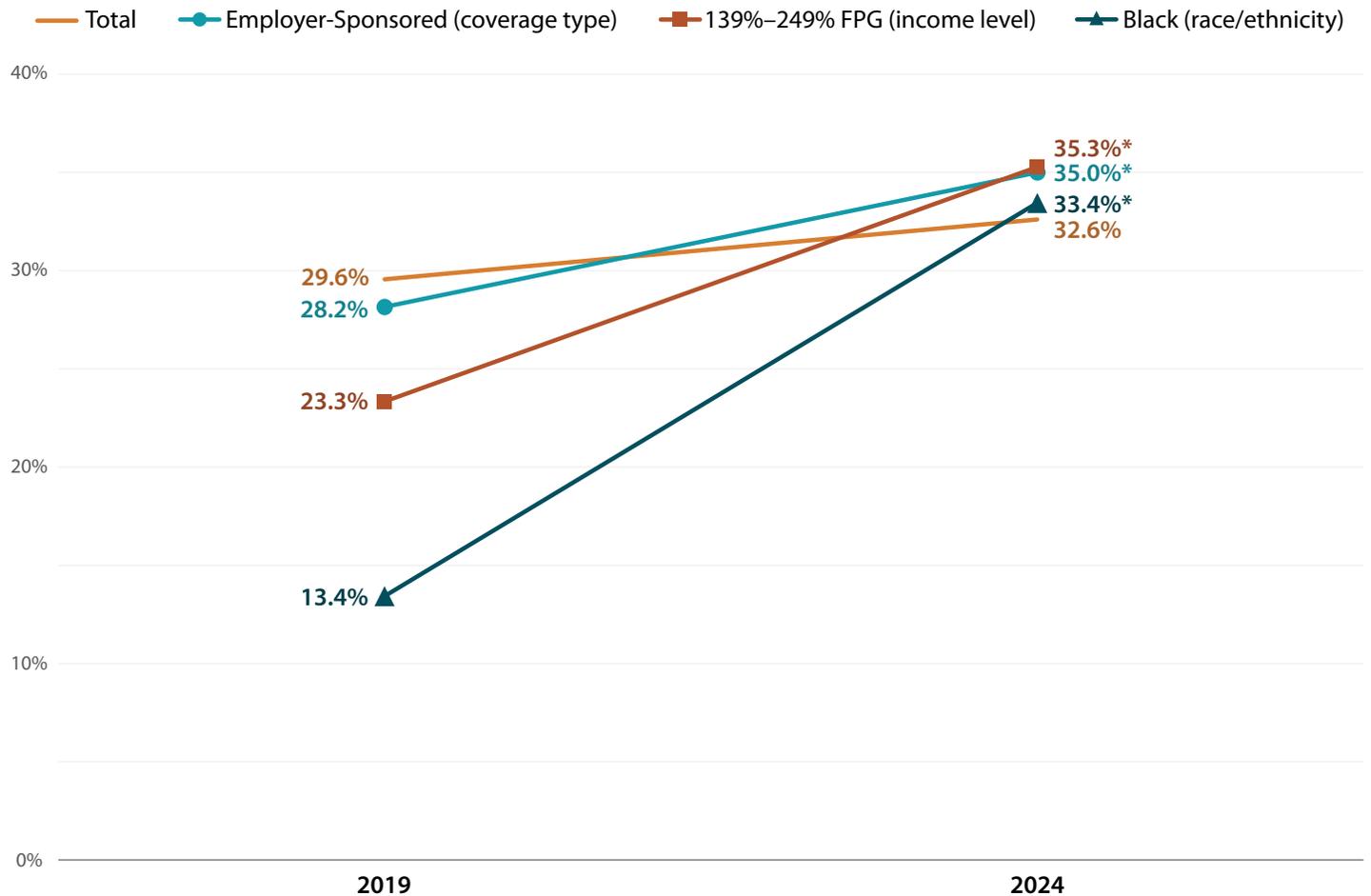
MEDICAL BILLS OF \$4,000 OR MORE

The CHIS asks people who report difficulty paying medical bills in the past twelve months how much medical debt they are facing. We examined trends in the share reporting [medical debt](#) of \$4,000 or more.

Sizable Increases in Large Medical Bills for Certain Groups

Overall, the share of people having trouble paying medical bills who had accumulated medical bills of \$4,000 or more was statistically unchanged from 2019 (29.6%) to 2024 (32.6%) (Appendix Table 2). However, certain subgroups did see sizable increases on this measure over time (Figure 3). The share of people with bills over \$4,000 increased from 28.2% to 35.0% among people with employer-sponsored coverage, from 23.3% to 35.3% among those with incomes 139–249% FPG, and nearly tripled for Black Californians, from 13.4% to 33.4%.

Figure 3. Californians Reporting Medical Bills of \$4,000 or More, 2019 vs. 2024



Source: SHADAC analysis of CHIS data.

* Statistically significant difference from 2019 at the 95% level.

TOOK ON CREDIT CARD DEBT TO PAY MEDICAL BILLS

Statewide, 54.4% of those who reported trouble paying medical bills said they used credit card debt to pay their medical bills, a share that was statistically unchanged from 2019 (56.5%) (Appendix Table 3). Use of credit cards to finance medical bills decreased since 2019 for people with incomes below 138% FPG and for rural Californians (Appendix Table 3).

White Californians, Those with Higher Incomes, and Those with Employer-Sponsored Coverage More Likely to Finance Medical Debt with Credit Cards

Taking on credit card debt to pay for medical bills varied across subgroups, with certain groups being more or less likely to report it. By coverage type, 62.9% of people with employment-based coverage who reported trouble paying medical bills said they used credit card debt to cover medical bills. The uninsured and people on Medi-Cal were less likely to use credit cards to finance the debt (at 34.3% and 44.2%, respectively) than the those with employer-sponsored coverage who reported trouble paying medical bills.

By income, people with lower incomes of up to 138% FPG were significantly less likely (42.8%) than those with incomes above 400% FPG (59.8%) to report use of credit card debt to pay medical bills.

By race/ethnicity, Latino/x (49.5%), Asian/Native Hawaiian/Pacific Islander (46.6%), and Black (47.5%) Californians who reported difficulty paying medical bills were significantly less likely than Whites (64.3%) to report use of credit card debt to finance medical bills.

DIFFICULTY AFFORDING BASIC NECESSITIES DUE TO MEDICAL BILLS

For the overall California population, 38.9% of those who reported trouble paying medical bills said those bills caused them difficulties affording basic necessities, such as food and housing. Similar to financing with credit card bills, this share was statistically unchanged from 2019 (39.8%) (Appendix Table 4).

There were also no significant changes over time by subgroups on this measure. However, we did find that difficulty affording basic necessities varied across subgroups, sometimes in distinctly opposite patterns compared to use of credit card debt (Table 2).

Of the subgroups examined, people with incomes 0–138% FPG and 139–249% FPG reported significantly higher rates of difficulty affording basic necessities than people with incomes above 400% FPG. Latino/x and Black Californians reported higher rates than their White counterparts. There was also wide variation across regions on this measure, ranging from a low of 24.5% in Sacramento Area Counties to nearly double that rate in the Central Coast (48.4%) and Los Angeles (48.5%) regions (Appendix Table 4).

Table 2. Californians with Trouble Paying Medical Bills Reported Use of Credit Card Debt to Finance Medical Bills, Difficulty Affording Basic Necessities Due to Medical Bills, 2024

Population	Use of Credit Card Debt to Finance Medical Bills, 2024	Difficulty Affording Necessities, 2024
Overall	54.4%	38.9%
Coverage Type (Reference: Employment-Based)	—	—
Uninsured	34.3% #	36.9%
Medi-Cal	44.2% #	45.0% #
Employment-Based	62.9% (REF)	36.8% (REF)
Individual-Market	57.2%	29.2%
Income, % FPG (Reference: 400%+)	—	—
0–138%	42.8% * #	44.8% #
139–249%	51.9%	45.6% #
250–399%	66.3%	36.3%
400%+	59.8% (REF)	30.5% (REF)
Race/Ethnicity (Reference: White, Non-Latino/x)	—	—
Latino/x	49.5% #	43.8% #
American Indian/Alaskan Native, Non-Latino/x	N/A	N/A
Asian/Native Hawaiian/Pacific Islander, Non-Latino/x	46.6% #	30.6%
Black, Non-Latino/x	47.5% #	49.1% #
White, Non-Latino/x	64.3% (REF)	32.4% (REF)
Other/Two or More Races, Non-Latino/x	64.0%	37.9%
Geography (Reference: Urban)	—	—
Urban	55.1% (REF)	39.1% (REF)
Rural	48.5% *	37.7%

Source: SHADAC analysis of CHIS data.

* Statistically significant difference from 2019 at the 95% level.

Statistically significant difference from reference group at the 95% level.

These data suggest that two consequences of unaffordable medical bills—use of credit card debt to pay medical bills and trouble affording basic necessities due to medical bills—may be inversely related. For example, Black and Latino/x Californians and people with low incomes are *less likely* to report using credit cards to pay for medical bills, but are simultaneously *more likely* to report trouble affording basic necessities because of those bills. That relationship could be due, at least in part, to access to credit: People may finance medical debt with credit cards when they have the option, while other people face difficulties paying for basic necessities if they do not have the option to finance medical bills with credit.

We were interested to see whether this pattern persisted when controlling for multiple demographic characteristics at the same time. To evaluate this, we ran logistic regressions with each outcome (i.e., credit card debt and trouble affording necessities) as a dependent variable with coverage, income, race/ethnicity, and geography serving as dependent variables (Appendix Table 5).

For credit card debt, people without insurance or with Medi-Cal had significantly lower odds of using credit cards to finance medical bills compared to people with ESI; Asian/Native Hawaiian/Pacific Islander, Black, and Latino/x people had significantly lower odds of using credit cards to finance medical bills than White people; and people in urban areas had significantly higher odds of using credit cards to finance medical bills than people in rural areas.

For trouble affording basic necessities, people with incomes 139%–249% FPG had higher odds of being unable to afford basic necessities due to medical bills than people with incomes of 400% FPG or higher; and Black and Latino/x people had higher odds of being unable to afford basic necessities due to medical bills than White people.

The results by race/ethnicity show the clearest evidence of an inverse relationship between use of credit card debt to finance medical bills and trouble affording basic necessities. This may suggest that access to credit is a particular problem for Black and Latino/x Californians, and that this challenge has the consequence of having difficulty paying for other basic necessities like food and housing. This aligns with other studies that have shown people of color face greater challenges accessing credit than their White counterparts.^{13,14}

HIGH BURDEN SPENDING: CALIFORNIA COMPARED TO THE U.S.

The CHIS provides high-quality, granular data to understand affordability within the state for key subgroups and geographic areas across a range of important measures. However, it does not allow for comparing California to the United States overall. The Current Population Survey (CPS), on the other hand, does have data that allows us to compare California to the U.S., including data on what percentage of people experience “high burden” medical spending, or spending that constitutes more than 10% of their income. These data provide helpful context for how affordability in California compares to what people are experiencing nationwide.

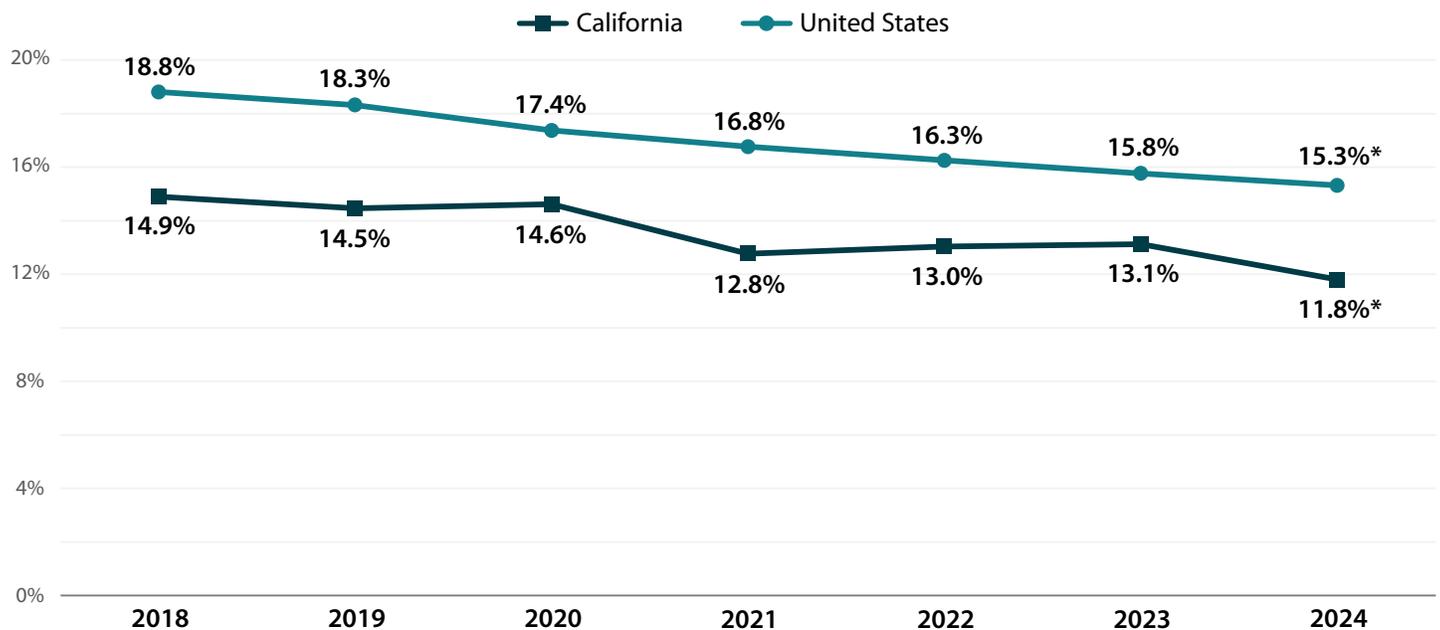
What Is High Burden Spending?

The CPS collects information about how much people spend on health care premiums and other out-of-pocket costs like deductibles, co-pays, and co-insurance. We measure high burden spending by comparing the total amount people report spending on health care costs to income: If spending is more than 10% of income, it’s considered high burden.

High Burden Spending in California Is Consistently Lower than the U.S.

Figure 4 below tracks the share of those reporting high burden spending from 2018 to 2024 for both the U.S. and California.ⁱⁱ The share of Californians who report spending more than 10% of their income on premiums and other health care costs was 14.9% in 2018, dropping to 11.8% in 2024, a difference that was statistically significant. High burden spending among Californians is consistently lower (by nearly four percentage points) than that reported in the U.S. overall, where rates went from 18.8% to 15.3% in the same time period. The change between 2018 and 2024 in the U.S. was also statistically significant.

Figure 4. High Burden Spending, California vs. U.S., 2018–2024



Source: SHADAC analysis of CPS data.

Definition: High burden spending represents share of individuals who are in families where out-of-pocket spending on health care, including premiums, accounted for more than 10% of annual income for the civilian non-institutionalized population.

Note: Data collection for the 2019 and 2020 estimates was impacted by the COVID-19 pandemic, which likely caused measurable non-response bias; response rates in 2021 also continued to be below pre-pandemic levels. Users should treat 2019–2021 estimates with caution.

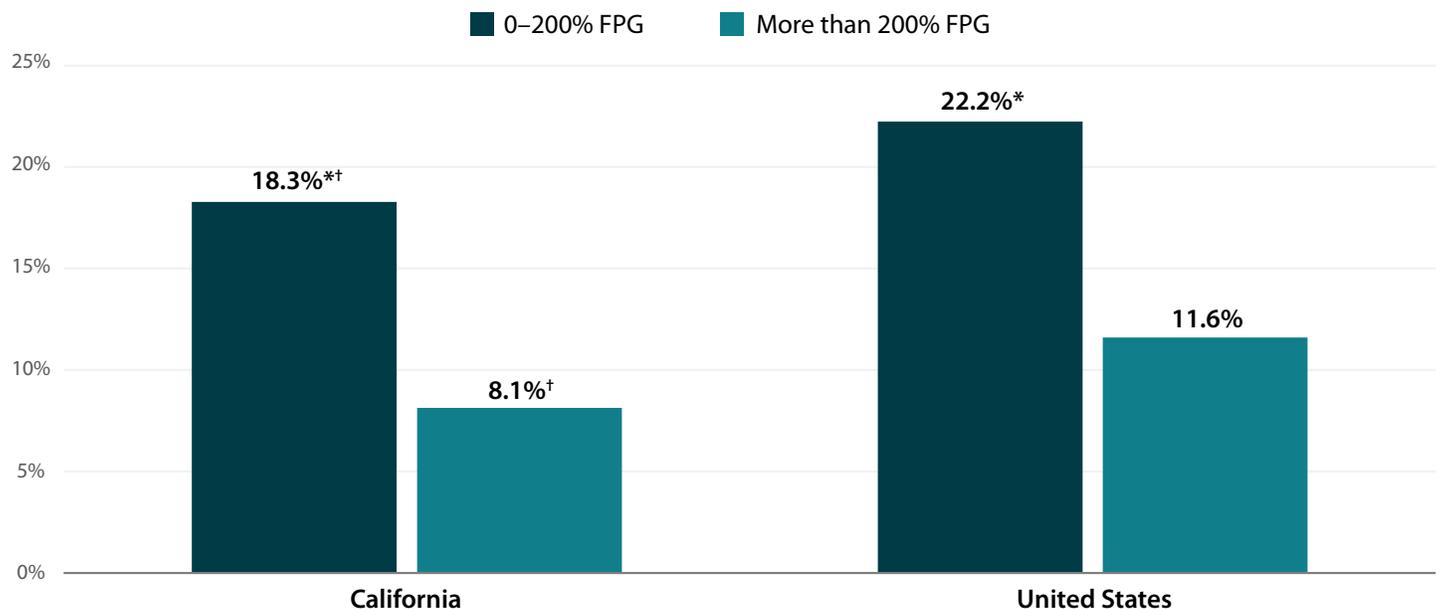
* Statistically significant difference from 2018 at the 95% level.

ⁱⁱ We use 2018 as baseline for this analysis because of potential bias in the 2019 CPS estimates related to the COVID-19 pandemic.

People with Lower Incomes Experience More High Burden Spending Nationally and in California

Not surprisingly, people with lower incomes are more likely to experience high burden spending. Figure 5 shows that the rate of high burden spending among people in California with incomes 200% FPG and below (18.3%) is more than double that of those with higher incomes (8.1%). There is a similar pattern by income nationwide. Figure 5 also shows, however, that high burden spending in California is lower than the U.S. for both lower and higher income people.

Figure 5. High Burden Spending by Income, California and U.S., 2024



Source: SHADAC analysis of CPS data.

* Statistically significant difference from more than 200% FPG at the 95% level.

† Statistically significant difference from U.S. at the 95% level.

CONCLUSION

Punctuated by the COVID-19 pandemic and multiple stages of policy responses, the years between 2019 and 2024 were an extraordinary time for the U.S. economy, broadly. In a period of just two months at the beginning of 2020, the U.S. unemployment rate more than quadrupled, with millions losing their jobs nationwide in response to the pandemic and efforts to control the spread of the virus.^{15,16} Federal lawmakers responded with financial and other supports for individuals and businesses to weather the storm, such as the CARES Act of 2020 and the American Rescue Plan of 2021.

There were also particular effects for the health sector. As the pandemic began and evolved, health care utilization and spending for both COVID-19 treatment and other health services whipsawed up and down.¹⁷ Congress also implemented policies designed to support health insurance coverage, such as the Families First Coronavirus Response Act of 2020, which allowed for people to keep their Medicaid coverage for the duration of the public health emergency. This Act also implemented additional subsidies to make the private-market coverage available on ACA marketplaces (such as Covered California) more affordable, and it established enhanced premium tax credits in 2021, which were extended in the Inflation Reduction Act of 2022. California also implemented additional policies to expand coverage and subsidize health care costs during this period. It is notable that Californians are less likely (11.8%) than the nation overall (15.3%) to report high burden spending, suggesting that these interventions may have had a measurable impact on the affordability of health care for Californians relative to the U.S. overall.

Considering this volatile environment, it is not surprising that our analysis presents a mixed picture for affordability of health care in California during this time period when we look across measures. Some measures improved, some measures remained steady, and some measures worsened. For instance, there was a statistically significant reduction between 2019 and 2024 in the percentage of Californians who reported trouble paying medical bills. However, among those reporting trouble paying medical bills, there was no change in the share who said they resorted to credit cards to finance their medical debt, or in the share who said their trouble paying medical bills caused them difficulties affording basic necessities, such as food and housing. Additionally, almost one-third of people who reported trouble paying medical bills said they faced large amounts of medical debt—\$4,000 or more—which was also statistically unchanged between 2019 and 2024.

The growth of deductibles over \$2,000 represented an area of erosion in the affordability of health care. People generally have to pay out of pocket for health care before they reach their deductible, so the statistically significant increase we found in the share of Californians with individual-market or employer-sponsored insurance with these large deductibles means that more people are exposed to the potential for large medical bills they may not be able to afford.

Despite a period defined by change and new policies, the longstanding disparities of health care affordability in California persisted. For example, the uninsured, people on Medi-Cal, and Black and Latino/x Californians were more likely to report trouble paying medical bills. People with incomes 139–249% FPG and Black and Latino/x Californians also were more likely to report trouble paying for basic necessities because of those bills.

Since 2024, there have been new developments that threaten to worsen issues of health care affordability in California and throughout the U.S. For instance, the enhanced premium tax credits created by Congress in 2021 and extended in 2022 ended in 2025, which has contributed to substantial premium increases for plans bought through Covered California and other states' health insurance marketplaces.¹⁸

Another major federal policy change that is expected to affect health care affordability is the implementation of Medicaid work requirements established by H.R. 1, which are scheduled to begin January 2027. These work requirements are expected to lead to a reduction in enrollment in Medi-Cal and result in higher rates of uninsurance.¹⁹ Those newly uninsured Californians are likely to face challenges accessing health care, as well as difficulty affording health care when they need it.

Finally, in addition to people who are removed from Medi-Cal as a result of changing federal policy, researchers have estimated that H.R. 1 will drive up costs for those with private coverage, as well.²⁰ This is particularly troubling as our analysis shows that deductibles are already increasing for those with private coverage, and California's recent employer survey found a 6% increase in family premiums between 2024 and 2025.²¹

While federal and state policies may have helped to mitigate some health care affordability concerns in recent years, the evolving federal health policy landscape raises doubts as to whether that relative stability will continue, and for whom. Ultimately, the foundational challenge of health care affordability in the U.S. is that the nation spends so much on health care—much more than other comparable countries.²² In order to truly improve health care affordability in a way that is both meaningful and durable, California and the rest of the U.S. will likely need to develop solutions that address the systemic drivers of high health care costs and unsustainable growth.²³

APPENDIX: SUPPLEMENTAL DATA TABLES

Appendix Table 1. Californians with Private Insurance with Deductibles Over \$2,000, 2019 vs. 2024

Population	2019 Rate	2024 Rate	2019–2024 Difference in Rates (percentage point change)	2024 Subgroup vs. Reference (percentage point difference)
Total	34.8%	37.8%	3.1% *	N/A
Coverage Type (Reference: Employment-Based)	—	—	—	—
Employment-Based	32.6%	37.5%	4.9% *	REF
Individual-Market	56.7%	51.2%	-5.5	13.7% #
Income, % FPG (Reference: 400%+)	—	—	—	—
0–138%	39.9%	31.7%	-8.2% *	-6.6% #
139–249%	38.7%	39.5%	0.8%	1.2%
250–399%	35.2%	38.7%	3.5%	0.4%
400%+	32.8%	38.3%	5.5% *	REF
Race/Ethnicity (Reference: White, Non-Latino/x)	—	—	—	—
Latino/x	36.1%	35.1%	-1.0%	-3.9% #
American Indian/Alaskan Native, Non-Latino/x	24.2%	42.9%	18.7%	3.8%
Asian/Native Hawaiian/Pacific Islander, Non-Latino/x	39.7%	42.1%	2.4%	3.0%
Black, Non-Latino/x	23.6%	27.9%	4.3%	-11.1% #
White, Non-Latino/x	33.8%	39.1%	5.2% *	REF
Other/Two or More Races, Non-Latino/x	28.5%	35.0%	6.5%	-4.0%
Geography (Reference: Urban)	—	—	—	—
Urban	34.7%	37.9%	3.1% *	REF
Rural	35.4%	37.5%	2.1%	-0.4%

Source: SHADAC analysis of CHIS data.

* Statistically significant difference from 2019 at the 95% level.

Statistically significant difference from reference group at the 95% level.

Appendix Table 2. Californians Reporting Bills of \$4,000 or More, Among those Reporting Trouble Paying Medical Bills in Past Twelve Months, 2019 vs. 2024

Population	2019 Rate	2024 Rate	2019–2024 Difference in Rates (percentage point change)	2024 Subgroup vs. Reference (percentage point difference)
Total	29.6%	32.6%	3.0%	N/A
Coverage Type (Reference: Employment-Based)	—	—	—	—
Uninsured	37.1%	24.9%	-12.2%	-10.1%
Medi-Cal	24.5%	29.9%	5.4%	-5.1%
Employment-Based	28.2%	35.0%	6.8% *	REF
Individual-Market	35.1%	34.0%	-1.1%	-1.0%
Income, % FPG (Reference: 400%+)	—	—	—	—
0–138%	25.6%	28.8%	3.2%	-4.9%
139–249%	23.3%	35.3%	11.9% *	1.6%
250–399%	34.4%	33.3%	-1.1%	-0.4%
400%+	34.2%	33.7%	-0.5%	REF
Race/Ethnicity (Reference: White, Non-Latino/x)	—	—	—	—
Latino/x	27.6%	29.3%	1.7%	-11.8% #
American Indian/Alaskan Native, Non-Latino/x	N/A	N/A	-11.1%	N/A
Asian/Native Hawaiian/Pacific Islander, Non-Latino/x	29.5%	25.7%	-3.8%	-15.4% #
Black, Non-Latino/x	13.4%	33.4%	20.0% *	-7.7%
White, Non-Latino/x	35.6%	41.1%	5.5%	REF
Other/Two or More Races, Non-Latino/x	30.9%	22.9%	-8.0%	-18.2% #
Geography (Reference: Urban)	—	—	—	—
Urban	29.4%	32.1%	2.6%	REF
Rural	30.6%	36.9%	6.3%	4.8%
Region	—	—	—	—
Northern/Sierra Counties	37.5%	30.8%	-6.7%	—
Bay Area Counties	34.3%	42.8%	8.5%	—
Sacramento Area Counties	26.9%	44.2%	17.3% *	—
San Joaquin Valley	28.5%	28.2%	-0.3%	—
Central Coast Counties	21.9%	33.1%	11.2%	—
Los Angeles County	22.5%	29.4%	6.9%	—
Other Southern California Counties	35.6%	30.0%	-5.6%	—

Source: SHADAC analysis of CHIS and AskCHIS (regional estimates) data.

* Statistically significant difference from 2019 at the 95% level.

Statistically significant difference from reference group at the 95% level.

Appendix Table 3. Californians Reporting Taking on Credit Card Debt Because of Medical Bills, Among those Reporting Trouble Paying Medical Bills in Past Twelve Months, 2019 vs. 2024

Population	2019 Rate	2024 Rate	2019–2024 Difference in Rates (percentage point change)	2024 Subgroup vs. Reference (percentage point difference)
Total	56.5%	54.4%	-2.1%	N/A
Coverage Type (Reference: Employment-Based)	—	—	—	—
Uninsured	46.8%	34.3%	-12.5%	-28.5% #
Medi-Cal	50.1%	44.2%	-5.9%	-18.7% #
Employment-Based	62.7%	62.9%	0.2%	REF
Individual-Market	52.8%	57.2%	4.4%	-5.7%
Income, % FPG (Reference: 400%+)	—	—	—	—
0–138%	51.7%	42.8%	-8.9% *	-17.0% #
139–249%	57.6%	51.9%	-5.7%	-7.9%
250–399%	60.0%	66.3%	6.2%	6.4%
400%+	57.7%	59.8%	2.1%	REF
Race/Ethnicity (Reference: White, Non-Latino/x)	—	—	—	—
Latino/x	55.9%	49.5%	-6.4%	-14.8% #
American Indian/Alaskan Native, Non-Latino/x	N/A	N/A	-17.1%	N/A
Asian/Native Hawaiian/Pacific Islander, Non-Latino/x	52.4%	46.6%	-5.8%	-17.7% #
Black, Non-Latino/x	57.1%	47.5%	-9.5%	-16.8% #
White, Non-Latino/x	59.4%	64.3%	4.9%	REF
Other/Two or More Races, Non-Latino/x	47.5%	64.0%	16.5%	-0.3%
Geography (Reference: Urban)	—	—	—	—
Urban	55.7%	55.1%	-0.6%	REF
Rural	63.7%	48.5%	-15.1% *	-6.6%

Source: SHADAC analysis of CHIS data.

* Statistically significant difference from 2019 at the 95% level.

Statistically significant difference from reference group at the 95% level.

Appendix Table 4. Californians Reporting Difficulty Affording Basic Necessities Due to Medical Bills, Among those Reporting Trouble Paying Medical Bills in Past Twelve Months, 2019 vs. 2024

Population	2019 Rate	2024 Rate	2019–2024 Difference in Rates (percentage point change)	2024 Subgroup vs. Reference (percentage point difference)
Total	39.8%	38.9%	-0.9%	N/A
Coverage Type (Reference: Employment-Based)	—	—	—	—
Uninsured	45.4%	36.9%	-8.5%	0.1%
Medi-Cal	45.3%	45.0%	-0.3%	8.2% #
Employment-Based	36.4%	36.8%	0.4%	REF
Individual-Market	36.2%	29.2%	-7.0%	-7.6%
Income, % FPG (Reference: 400%+)	—	—	—	—
0–138%	43.0%	44.8%	1.9%	14.3% #
139–249%	46.5%	45.6%	-1.0%	15.1% #
250–399%	39.6%	36.3%	-3.3%	5.8%
400%+	32.4%	30.5%	-1.9%	REF
Race/Ethnicity (Reference: White, Non-Latino/x)	—	—	—	—
Latino/x	45.4%	43.8%	-1.6%	11.3% #
American Indian/Alaskan Native, Non-Latino/x	N/A	N/A	-7.1%	N/A
Asian/Native Hawaiian/Pacific Islander, Non-Latino/x	38.9%	30.6%	-8.3%	-1.9%
Black, Non-Latino/x	37.7%	49.1%	11.4%	16.6% #
White, Non-Latino/x	31.3%	32.4%	1.1%	REF
Other/Two or More Races, Non-Latino/x	38.0%	37.9%	-0.1%	5.5%
Geography (Reference: Urban)	—	—	—	—
Urban	39.0%	39.1%	0.0%	REF
Rural	46.5%	37.7%	-8.8%	-1.4%
Region	—	—	—	—
Northern/Sierra Counties	35.1%	31.4%	—	—
Bay Area Counties	30.5%	39.2%	—	—
Sacramento Area Counties	39.8%	24.5%	—	—
San Joaquin Valley	52.1%	41.6%	—	—
Central Coast Counties	42.4%	48.4%	—	—
Los Angeles County	38.0%	48.5%	—	—
Other Southern California Counties	39.9%	32.0%	—	—

Source: SHADAC analysis of CHIS data.

* Statistically significant difference from 2019 at the 95% level.

Statistically significant difference from reference group at the 95% level.

Appendix Table 5. Characteristics Associated with Californians Use of Credit Card Debt to Finance Medical Bills, Difficulty Affording Basic Necessities Due to Medical Bills, 2024

Population	Use of Credit Card Debt to Finance Medical Bills, Adjusted Odds Ratio	Use of Credit Card Debt to Finance Medical Bills, 95% Confidence Interval	Trouble Affording Necessities, Adjusted Odds Ratio	Trouble Affording Necessities, 95% Confidence Interval
Coverage Type (Reference: Employment-Based)	1.00	(1.00, 1.00)	1.00	(1.00, 1.00)
Uninsured	0.36***	(0.21, 0.62)	0.80	(0.45, 1.42)
Medi-Cal	0.58**	(0.38, 0.87)	1.10	(0.75, 1.63)
Individual-Market	0.74	(0.47, 1.17)	0.71	(0.41, 1.22)
Medicare or Other Public	1.21	(0.27, 5.44)	2.30	(0.95, 5.59)
Income, % FPG (Reference: 400%+)	1.00	(1.00, 1.00)	1.00	(1.00, 1.00)
0–138%	0.70	(0.48, 1.03)	1.54	(0.99, 2.41)
139–249%	0.88	(0.62, 1.26)	1.79**	(1.25, 2.56)
250–399%	1.37	(0.89, 2.10)	1.19	(0.83, 1.73)
Race/Ethnicity (Reference: White, Non-Latino/x)	1.00	(1.00, 1.00)	1.00	(1.00, 1.00)
Latino/x	0.66**	(0.51, 0.87)	1.54**	(1.17, 2.02)
American Indian/Alaskan Native, Non-Latino/x	0.49	(0.06, 4.24)	3.70	(0.37, 36.64)
Asian/Native Hawaiian/Pacific Islander, Non-Latino/x	0.49**	(0.31, 0.76)	0.96	(0.61, 1.51)
Black, Non-Latino/x	0.52*	(0.28, 0.95)	1.75*	(1.06, 2.87)
Other/Two or More Races, Non-Latino/x	1.05	(0.56, 1.98)	1.26	(0.66, 2.41)
Rurality (Reference: Rural)	1.00	(1.00, 1.00)	1.00	(1.00, 1.00)
Urban	1.56*	(1.11, 2.19)	1.04	(0.75, 1.45)

Source: SHADAC analysis of CHIS data.

Adjusted odds ratios and 95% confidence intervals are reported from logistic regression models for each outcome, controlling for coverage, income, race/ethnicity, and rurality.

Indicates statistical significance: *p<0.05, **p<0.01, ***p<0.001.

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