THE UNINSURED
A PRIMER

OCTOBER 2007

KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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The Uninsured: A Primer

Nearly 47 million Americans under the age of 65
lacked health insurance coverage in 2006, an increase of 2.1 million
from the year before.

Despite an improving economy, the chances of being uninsured increased—
particularly among children.

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Most people under the age of 65 obtain health coverage as an employer benefit. While Medicare covers all of the elderly, the nonelderly who do not have access to or cannot afford private insurance go without health coverage unless they qualify for the Medicaid program, SCHIP, or other state-subsidized insurance programs.

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While the number of uninsured has been growing, who the uninsured are and the social and economic factors that place a person at risk of being uninsured, have not changed substantially over time. The uninsured are largely low-income adults in working families, for whom coverage is either unavailable or unaffordable.

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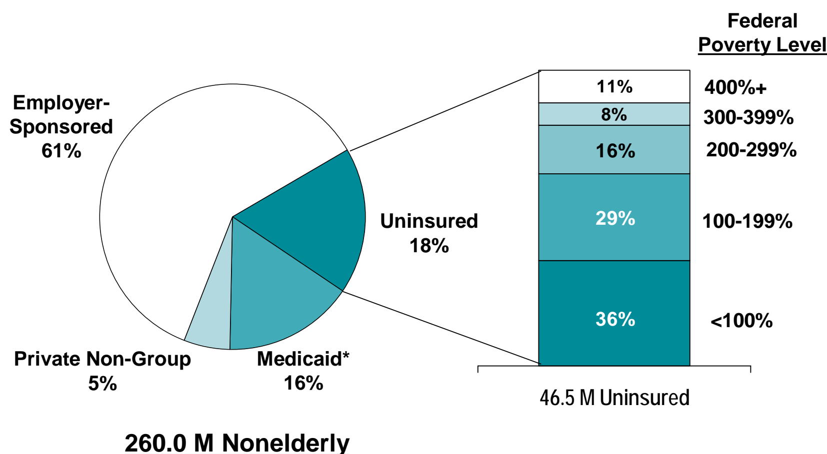
Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. The consequences of reduced access to care over time can be serious, including preventable hospitalizations, declines in overall health, disability, and premature death.

Introduction

One in every six Americans under the age of 65 did not have health insurance (18%) in 2006, for a total of 46.5 million people. As throughout most of the 1990s, the number of uninsured has continued to grow steadily every year since 2000. Between 2000 and 2004, the number of uninsured grew by nearly six million. In the past two years—and despite an improving economy between 2004 and 2006—the number of uninsured grew by an additional 3.4 million. Reversing years of steady improvement in children's health coverage, the number of uninsured children grew by one million over the past two years and accounted for a third of the growth in the uninsured in the most recent year, 2006.

While the number of uninsured Americans has been growing, who the uninsured are, and the social and economic factors that place a person at risk of being uninsured, have not changed substantially over time. Two-thirds of the uninsured are individuals and families who are poor (incomes less than the federal poverty level or $20,614 for a family of four in 2006) or near-poor (with incomes between one and two times the poverty level). Another 16% have incomes just above this level (between two and three times the poverty level).

The Uninsured -- As a Share of the Population and by Poverty Levels, 2006



* Medicaid also includes other public programs: SCHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of four in 2006 was $20,614.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

Over eight in ten of the uninsured come from working families. More than 70% are from families with one or more full-time workers. Employer-sponsored insurance is not an option for the large majority of uninsured employees—70% work where health benefits are not offered either by their own employer or a spouse's or they are not eligible for them. Young adults, racial and ethnic minorities, and those who are not U.S. citizens are more likely to be uninsured. However, 45% of the uninsured are white, and the large majority of uninsured are adults over the age of 25 and American citizens.

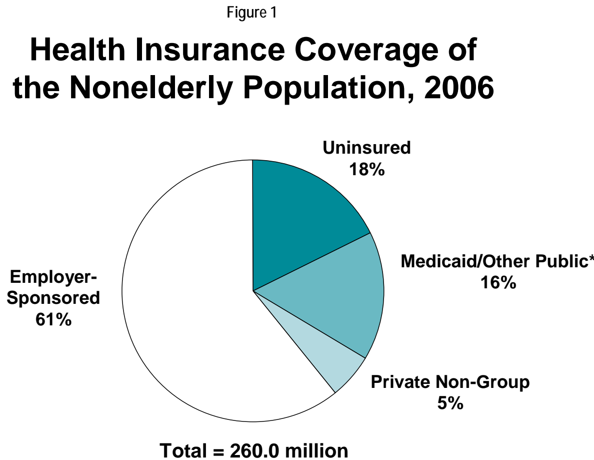
The purpose of this primer is to present basic information about the uninsured—who they are and why they do not have health coverage. It also provides a necessary understanding of the difference health insurance makes in people's lives. Beyond this, *The Uninsured: A Primer* also explains how and why the problem is growing and concludes with an overview of currently proposed solutions.

How Do Most Americans Obtain Health Insurance?

Most Americans under the age of 65 receive health insurance coverage as an employer benefit—61% in 2006. While Medicare covers virtually all those who are 65 years or older, the nonelderly who do not have access to or cannot afford private insurance go without health coverage unless they qualify for the Medicaid program, State Children's Health Insurance Program (SCHIP), or other state-subsidized insurance programs. The gaps in our private and public health insurance systems left 46.5 million nonelderly Americans—18% of those under age 65—without health coverage in 2006 (Figure 1).

Figure 1

Health Insurance Coverage of the Nonelderly Population, 2006



Total = 260.0 million

* Medicaid/Other Public includes Medicaid, SCHIP, other state programs, Medicare and military-related coverage.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

Private Health Insurance Coverage

Many, but not all, employers offer group health insurance policies to their employees as a benefit and also often extend coverage to their employees' families. About half of Americans insured through employer-sponsored health plans are covered by their own employer (51%) and half are covered as an employee's dependent (49%). Health insurance offer rates vary among businesses, with large firms and those with more high-wage workers more likely to offer coverage.[1]

Employer-sponsored health insurance is voluntary; businesses are not legally required to offer a health benefit, and employees can choose not to participate. In 2007, 60% of firms offered health benefits to at least some of their employees, down from 69% in 2000.[2] Even when businesses offer health benefits, some employees are ineligible because they are part-time employees or recent hires and some do not sign up because of the required employee share of the premium.

Private policies directly purchased in the non-group market (i.e., outside of employer-sponsored benefits) cover only 5% of nonelderly Americans. Private non-group insurance premiums are based on individual health risk and are substantially more expensive than group plans purchased by employers, with cost varying by age and health status. The share of the nonelderly population with private non-group insurance has changed very little over time. Obtaining coverage in the individual market can be difficult—in 2005, nearly three in five adults who sought coverage had difficulty finding a plan they could afford, and one in five were denied coverage, charged a higher price, or had a specific health condition excluded from coverage.[3]

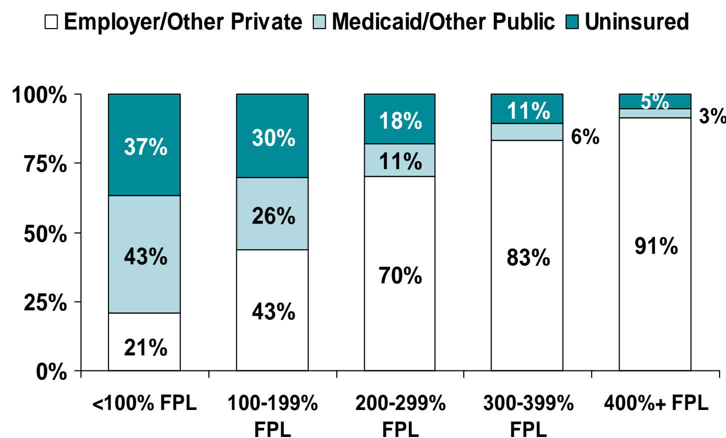
Private health insurance coverage is subsidized through the federal tax system in several ways. The most common form of private insurance subsidy is the employee tax exclusion of the health insurance premiums paid by employers. Those who are self-employed are now allowed to deduct all of the costs of their insurance premiums from their taxes. In addition, persons with high health care expenses (exceeding 7.5% of their adjusted gross income) can deduct the costs, including premiums, on their tax returns. Tax advantages are also available for health savings accounts (HSAs) and flexible spending accounts.

Public Health Insurance Coverage

The Medicaid program provides coverage to some, but not all, low-income individuals and families and people with disabilities. Covering 13% of the nonelderly, Medicaid is larger than any single private health insurer. It provides health coverage based on both income and categories of eligibility, primarily covering four main groups of nonelderly low-income people: children, their parents, pregnant women, and individuals with disabilities. Although public insurance covers over 40% of the poor, the categorical nature of the Medicaid program means that 37% of those below the poverty level remain uninsured (Figure 2).

Figure 2

Health Insurance Coverage by Poverty Level, 2006



The federal poverty level (FPL) was $20,614 for a family of four in 2006. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

Medicaid and the State Children's Health Insurance Program (SCHIP) cover over one quarter of all children and half of low-income children. Medicaid is the largest source of health insurance for children in the U.S., enrolling 28 million children in 2005. SCHIP supplements Medicaid by covering six million children who are low-income but whose family incomes are too high to qualify for Medicaid.

Medicaid provides health and long-term care coverage for eight million nonelderly people with disabilities, including over one million children. Its role is more prominent for people with certain conditions, such as HIV/AIDS. However, eligibility for Medicaid for people with disabilities in most states is limited to those with incomes below the federal poverty level.

Who Are the Uninsured?

In 2006, 46.5 million Americans under age 65 lacked health insurance. While the number of uninsured Americans has been growing, who the uninsured are, and the social and economic factors that place a person at risk of being uninsured, have not changed substantially over time.

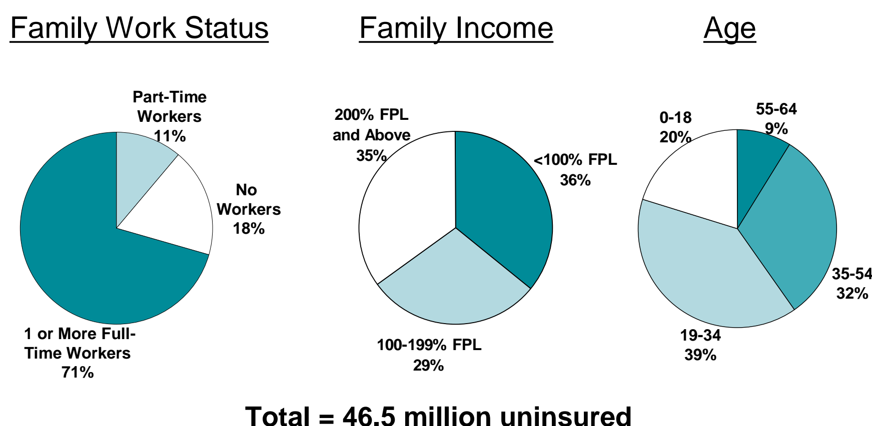
In 2006, over eight in ten of the uninsured came from working families—more than 70% from families with one or more full-time workers and 11% from families with part-time workers. Only 18% of the uninsured are from families that have no connection to the workforce (Figure 3). Even at lower income levels, the majority of the uninsured are in working families. Fifty-five percent of the uninsured who are poor have at least one worker in the family. (Poor is defined as an income less than 100% of the federal poverty level – $20,614 for a family of four in 2006).

Because of the high cost of health insurance, the poor and near-poor are the most likely to be uninsured. The uninsured rate among the nonelderly poor is twice as high as the national average (37% vs.18%). Were it not for the Medicaid program, many more of the poor would be uninsured. The near-poor (those with incomes between 100% and 199% of the poverty level) also run a high risk of being uninsured (30%), in part, because they are less likely to be eligible for Medicaid. About two-thirds of the uninsured are either poor or near-poor.

Adults are more likely to be uninsured than children. Adults make up 70% of the nonelderly population, but 80% of the uninsured (Figure 3). Most low-income children qualify for Medicaid or SCHIP, but low-income adults under age 65 qualify for Medicaid only if they are disabled, pregnant, or have dependent children. Income eligibility levels are generally much lower for parents than for children.

Figure 3

Characteristics of the Uninsured, 2006



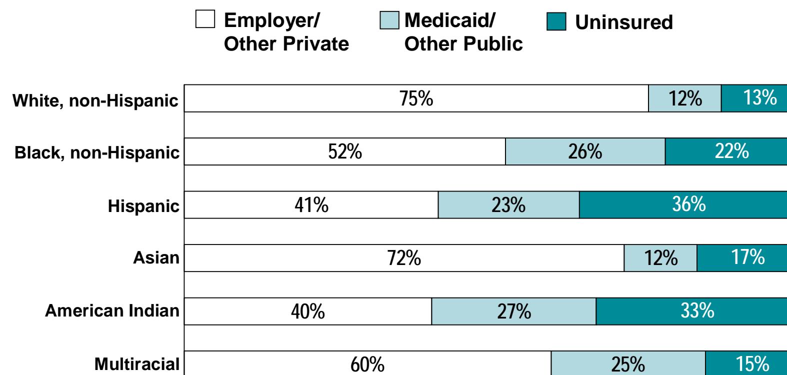
The federal poverty level was $20,614 for a family of four in 2006.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

Almost 65% of non-elderly uninsured adults did not attend college, making them less able to get higher-skilled jobs that more typically provide health coverage. Those with less education are also more likely to be uninsured for longer periods of time.

Minorities are much more likely to be uninsured than whites. About one third of Hispanics and Native Americans are uninsured compared to 13% of whites. The uninsured rate among African Americans (22%) is also much higher than that of whites (Figure 4). This disparity reflects the fact that minorities are much less likely to have health insurance offered through their jobs, to be eligible for the benefit, or be able to afford their share of the premiums. Because racial and ethnic minority groups are more likely to come from low-income families, Medicaid is an important source of health insurance for them. However, its limited reach leaves large numbers of minorities uninsured.

Figure 4

Insurance Coverage of Nonelderly, by Race/Ethnicity, 2006

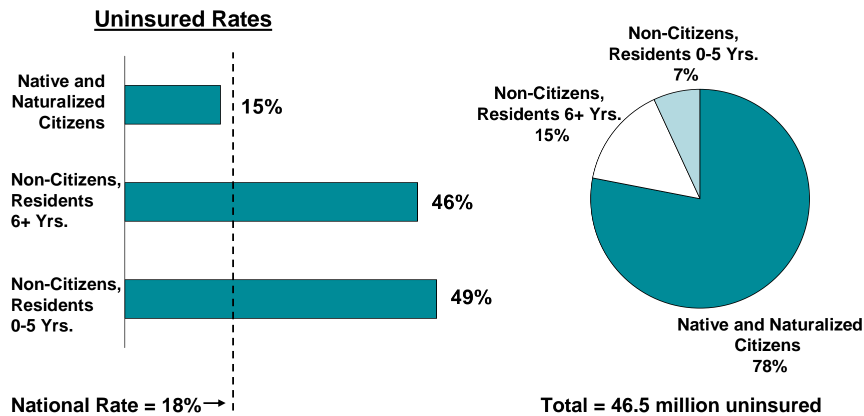


Asian group includes Pacific Islanders. American Indian group includes Aleutian Eskimos.
Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

The large majority of the uninsured (78%) are native or naturalized U.S. citizens. Non-citizens have high uninsured rates (47%) compared to citizens due to their employment in low-wage jobs that are less likely to offer health coverage and restrictions on their eligibility for public coverage (Figure 5). However, studies show that new immigrants are not primarily responsible for the growth in the overall uninsured population, mainly because they comprise a small share of the total U.S. population.[4]

Figure 5

Nonelderly Uninsured by Citizenship, 2006



SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

The uninsured tend to be in worse health than the privately insured. Eleven percent of the uninsured are in fair or poor health, compared to 5% of those with private coverage. Almost half of all uninsured nonelderly adults have a chronic condition.[5] Those with such conditions and others who are not in good health may find non-group coverage to be unavailable or unaffordable if they do not have job-based coverage.

The majority of uninsured adults (75%) have gone without coverage for a period of at least one year.[6] Because health insurance is primarily obtained as an employment benefit, health coverage is disrupted when people change jobs. Temporary gaps in health coverage are also caused by other changes, for example, shifts in family income or the loss of a working spouse. Those who are ineligible for Medicaid and not offered affordable employer-sponsored coverage are often left uninsured for long periods of time because individual coverage is either unaffordable or unavailable to them, particularly if they have health problems.

How Does Lack of Insurance Affect Access to Health Care Services?

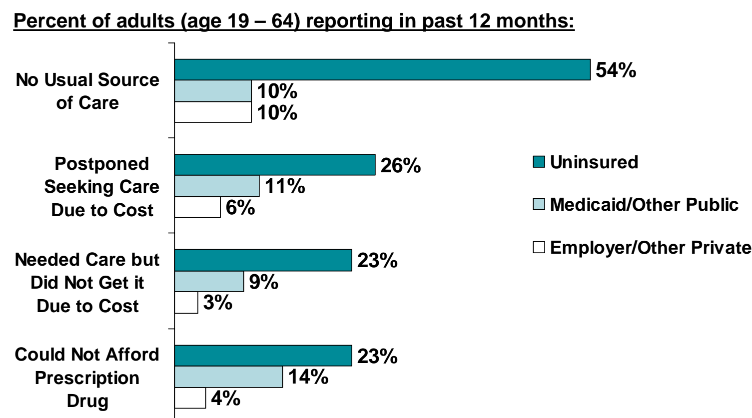
Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. Uninsured adults are far more likely than the insured to postpone or forgo health care altogether and less able to afford prescription drugs or follow through with recommended treatments. The consequences of reduced access to care can be severe, particularly when preventable conditions go undetected.

The uninsured are far more likely than those with insurance to report problems getting needed medical care. About a quarter of uninsured adults say that they have postponed or forgone care in the past year because of its cost—compared to only about 5% of adults with private coverage. Part of the reason for this is that nearly 60% of uninsured adults do not have a regular place to go when they are sick or need medical advice (Figure 6).

Anticipating high medical bills, many of the uninsured are not able to follow recommended treatment. Nearly a quarter of uninsured adults say they did not fill a drug prescription in the past year because they could not afford it. While persons who have been injured or recently diagnosed with a new chronic condition are equally likely to have follow-up care recommended after seeing a physician, the uninsured are less likely than the insured to receive all the services that were advised.[7]

Figure 6

Barriers to Health Care Among Nonelderly Adults, by Insurance Status, 2006

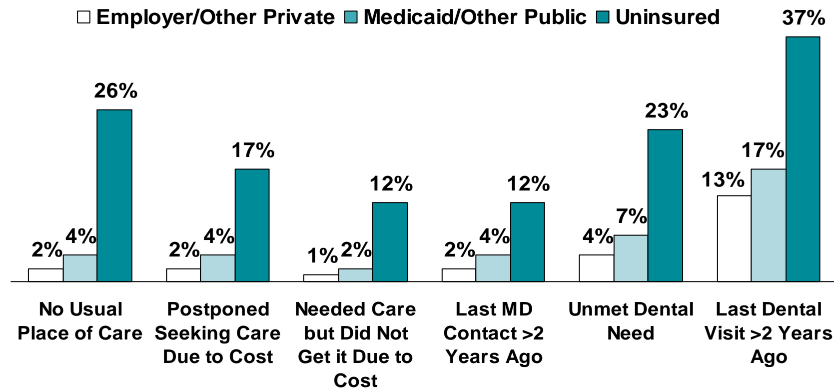


Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.
SOURCE: KCMU analysis of 2006 NHIS data.

Problems getting needed care also exist for uninsured children. Uninsured children are much more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance (Figure 7).[8] Uninsured children with common childhood illnesses and injuries do not receive the same level of care. As a result, they are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.[9]

Figure 7

Children's Access to Care, by Health Insurance Status, 2006



MD contact includes MD or any health care professional, including time spent in a hospital. Data is for all children under age 18, except for dental visit and unmet dental need, which are for children age 2-17. All estimates are age-adjusted.
SOURCE: *Summary of Health Statistics for U.S. Children: NHIS, 2006.* 2007.

Access to health care improves after an uninsured person obtains health insurance; similarly, losing coverage, whether it is private insurance or Medicaid, substantially decreases access to care. For example, persons who have lost Medicaid coverage are two to three times more likely than Medicaid beneficiaries to report going without medical care because it is too expensive and they are worried about medical bills.[10]

Lack of health coverage, even for short periods of time, results in decreased access to care. Those who have been uninsured for less than six months are already less likely than those with continuous health coverage to have a usual source of care and more likely to report having an unmet need for medical care or a prescription drug in the past year. As the period without coverage lengthens, more of the uninsured face these kinds of access problems.[11]

Because the uninsured are less likely than the insured to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and experience declines in their overall health. When they are hospitalized, they are more likely to receive fewer diagnostic and therapeutic services and also are more likely to die in the hospital than are insured patients.[12,13] Middle-aged adults who are continuously uninsured are much more likely to experience a decline in their health and/or develop problems with their mobility over a four year period than continuously insured adults.[14]

The uninsured are also less likely to receive timely preventive care. Insured nonelderly adults are at least 50% more likely to have had preventive care such as pap smears, mammograms, and prostate exams compared to uninsured adults.[15] Consequently, uninsured cancer patients are diagnosed in later stages of the disease and die earlier than those with insurance.[16,17]

Having insurance improves health overall and could reduce mortality rates for the uninsured by 10-25%. The number of excess deaths in 2000 among uninsured adults age 25-64 was estimated to be about 18,000 a year.[18]

How Do the Uninsured Pay for Medical Care?

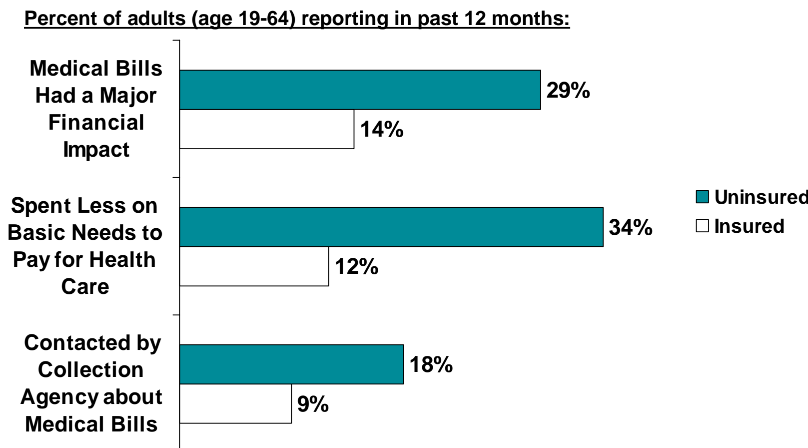
For many of the uninsured, the costs of health insurance and medical care are weighed against equally essential needs. The uninsured are almost three times as likely as those with health coverage to live in a household that is having difficulty paying monthly expenses as basic as rent, food, and utilities. Medical bills for even minor problems can mount quickly for the uninsured and the financial impact on a family can be serious.

The costs of medical care received by those uninsured for an entire year are just over half that of those with insurance. Because the uninsured receive less care, their per capita costs were $1,629 compared to $2,975 for the insured in 2004. These costs create a significant financial burden to many because the full charge for health services are billed to them. Over a third (35%) of the health care costs of those uninsured for a full year in 2004 were paid out-of-pocket.[19] Over 14% of the uninsured spend more than 10% of their family income on out-of-pocket health care costs.[20]

Having health insurance makes a difference in the debt individuals and families face because of medical bills. The uninsured are about twice as likely to have had problems paying medical bills in the past year as those who have coverage. In addition, the impact of these bills is much greater on uninsured families (Figure 8). About one-third of the uninsured reported spending less on other basic needs such as food and heat in order to pay medical bills.

Having health insurance makes a difference to a person's credit history. Like any bill, when medical bills are not paid or paid off too slowly, they are turned over to a collection agency, and a person's ability to get further credit is significantly limited. Almost one-fifth (18%) of the uninsured report that they were contacted by a collection agency about unpaid medical bills in just the past year.

Figure 8



The uninsured are increasingly paying "up front" before services will be rendered. When the uninsured are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or can be turned away.[21]

Most of the uninsured do not receive health services for free or at reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.[22] Slightly less than half of the uninsured know of a provider in their community who charges less to patients without insurance.[23] Only about one quarter of low-income uninsured adults (those with incomes under twice the poverty level) report they have received care for free or at reduced rates in the past year.[24]

How Is Uncompensated Care Financed?

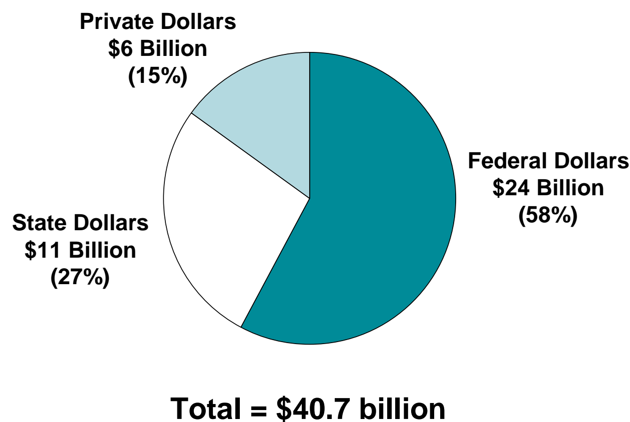
When the uninsured are unable to pay for care they receive, that uncompensated care is paid for through a patchwork of federal, state, and private funds. The bulk of such care is funded by the government and is crucial to the strength of the nation's public hospitals and clinics, which provide most of the uncompensated care the uninsured receive. Although this funding remains important, it has not kept pace with the rising numbers of uninsured and increasing medical costs.

The costs of uncompensated care were estimated to be about $41 billion in 2004 (the most recent estimate of this kind). Projected government spending available to pay for the care of the uninsured in 2004 was $34.6 billion—about 85% of the total uncompensated care bill (Figure 9). More than half of all funds for uncompensated care come from the federal government, with the majority of federal dollars flowing through Medicare and Medicaid.

Most government dollars for uncompensated care are paid to hospitals based partly on the share of uncompensated care they provide. Uncompensated care costs for direct service programs, such as community health centers and the Veterans Affairs health system, are funded almost completely by public dollars.[25]

Figure 9

Payment Sources for Uncompensated Care, 2004

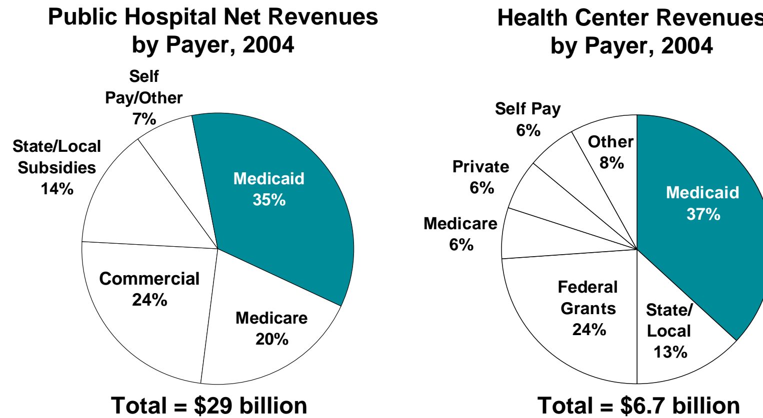


Total = $40.7 billion

SOURCE: Derived from Hadley J. and J. Holahan. 2004.

The federal uncompensated care funding that flows through Medicaid is a major source of financing for health care providers that serve the low-income and uninsured populations. Medicaid is the largest source of third-party payments for community health centers, accounting for over one-third of their operating revenues. Medicaid also provides 35% of public hospital net revenues (Figure 10).[26, 27]

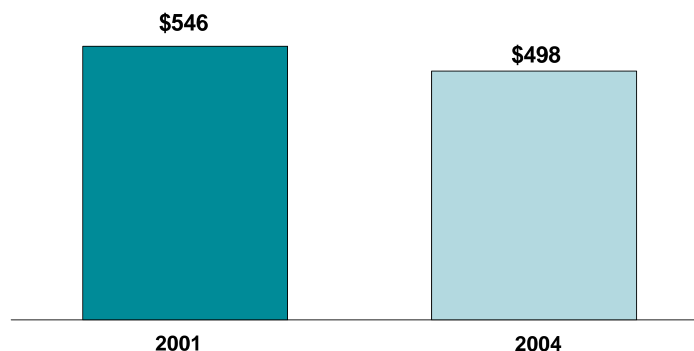
Figure 10



SOURCE: *America's Public Hospitals and Health Systems, 2004*. 2006. Rosenbaum and Shin. 2006.

Federal spending on uncompensated care has not kept up with the recent growth in the number of uninsured. Although federal support for community health centers increased by more than 50% between 2001 and 2004 (from $430 million to $670 million), these expenditures account for less than 3% of total federal spending for uncompensated care. As the number of uninsured increased by 11% between 2001 and 2004, total federal spending on the health care safety net increased by only 1%, leading to a decline in federal spending per uninsured person from an average of $546 in 2001 to $498 in 2004 (Figure 11).[28]

Figure 11



SOURCE: Hadley J, M Cravens, T Coughlin, J Holahan. 2005.

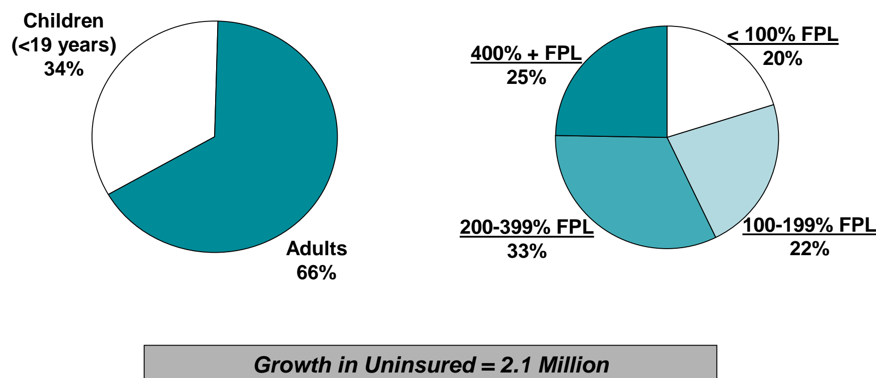
The cost of uncompensated care provided by physicians is not directly or indirectly reimbursed by public dollars.[29] Financial pressures and time constraints, coupled with changing physician practice patterns, have contributed to a decline in charity care provided by physicians. The percent of all doctors who provide charity care fell to 68% in 2004-2005 from 76% in 1996-1997.[30]

Between 2005 and 2006, the economy appeared to rebound with family incomes increasing and the number of people in poverty decreasing. However employer-sponsored insurance continued to decline. In just one year the number of nonelderly uninsured spiked upward by 2.1 million people in 2006, for a total of 46.5 million uninsured. Medicaid coverage among the nonelderly remained steady, not compensating for the decline in private coverage.

Declines in employer coverage had a large impact on children, with one-third (710,000) of the total growth in the uninsured occurring among children. Decreases in employer coverage at each income level were greater for children than for adults in 2006, which suggests that dependent coverage declined. Children's chances of being uninsured grew by almost a full percentage point (11.2% to 12.1%) during that year, leaving a total of 9.4 million children uninsured. Nearly half of the increase in the number of uninsured children came from families with incomes between 200% and 400% of poverty—a level where most are not eligible for public coverage.

Figure 14

Growth in Nonelderly Uninsured, by Age and Family Income, 2005 to 2006



SOURCE: Holahan, J and A Cook. 2007.

Growth in the number of uninsured between 2005 and 2006 affected those with higher incomes as well. The uninsured rate increased across all income groups. While the highest income group (400% + FPL) experienced the smallest increase in their uninsured rate, their numbers were growing with an improved economy—and so they comprised a quarter of the growth in the uninsured between 2005 and 2006. Those with low incomes (the poor and near-poor) made up more than 40% of the growth in the uninsured, while those with incomes between two and four times the poverty level made up a third of the growth in the uninsured in the past year (Figure 14).[33]

Why Doesn't Employer-Sponsored Insurance Cover More Americans?

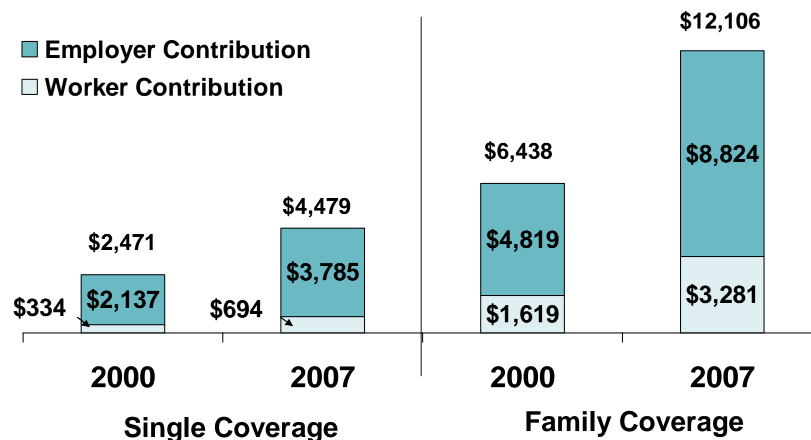
Employer-sponsored health insurance covered 158 million Americans—(61%) of the nonelderly population —in 2006. Yet, 38 million people from working families were uninsured in that year because not all businesses offer health benefits, not all workers qualify for coverage, and many employees cannot afford their share of the health premium. The strength of the economy and the growth rate of health insurance premiums are the primary factors influencing the proportion of Americans insured through employer-sponsored benefits.

Employer-sponsored health insurance is sensitive to sharp changes in health insurance premiums. Between 1988 and 1993, health insurance premiums grew by at least 8% annually and the proportion of workers covered by job-based insurance decreased. By 1996, premiums had stabilized, even dropping below the overall rate of inflation as insurers competed to increase their market share. Low premium growth combined with the prospering economy very gradually reversed the trend in employer-sponsored coverage, and the percent of the population covered by employer-sponsored coverage grew slightly.

However, an economic downturn in early 2001, coupled with the return of double-digit inflation in health insurance premiums, decreased employer-sponsored coverage again. Both factors also adversely affect the type of health benefits offered and the amount employees are required to contribute towards their health benefits. Although the growth rate of health insurance premiums has declined recently, premiums continue to grow more than twice as fast as wage increases, and employer-sponsored coverage continues to erode.

Figure 15

Average Annual Premium Costs for Covered Workers, 2000 and 2007



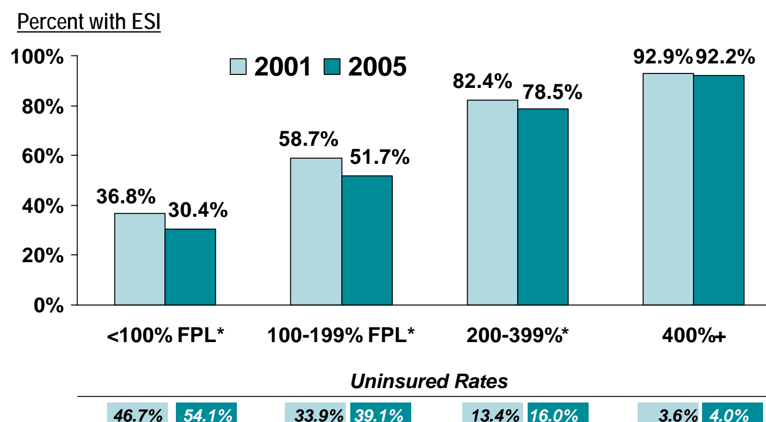
Family coverage is defined as health coverage for a family of four.
SOURCE: Kaiser/HRET Employer Health Benefits Survey, 2007.

In 2007, annual employer-sponsored group premiums cost, on average, $4,479 for individual coverage and $12,106 for family coverage. Total family premiums have doubled since 2000 and now exceed the annual salary of a full-time, minimum-wage worker. The employee's share of a family premium has also doubled since 2000, averaging $3,281 in 2007 (Figure 15).[34]

The share of employees who were covered by employer-sponsored insurance (ESI) decreased markedly between 2001 and 2005, with a corresponding increase in the share who were uninsured. Decreases in job-based coverage—and increases in the share who were uninsured—were greatest among low-income workers, those who were already the most likely to be uninsured. The share of poor employees who had ESI dropped from 37% in 2001 to 30% by 2005 and among the near-poor dropped from 59% to 52%, while among those with the highest incomes, ESI rates stayed at over 92% (Figure 16).[35]

Figure 16

Changes in Employees' ESI Coverage and Uninsured Rates, by Family Income Levels, 2001-2005

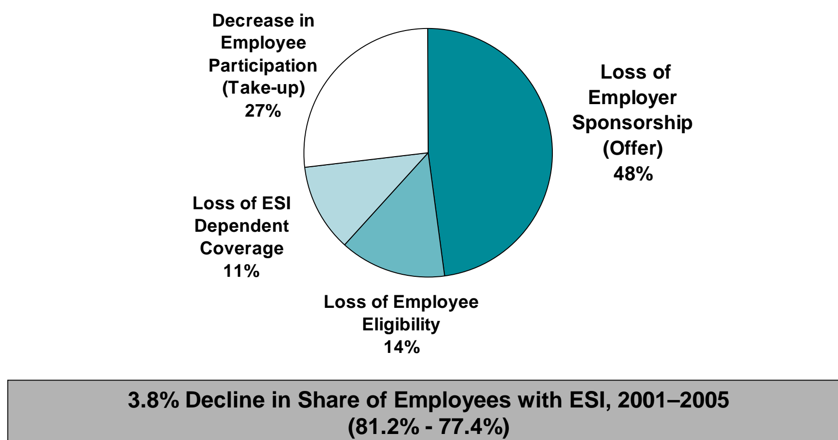


* Statistically significant changes for both ESI and uninsured rates for these groups (p<.05).
SOURCE: Clemans-Cope, L and B Garrett. 2006.

The main reason for this change was because fewer employees worked for employers who sponsored health benefits. Over 70% of the decline in job-based coverage was due to loss of employer sponsorship, eligibility, or loss of job-based coverage as a dependent of another worker. About a quarter of the drop was due to employees not participating in health benefits offered to them (Figure 17). Declines in employer sponsorship between 2001 and 2005 were deepest among poor and near-poor employees.[36]

Figure 17

Reasons for Decline in Employer-Sponsored Insurance Among Employees, 2001- 2005



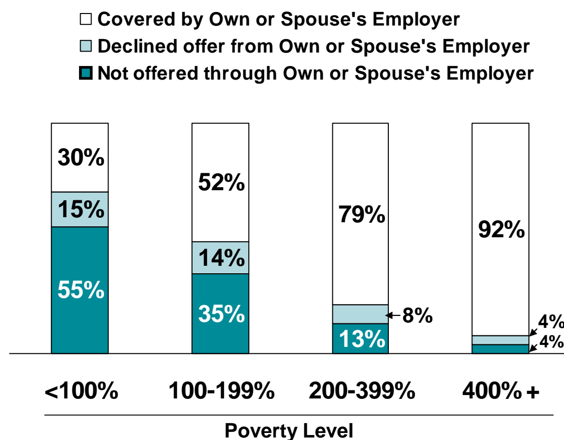
3.8% Decline in Share of Employees with ESI, 2001–2005 (81.2% - 77.4%)

SOURCE: Clemans-Cope, L and B Garrett. 2006.

Workers from low-income families have less access to job-based insurance, even when benefits from a spouse's job are considered. In 2005, 55% of employees from poor families did not have employer-sponsored insurance available to them, either through their own job or a family member's job, compared to only 4% of employees from higher income families (400% or more of the poverty level; Figure 18).[37]

Figure 18

Employee Access to ESI within the Family by Family Income, 2005



Data may not total 100% due to rounding.
SOURCE: Clemans-Cope, L and B Garrett. 2006.

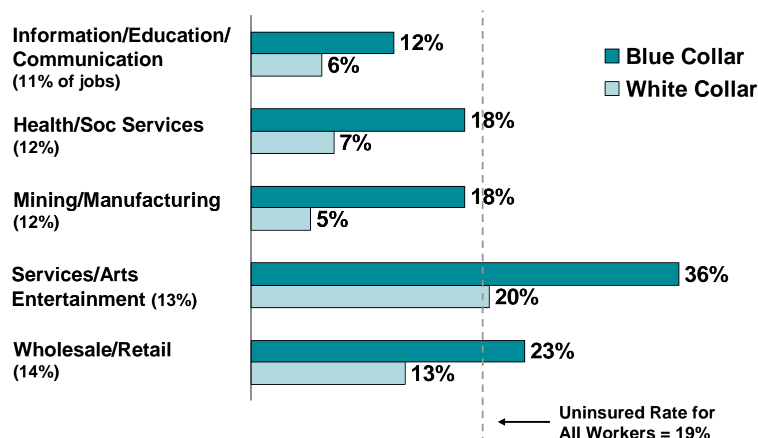
Employer-sponsored insurance is not an option for the large majority of uninsured employees. Over half work where health benefits are not offered (56%) and another 14% are not eligible for the health benefits offered to other employees; this includes employee health benefits possibly available through one's spouse. Only 30% of uninsured employees go without health coverage because they choose not to participate.[38]

The required employee share of premiums makes employer-sponsored coverage unaffordable for some, particularly low-wage workers. Poor employees compared to higher-wage workers are less likely to participate when health benefits are offered (64% participation among poor employees vs. 84% of those with family incomes greater than four times the poverty level).[39] Low-wage workers often work in firms where employees are required to pay a larger share of the premium. Among businesses offering health benefits in 2007, employees in lower-wage firms paid 34% of the premium costs for family coverage compared to 27% paid by employees in higher-wage firms.[40]

Employees of small businesses (less than 100 employees) are less likely than those in larger firms to have health benefits offered to them. And the gap widened between 2001 and 2005, with employees of the smallest firms (less than 10 employees) experiencing the greatest change. The share of employees in these small firms who were offered health benefits declined from 54% in 2001 to 50% by 2005.[41]

Health coverage varies both by industry and by type of occupation. Across industries, uninsured rates range from 37% in construction to just 5% in public administration. But even in industries where health benefits are better than average, the gap in health coverage between blue and white collar workers is nearly two-fold or greater (Figure 19). Over 80% of uninsured workers are in blue-collar jobs.

Figure 19



Analysis of workers age 18 to 64. White collar workers include all professionals and managers; all other workers classified as blue collar.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS

What is Medicaid's Role?

Medicaid is the nation's major public health insurance program for low-income Americans, providing health coverage based not only on income levels, but also eligibility categories. As a federal-state program, Medicaid's combination of federal rules and state options for coverage has created different eligibility rules for different groups across the country.

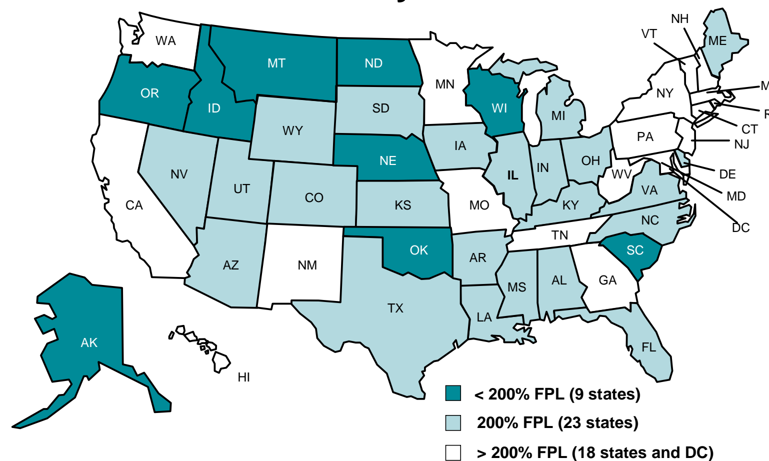
Medicaid covers four main groups of nonelderly, low-income people: children, their parents, pregnant women, and people with disabilities—with the program playing its broadest role among children. Half of all Medicaid beneficiaries are children.

Federal law requires states to cover children under age 19 who come from poor families. The threshold is higher (133% of the poverty level) for children under age six and pregnant women, and states have the option to expand coverage beyond these federal minimum requirements.

SCHIP works as a complement to Medicaid by covering low-income children not eligible for Medicaid. The two programs together aim to cover nearly all low-income children. SCHIP gives states the option to cover children through their existing Medicaid program or a separate child health program. Most states cover children up to 200% of the poverty level through Medicaid or SCHIP (Figure 20).

Figure 20

Children's Eligibility for Medicaid/SCHIP by Income, July 2007



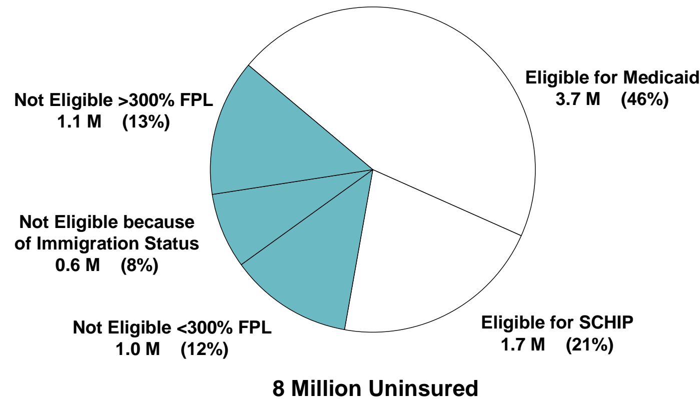
IL uses state only funds to cover children above 200% FPL
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

Despite broad Medicaid and SCHIP eligibility for low-income children, many eligible children are not enrolled in the programs. Two-thirds of uninsured children are eligible for Medicaid or SCHIP but are not enrolled (Figure 21).[42] Some families are not aware of the availability of the programs or may not believe their children are eligible. But, many families face barriers to enrolling and renewing their children in public programs, and new rules require U.S. citizens to document their citizenship and identity when applying for Medicaid or renewing their coverage.

Figure 21

Distribution of Uninsured Children, 2004

(in millions)

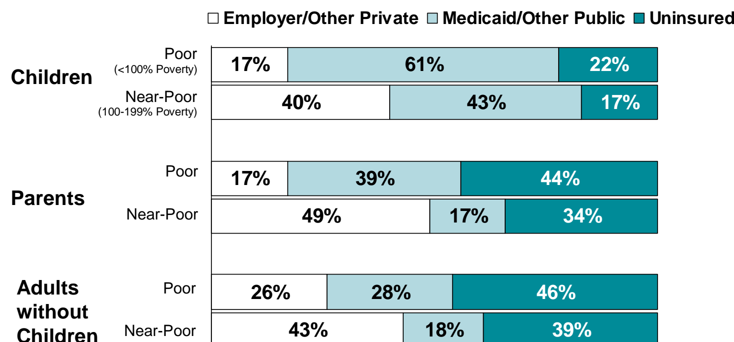


Data has been adjusted for the Medicaid undercount.
SOURCE: Urban Institute analysis of the 2005 Annual and Social Economic Supplements to the CPS for KCMU.

In contrast, the role of Medicaid for nonelderly adults is far more limited. Medicaid covers some parents and low-income disabled individuals, but most adults without dependent children—regardless of how poor—are ineligible for Medicaid. Parents of dependent children qualify for Medicaid though income eligibility levels are set much lower than congressionally mandated standards for children and pregnant women. These eligibility restrictions, coupled with barriers to Medicaid enrollment, leave 44% of poor parents under age 65 uninsured (Figure 22).

Figure 22

Health Insurance Coverage of Low-Income Adults and Children, 2006

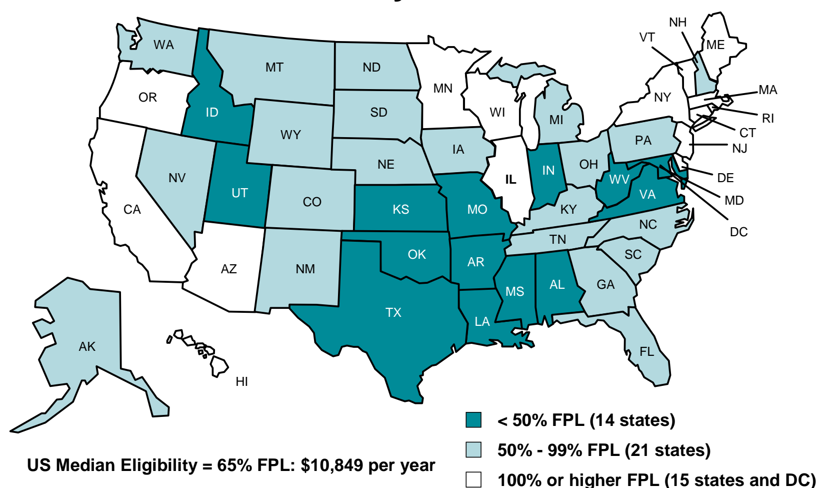


SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

Some states have expanded Medicaid eligibility for low-income parents, but most states continue to tie income eligibility levels for parents to former welfare assistance levels. Nearly one-third of states have used the flexibility available to them under federal law to extend Medicaid eligibility for parents to 100% of the poverty level or higher. However, in the remaining states, parents still must have income below the poverty level in order to qualify for health coverage (Figure 23). As a result, millions of poor parents are ineligible for Medicaid. For example, a parent in a family of three working full-time at the minimum wage could not qualify for Medicaid in 24 states in 2006.[43]

Figure 23

Medicaid Eligibility for Working Parents by Income, July 2006

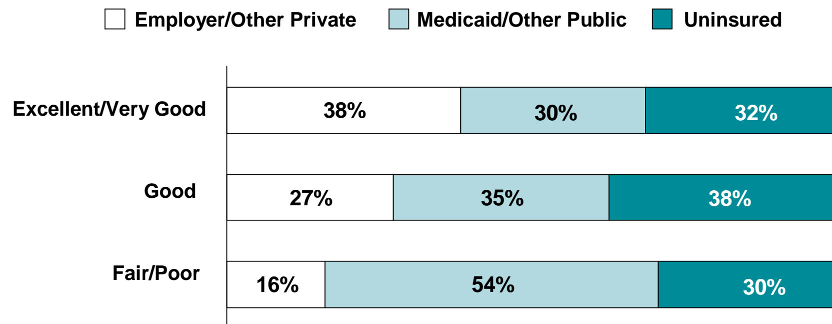


SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

Growth in Medicaid and SCHIP enrollment from 2000 to 2004 contributed to the decrease in the share of children who were uninsured; however, Medicaid and SCHIP coverage leveled off in 2005 and 2006 leading to a reversal in the progress made in covering children. With improving fiscal conditions, many states sought to expand coverage, particularly for children. In 2006 and 2007, 19 states and the District of Columbia enacted legislation to expand coverage for children, in most cases by increasing the eligibility limit for SCHIP. Another six states provided additional funding for outreach and enrollment efforts targeting children who are eligible for public programs but not enrolled.[44]

Medicaid covers the majority of the low-income nonelderly who are in fair or poor health. Over 50% of low-income people in fair and poor health are covered by Medicaid, while only 16% are covered by private insurance (Figure 24). Medicaid beneficiaries are also poorer and more likely to have health conditions that limit work compared to the low-income privately insured. Most Medicaid beneficiaries do not have access to private health insurance, and without Medicaid, they would become uninsured.

Figure 24



SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

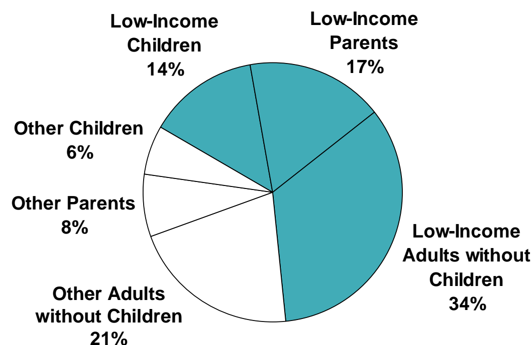
What Can Be Done to Decrease the Number of Uninsured?

Public opinion surveys over time show that the majority of Americans believe decreasing the number of uninsured is an important policy priority. However, there is little agreement on how to achieve this goal. Policy options that have been proposed to guarantee universal coverage range from a single public plan that covers all Americans to more targeted strategies that extend employer-based coverage to reform of the federal tax code. Some build on public coverage while others require individuals to purchase coverage directly. Most strategies recognize the need to subsidize the cost for the lowest income groups, given that those with incomes less than twice the poverty level make up two-thirds of the uninsured (Figure 25).

Many of the recent proposals combine strategies in order to expand health insurance coverage. Building on the nation's mixed system of public and private insurance, the strategies being discussed vary not only by the means of insuring more Americans, but also by who is targeted for coverage. The uninsured population is diverse; therefore, applying different strategies may be necessary to meet the needs of a growing uninsured population.

Figure 25

The Nonelderly Uninsured, by Age and Income Groups, 2006



Total = 46.5 million uninsured

Low-income includes those with family incomes less than 200% of the federal poverty level.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

Components of proposed strategies include:

Expanding public coverage for the low-income uninsured by building on Medicaid and SCHIP. Medicaid and SCHIP provide government financed coverage, but care is typically delivered by private health plans and providers. While Medicaid offers comprehensive benefits with no or minimal cost-sharing, the more limited benefit package in some SCHIP programs and the higher levels of cost sharing in SCHIP are designed to meet the needs of those with more moderate incomes. These programs are explicitly designed to cover those most at risk of being uninsured—lower-income families and the disabled. However, neither program has reached its full enrollment potential.

With the introduction of SCHIP, several states successfully implemented system-wide changes in order to improve enrollment and retention efforts in both Medicaid and SCHIP. However, not all of these efforts could be fully sustained during recent state budget crises. With major budgetary problems now behind many states, more states are again considering ways of expanding coverage to more of the low-income population through their public programs.

Increasing federal and state funding to expand public coverage offers the potential (as shown in Figure 25) to reach nearly two-thirds of the uninsured population, if coverage is extended to low-income adults without children, as well as to more parents.

Expanding private group coverage by bolstering the current employer-sponsored system and/or building new group insurance options. The share of Americans with job-based coverage has been declining, particularly since 2000. While the majority of Americans obtain their health insurance through the workplace, over 80% of the uninsured are working themselves or have a connection to the workforce. Proposals aimed at increasing coverage through the workplace range from encouraging more job-based coverage with financial incentives for employers, including tax incentives, to mandating that businesses provide health coverage.

Some proposals would create new group insurance options for individuals or businesses, sometimes modeled after the Federal Employee Health Benefits Program, that would provide a wide range of health plans with statewide or regional risk pools. Others would make it easier for small employers and the self-employed to band into larger insurance purchasing pools, potentially giving them large group negotiating power when buying insurance. Other proposals aim to prevent insurers from either denying coverage to those with health problems or charging higher premiums to those in poor health. These types of strategies could lower premiums and broaden the choice of policies available to the uninsured, but many experts believe the government will need to subsidize the premiums for low-wage workers or some small firms, or at least, provide some form of federal reinsurance for high cost enrollees to reduce employer premiums.

Tax code reform to encourage the purchase of private insurance. Some believe job-based coverage is an outdated approach in a country where workers change employers several times during their lives and are unable to maintain their health benefits across jobs. It has also been argued that tax exclusions tied to employer health insurance unfairly benefit only those who have group coverage through a business.

Reforming the tax code to "level the playing field" for those who purchase insurance on their own provides an alternative to employment-linked coverage. Some proposals would replace the current tax exclusion for employer-based insurance with a standard health care deduction for individuals and families, thus eliminating the primary incentive for purchasing insurance through an employer. Individuals would then be encouraged to purchase health insurance on their own through the non-group insurance market. The tax code reform could also be coupled with tax credits for low-income individuals and families to make coverage more affordable. However, the success of these options depends on whether the individual health insurance market can evolve to meet the needs of people with higher health needs. Many people with health problems or a chronic condition currently are either excluded from non-group insurance or find policies unaffordable. Private non-group coverage has not grown over time, still covering just over 5% of the nonelderly population.

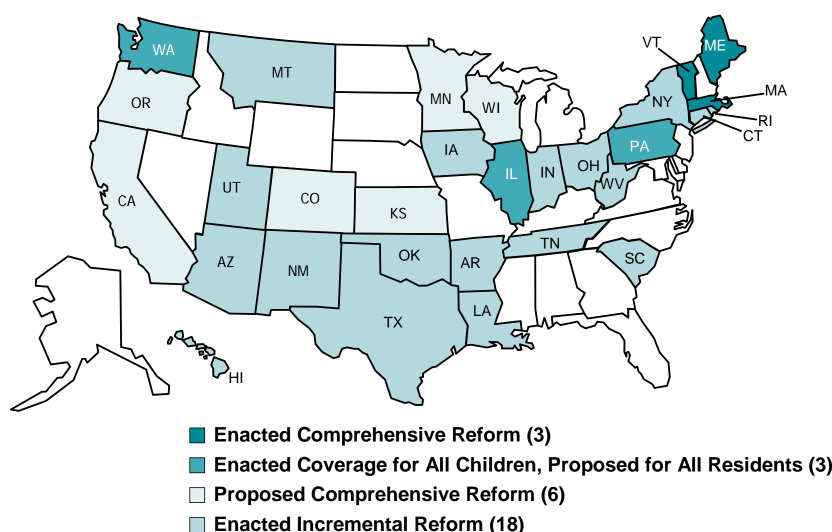
Another set of proposals would make it easier for people to take advantage of health savings accounts (HSAs) if they purchase a high deductible health plan. Contributions and withdrawals to HSAs are made tax-free and are to be used for paying out-of-pocket medical expenses. While high deductible plans could potentially make people more cost-conscious, for many, particularly the low-income uninsured, they are not more affordable than other plans and could attract only healthy people, driving up the cost of coverage for others. HSA-qualified health plans are still relatively uncommon; just 7% of businesses that provide health benefits offered a high deductible health savings account plan in 2007.

Proposals that offer tax credits or deductions to individuals vary by whom they would assist. Some would target tax provisions to the low-income; others would assist all the uninsured. The cost to the government of tax-based approaches could be high, since those least able to afford insurance would require substantial financial assistance to pay their premiums. Moreover, such tax credits are likely to also be used by many who are already insured, providing greater tax equity, but also increasing the cost of expanding coverage.

The states and health care reform. A landmark health care reform plan now being implemented in Massachusetts has renewed interest in comprehensive health system reform, sparking debate in statehouses across the county, and more recently, at the national level. As state economic situations improve, more governors and state legislators are seeking solutions to address their states' growing number of uninsured—and are proposing a diverse mix of reforms. In addition to Massachusetts, two other states, Maine and Vermont, have enacted reform plans that seek to provide health coverage to nearly all residents. Comprehensive reform proposals have been announced in several other states, most notably in California (Figure 26).

Figure 26

States Moving Toward Comprehensive Reform



These comprehensive state proposals, along with a number of other state efforts to expand coverage in more incremental ways, demonstrate the high priority states are giving to this problem—potentially building momentum for broader reforms at the national level. Given the size of the uninsured problem and the variability in state resources, it will not be possible to achieve national health reform on a state-by-state basis. However, states can and are testing possible solutions that under the right set of circumstances could be adopted nation-wide.

Health care reform and the 2008 election. At the national level, the 2008 presidential campaign has provided a forum for fostering a national debate over health care issues. Health care has emerged as one of the top priorities for the public, making ways to cover the uninsured and reign in rising health care costs a key element in the 2008 Presidential campaign debate. With interest in the issue remaining high among key stakeholders as well as the American public, solutions to address the problems that plague our health care system and addressing the 47 million uninsured will undoubtedly be a focus of domestic policy discussions throughout the campaign.

Tables

Table 1: Characteristics of the Nonelderly Uninsured, 2006

Table 2: Characteristics of Uninsured Children, 2006

Table 3: Health Insurance Coverage of the Nonelderly, 2006

Table 4: Health Insurance Coverage of Children, 2006

Table 5: Health Insurance Coverage of the Nonelderly by State, 2005-2006

Table 6: Health Insurance Coverage of Children by State, 2005-2006

Additional detailed national and state tables are available online at www.kff.org/uninsured/7451.cfm

Table 1
Characteristics of the Nonelderly Uninsured, 2006

	Nonelderly (millions)	Percent of Nonelderly	Uninsured Nonelderly (millions)	Percent of Uninsured Nonelderly	Uninsured Rate for Nonelderly
Total - Nonelderly[a]	**260.0**	**100.0%**	**46.5**	**100.0%**	**17.9%**
Age					
Children - Total	**78.2**	**30.1%**	**9.4**	**20.3%**	**12.1%**
Adults - Total	**181.8**	**69.9%**	**37.0**	**79.7%**	**20.4%**
Adults 19-24	24.1	9.3%	7.5	16.2%	31.2%
Adults 25-34	39.6	15.2%	10.7	23.1%	27.1%
Adults 35-44	42.5	16.4%	8.0	17.3%	18.9%
Adults 45-54	43.4	16.7%	6.6	14.3%	15.3%
Adults 55-64	32.2	12.4%	4.1	8.8%	12.7%
Annual Family Income					
<$20,000	58.7	22.6%	21.9	47.0%	37.2%
$20,000 - $39,999	52.8	20.3%	13.4	28.9%	25.4%
$40,000 +	148.5	57.1%	11.2	24.0%	7.5%
Family Poverty Level[b]					
<100%	**45.5**	**17.5%**	**16.6**	**35.8%**	**36.5%**
100-199%	**45.3**	**17.4%**	**13.6**	**29.3%**	**30.1%**
...100-149%	22.7	8.7%	7.4	15.9%	32.5%
...150-199%	22.6	8.7%	6.3	13.5%	27.7%
200-399%	**74.2**	**28.5%**	**11.0**	**23.8%**	**14.9%**
...200-299%	41.7	16.0%	7.6	16.3%	18.1%
...300-399%	32.5	12.5%	3.5	7.5%	10.7%
400%+	**95.1**	**36.6%**	**5.2**	**11.1%**	**5.4%**
Household Type					
Single Adults Living Alone	19.7	7.6%	3.6	7.8%	18.4%
Single Adults Living Together	29.6	11.4%	10.4	22.3%	35.1%
Married Adults	53.8	20.7%	8.0	17.2%	14.9%
1 Parent with children[c]	32.1	12.4%	6.5	14.1%	20.4%
2 Parents with children[c]	112.2	43.1%	14.1	30.3%	12.5%
Multigenerational/Other with children[d]	12.7	4.9%	3.8	8.3%	30.2%
Family Work Status					
2 Full-time	73.4	28.2%	5.9	12.7%	8.0%
1 Full-time	139.2	53.5%	26.9	57.9%	19.3%
Only Part-time[e]	17.7	6.8%	5.2	11.1%	29.2%
Non-Workers	29.6	11.4%	8.5	18.3%	28.7%
Race/Ethnicity					
White only (non-Hispanic)	166.7	64.1%	21.0	45.1%	12.6%
Black only (non-Hispanic)	32.9	12.6%	7.2	15.4%	21.8%
Hispanic	42.3	16.3%	15.1	32.5%	35.7%
Asian/S. Pacific Islander only	12.4	4.8%	2.1	4.4%	16.6%
Am. Indian/Alaska Native	1.7	0.6%	0.6	1.2%	33.0%
Two or More Races[f]	4.0	1.5%	0.6	1.3%	15.2%
Citizenship					
U.S. citizen - native	226.8	87.2%	34.1	73.4%	15.0%
U.S. citizen - naturalized	11.7	4.5%	2.3	5.0%	19.9%
Non-U.S. citizen, resident for < 6 years	6.2	2.4%	3.0	6.5%	48.8%
Non-U.S. citizen, resident for 6+ years	15.3	5.9%	7.0	15.1%	45.7%
Health Status					
Excellent/Very Good	181.0	69.6%	28.1	60.5%	15.5%
Good	57.3	22.0%	13.4	28.9%	23.4%
Fair/Poor	21.8	8.4%	4.9	10.6%	22.6%

Confidence intervals were calculated only for uninsured rates. ( ) = Uninsured rate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates of uninsured rates that have larger margins of error are not provided.

Table 2
Characteristics of Uninsured Children, 2006

	Children (millions)	Percent of Children	Uninsured Children (millions)	Percent of Uninsured Children	Uninsured Rate for Children
Total - Children[g]	**78.2**	**100.0%**	**9.4**	**100.0%**	**12.1%**
Age					
<1	4.1	5.2%	0.6	6.0%	14.0%
1-5	20.5	26.2%	2.2	23.3%	10.8%
6-18	53.6	68.6%	6.7	70.6%	12.4%
Family Income					
<$20,000	17.6	22.5%	3.9	41.0%	22.0%
$20,000 - $39,999	14.8	18.9%	2.6	27.3%	17.4%
$40,000 +	45.8	58.5%	3.0	31.7%	6.5%
Family Poverty Level[b]					
<100%	**17.5**	**22.3%**	**3.9**	**40.9%**	**22.1%**
100-199%	**15.6**	**20.0%**	**2.6**	**27.9%**	**16.9%**
...100-149%	8.1	10.4%	1.5	15.6%	18.2%
...150-199%	7.5	9.6%	1.2	12.3%	15.4%
200-399%	**22.6**	**28.9%**	**2.1**	**21.9%**	**9.1%**
...200-299%	13.3	17.0%	1.4	15.0%	10.7%
...300-399%	9.3	11.9%	0.6	6.9%	6.9%
400%+	**22.5**	**28.7%**	**0.9**	**9.3%**	**3.9%**
Household Type[h]					
1 Parent[c]	19.1	24.4%	2.7	28.7%	14.2%
2 Parents[c]	52.9	67.7%	5.0	53.0%	9.5%
Multigenerational/Other[d]	5.5	7.0%	1.4	15.3%	26.3%
Family Work Status					
2 Full-time	22.9	29.3%	1.6	16.8%	6.9%
1 Full-time	42.0	53.7%	5.2	55.3%	12.4%
Only Part-time[e]	4.5	5.7%	0.7	7.2%	15.2%
Non-Workers	8.8	11.3%	2.0	20.8%	22.3%
Race/Ethnicity					
White only (non-Hispanic)	44.9	57.4%	3.4	36.2%	7.6%
Black only (non-Hispanic)	11.5	14.7%	1.7	17.7%	14.6%
Hispanic	15.9	20.4%	3.6	38.5%	22.8%
Asian/S. Pacific Islander only	3.2	4.1%	0.4	4.2%	12.3%
Am. Indian/Alaska Native*	0.5	0.7%	0.1	1.4%	(23.9%)
Two or More Races[f]	2.1	2.6%	0.2	1.9%	8.7%
Citizenship					
U.S. Citizen	75.4	96.4%	8.4	88.5%	11.1%
Non-U.S. citizen, resident for < 6 years	1.4	1.8%	0.5	5.8%	39.6%
Non-U.S. citizen, resident for 6+ years	1.5	1.9%	0.5	5.7%	36.8%
Health Status					
Excellent/Very Good	64.0	81.8%	7.1	75.5%	11.1%
Good	12.5	16.0%	2.1	22.1%	16.7%
Fair/Poor	1.7	2.2%	0.2	2.3%	12.7%

* Due to small sample size, all estimates for American Indian/Alaska Native children are imprecise, i.e., they have large standard errors and should be interpreted as approximations.

Confidence intervals were calculated only for uninsured rates. ( ) = Uninsured rate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates of uninsured rates that have larger margins of error are not provided.

Table 3
Health Insurance Coverage of the Nonelderly, 2006

	Nonelderly (millions)	Percent Distribution by Coverage Type: Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[i]	
Total - Nonelderly[a]	**260.0**	**60.9%**	**5.4%**	**13.5%**	**2.3%**	**17.9%**
Age						
Children - Total	**78.2**	**55.5%**	**4.5%**	**26.6%**	**1.4%**	**12.1%**
Adults - Total	**181.8**	**63.2%**	**5.9%**	**7.8%**	**2.8%**	**20.4%**
Adults 19-24	24.1	45.6%	11.1%	10.8%	1.3%	31.2%
Adults 25-34	39.6	58.9%	4.3%	8.5%	1.2%	27.1%
Adults 35-44	42.5	67.9%	4.6%	7.0%	1.6%	18.9%
Adults 45-54	43.4	69.9%	5.0%	6.7%	3.0%	15.3%
Adults 55-64	32.2	66.3%	6.7%	7.4%	6.8%	12.7%
Annual Family Income						
<$20,000	58.7	18.5%	6.8%	33.4%	4.1%	37.2%
$20,000 - $39,999	52.8	49.1%	5.5%	17.0%	2.9%	25.4%
$40,000 +	148.5	81.8%	4.9%	4.3%	1.4%	7.5%
Family Poverty Level[b]						
<100%	**45.5**	**14.6%**	**6.2%**	**39.5%**	**3.2%**	**36.5%**
100-199%	**45.3**	**37.7%**	**5.8%**	**22.5%**	**3.9%**	**30.1%**
...100-149%	22.7	29.6%	5.6%	28.1%	4.2%	32.5%
...150-199%	22.6	45.8%	6.0%	17.0%	3.6%	27.7%
200-399%	**74.2**	**70.5%**	**5.6%**	**6.6%**	**2.3%**	**14.9%**
...200-299%	41.7	64.7%	5.7%	8.7%	2.7%	18.1%
...300-399%	32.5	78.1%	5.4%	4.0%	1.8%	10.7%
400%+	**95.1**	**86.5%**	**4.8%**	**2.0%**	**1.2%**	**5.4%**
Household Type						
Single Adults Living Alone	19.7	59.5%	8.4%	9.1%	4.6%	18.4%
Single Adults Living Together	29.6	44.5%	9.1%	8.7%	2.7%	35.1%
Married Adults	53.8	70.9%	5.6%	4.9%	3.7%	14.9%
1 Parent with children[c]	32.1	37.0%	4.6%	36.6%	1.4%	20.4%
2 Parents with children[c]	112.2	70.2%	4.3%	11.6%	1.4%	12.5%
Multigenerational/Other with children[d]	12.7	37.3%	3.7%	26.2%	2.6%	30.2%
Family Work Status						
2 Full-time	73.4	82.8%	3.2%	5.1%	0.9%	8.0%
1 Full-time	139.2	62.7%	5.5%	11.1%	1.4%	19.3%
Only Part-time[e]	17.7	30.6%	12.4%	24.6%	3.2%	29.2%
Non-Workers	29.6	16.2%	6.7%	38.9%	9.5%	28.7%
Race/Ethnicity						
White only (non-Hispanic)	166.7	69.0%	6.5%	9.5%	2.4%	12.6%
Black only (non-Hispanic)	32.9	49.1%	3.1%	22.8%	3.1%	21.8%
Hispanic	42.3	38.7%	2.7%	21.4%	1.5%	35.7%
Asian/S. Pacific Islander only	12.4	63.8%	7.8%	10.1%	1.7%	16.6%
Am. Indian/Alaska Native	1.7	38.2%	2.1%	23.2%	3.4%	33.0%
Two or More Races[f]	4.0	55.8%	3.8%	22.1%	3.0%	15.2%
Citizenship						
U.S. citizen - native	226.8	63.0%	5.6%	13.9%	2.5%	15.0%
U.S. citizen - naturalized	11.7	62.3%	6.5%	9.1%	2.3%	19.9%
Non-U.S. citizen, resident for < 6 years	6.2	35.8%	4.4%	10.4%	0.6%	48.8%
Non-U.S. citizen, resident for 6+ years	15.3	38.9%	3.4%	11.1%	0.9%	45.7%
Health Status						
Excellent/Very Good	181.0	66.1%	6.0%	11.0%	1.3%	15.5%
Good	57.3	53.6%	4.4%	16.0%	2.6%	23.4%
Fair/Poor	21.8	36.4%	3.5%	27.3%	10.2%	22.6%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with larger margins of error are not provided.

Table 4
Health Insurance Coverage of Children, 2006

	Children (millions)	Percent Distribution by Coverage Type: Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[i]	
Total - Children[g]	**78.2**	**55.5%**	**4.5%**	**26.6%**	**1.4%**	**12.1%**
Age						
<1	4.1	47.5%	2.6%	34.8%	1.1%	14.0%
1-5	20.5	53.1%	3.1%	31.6%	1.4%	10.8%
6-18	53.6	57.1%	5.1%	24.0%	1.3%	12.4%
Annual Family Income						
<$20,000	17.6	13.7%	3.6%	59.3%	1.4%	22.0%
$20,000 - $39,999	14.8	36.2%	4.1%	40.7%	1.7%	17.4%
$40,000 +	45.8	77.9%	4.9%	9.4%	1.2%	6.5%
Family Poverty Level[b]						
<100%	**17.5**	**13.5%**	**3.5%**	**59.6%**	**1.3%**	**22.1%**
100-199%	**15.6**	**36.3%**	**3.9%**	**41.4%**	**1.6%**	**16.9%**
...100-149%	8.1	27.3%	3.6%	49.5%	1.5%	18.2%
...150-199%	7.5	46.1%	4.2%	32.6%	1.7%	15.4%
200-399%	**22.6**	**70.8%**	**5.0%**	**13.3%**	**1.7%**	**9.1%**
...200-299%	13.3	65.1%	4.9%	17.3%	2.0%	10.7%
...300-399%	9.3	79.0%	5.2%	7.6%	1.3%	6.9%
400%+	**22.5**	**86.1%**	**5.1%**	**4.0%**	**0.9%**	**3.9%**
Household Type[h]						
1 Parent with children[c]	19.1	33.9%	4.3%	46.5%	1.1%	14.2%
2 Parents with children[c]	52.9	66.8%	4.4%	17.9%	1.4%	9.5%
Multigenerational/Other with children[d]	5.5	26.3%	4.3%	41.6%	1.5%	26.3%
Family Work Status						
2 Full-time	22.9	77.2%	3.3%	11.5%	1.1%	6.9%
1 Full-time	42.0	56.2%	5.0%	25.1%	1.3%	12.4%
Only Part-time[e]	4.5	22.2%	7.4%	53.8%	1.4%	15.2%
Non-Workers	8.8	13.0%	3.5%	59.2%	2.0%	22.3%
Race/Ethnicity						
White only (non-Hispanic)	44.9	66.5%	5.8%	18.7%	1.3%	7.6%
Black only (non-Hispanic)	11.5	41.3%	2.7%	39.9%	1.5%	14.6%
Hispanic	15.9	34.1%	2.2%	39.6%	1.3%	22.8%
Asian/S. Pacific Islander only	3.2	63.9%	4.6%	17.9%	1.3%	12.3%
Am. Indian/Alaska Native*	0.5	(32.9%)	1.6%	----	0.7%	(23.9%)
Two or More Races[f]	2.1	53.7%	2.8%	32.4%	2.4%	8.7%
Citizenship						
U.S. citizen	75.4	56.4%	4.5%	26.6%	1.4%	11.1%
Non-U.S. citizen, resident for < 6 years	1.4	33.7%	2.0%	24.2%	0.4%	39.6%
Non-U.S. citizen, resident for 6+ years	1.5	31.4%	3.2%	28.2%	0.3%	36.8%
Health Status						
Excellent/Very Good	64.0	59.6%	4.7%	23.2%	1.4%	11.1%
Good	12.5	38.3%	3.5%	40.1%	1.3%	16.7%
Fair/Poor	1.7	30.3%	3.5%	52.5%	1.0%	12.7%

* Due to small sample size, all estimates for American Indian/Alaska Native children are imprecise, i.e., they have large standard errors and should be interpreted as approximations.
( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with larger margins of error are not provided.

Table 5
Health Insurance Coverage of the Nonelderly by State, 2005-2006

	Nonelderly (thousands)[a]	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[i]	
United States	**258,732**	**61.2%**	**5.4%**	**13.5%**	**2.3%**	**17.6%**
Alabama	3,935	61.2%	3.7%	15.3%	2.8%	17.0%
Alaska	602	56.8%	4.0%	14.3%	6.5%	18.3%
Arizona	5,426	53.1%	4.3%	17.5%	2.4%	22.8%
Arkansas	2,409	53.2%	5.8%	15.6%	4.5%	20.8%
California	32,144	54.1%	7.6%	16.0%	1.6%	20.7%
Colorado	4,249	62.3%	7.8%	8.3%	3.0%	18.6%
Connecticut	3,015	70.6%	4.4%	11.6%	1.8%	11.6%
Delaware	733	69.1%	3.2%	11.2%	2.5%	13.9%
District of Columbia	491	56.2%	6.2%	22.8%	1.4%	13.5%
Florida	15,054	55.8%	5.9%	10.7%	3.1%	24.5%
Georgia	8,348	58.9%	4.3%	13.3%	3.9%	19.7%
Hawaii	1,068	69.8%	4.3%	11.0%	4.9%	10.0%
Idaho	1,290	61.4%	6.8%	13.0%	1.7%	17.0%
Illinois	11,140	66.7%	4.6%	11.4%	1.7%	15.5%
Indiana	5,577	67.7%	4.8%	11.7%	1.7%	14.1%
Iowa	2,525	68.4%	6.8%	12.9%	1.1%	10.8%
Kansas	2,337	66.0%	7.3%	11.8%	2.0%	12.9%
Kentucky	3,593	61.8%	4.1%	14.8%	3.7%	15.7%
Louisiana	3,575	53.6%	5.8%	15.5%	2.4%	22.7%
Maine	1,135	60.9%	5.2%	19.7%	2.9%	11.3%
Maryland	4,907	69.2%	4.2%	9.3%	2.1%	15.3%
Massachusetts	5,536	68.2%	4.8%	14.5%	1.3%	11.1%
Michigan	8,772	67.8%	4.4%	14.5%	1.5%	11.7%
Minnesota	4,494	69.9%	7.8%	11.1%	1.5%	9.7%
Mississippi	2,528	51.8%	4.9%	18.7%	3.4%	21.2%
Missouri	5,001	63.2%	6.7%	13.2%	2.5%	14.3%
Montana	801	56.1%	9.6%	11.6%	3.9%	18.8%
Nebraska	1,543	66.5%	8.5%	9.8%	2.3%	12.9%
Nevada	2,174	63.9%	5.0%	7.4%	2.9%	20.7%
New Hampshire	1,135	74.0%	5.1%	6.8%	2.0%	12.0%
New Jersey	7,593	70.9%	3.2%	7.9%	1.3%	16.7%
New Mexico	1,680	49.6%	4.6%	17.7%	3.4%	24.7%
New York	16,538	60.2%	4.4%	18.9%	1.2%	15.4%
North Carolina	7,620	58.5%	5.6%	13.8%	3.3%	18.9%
North Dakota	538	64.9%	10.4%	8.9%	2.4%	13.3%
Ohio	9,894	67.0%	4.5%	14.1%	2.2%	12.2%
Oklahoma	3,002	55.8%	4.6%	14.3%	4.0%	21.3%
Oregon	3,201	60.2%	6.4%	12.3%	2.0%	19.2%
Pennsylvania	10,533	68.1%	6.3%	12.9%	1.4%	11.3%
Rhode Island	924	64.0%	4.2%	18.3%	2.1%	11.4%
South Carolina	3,677	58.7%	4.4%	14.4%	3.5%	18.9%
South Dakota	660	61.4%	10.1%	11.4%	3.5%	13.6%
Tennessee	5,064	58.4%	5.6%	16.3%	3.9%	15.7%
Texas	20,458	53.2%	4.9%	12.7%	2.4%	26.8%
Utah	2,322	62.5%	6.9%	10.5%	1.7%	18.3%
Vermont	546	61.1%	4.4%	20.3%	1.9%	12.3%
Virginia	6,616	68.5%	3.9%	7.7%	5.3%	14.6%
Washington	5,533	65.0%	5.5%	12.2%	3.3%	14.1%
West Virginia	1,557	59.4%	2.0%	16.9%	4.1%	17.6%
Wisconsin	4,791	69.0%	5.9%	12.9%	1.9%	10.3%
Wyoming	444	62.0%	7.6%	10.5%	3.1%	16.7%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with larger margins of error are not provided.

Table 6

Health Insurance Coverage of Children by State, 2005-2006

	Children (thousands)[g]	Percent Distribution by Coverage Type: Private – Employer	Private – Individual	Public – Medicaid	Public – Other[i]	Uninsured
United States	**78,056**	**56.1%**	**4.5%**	**26.4%**	**1.4%**	**11.6%**
Alabama	1,165	58.4%	2.8%	31.1%	1.5%	6.3%
Alaska	192	52.2%	3.2%	27.7%	7.5%	9.4%
Arizona	1,727	47.9%	3.3%	30.4%	0.9%	17.4%
Arkansas	719	44.3%	4.6%	39.0%	1.1%	11.0%
California	10,159	49.6%	6.2%	29.3%	1.3%	13.6%
Colorado	1,252	60.8%	6.7%	15.7%	2.7%	14.0%
Connecticut	868	68.3%	3.1%	20.7%	0.7%	7.1%
Delaware	214	63.2%	2.5%	20.5%	1.8%	12.0%
District of Columbia*	118	42.3%	2.0%	(47.7%)	0.3%	7.8%
Florida	4,279	50.6%	5.1%	23.5%	1.6%	19.1%
Georgia	2,530	51.4%	3.2%	29.4%	3.6%	12.4%
Hawaii	315	62.6%	2.9%	21.7%	6.6%	6.2%
Idaho	420	54.6%	7.3%	25.0%	0.8%	12.3%
Illinois	3,406	63.8%	3.7%	22.1%	0.3%	10.0%
Indiana	1,675	62.3%	3.7%	24.4%	0.5%	9.1%
Iowa	740	63.6%	5.2%	24.6%	0.7%	5.9%
Kansas	729	59.1%	6.4%	26.1%	1.4%	7.0%
Kentucky	1,056	55.9%	3.9%	30.1%	1.6%	8.6%
Louisiana	1,126	49.6%	5.6%	31.0%	0.8%	12.9%
Maine	304	57.0%	3.8%	30.3%	1.8%	7.1%
Maryland	1,452	65.7%	3.8%	20.3%	1.1%	9.0%
Massachusetts	1,588	68.7%	4.1%	21.1%	0.4%	5.7%
Michigan	2,635	63.5%	3.6%	27.0%	0.6%	5.3%
Minnesota	1,319	68.5%	5.7%	18.1%	0.4%	7.3%
Mississippi	819	43.1%	4.7%	35.4%	1.1%	15.6%
Missouri	1,469	55.1%	7.0%	28.5%	0.7%	8.7%
Montana	229	53.5%	7.9%	22.5%	2.0%	14.2%
Nebraska	463	64.0%	6.0%	20.2%	1.8%	8.0%
Nevada	680	64.1%	3.5%	14.4%	1.0%	17.0%
New Hampshire	316	72.3%	3.9%	16.4%	0.7%	6.7%
New Jersey	2,250	68.1%	2.5%	16.9%	0.3%	12.2%
New Mexico	541	40.9%	2.4%	36.0%	1.6%	19.1%
New York	4,793	56.3%	3.3%	31.6%	0.4%	8.4%
North Carolina	2,314	51.9%	5.1%	27.8%	2.0%	13.2%
North Dakota	155	61.7%	7.1%	19.7%	1.9%	9.6%
Ohio	2,902	61.6%	3.7%	27.0%	0.5%	7.1%
Oklahoma	930	46.8%	4.6%	33.6%	2.8%	12.2%
Oregon	923	55.0%	7.6%	24.5%	0.5%	12.5%
Pennsylvania	2,959	62.7%	4.1%	25.6%	0.2%	7.3%
Rhode Island	259	58.6%	3.5%	30.5%	1.3%	6.0%
South Carolina	1,075	52.5%	3.9%	30.8%	2.1%	10.7%
South Dakota	203	55.3%	7.9%	25.6%	2.1%	9.1%
Tennessee	1,527	54.4%	5.0%	30.5%	2.2%	8.0%
Texas	6,846	46.7%	3.7%	27.2%	1.9%	20.5%
Utah	820	59.4%	6.1%	19.4%	1.1%	13.9%
Vermont	143	50.7%	3.3%	38.2%	1.0%	6.9%
Virginia	1,921	64.1%	3.2%	17.3%	5.8%	9.6%
Washington	1,604	59.6%	4.3%	24.8%	3.2%	8.0%
West Virginia	416	52.2%	1.0%	36.9%	1.6%	8.3%
Wisconsin	1,382	64.3%	4.5%	24.2%	1.0%	6.0%
Wyoming	128	59.3%	5.4%	22.9%	2.6%	9.8%

* Due to small sample size, all estimates for the District of Columbia are imprecise, i.e., they have large standard errors, and should be interpreted as approximations.

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with larger margins of error are not provided.

Table Endnotes

The term family as used in family income, family poverty levels, and family work status, is defined as a health insurance unit (those who are eligible as a group for "family" coverage in a health plan) throughout this report.

[a] Nonelderly includes all individuals under age 65.

[b] The 2006 federal poverty level for a family of four was $20,614, according to Census Bureau thresholds.

[c] Parent includes any person with a dependent child.

[d] Multigenerational/other families with children include families with at least three generations in a household, plus families in which adults are caring for children other than their own (e.g., a niece living with her aunt).

[e] Part-time workers were defined as working < 35 hours per week.

[f] For the first time in 2003, respondents could identify themselves in more than one racial group. Since there is no way of knowing how people who reported more than one race in 2003 previously reported their race, comparisons in health insurance coverage by race/ethnicity cannot be made with earlier years.

[g] Children includes all individuals under age 19.

[h] Approximately 1% of children live in households with no adult, three-quarters of whom are 17-18 years old.

[i] Other includes other public insurance (mostly Medicare and military-related). S-CHIP is included in Medicaid.

Data Notes

Much of the health insurance coverage information in this primer (including data in the tables) is based on a collaborative analysis of the Census Bureau's March Current Population Survey (CPS; Annual Social and Economic Supplement) by analysts at the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute. The CPS supplement is the primary source of annual health insurance coverage information in the United States.

While other ongoing national surveys may be able to more precisely determine health coverage over a specific time period, the CPS remains the most frequently cited national survey on health insurance coverage. Since the CPS began asking questions about health insurance in 1980, its design has been changed a number of times so that better estimates of the number of people with health coverage could be obtained. Despite these changes, the CPS remains the best survey for trending changes in health insurance from year to year.

This report was co-authored by Catherine Hoffman, Karyn Schwartz, and Jennifer Tolbert of the Kaiser Commission on Medicaid and the Uninsured, with Allison Cook and Aimee Williams of the Urban Institute.

Endnotes

[1] Kaiser Family Foundation and Health Research and Educational Trust. 2007. *Employer Health Benefits 2007 Annual Survey*. Available at www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf

[2] Kaiser Family Foundation and Health Research and Educational Trust. 2007.

[3] Collins S, et al. 2006. *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-being of American Families.* The Commonwealth Fund. (September).

[4] Holahan J and A Cook. 2005. *Are Immigrants Responsible for Most of the Growth of the Uninsured?* Kaiser Commission on Medicaid and the Uninsured paper (#7411; October).

[5] Davidoff AJ and G Kenney. 2005. *Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey*. Available at: http://www.urban.org/publications/411161.html

[6] KCMU analysis of 2004 MEPS data.

[7] Hadley, J. 2007. "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentinal Injury or the Onset of a Chronic Condition." JAMA 297(10):1073-84.

[8] National Center for Health Statistics, CDC. 2007. *Summary of Health Statistics for U.S. Children: NHIS, 2006.*

[9] Institute of Medicine. 2002. *Health Insurance is a Family Matter*. Washington, DC.

[10] Kasper J, T Giovannini, C Hoffman. 2000. "Gaining and Losing Health Insurance: Strengthening the Evidence for Efforts on Access to Care and Health Outcomes." *MCRR.* 57(3): 298-318.

[11] Haley and Zuckerman. 2003. *Is Lack of Coverage a Short-Term or Chronic Condition?* Kaiser Commission on Medicaid and the Uninsured report (#4120; June).

[12] Hadley J. 2003. "Sicker and Poorer – The Consequences of Being Uninsured." *MCRR*. 60(2): 3-76.

[13] Canto J et al. 2000. "Payer Status and the Utilization of Hospital Resources in Acute Myocardial Infarction". *Arch Intern Med* 160(6):817-23.

[14] Baker D et al. 2001. "Lack of Health Insurance and Decline in Overall Health in Late Middle Age". *NEJM* 345(15):1106-12.

[15] NewsHour with Jim Lehrer/Kaiser Family Foundation National Survey on the Uninsured. March 2003.

[16] Ayanian J et al. 2000. "Unmet Health Needs of Uninsured Adults in the United States". *JAMA* 284(16):2061-9.

[17] Roetzheim R et al. 2000. "Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes". *American Journal of Public Health* 90(11):1746-54.

[18] Institute of Medicine. 2002. *Care Without Coverage, Too Little, Too Late*. Washington, DC. P. 161-65.

[19] Hadley J and J Holahan. 2004. *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* Kaiser Commission on Medicaid and the Uninsured. Issue Update (# 7084; May). Hadley J and J Holahan. 2003. *Who Pays and How Much? The Cost of Caring for the Uninsured*. Kaiser Commission on Medicaid and the Uninsured (# 4088; February).

[20] Banthin JS and DM Bernard. 2007. "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger Than 65 Years, 1996 to 2003". *JAMA* 296(22):2712-19.

[21] Asplin B, et al. 2005. "Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments." *JAMA* 294(10):1248-54.

[22] Anderson G. 2007. "From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing." *Health Affairs* 26(4): 780-789.

[23] Cunningham P, J Hadley, G Kenney, A Davidoff. 2007. "Identifying Affordable Sources of Medical Care among Uninsured Persons." *Health Services Research* 42 (1p1), 265–285.

[24] Kaiser Commission on Medicaid and the Uninsured, 2005 Low-Income Coverage and Access Survey. Unpublished Data.

[25] Hadley J and J Holahan, 2004.

[26] *America's Public Hospitals and Health Systems, 2004*, National Association of Public Hospitals and Health Systems, October 2006.

[27] Rosenbaum and Shin, *Health Centers Reauthorization: An Overview of Achievements and Challenges*, Kaiser Commission on Medicaid and the Uninsured, March 2006.

[28] Hadley J, M Cravens, T Coughlin, J Holahan. 2005. *Federal Spending on the Health Care Safety Net from 2001-2004: Has Spending Kept Pace with the Growth in the Uninsured?* Kaiser Commission on Medicaid and the Uninsured (#7425; November).

[29] Hadley J and J Holahan. 2003.

[30] Cunningham PJ and JH May. 2006. *A Growing Hole in the Safety Net: Physician Charity Care Declines Again.* Center for Studying Health Systems Change Tracking Report.

[31] Holahan J and MB Pohl. 2002. "Changes in Insurance Coverage: 1994-2000 and Beyond". *Health Affairs.* Web Exclusive: April 2002.

[32] Holahan J and A Cook. 2005. "Changes in Economic Conditions and Health Insurance Coverage, 2000-2004". *Health Affairs.* W5-498-508.

[33] Holahan, J and A Cook. 2007. "What Happened to the Insurance Coverage of Children and Adults in 2006?" KCMU report (#7694; September).

[34] Kaiser Family Foundation and Health Research and Educational Trust. 2007.

[35] Clemans-Cope, L and B Garrett. *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 – 2005*. Kaiser Commission on Medicaid and the Uninsured Report, December, 2006.

[36] Clemans-Cope, L and B Garrett. 2006.

[37] Clemans-Cope, L and B Garrett. 2006.

[38] Clemans-Cope, L and B Garrett. 2006.

[39] Clemans-Cope, L and B Garrett. 2006.

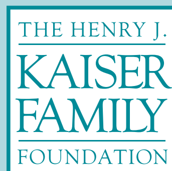
[40] Kaiser Family Foundation and Health Research and Educational Trust, 2007.

[41] Clemans-Cope, L and B Garrett. 2006.

[42] Urban Institute analysis of the 2005 Annual and Social Economic Supplements to the CPS for the Kaiser Commission on Medicaid and the Uninsured. Data has been adjusted for the Medicaid undercount.

[43] Cohen Ross D and L Cox. 2007. *Resuming the Path to Health Coverage for Children and Parents.* KCMU report (# 7608; January).

[44] *State Coverage Initiatives for Children.* Kaiser Commission on Medicaid and the Uninsured web posting. Available at http://www.kff.org/uninsured/kcmu051607oth.cfm



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