THE UNINSURED
A PRIMER

OCTOBER 2008

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

45 million people under the age of 65
had no health insurance coverage in 2007.

As job-based coverage idled, greater public insurance coverage in 2007
reduced the number of uninsured — the first decline in the
country's number of uninsured since the late 1990s.

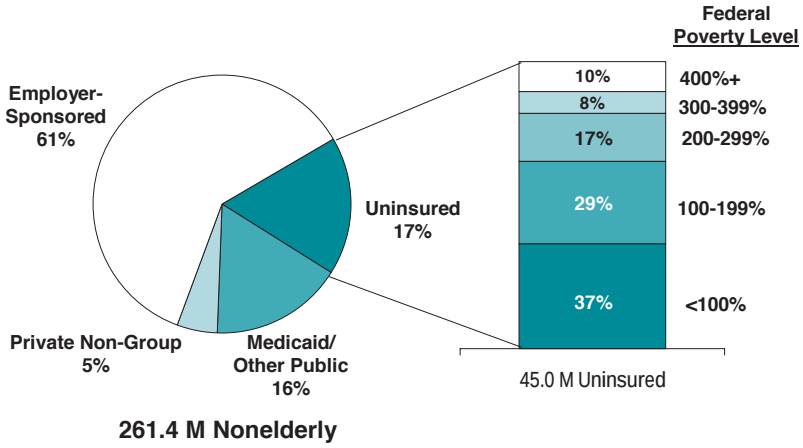
Introduction

There were 45 million people under the age of 65, including close to nine million children, who did not have health insurance in 2007. Over the past decade, the number of uninsured has increased as rates of employer-based coverage have stalled or declined. Growth in Medicaid and the State Children's Health Insurance Program (SCHIP) in many of the past ten years has helped compensate for the loss of job-based coverage. Expansions of these programs during 2007—driven by a positive fiscal outlook and more poor children to cover—largely accounted for a 1.5 million decrease in the number of uninsured. Despite the one-year decline, one in six (17%) of the nonelderly was uninsured in 2007 (Figure 1).

The gaps in our health care system affect people of all ages, races and ethnicities, and income levels; however, those with the lowest income face the greatest risk of being uninsured. Despite strong ties to the workforce—over eight in ten uninsured come from working families—about two-thirds of the uninsured are individuals and families who are poor (incomes less than the federal poverty level or $21,203 for a family of four in 2007) or near-poor (with incomes between one and two times the poverty level).

Figure 1

The Uninsured -- As a Share of the Population and by Poverty Levels, 2007



Medicaid/other public includes other public programs: SCHIP, other state programs, Medicare and military-related coverage.
The federal poverty level for a family of four in 2007 was $21,203. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Not having health insurance makes a difference in people's access to needed medical care and their financial security. The barriers the uninsured face in getting the care that they need means they are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact can also be severe. Uninsured families already struggle financially to meet basic needs, and medical bills, even for minor problems, can quickly lead to medical debt.

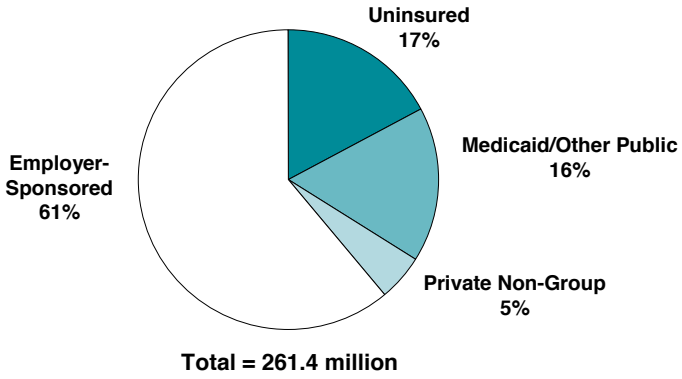
This primer presents basic information about the uninsured—who they are and why they do not have health coverage, and provides a necessary understanding of the difference health insurance makes in people's lives. Beyond this, *The Uninsured: A Primer* discusses how and why the number of uninsured has changed over time and concludes with a discussion of strategies to reduce the number of uninsured.

How Do Most Americans Obtain Health Insurance?

More than half (61%) of people in the U.S. under age 65 receive health insurance coverage as an employer benefit. 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 insurance through the Medicaid program, State Children's Health Insurance Program (SCHIP), or another state-subsidized program. The gaps in our private and public health insurance systems left 45 million nonelderly people in the U.S.—17% of those under age 65—without health coverage in 2007 (Figure 2).

Figure 2

Health Insurance Coverage of the Nonelderly Population, 2007



Medicaid/Other Public includes Medicaid, SCHIP, other state programs, Medicare and military-related coverage. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Private Health Insurance Coverage

Most, but not all, employers offer group health insurance policies to their employees and to their employees' families. About half of those insured through employer-sponsored health plans are covered by their own employer (52%) and half are covered as an employee's dependent (48%). 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. Even when businesses offer health benefits, some employees are ineligible because they are part-time employees or recent hires and others do not sign up because of difficulty affording the required employee share of the premium. Among firms that offered coverage in 2008, an average of 80% of their workers were eligible for the health benefits.[2]

Private policies directly purchased in the non-group market (i.e., outside of employer-sponsored benefits) cover only 5% of people younger than 65. The share of the nonelderly population with private non-group insurance has changed very little over time. Non-group insurance premiums vary by age and health status and can be more expensive and less comprehensive than group plans purchased by employers. Obtaining coverage in the individual market can be difficult—in 2005, nearly three in five adults who considered buying coverage had difficulty finding a plan they could afford, and one in five were denied coverage, charged a higher price based on their health status, or had a specific health condition excluded from coverage.[3]

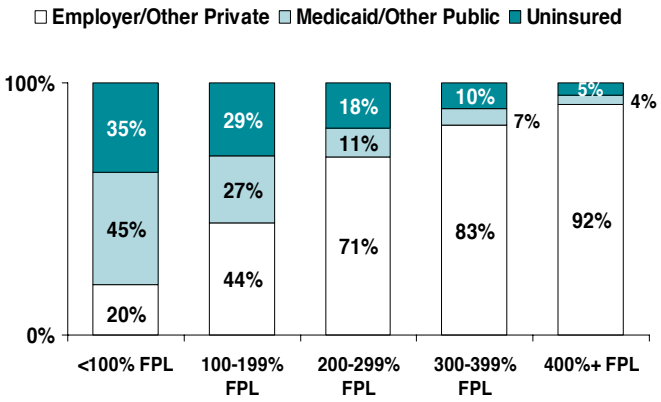
Private health insurance coverage is subsidized through the federal tax system in several ways. The most common form of private insurance subsidy is the employee tax exclusion of the health insurance premiums paid for by employers. In addition, those who are self-employed are allowed to deduct the costs of their insurance premiums from their taxes. Persons with high health care expenses (exceeding 7.5% of their adjusted gross income) can also 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 people with disabilities. Medicaid covers about 14% of the nonelderly population, making it larger than any single private health insurer. Medicaid primarily covers four main categories of nonelderly low-income individuals: children, their parents, pregnant women, and individuals with disabilities. Individuals who do not fall into one of these groups may be ineligible for public coverage regardless of their income. Although public insurance covers 45% of those below poverty ($21,203 for a family of four in 2007), the categorical nature of the Medicaid program means that 35% of those below the poverty level remain uninsured (Figure 3).

Figure 3

Health Insurance Coverage by Poverty Level, 2007



The federal poverty level (FPL) was $21,203 for a family of four in 2007. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Medicaid and the State Children's Health Insurance Program (SCHIP) cover more than one quarter of all children and just over half of low-income children. Medicaid is the largest source of health insurance for children in the U.S., enrolling 29 million children at some point in the year during 2005 (the most recent year of enrollment data available). SCHIP supplements Medicaid by covering six million children who are low or moderate income but whose family incomes are too high to qualify for Medicaid.

Medicaid provides health and long-term care coverage for 8 million nonelderly people with disabilities, including 1.3 million children (2005 estimates). Its role is more prominent for people with certain conditions, such as HIV/AIDS. However, eligibility for Medicaid for people with disabilities is limited to those with very low incomes and few assets.

Who Are the Uninsured?

In 2007, 45 million people in the U.S. under age 65 lacked health insurance. Most of these individuals come from working families and have low incomes. Adults make up more than their share of the uninsured because they are less likely than children to be eligible for Medicaid—especially young adults whose low incomes make it more it difficult to afford coverage.

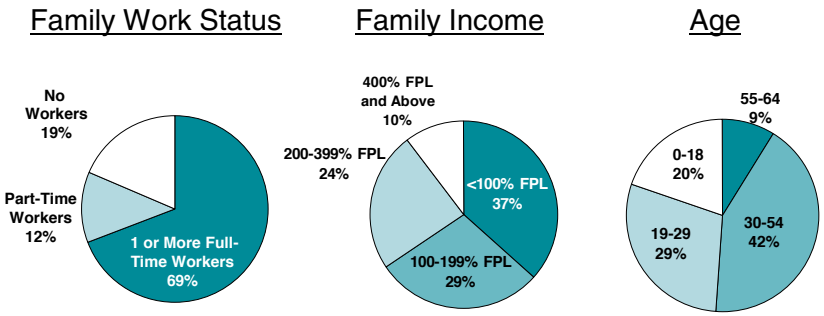
More than eight in ten of the uninsured are in working families—about 70% are from families with one or more full-time workers and 12% are from families with part-time workers. Only 19% of the uninsured are from families that have no connection to the workforce (Figure 4). Even at lower income levels, the majority of the uninsured are in working families. Among the uninsured who are below poverty ($21,203 for a family of four in 2007), 54% have at least one worker in the family.

About two-thirds of the uninsured are poor or near poor (Figure 4). These individuals are less likely to be offered employer-sponsored coverage or to be able to afford to purchase their own coverage. Those who are poor (below 100% of the poverty level) are about twice as likely to be uninsured as the entire nonelderly population (35% vs.17%). 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 (29%), in part, because they are less likely to be eligible for Medicaid. Only 10% of the uninsured are from families at or above 400% of poverty.

Adults are more likely to be uninsured than children. Adults make up 70% of the nonelderly population, but 80% of the uninsured (Figure 4). Most low-income children qualify for Medicaid or SCHIP, but low-income adults under age 65 typically 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 4

Characteristics of the Uninsured, 2007



Total = 45.0 million uninsured

The federal poverty level was $21,203 for a family of four in 2007.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

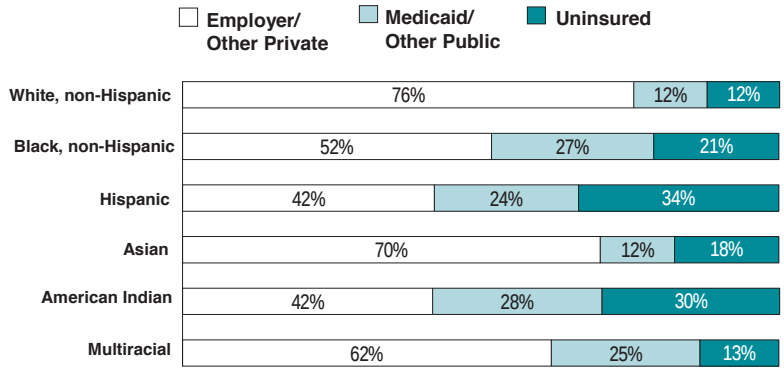
Young adults, ages 19 to 29, comprise a disproportionately large share of the uninsured, mostly because of their low incomes. Young adults have the highest uninsured rate (30%) of any age group. More than half of uninsured young adults are full-time workers, but their low incomes make it more difficult for them to afford coverage.[4] The median income of uninsured young adults in 2007 was $15,600.

More than half (63%) of nonelderly uninsured adults have no education beyond high school, making them less able to get higher-skilled jobs that are more likely to provide health coverage. Those with less education are also more likely to be uninsured for longer periods of time.[5]

Minorities are much more likely to be uninsured than whites. About one third of Hispanics and Native Americans are uninsured compared to 12% of whites. The uninsured rate among African-Americans (21%) is also much higher than that of whites (Figure 5). 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 5

Insurance Coverage of Nonelderly, by Race/Ethnicity, 2007



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 2008 ASEC Supplement to the CPS.

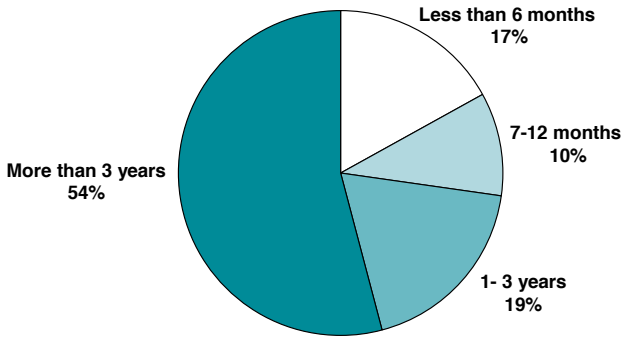
The large majority of the uninsured (79%) are native or naturalized U.S. citizens. However, non-citizens are about three times more likely to be uninsured than citizens. Non-citizens have less access to employer coverage because they are more likely to have low-wage jobs and work for firms that do not offer coverage. At the same time, they are often restricted from public coverage.

The uninsured tend to be in worse health than the privately insured. Ten 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.[6] Those with such conditions and others who are not in good health and who do not have access to employer-sponsored coverage may find non-group coverage to be unavailable or unaffordable.

About three-quarters of the uninsured (73%) have gone without coverage for more than one year (Figure 6). Because health insurance is primarily obtained as an employment benefit, health coverage is disrupted when people change jobs. When people are unable to obtain employer-sponsored coverage and are ineligible for Medicaid, they may be left uninsured for long periods of time if individual coverage is either unaffordable or unavailable due to their health status.

Figure 6

Duration of Time Without Coverage Among the Nonelderly Uninsured, 2006



More than three years includes those who said they never had health insurance. Percentages are age adjusted.
SOURCE: *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2006.* 2008.

How Does Lack of Insurance Affect Access to Health Care?

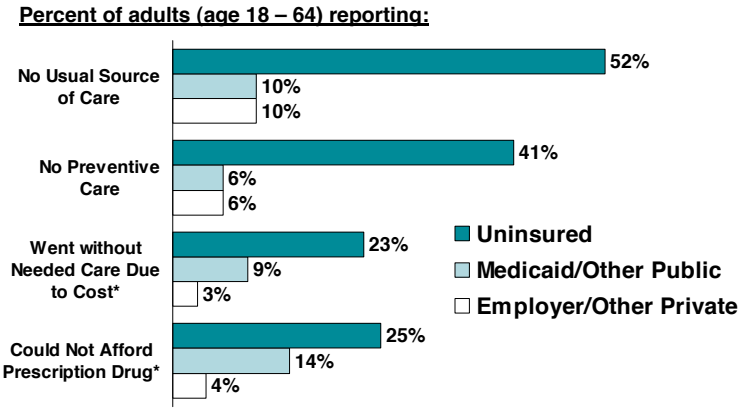
Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. Uninsured adults are far more likely than the insured to postpone or forgo health care altogether. The consequences of this can be severe, particularly when preventable conditions go undetected.

The uninsured are far more likely than those with insurance to report problems getting needed medical care. Nearly one-quarter of uninsured adults say that they have forgone care in the past year because of its cost—compared to 3% of adults with private coverage. Part of the reason for this is that slightly more than half of uninsured adults do not have a regular place to go when they are sick or need medical advice (Figure 7).

Anticipating high medical bills, many of the uninsured are not able to follow recommended treatments. A quarter of uninsured adults say they did not fill a drug prescription in the past year because they could not afford it. Regardless of a person's insurance coverage, those injured or newly diagnosed with a chronic condition receive similar follow-up care plans, however the uninsured are less likely than the insured to actually obtain all the services that are recommended.[7]

Figure 7

Barriers to Health Care Among Nonelderly Adults, by Insurance Status, 2007

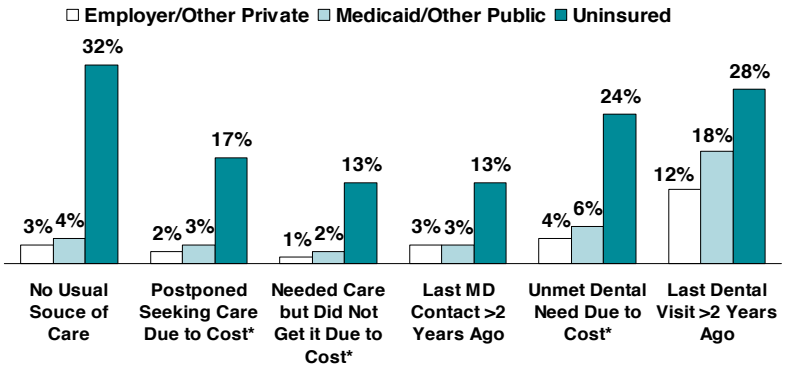


* In past 12 months.
Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.
SOURCE: KCMU analysis of 2007 NHIS data.

Problems getting needed care also exist among 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 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.[8]

Figure 8

Children's Access to Care, by Health Insurance Status, 2007



* In past 12 months
Questions about dental care were analyzed for children age 2-17. All other questions were analyzed for all children under age 18. MD contact includes other health professionals. 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 2007 NHIS data.

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 more likely than those with continuous health coverage to report having an unmet need for medical care or a prescription drug in the past year.[9]

Access to health care has eroded over time for many. The uninsured have been the hardest hit as rising health care costs have made health care less affordable. On top of this, more of the uninsured are also having problems accessing basic primary care services. Between 1997 and 2006 the differences in access to care between the uninsured and insured widened, even among those with chronic conditions. The disparities in access to a usual source of care, annual check-ups, and preventive health care are the greatest and grew the most over the decade.[10,11]

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, the uninsured 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 less likely to receive timely preventive care. Uninsured nonelderly adults are far less likely to have had preventive care such as pap smears, mammograms, and prostate exams compared to insured 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 at least 25%. The number of excess deaths attributed to being uninsured among adults age 25-64 in 2006 has been estimated to be between 22,000 and 27,000.[18] The economic loss to the U.S. economy in that year due to the poorer health and shorter life spans of the uninsured may have been as high as $200 billion.[19]

How Does Lack of Insurance Affect Family Finances?

For many of the uninsured, the costs of health insurance and medical care are weighed against equally essential needs. The uninsured are about 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.[20] When the uninsured do receive health care, they may be charged for the full cost of that care, which can strain family finances and lead to medical debt.

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.[21] Slightly less than half of the uninsured know of a provider in their community who charges less to patients without insurance.[22] Only about one quarter of low-income uninsured adults (those with incomes under twice the poverty level) report that they have received care for free or at reduced rates in the past year.[23]

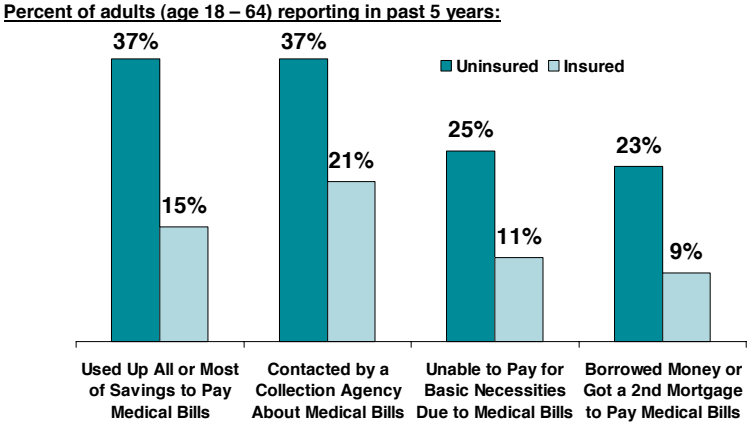
The uninsured are increasingly paying "up front" before services will be rendered. When the uninsured are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or can be turned away.[24]

Most of the uninsured have few, if any, savings and assets they can easily use to pay health care costs. Half of uninsured households had $600 or less in total assets (not including their house and cars) in 2004, compared to median assets of $5,500 for insured households.[25] Moreover, after households' debts are subtracted from assets, the median net worth of uninsured households drops to zero—leaving many of the uninsured with no financial reserves to pay unexpected medical bills.

Having health insurance makes a difference in the toll medical bills take on a person's finances. Uninsured adults are more than twice as likely as the insured to have used up all or most of their savings to pay medical bills (Figure 9). One-quarter of uninsured adults report that at some point in the past five years they spent less on basic needs, such as food and housing in order to pay medical bills.

Figure 9

Financial Consequences of Medical Bills, by Insurance Status, 2008



SOURCE: Kaiser Family Foundation, 2008 "Economic Problems Facing Families," (#7773 April).

Unprotected from medical costs, the uninsured are at risk of being unable to pay off medical debt. 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. More than one-third (37%) of uninsured adults report that a collection agency has contacted them about unpaid medical bills in the past five years.

The uninsured pay for more than a third (35%) of their health care costs out-of-pocket.[26] When the uninsured pay for their own care, it can lead to high medical bills. In 2004, 14% of the uninsured spent more than 10% of their family income on out-of-pocket health care costs.[27]

How Is Uncompensated Care Financed?

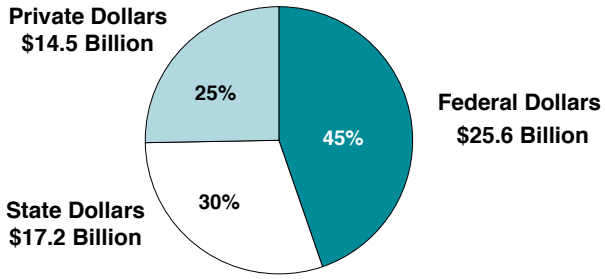
When the uninsured are unable to pay for the health care they receive, that uncompensated care is paid for through a patchwork of federal, state, and private funds. The bulk of such care is funded by the government and is crucial to the strength of the nation's safety-net hospitals and clinics.

The uninsured spend less than half of what the insured spend on health care. In 2008, the average person who is uninsured for a full-year will incur $1,686 in total health care costs compared to $4,463 for the nonelderly with coverage.[28] The uninsured will pay for about a third of this care out of pocket themselves, totaling $30 billion in 2008. This includes the health care costs for those uninsured all year and the costs incurred during the months the part-year uninsured have no health coverage.[29]

The remaining costs of their care, the uncompensated costs, will amount to about $57 billion in 2008. About 75% of this total ($42.9 billion) will be paid by federal, state, and local funds appropriated for care of the uninsured. Nearly half of all funds for uncompensated care come from the federal government, with the majority of federal dollars flowing through Medicare and Medicaid (Figure 10). While substantial, these government dollars will amount to a small slice (2%) of total health care spending in the U.S. this year.

Figure 10

Payment Sources for Uncompensated Care, 2008



Total = $57.4 billion

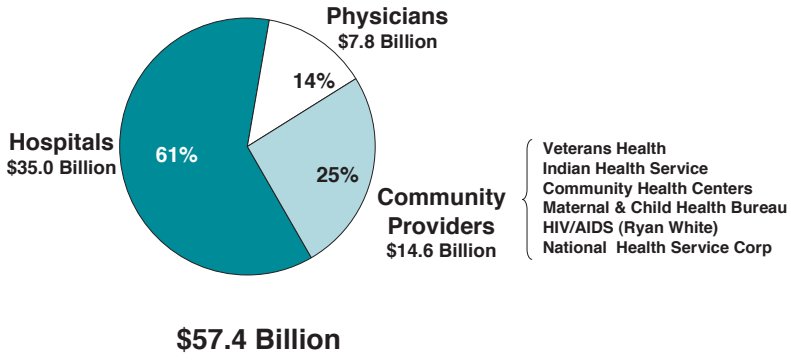
SOURCE: Hadley J. et al. 2008. "Covering the Uninsured In 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs Web-Exclusive*, Aug 25, 2008.

Hospitals, community clinics, and physicians provide care to the uninsured. While physicians and community clinics see more uninsured patients, 60% of uncompensated care is provided in hospitals because medical needs requiring hospitalization are the most expensive (Figure 11).[30] Most government dollars for uncompensated care are paid to hospitals based indirectly on the share of uncompensated care they may provide.

Uncompensated care costs for direct service programs, such as the Veterans Affairs health system and community health centers, are funded largely by public dollars. Community health centers and public hospitals also rely heavily on the Medicaid program as their largest source of third-party insurance payments. Over one-third of all revenues in Federally Qualified Health Centers and public hospitals are paid by Medicaid, evidence of the large share of low-income patients they serve.[31]

Figure 11

Funding Available to Providers for Uncompensated Care, 2008

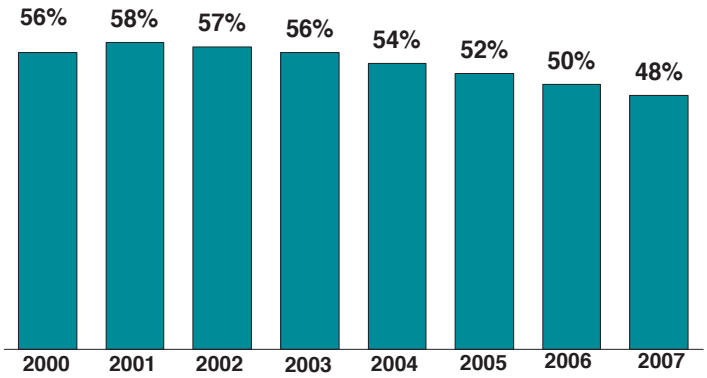


SOURCE: Hadley J. et al. 2008. "Covering the Uninsured In 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs Web-Exclusive*, Aug 25, 2008.

In recent years federal funding for community health centers has been increasing, however it has not kept pace with the growing numbers of uninsured and the costs of caring for them.[32] Federal dollars cover a good share of the costs of caring for uninsured patients in health centers, but that share has declined between 2000 and 2007 from 56% to 48% (Figure 12). Less than $1 billion out of $26 billion of federal spending for uncompensated care will go to community health centers this year.[33]

Figure 12

Community Health Centers: Federal Grants as a Percent of Uninsured Patient Costs, 2000-2007



SOURCE: National Association of Community Health Centers. "Health Center and the Uninsured: Improving Health and Access to Care". Fact Sheet, August 2008.

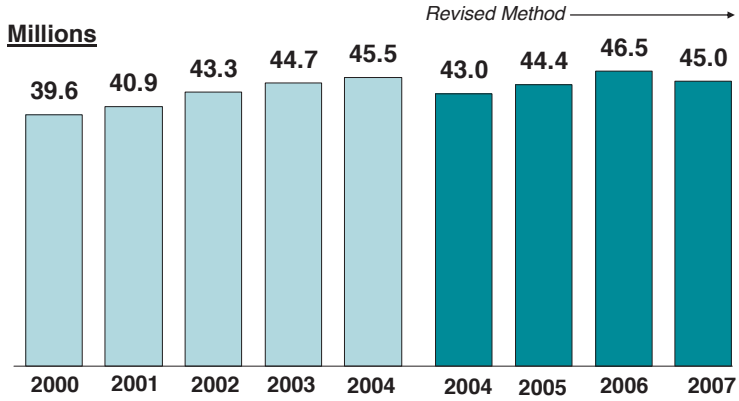
The cost of uncompensated care provided by physicians is not directly or indirectly reimbursed by public dollars.[34] Financial pressures and time constraints, coupled with changing physician practice patterns, have contributed to a decline in charity care provided by physicians. The percent of all doctors who provide charity care fell to 68% in 2004-2005 from 76% in 1996-1997.[35]

How and Why Has the Number of Uninsured Changed?

Since 2000 the number of nonelderly uninsured has grown by one to two million a year—with the only decline in the number of uninsured occurring in 2007 (Figure 13). This is likely to be short-lived however, given the weakened economy and rising unemployment in 2008.

Figure 13

Number of Nonelderly Uninsured Americans, 2000-2007



The Census Bureau periodically revises its CPS methods, which means data before and after the revision are not comparable. Comparison across years can be made from 2000 through 2004, and revised estimates for 2004 through 2007.
SOURCE: KCMU/Urban Institute analysis of CPS Supplements for each year.

Trends in Health Coverage, 2000-2004

The brief 2001 recession triggered a prolonged downturn in job-based health coverage. The share of nonelderly Americans with employer-sponsored health insurance decreased for the first time since 1993, dropping from 66% in 2000 to 61% by 2004. As the economy began to stall in 2001, both employment and incomes shifted. By 2004, more workers were either self-employed or were working in small firms (< 25 workers) in the kinds of jobs that are less likely to offer health benefits. Incomes shifted downward so that a greater share of Americans came from low-income families, where uninsured rates are the highest.

Enrollment in both Medicaid and SCHIP increased between 2000 and 2004 in response to greater numbers who qualified, improved program outreach efforts, and streamlined enrollment systems in some states. Declines in employer-sponsored insurance among children over this period were fully offset by increases in Medicaid and SCHIP enrollment. Public coverage had also increased among adults between 2000 and 2004, but with Medicaid's limits on adult eligibility, it was not enough to buffer the loss of job-based coverage.

Adults accounted for all of the growth in the number of uninsured over these years—increasing by 6.3 million. The number of uninsured children did not grow and the risk of children being uninsured actually decreased slightly between 2000 and 2004.[36]

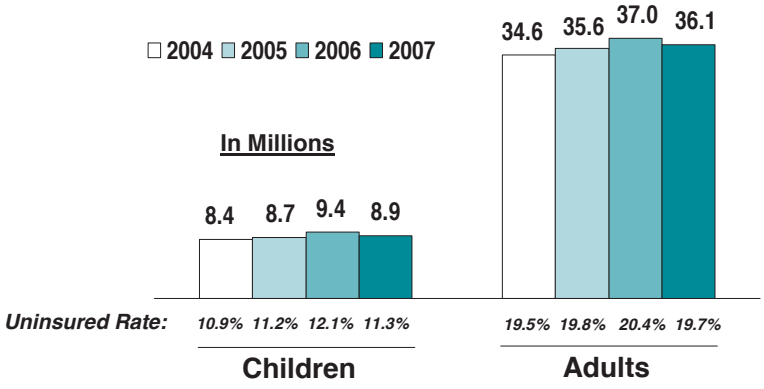
Trends in Health Coverage, 2005-2007

Even as the economy rebounded and with family incomes increasing, the share of the nonelderly population with job-based coverage continued to fall between 2005 and 2006; leveling off by 2007. This began to affect those with higher incomes as well.

Public insurance programs were able to fill in some, but not all of the gaps in private health coverage. In 2005 and 2006, as the economy and employment opportunities improved, enrollment in Medicaid and SCHIP stabilized. However, the number of uninsured continued to climb—by 3.5 million over two years, totaling 46.5 million nonelderly—because of continued declines in employer-based coverage. The majority of the growth in the number of uninsured still occurred among those with low incomes. Children were no longer shielded from the loss of employer-sponsored insurance and for the first time since 2000 the annual growth in the uninsured included children (Figure 14).

Figure 14

Uninsured Children vs. Nonelderly Adults
Numbers and Rates, 2004-2007



SOURCE: KCMU/Urban Institute analysis of ASEC Supplements to the CPS for these years.

By 2007, many states had budget surpluses and began expanding their Medicaid and SCHIP programs to reach more of the uninsured. As the poverty rate among children continued to grow, the share of children with Medicaid/SCHIP coverage increased to almost 28% in 2007. Public coverage among nonelderly adults also grew last year. Rates of both Medicare coverage (among low-income adults)) and military-related coverage among higher income adults (VA health care and TRICARE for military dependents and retirees) increased.

The combined effect of greater public program coverage in 2007 among both children and adults decreased the number of nonelderly uninsured by 1.5 million—the first decrease the country has experienced since the late 1990s. Children disproportionately gained coverage, making up nearly 40% of the decrease in the number of uninsured.

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

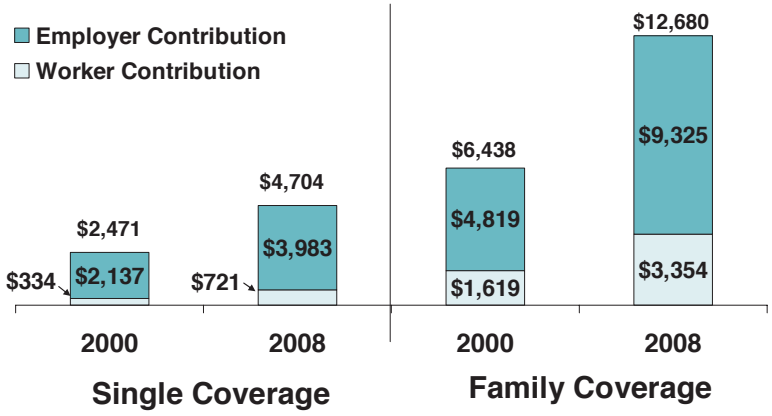
Employer-sponsored health insurance covered 159 million Americans—(61%) of the nonelderly population in 2007. Yet, 37 million people from working families were uninsured in 2007 because not all businesses offer health benefits, not all workers qualify for coverage, and many employees cannot afford their 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 and the economy. In the late 1990s, health insurance premiums were growing slowly and the economy was strong. Those trends contributed to a slight increase in the percent of the U.S. population covered by employer-sponsored insurance. However, an economic downturn in early 2001, coupled with the return of double-digit inflation in health insurance premiums, decreased employer-sponsored coverage. In recent years, the growth rate of health insurance premiums has slowed, but the percentage of people with employer-sponsored coverage has not increased.

In 2008, annual employer-sponsored group premiums averaged $4,704 for individual coverage and $12,680 for family coverage. Total family premiums have doubled since 2000. The employee's share of a family premium has also doubled since 2000, averaging $3,354 in 2008 (Figure 15).[37]

Figure 15

Average Annual Premium Costs for Covered Workers, 2000 and 2008

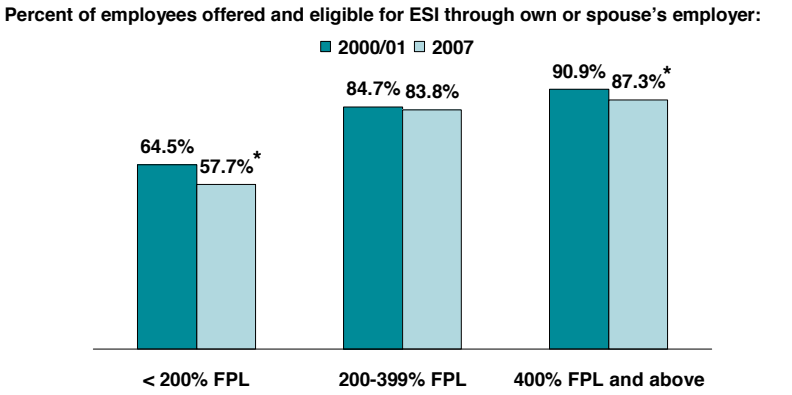


Family coverage is defined as health coverage for a family of four.
SOURCE: Kaiser/HRET Employer Health Benefits Survey, 2008.

From 2000 to 2007, there were declines in both the percentage of employees offered employer-sponsored insurance and the percentage of those offered coverage who chose to enroll. Both of these trends were most pronounced among workers in low-income families (families below 200% of poverty or $42,406 for a family of four). In 2007, 58% of all low-income employees were offered and eligible for employer-sponsored coverage, leaving more than four in ten without access to this coverage (Figure 16).

Figure 16

Changes in the Percent of Employees Offered Employer-Sponsored Coverage, 2000-2007



* Change from previous period is statistically significant (p<0.05)
In 2007 200% of the federal poverty level was $42,406 for a family of four; 400% of the poverty level for a family of four was $84,812.
SOURCE: Cunningham P, "The Fraying Link Between Work and Health Insurance: Trends in Employer-Sponsored Insurance for Employees, 2000-2007," KCMU report, forthcoming.

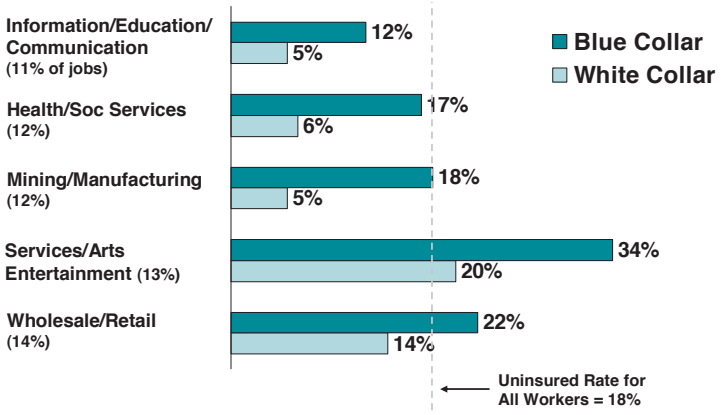
The majority of employees in low-income families participate in their employer's health plan when they are offered coverage. Despite having lower incomes and thus typically fewer resources to pay for necessities, 62% of low-income employees who are eligible for employer-sponsored coverage choose to enroll. Participation rates are higher (84%) for those with family incomes above 400% of poverty.[38] Low-wage workers may have lower participation rates because they often work in firms where employees are required to pay a larger share of the premium. Among businesses offering health benefits in 2008, employees in lower-wage firms paid 34% of the premium costs for family coverage compared to 26% paid by employees in higher-wage firms.[39]

Small firms are much less likely to offer coverage than large firms. Nearly all businesses (99%) with at least 200 workers offered health benefits to their workers in 2008, but only 62% of firms with fewer than 200 workers offered these benefits.[40] On average, small firms ask employees to contribute a smaller amount towards their own health benefits compared to large firms ($624 vs. $769 per year). However, small firms ask for much larger annual contributions for family coverage ($4,101 vs. $2,982).

Health coverage varies both by industry and by type of occupation. Across industries, uninsured rates for workers range from 36% in agriculture to just 4% 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 often two-fold or greater (Figure 17). Over 80% of uninsured workers are in blue-collar jobs.

Figure 17

Uninsured Rates Among Selected Industry Groups, White vs. Blue Collar Jobs, 2007



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 2008 ASEC Supplement to the CPS.

When unemployment rises, it generally results in an increase in the uninsured rate. A recent study estimated that a one percent increase in the unemployment rate in 2008 would result in 1.1 million more people without health insurance.[41] Virtually all of this increase would occur among adults, since children who lose employer coverage would typically be eligible for Medicaid or SCHIP.

What is Medicaid's Role?

Medicaid is the nation's major public health insurance program for low-income Americans, covering 59 million low-income children, families, seniors and people with disabilities. Over the past decade, growth in Medicaid enrollment has helped to buffer against losses of job-based coverage, preventing larger increases in the number of uninsured from occurring. More recently, as states have sought to reduce the number of uninsured, they have used Medicaid as the foundation for broader coverage expansions.

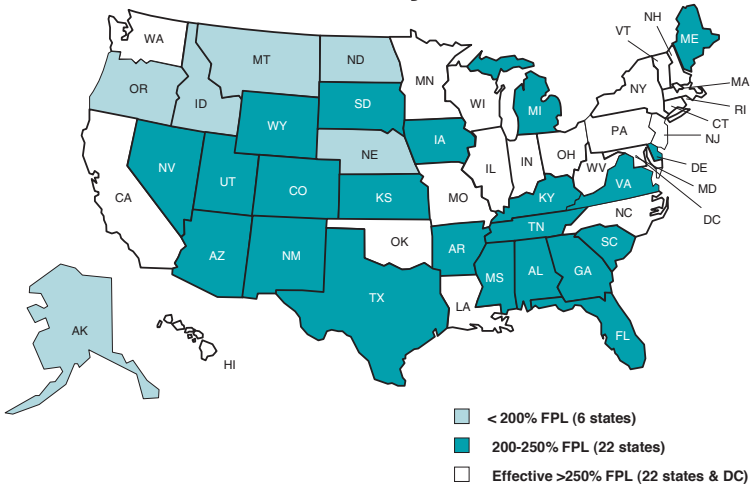
Medicaid is a federal-state partnership providing coverage based on income levels and eligibility categories. Medicaid covers four main groups of nonelderly, low-income people: children, their parents, pregnant women, and people with disabilities—with the program playing its broadest role among children. However, Medicaid's combination of federal rules and state options for coverage has created different eligibility rules for different groups across the country.

Medicaid beneficiaries are much poorer and in markedly worse health than the privately insured population. Compared to the low-income privately insured, Medicaid beneficiaries are more likely to have incomes below the poverty line, to have health conditions that limit work, and to be in fair or poor health. Importantly, without Medicaid most beneficiaries would be uninsured.

SCHIP works as a complement to Medicaid by covering low-income children not eligible for Medicaid. SCHIP was created in 1997 to expand coverage to children, particularly low-income children. Together Medicaid and SCHIP aim to cover nearly all uninsured low-income children. Most states cover children up to or above 200% of the poverty level through Medicaid or SCHIP (Figure 18).[42]

Figure 18

Children's Eligibility for Medicaid/SCHIP by Income, January 2008



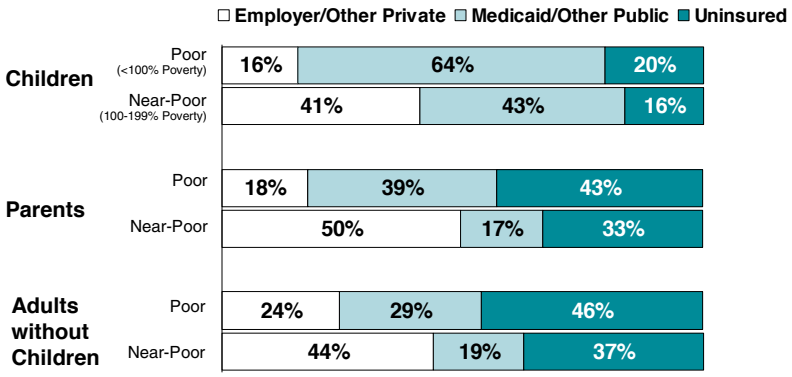
*Eligibility levels have been authorized, but not necessarily implemented.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

Medicaid and SCHIP cover half of all low-income children. These programs have played a critical role in improving access to care for children. Still, two-thirds of uninsured children are eligible for Medicaid or SCHIP but are not enrolled.[43] 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 keeping their children in public programs, including rules that require U.S. citizens to document their citizenship and identity when applying for Medicaid or renewing their coverage.

In contrast to coverage for children, the role of Medicaid for nonelderly adults is more limited. Medicaid covers nearly two-thirds of poor children and about half of all low-income children. However, eligibility for adults is more restricted. Medicaid covers some parents and low-income individuals with disabilities, but most adults without dependent children—regardless of how poor—are ineligible for Medicaid. As a result, over 40% of poor parents and adults without children are uninsured (Figure 19).

Figure 19

Health Insurance Coverage of Low-Income Adults and Children, 2007

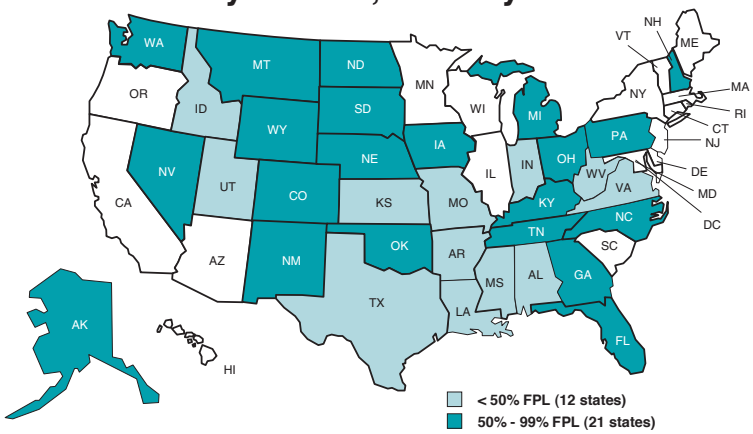


Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Some states have expanded Medicaid eligibility to cover more poor and near poor parents. Over one-third (35%) 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 20). 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 29 states in 2007.[44]

Figure 20

Medicaid Eligibility for Working Parents by Income, January 2008



US Median Eligibility = 63% FPL: $10,849 per year

*Eligibility levels have been authorized by state legislatures, but not necessarily implemented.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

In recent years, states have used their Medicaid and SCHIP programs as a foundation for broader health care coverage expansions. Seventeen states and the District of Columbia have obtained waivers of federal requirements to expand coverage to childless adults through their Medicaid programs.[45] These programs, along with coverage expansions for low-income children and families, are a key component of state strategies to address the problem of the uninsured. States have built on public programs to take advantage of the existing delivery and administrative systems as well as federal matching funds to help finance the expansions.

Increases in Medicaid and SCHIP coverage in 2007 largely explain the decline in the number of nonelderly uninsured that year. Bolstered by a strong fiscal outlook in 2007, 26 states authorized or adopted eligibility expansions in Medicaid and SCHIP for low-income children, pregnant women, and parents. Three-quarters of these expansions (20 states) were for children. Combined, these efforts contributed to the 1.5 million decrease in the number of uninsured.

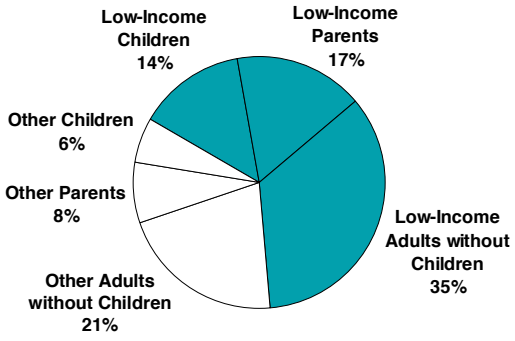
As the economy worsens, enrollment in Medicaid is expected to increase. The Medicaid program is designed as a health coverage safety net, and as such, enrollment in the program increases during economic downturns when people lose their jobs and, therefore, their access to employer-sponsored health insurance. State Medicaid Directors are projecting Medicaid enrollment to increase by 3.6% in FY 2009.[46] Unlike the Medicaid expansions in 2007, this enrollment growth will occur at a time when most states are facing budget shortfalls and will have difficulties financing such increases.

What Can Be Done to Decrease the Number of Uninsured?

Public interest in addressing the problem of the uninsured has risen in recent years, sparking the first major national discussion on the issue in over a decade. While many agree on the need to reduce the number of uninsured, there is little accord on how to achieve this goal. The strategies being discussed reflect different views over how the health care system should be organized and health insurance coverage provided. Some would build on the existing system of private and public coverage while others would revise the tax code to change the sponsorship and financing of health coverage. Despite these differences, most proposals seeking to achieve broader coverage subsidize the cost of coverage for the lowest income groups, given that two-thirds of the uninsured are low-income (Figure 21).

Figure 21

The Nonelderly Uninsured, by Age and Income Groups, 2007



Total = 45.0 million uninsured

Low-income includes those with family incomes less than 200% of the federal poverty level. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Options for Covering the Uninsured

Building on the Current System

One approach to addressing the problem of the uninsured is to build on and strengthen the current mechanisms for providing individuals and families with coverage, including employer-based coverage and public insurance programs. This approach would also create new avenues to coverage by redesigning existing markets for obtaining coverage outside the employer system.

Increase the availability of employer-based health coverage. Currently in the U.S., three-fifths of the nonelderly obtain health insurance through an employer and one approach to expanding coverage would build on this employer-based system. Proposals aimed at increasing coverage through the workplace combine requirements for large employers to offer coverage with incentives for small employers to voluntarily offer health benefits.

Employer mandates usually take the form of "play or pay" proposals, which require employers either to provide health coverage or pay into a pool to help finance the cost of coverage for their employees.

Recognizing the potential economic burden of these mandates on some employers, incentives in the form of tax credits or premium subsidies have been proposed for small employers to encourage them to provide coverage to their employees.

Expand public coverage by building on Medicaid and SCHIP. The Medicaid and SCHIP programs provide an important health coverage safety net for those most at risk of being uninsured—low-income families and people with disabilities. As such, they can provide a foundation for expanding coverage, particularly to low and modest income individuals and families. Some proposals would expand Medicaid eligibility to all poor adults. Others would also expand SCHIP to cover children with family incomes up to 300% of the federal poverty level.

Create new group insurance options for individuals and businesses. For those without access to employer-based coverage and who are not eligible for public programs, some proposals would create new national or regional purchasing pools, modeled after the Federal Employee Health Benefits Program and offering a range of health plan options that could be purchased by individuals or by businesses for their employees. Premium subsidies based on income would be available to ensure that coverage is affordable, even for those with low incomes.

Changing the Tax System

Our current system promotes employer-based coverage by not counting the value of the health care benefits as taxable income for the employee; however, this same tax benefit is not available to those who purchase insurance on their own. Another option for expanding coverage is to change the tax code to alter the incentives for purchasing coverage.

Change the sponsorship and financing of health coverage through the tax system. 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. Restructuring the tax code to eliminate the tax preference for employer-based coverage provides an alternative to employment-linked coverage. Some proposals would replace the current tax exclusion for employer-based insurance with a refundable tax credit for individuals and families, thus eliminating the primary incentive for purchasing insurance through an employer. Individuals could obtain coverage through an employer if offered, but would be encouraged to purchase health insurance on their own through the individual insurance market.

Adopting a Single-Payer System

To fully address the inefficiencies and gaps in the current system, some argue that it is necessary to fundamentally change the way we finance and provide health care coverage. A third approach would replace the current system with one in which the government finances coverage through income and other taxes. One proposal would create a new national insurance plan, modeled on Medicare, that would contract directly with private providers and possibly insurance companies to provide services to beneficiaries. Another proposal would create a new government financed health care system in which individuals purchase insurance on their own through state or regional purchasing pools.

The Future of Health Care Reform

Reflecting the public's interest in health care this election season, the two major party candidates have proposed broad reform plans. The goals of the plans and the approaches to expanding coverage differ in key ways that are likely to be fundamental for policymakers' choices in any future health reform discussions. Senator Obama favors an approach that aims to achieve near-universal coverage by building on the existing employer-based system, expanding public programs, and providing new coverage options through the creation of a National Health Insurance Exchange. Senator McCain favors a plan that would emphasize strategies to control rising health care costs and replace the existing tax preference for employer-based coverage with a refundable tax credit as a way to give individuals more choice over their health plan and help to expand coverage.

The national debate is built on the experiences of a number of states that have taken action. In 2006, Massachusetts became the first state to enact a near-universal health care reform plan. Within 18 months of enactment, nearly 440,000 people had gained coverage, cutting the state's uninsured rate in half. Many other states expanded coverage, mainly through Medicaid and SCHIP expansions. With the economic downturn beginning in late 2007, the ability of states to invest in broad coverage expansions diminished and the need to reign in rising health care costs became a higher priority with several states enacting reform plans focusing primarily on constraining health care costs and improving quality.

Although the prospects for health care reform at the national level remain uncertain, the debate over the past year has refocused attention on the problem of the uninsured and why addressing this problem should be a public priority. It has also highlighted the importance of maintaining the coverage gains realized over the past years, especially in the face of a worsening economic situation. Many challenges must be overcome before the enactment of major health care legislation can become a reality. If any plan emerges, it will likely reflect a consensus approach incorporating different aspects of the major strategies being discussed.

Tables

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

Table 1
Characteristics of the Nonelderly Uninsured, 2007

	Nonelderly (millions)	Percent of Nonelderly	Uninsured Nonelderly (millions)	Percent of Uninsured Nonelderly	Uninsured Rate for Nonelderly
Total - Nonelderly[a]	**261.4**	**100.0%**	**45.0**	**100.0%**	**17.2%**
Age					
Children - Total	**78.6**	**30.1%**	**8.9**	**19.7%**	**11.3%**
Adults - Total	**182.8**	**69.9%**	**36.1**	**80.3%**	**19.7%**
Adults 19-24	24.0	9.2%	7.3	16.2%	30.3%
Adults 25-34	39.8	15.2%	10.3	23.0%	26.0%
Adults 35-44	41.9	16.0%	7.7	17.2%	18.4%
Adults 45-54	43.8	16.8%	6.8	15.1%	15.4%
Adults 55-64	33.3	12.7%	4.0	8.9%	12.0%
Annual Family Income					
<$20,000	58.1	22.2%	21.0	46.6%	36.1%
$20,000 - $39,999	52.5	20.1%	13.2	29.4%	25.2%
$40,000 +	150.8	57.7%	10.8	24.0%	7.2%
Family Poverty Level[b]					
<100%	**46.4**	**17.8%**	**16.4**	**36.5%**	**35.4%**
100-199%	**44.6**	**17.1%**	**13.0**	**28.8%**	**29.0%**
...100-149%	23.0	8.8%	7.3	16.2%	31.6%
...150-199%	21.6	8.3%	5.7	12.7%	26.4%
200-399%	**75.2**	**28.8%**	**10.9**	**24.3%**	**14.5%**
...200-299%	41.1	15.7%	7.4	16.5%	18.1%
...300-399%	34.1	13.0%	3.5	7.8%	10.3%
400%+	**95.2**	**36.4%**	**4.7**	**10.3%**	**4.9%**
Household Type					
Single Adults Living Alone	20.3	7.8%	3.9	8.7%	19.3%
Single Adults Living Together	30.7	11.7%	10.3	23.0%	33.7%
Married Adults	54.6	20.9%	7.3	16.3%	13.4%
1 Parent with children[c]	32.8	12.5%	6.2	13.8%	19.0%
2 Parents with children[c]	109.4	41.9%	13.3	29.5%	12.1%
Multigenerational/Other with children[d]	13.7	5.2%	3.9	8.7%	28.6%
Family Work Status					
2 Full-time	72.9	27.9%	5.5	12.2%	7.5%
1 Full-time	139.6	53.4%	25.6	56.9%	18.3%
Only Part-time[e]	18.6	7.1%	5.5	12.2%	29.4%
Non-Workers	30.2	11.6%	8.4	18.7%	27.8%
Race/Ethnicity					
White only (non-Hispanic)	166.7	63.8%	20.3	45.1%	12.2%
Black only (non-Hispanic)	33.2	12.7%	6.9	15.4%	20.9%
Hispanic	43.4	16.6%	14.6	32.4%	33.5%
Asian/S. Pacific Islander	12.3	4.7%	2.2	4.8%	17.5%
Am. Indian/Alaska Native	1.7	0.6%	0.5	1.1%	29.7%
Two or More Races	4.1	1.6%	0.5	1.2%	13.2%
Citizenship					
U.S. citizen - native	228.6	87.4%	32.9	73.2%	14.4%
U.S. citizen - naturalized	11.9	4.6%	2.6	5.7%	21.5%
Non-U.S. citizen, resident for < 5 years	4.8	1.8%	2.2	5.0%	47.2%
Non-U.S. citizen, resident for 5+ years	16.2	6.2%	7.2	16.1%	44.7%
Health Status					
Excellent/Very Good	181.7	69.5%	27.1	60.2%	14.9%
Good	57.8	22.1%	13.2	29.4%	22.9%
Fair/Poor	21.9	8.4%	4.6	10.3%	21.2%

Confidence intervals and standard errors were calculated only for uninsured rates. ( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 2
Characteristics of Uninsured Children, 2007

	Children (millions)	Percent of Children	Uninsured Children (millions)	Percent of Uninsured Children	Uninsured Rate for Children
Total - Children[f]	**78.6**	**100.0%**	**8.9**	**100.0%**	**11.3%**
Age					
<1	4.3	5.4%	0.6	6.2%	12.9%
1-5	20.7	26.3%	2.1	23.3%	10.0%
6-18	53.7	68.3%	6.3	70.5%	11.6%
Family Income					
<$20,000	17.7	22.5%	3.6	40.6%	20.3%
$20,000 - $39,999	14.8	18.8%	2.5	28.5%	17.1%
$40,000 +	46.2	58.7%	2.7	30.9%	5.9%
Family Poverty Level[b]					
<100%	**18.2**	**23.2%**	**3.7**	**41.9%**	**20.4%**
100-199%	**15.4**	**19.5%**	**2.5**	**28.2%**	**16.3%**
...100-149%	8.1	10.3%	1.4	15.6%	17.1%
...150-199%	7.2	9.2%	1.1	12.6%	15.4%
200-399%	**22.8**	**29.0%**	**1.9**	**21.4%**	**8.3%**
...200-299%	12.8	16.3%	1.3	14.9%	10.3%
...300-399%	10.0	12.7%	0.6	6.5%	5.8%
400%+	**22.2**	**28.3%**	**0.8**	**8.5%**	**3.4%**
Household Type[g]					
1 Parent[c]	19.6	25.0%	2.5	28.3%	12.8%
2 Parents[c]	52.3	66.6%	4.7	52.5%	8.9%
Multigenerational/Other[d]	5.9	7.5%	1.4	16.3%	24.5%
Family Work Status					
2 Full-time	22.7	28.9%	1.5	17.1%	6.7%
1 Full-time	41.9	53.3%	4.7	52.8%	11.2%
Only Part-time[e]	5.1	6.5%	0.8	8.9%	15.6%
Non-Workers	9.0	11.4%	1.9	21.2%	20.9%
Race/Ethnicity					
White only (non-Hispanic)	44.7	56.9%	3.4	37.8%	7.5%
Black only (non-Hispanic)	11.6	14.7%	1.5	16.6%	12.8%
Hispanic	16.5	20.9%	3.4	38.4%	20.7%
Asian/S. Pacific Islander	3.3	4.1%	0.4	4.3%	11.6%
Am. Indian/Alaska Native	0.5	0.7%	0.1	1.2%	(18.8%)
Two or More Races	2.1	2.6%	0.2	1.7%	7.5%
Citizenship					
U.S. Citizen	76.0	96.6%	7.9	89.1%	10.4%
Non-U.S. citizen, resident for < 5 years	1.1	1.4%	0.4	4.6%	(38.0%)
Non-U.S. citizen, resident for 5+ years	1.6	2.0%	0.6	6.4%	35.6%
Health Status					
Excellent/Very Good	64.0	81.3%	6.6	74.3%	10.3%
Good	13.0	16.5%	2.1	24.0%	16.4%
Fair/Poor	1.7	2.1%	0.2	1.7%	9.3%

Confidence intervals and standard errors were calculated only for uninsured rates. ( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 3
Health Insurance Coverage of the Nonelderly, 2007

	Nonelderly (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[h]	
Total - Nonelderly[a]	**261.4**	**60.9%**	**5.5%**	**13.9%**	**2.5%**	**17.2%**
Age						
Children - Total	**78.6**	**55.3%**	**4.4%**	**27.6%**	**1.4%**	**11.3%**
Adults - Total	**182.8**	**63.2%**	**6.0%**	**8.0%**	**3.0%**	**19.7%**
Adults 19-24	24.0	45.4%	11.3%	11.5%	1.4%	30.3%
Adults 25-34	39.8	60.0%	4.5%	8.2%	1.3%	26.0%
Adults 35-44	41.9	67.9%	4.6%	7.3%	1.8%	18.4%
Adults 45-54	43.8	69.1%	5.4%	7.1%	3.0%	15.4%
Adults 55-64	33.3	66.4%	6.3%	7.4%	7.8%	12.0%
Annual Family Income						
<$20,000	58.1	17.9%	6.6%	35.0%	4.4%	36.1%
$20,000 - $39,999	52.5	48.5%	5.4%	18.0%	2.9%	25.2%
$40,000 +	150.8	81.7%	5.1%	4.4%	1.7%	7.2%
Family Poverty Level[b]						
<100%	**46.4**	**14.1%**	**5.7%**	**41.4%**	**3.4%**	**35.4%**
100-199%	**44.6**	**38.3%**	**6.1%**	**22.7%**	**3.9%**	**29.0%**
...100-149%	23.0	29.0%	6.3%	28.7%	4.5%	31.6%
...150-199%	21.6	48.2%	5.9%	16.2%	3.4%	26.4%
200-399%	**75.2**	**70.6%**	**5.6%**	**6.8%**	**2.4%**	**14.5%**
...200-299%	41.1	65.1%	5.5%	8.7%	2.7%	18.1%
...300-399%	34.1	77.4%	5.8%	4.5%	2.1%	10.3%
400%+	**95.2**	**86.5%**	**5.0%**	**2.0%**	**1.5%**	**4.9%**
Household Type						
Single Adults Living Alone	20.3	57.8%	8.4%	9.9%	4.6%	19.3%
Single Adults Living Together	30.7	45.8%	8.5%	9.0%	3.0%	33.7%
Married Adults	54.6	71.6%	5.8%	5.0%	4.3%	13.4%
1 Parent with children[c]	32.8	37.5%	5.0%	37.0%	1.5%	19.0%
2 Parents with children[c]	109.4	70.3%	4.4%	11.7%	1.5%	12.1%
Multigenerational/Other with children[d]	13.7	37.4%	3.3%	28.3%	2.4%	28.6%
Family Work Status						
2 Full-time	72.9	83.3%	3.4%	4.7%	1.1%	7.5%
1 Full-time	139.6	63.0%	5.5%	11.6%	1.5%	18.3%
Only Part-time[e]	18.6	29.9%	11.8%	25.9%	3.0%	29.4%
Non-Workers	30.2	15.9%	6.5%	39.5%	10.2%	27.8%
Race/Ethnicity						
White only (non-Hispanic)	166.7	69.0%	6.6%	9.6%	2.7%	12.2%
Black only (non-Hispanic)	33.2	48.8%	3.0%	23.9%	3.4%	20.9%
Hispanic	43.4	39.3%	3.0%	22.6%	1.5%	33.5%
Asian/S. Pacific Islander	12.3	63.6%	6.5%	10.7%	1.7%	17.5%
Am. Indian/Alaska Native	1.7	39.4%	2.6%	23.8%	4.6%	29.7%
Two or More Races	4.1	57.3%	4.5%	21.5%	3.4%	13.2%
Citizenship						
U.S. citizen - native	228.6	63.0%	5.5%	14.4%	2.7%	14.4%
U.S. citizen - naturalized	11.9	61.1%	6.4%	8.7%	2.3%	21.5%
Non-U.S. citizen, resident for < 5 years	4.8	34.8%	5.5%	12.0%	---	47.2%
Non-U.S. citizen, resident for 5+ years	16.2	38.6%	3.9%	11.8%	1.0%	44.7%
Health Status						
Excellent/Very Good	181.7	66.2%	6.1%	11.4%	1.4%	14.9%
Good	57.8	53.5%	4.4%	16.5%	2.7%	22.9%
Fair/Poor	21.9	35.6%	3.7%	28.4%	11.1%	21.2%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 4
Health Insurance Coverage of Children, 2007

	Children (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[h]	
Total - Children[f]	**78.6**	**55.3%**	**4.4%**	**27.6%**	**1.4%**	**11.3%**
Age						
<1	4.3	47.0%	2.4%	36.1%	1.6%	12.9%
1-5	20.7	52.5%	3.0%	33.0%	1.5%	10.0%
6-18	53.7	57.1%	5.1%	24.8%	1.4%	11.6%
Annual Family Income						
<$20,000	17.7	12.8%	3.5%	61.9%	1.4%	20.3%
$20,000 - $39,999	14.8	34.4%	3.6%	43.4%	1.4%	17.1%
$40,000 +	46.2	78.3%	5.0%	9.4%	1.4%	5.9%
Family Poverty Level[b]						
<100%	**18.2**	**12.6%**	**3.1%**	**62.5%**	**1.4%**	**20.4%**
100-199%	**15.4**	**37.1%**	**3.9%**	**41.3%**	**1.3%**	**16.3%**
...100-149%	8.1	26.6%	4.2%	51.1%	1.1%	17.1%
...150-199%	7.2	49.0%	3.6%	30.4%	1.6%	15.4%
200-399%	**22.8**	**71.2%**	**5.2%**	**13.6%**	**1.6%**	**8.3%**
...200-299%	12.8	65.6%	4.8%	17.5%	1.8%	10.3%
...300-399%	10.0	78.4%	5.7%	8.6%	1.5%	5.8%
400%+	**22.2**	**86.5%**	**5.0%**	**3.9%**	**1.2%**	**3.4%**
Household Type[g]						
1 Parent with children[c]	19.6	34.1%	4.5%	47.5%	1.2%	12.8%
2 Parents with children[c]	52.3	67.1%	4.3%	18.2%	1.5%	8.9%
Multigenerational/Other with children[d]	5.9	25.5%	3.2%	45.9%	0.9%	24.5%
Family Work Status						
2 Full-time	22.7	78.2%	3.1%	10.7%	1.2%	6.7%
1 Full-time	41.9	56.0%	4.9%	26.5%	1.4%	11.2%
Only Part-time[e]	5.1	21.7%	6.7%	54.6%	1.4%	15.6%
Non-Workers	9.0	12.9%	4.2%	60.1%	1.8%	20.9%
Race/Ethnicity						
White only (non-Hispanic)	44.7	66.9%	5.7%	18.6%	1.3%	7.5%
Black only (non-Hispanic)	11.6	40.3%	2.3%	42.9%	1.8%	12.8%
Hispanic	16.5	34.0%	2.4%	41.8%	1.1%	20.7%
Asian/S. Pacific Islander	3.3	62.4%	5.4%	19.4%	---	11.6%
Am. Indian/Alaska Native	0.5	(31.1%)	---	---	---	(18.8%)
Two or More Races	2.1	54.5%	3.9%	30.9%	3.3%	7.5%
Citizenship						
U.S. citizen	76.0	56.2%	4.4%	27.6%	1.4%	10.4%
Non-U.S. citizen, resident for < 5 years	1.1	(30.9%)	5.6%	24.9%	---	(38.0%)
Non-U.S. citizen, resident for 5+ years	1.6	31.3%	3.1%	29.4%	---	35.6%
Health Status						
Excellent/Very Good	64.0	59.7%	4.7%	23.9%	1.4%	10.3%
Good	13.0	37.5%	3.0%	41.8%	1.3%	16.4%
Fair/Poor	1.7	27.2%	2.6%	59.3%	---	9.3%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 5
Health Insurance Coverage of the Nonelderly by State, 2006-2007

	Nonelderly (thousands)[a]	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[h]	
United States	**260,724**	**60.9%**	**5.5%**	**13.7%**	**2.4%**	**17.5%**
Alabama	3,943	63.8%	4.1%	13.7%	3.0%	15.4%
Alaska	608	58.1%	4.0%	12.3%	6.7%	18.9%
Arizona	5,603	53.6%	4.5%	17.3%	2.8%	21.8%
Arkansas	2,435	53.5%	5.1%	17.2%	4.3%	19.9%
California	32,291	54.7%	7.4%	16.0%	1.5%	20.4%
Colorado	4,355	62.4%	7.6%	8.6%	3.0%	18.5%
Connecticut	3,003	70.4%	4.6%	12.5%	1.8%	10.7%
Delaware	745	68.9%	3.4%	12.1%	2.3%	13.4%
District of Columbia	511	58.6%	6.2%	22.0%	1.6%	11.6%
Florida	15,099	56.1%	6.1%	10.3%	3.0%	24.4%
Georgia	8,538	60.5%	4.0%	12.8%	3.5%	19.3%
Hawaii	1,060	71.2%	3.8%	11.5%	4.0%	9.5%
Idaho	1,295	62.0%	7.3%	11.8%	2.2%	16.7%
Illinois	11,238	65.6%	4.9%	12.2%	2.0%	15.2%
Indiana	5,557	69.2%	4.3%	11.8%	1.7%	13.0%
Iowa	2,546	67.9%	6.5%	13.1%	1.1%	11.4%
Kansas	2,356	63.0%	7.2%	12.8%	2.7%	14.2%
Kentucky	3,637	59.3%	4.7%	15.6%	4.0%	16.4%
Louisiana	3,645	52.5%	5.3%	16.8%	2.3%	23.1%
Maine	1,118	61.5%	5.6%	19.6%	2.7%	10.6%
Maryland	4,912	69.1%	4.4%	9.2%	1.9%	15.5%
Massachusetts	5,496	68.3%	5.0%	16.7%	1.0%	8.9%
Michigan	8,633	67.0%	4.4%	14.2%	2.0%	12.4%
Minnesota	4,543	69.5%	7.1%	12.1%	1.4%	9.9%
Mississippi	2,556	51.0%	5.0%	18.7%	3.2%	22.1%
Missouri	5,024	62.4%	6.4%	13.4%	3.0%	14.8%
Montana	811	55.6%	9.2%	13.2%	3.3%	18.7%
Nebraska	1,548	65.5%	8.2%	9.5%	2.4%	14.4%
Nevada	2,233	65.0%	4.9%	6.9%	2.4%	20.7%
New Hampshire	1,148	73.7%	5.1%	6.8%	1.9%	12.4%
New Jersey	7,488	68.6%	3.8%	8.5%	1.5%	17.6%
New Mexico	1,697	48.0%	5.6%	17.1%	3.6%	25.7%
New York	16,552	59.9%	4.0%	19.5%	1.2%	15.4%
North Carolina	7,863	57.4%	5.5%	13.9%	3.7%	19.5%
North Dakota	536	64.2%	11.5%	9.3%	2.3%	12.7%
Ohio	9,898	66.4%	4.8%	14.0%	2.5%	12.4%
Oklahoma	3,029	55.0%	4.5%	14.8%	4.5%	21.2%
Oregon	3,263	59.6%	7.0%	11.6%	2.1%	19.7%
Pennsylvania	10,483	67.6%	6.1%	13.3%	1.7%	11.3%
Rhode Island	915	64.7%	4.6%	17.7%	2.0%	11.0%
South Carolina	3,746	58.8%	4.8%	14.4%	3.5%	18.5%
South Dakota	666	63.4%	9.5%	10.8%	3.5%	12.8%
Tennessee	5,176	58.0%	5.8%	15.8%	4.1%	16.2%
Texas	20,887	52.1%	4.9%	12.9%	2.6%	27.5%
Utah	2,378	64.9%	7.6%	9.8%	1.5%	16.3%
Vermont	537	61.9%	4.1%	19.6%	2.1%	12.3%
Virginia	6,658	66.2%	4.4%	8.2%	5.4%	15.8%
Washington	5,651	64.6%	5.7%	13.5%	3.3%	13.0%
West Virginia	1,561	59.8%	2.3%	17.7%	4.3%	15.9%
Wisconsin	4,811	69.5%	6.0%	13.1%	1.8%	9.6%
Wyoming	447	62.7%	7.8%	10.3%	2.9%	16.2%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 6
Health Insurance Coverage of Children by State, 2006-2007

	Children	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
	(thousands)[f]	Employer	Individual	Medicaid	Other[h]	
United States	**78,425**	**55.4%**	**4.4%**	**27.1%**	**1.4%**	**11.7%**
Alabama	1,187	60.5%	2.5%	28.0%	---	7.7%
Alaska	192	54.1%	3.5%	23.6%	7.6%	11.2%
Arizona	1,769	48.9%	3.3%	31.1%	---	15.9%
Arkansas	742	42.6%	4.2%	43.8%	---	8.4%
California	10,036	49.7%	6.1%	30.7%	1.2%	12.3%
Colorado	1,260	61.5%	6.7%	15.5%	2.5%	13.8%
Connecticut	872	66.8%	3.2%	23.0%	---	6.3%
Delaware	220	63.7%	2.7%	22.0%	---	10.0%
District of Columbia	119	45.6%	---	44.0%	---	7.6%
Florida	4,332	50.7%	5.2%	23.3%	1.3%	19.5%
Georgia	2,604	52.6%	2.7%	29.3%	2.9%	12.5%
Hawaii	307	62.5%	2.6%	23.3%	5.7%	5.8%
Idaho	433	56.4%	6.2%	23.7%	1.6%	12.2%
Illinois	3,362	61.8%	3.6%	25.5%	0.7%	8.3%
Indiana	1,686	64.0%	3.5%	25.5%	---	6.7%
Iowa	750	62.1%	5.9%	26.0%	---	5.5%
Kansas	742	55.9%	6.3%	28.0%	2.0%	7.7%
Kentucky	1,068	53.6%	4.4%	31.3%	---	9.4%
Louisiana	1,149	45.2%	5.1%	34.8%	---	14.5%
Maine	301	57.2%	4.4%	31.4%	---	5.6%
Maryland	1,457	65.4%	4.1%	19.0%	---	10.4%
Massachusetts	1,549	67.3%	3.3%	24.1%	---	5.1%
Michigan	2,579	61.6%	4.2%	27.7%	---	5.9%
Minnesota	1,327	67.2%	5.2%	20.0%	---	7.2%
Mississippi	823	41.2%	4.5%	36.7%	---	16.2%
Missouri	1,491	53.8%	6.0%	29.7%	---	9.8%
Montana	231	49.5%	7.2%	28.1%	---	13.8%
Nebraska	472	62.6%	5.9%	19.3%	1.9%	10.4%
Nevada	689	63.3%	4.7%	14.5%	---	16.8%
New Hampshire	317	71.5%	4.2%	16.6%	---	7.1%
New Jersey	2,209	66.4%	3.5%	16.4%	---	13.3%
New Mexico	539	40.6%	3.7%	36.7%	2.3%	16.6%
New York	4,744	55.9%	2.7%	32.3%	---	9.0%
North Carolina	2,340	49.6%	5.0%	29.7%	2.4%	13.3%
North Dakota	156	60.1%	8.0%	20.7%	2.1%	9.1%
Ohio	2,948	60.3%	3.8%	27.9%	---	7.5%
Oklahoma	971	46.5%	4.2%	32.4%	3.6%	13.3%
Oregon	916	55.4%	7.6%	23.3%	---	12.8%
Pennsylvania	2,917	62.4%	4.4%	25.3%	---	7.7%
Rhode Island	252	60.1%	2.9%	29.1%	---	6.6%
South Carolina	1,108	52.7%	3.9%	28.9%	---	13.1%
South Dakota	207	57.2%	7.4%	24.2%	2.5%	8.8%
Tennessee	1,553	51.8%	5.0%	31.7%	3.4%	8.1%
Texas	6,989	45.1%	3.8%	27.3%	2.0%	21.8%
Utah	861	61.2%	7.1%	18.0%	---	13.1%
Vermont	138	51.6%	2.9%	36.0%	---	8.5%
Virginia	1,939	61.1%	3.6%	19.1%	5.5%	10.7%
Washington	1,623	60.9%	4.4%	24.8%	2.7%	7.1%
West Virginia	422	52.7%	---	38.2%	---	6.6%
Wisconsin	1,393	64.6%	4.1%	25.3%	---	5.2%
Wyoming	132	59.0%	6.7%	22.3%	2.8%	9.2%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% 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 2007 federal poverty level for a family of four was $21,203. The poverty level for an individual was $10,590 in 2007.

[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] Children includes all individuals under age 19.

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

[h] Other includes other public insurance (mostly Medicare and military-related, e.g., Veterans Administration and TRICARE). SCHIP 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 Supplement to the Current Population Survey (the CPS Annual Social and Economic Supplement or ASEC) 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.

The ASEC asks respondents about their health insurance coverage throughout the previous calendar year and therefore some report having more than one type of coverage. In the analysis used here, individuals are sorted into only one category of insurance coverage. In order to do this a hierarchy was created as follows:

- Medicaid: Includes those covered by Medicaid, SCHIP, and those who have both Medicaid and another type of coverage, such as dual-eligibles who are also covered by Medicare.
- Employer: Includes employer-sponsored coverage for employees and their dependents.
- Other Public: Those covered under the military or Veterans Administration as well as some non-elderly Medicare enrollees.
- Individual: Those covered by private insurance other than employer-sponsored coverage.
- Uninsured: Those without health insurance and those who have coverage under the Indian Health Service only.

So for example, a person having Medicaid coverage in the first of the year, but employer coverage in the last months of the year would be categorized as having Medicaid coverage in this analysis.

Another important difference in this analysis is that for all income data (mostly categorized into multiples of the federal poverty level), income is aggregated by "health insurance units". This unit includes members of the nuclear family who can be covered under one insurance policy: the policy holder, spouse, children under age 19 and full-time students under age 23. Other family members (e.g., grandparents) who may be living in the same household are not included, therefore their incomes are not part of the income used to calculate poverty levels in this analysis. The health insurance unit more accurately reflects the income actually available to people to buy health insurance, as well as the income that would be counted if they were to apply for a public insurance program.

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

Endnotes

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