THE UNINSURED
A PRIMER

DECEMBER 2010

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 number of nonelderly uninsured grew to 50.0 million due to the recent recession, which contributed to the continued erosion of job-based coverage. As incomes dropped more qualified for Medicaid, buffering the loss of health insurance for millions.

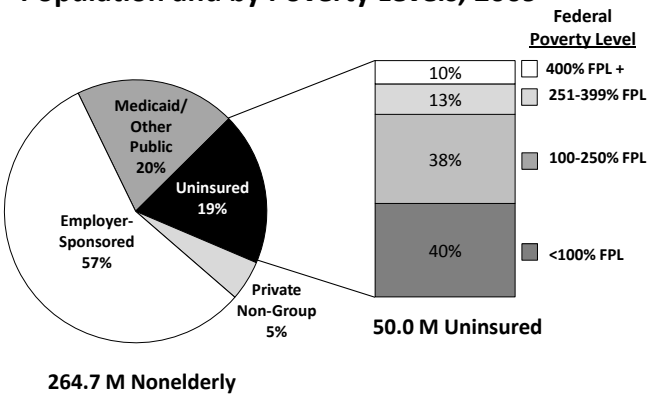
Introduction

The number of nonelderly uninsured Americans rose to 50.0 million in 2009—an increase of 4.3 million people—amidst rising unemployment rates and an economic recession.* Nearly all of the elderly are insured by Medicare, yet nearly 700,000 of the elderly were uninsured last year. Because the majority of the nonelderly still receive their health insurance as a job benefit, the steady decline in employer-sponsored health coverage since 2000 and the current weak job market largely explain the growing numbers of uninsured. The safety net of Medicaid and the Children's Health Insurance Program (CHIP) has prevented a larger increase in the uninsured and, in particular, buffered children from the full effects of the recession. Almost one in five (19%) of the nonelderly was uninsured in 2009 (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—more than three-quarters of the uninsured come from working families—four in ten of the uninsured are individuals and families who are poor (incomes less than the federal poverty level or $22,050 for a family of four in 2009).

Figure 1

The Uninsured—As a Share of the Nonelderly Population and by Poverty Levels, 2009



Medicaid and other public coverage includes: CHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of four in 2009 was $22,050.
SOURCE: KCMU/Urban Institute analysis of 2010 ASEC Supplement to 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.

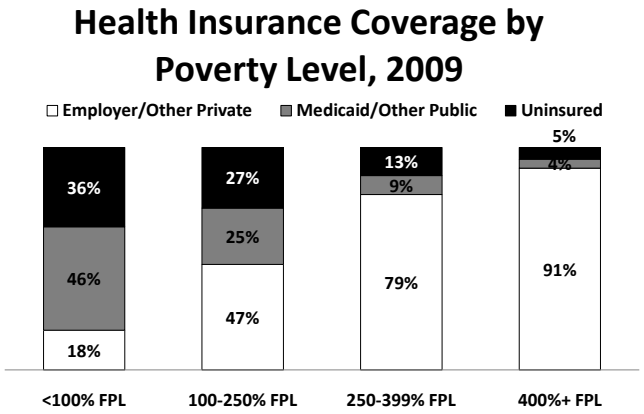
This primer presents basic information about the uninsured—who they are and why they do not have health coverage—and provides an understanding of the difference health insurance makes in people's lives. *The Uninsured: A Primer* also discusses how and why the number of uninsured has changed and ends with a discussion of the 2010 Patient Protection and Affordable Care Act and how it will expand coverage to the majority of the uninsured by expanding Medicaid and providing subsidies for private insurance premiums.

* The Census Bureau reports a total of 50.7 million uninsured in 2009 which includes 676,000 persons who are elderly (65+ years old). This primer focuses on the nonelderly uninsured. Our analysis of the Current Population Survey's ASEC supplement differs from estimates by the Census Bureau in several other ways that are outlined in the Data Notes in the back of this primer.

How Do Most Americans Obtain Health Insurance?

More than half (57%) 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 now go without health coverage unless they qualify for insurance through the Medicaid program, Children's Health Insurance Program (CHIP), or a state-subsidized program. The gaps in our private and public health insurance systems leave 50 million nonelderly people in the U.S.—19% of those under age 65—without health coverage. The Patient Protection and Affordable Care Act of 2010 is designed to expand access to health coverage, and most of the law's key provisions regarding the affordability of coverage will take effect in 2014. The risk of being uninsured is greatest for those with the lowest incomes, and the new health reform law targets this population through federal subsidies to help purchase private insurance coverage and expanded eligibility for Medicaid. (Figure 2)

Figure 2



The federal poverty level (FPL) was $22,050 for a family of four in 2009. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2010 ASEC Supplement to the CPS.

Private Health Insurance Coverage

The majority of employers offer group health insurance policies to their employees and to their employees' families. In 2010, 69% of firms offer coverage to their employees. Among individuals with employer-sponsored coverage, about half 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 being 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 work part-time or are recent hires and others do not sign up because of difficulty affording the required employee share of the premium. Among firms that offer coverage in 2010, an average of 79% of their workers are eligible for the health benefits.[2] The new health reform law aims to expand access to employer-sponsored coverage through both temporary subsidies for the smallest firms and penalties for larger firms that do not offer adequate coverage.

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, particularly for those who are older or have had health problems. In 2008, 29% of individuals age 60 to 64 who applied for non-group insurance were denied coverage based on their health status.[3] Under the current system, applicants who are offered coverage may find that they are charged a higher premium due to their medical history, or specific conditions may be excluded from their policy through an elimination rider.

Starting in 2014, insurers will be barred from taking pre-existing conditions into account when issuing policies. And, beginning in September 2010, the new health reform law prohibits individual and group health plans from denying children coverage based on pre-existing medical conditions and from including pre-existing condition exclusions for children.

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. Tax advantages are also available for health savings accounts (HSAs) and flexible spending accounts.

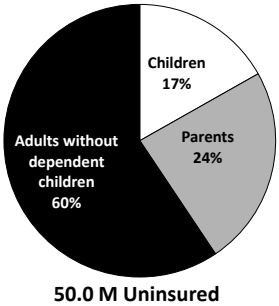
Public Health Insurance Coverage

The Medicaid program and The Children's Health Insurance Program (CHIP) currently provide coverage to some, but not all, low-income individuals and people with disabilities. Medicaid and CHIP cover 20% of the nonelderly population by primarily covering four main categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities. Individuals who do not fall into one of these groups—most notably adults without dependent children—are now generally ineligible for public coverage regardless of their income. While some children and parents are still uninsured, adults without dependent children comprise the majority of the uninsured largely because they are the least likely to qualify for Medicaid (Figure 3).

The new health reform law will extend Medicaid to all individuals at or below 138% of poverty starting in 2014.[4] This will expand public coverage to childless adults, and to parents who were previously ineligible because of low eligibility thresholds for parents. Undocumented immigrants and legal immigrants who have been in the U.S. for less than five years will continue to be ineligible for Medicaid.[5]

Figure 3

The Nonelderly Uninsured by Age and Parent Status, 2009



50.0 M Uninsured

Children includes all individuals ages 0-18. Parents are defined as adults with dependent children ages 0-18 and adults without children do not have dependent children ages 0-18. Both parents and adults without children include adults ages 19-64. . Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2010 ASEC Supplement to the CPS.

Medicaid and CHIP cover one-third of all children and more than two-thirds of all children in families below the poverty level. 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 2007 (the most recent year of enrollment data available). CHIP supplements Medicaid by covering seven million children who are low or moderate income but whose family incomes are too high to qualify for Medicaid. Eligibility levels for parents are generally much lower than for children.

Medicaid provides health and long-term care coverage for 8.5 million nonelderly people with disabilities (2007 estimates). Its role is more prominent for people with certain conditions, such as HIV/AIDS. However, Medicaid eligibility for people with disabilities is limited to those with very low incomes and few assets. Medicaid coverage is particularly crucial to this population because it provides more comprehensive coverage than most private insurers. For example, Medicaid commonly pays for medical equipment as well as rehabilitation, speech therapy and other services that people with disabilities may need.

Who Are the Uninsured?

In 2009, 50 million people in the U.S. under age 65 lacked health insurance. Most of these individuals come from working families and have low incomes. The recent recession has contributed to significant declines in employer-sponsored coverage. 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. A high unemployment rate and increases in the number of individuals living below poverty put employer-sponsored coverage out of reach for many individuals.

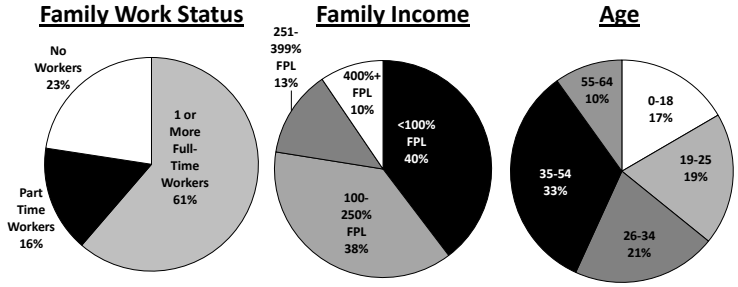
More than three-quarters of the uninsured are in working families—sixty-one percent are from families with one or more full-time workers and 16% are from families with part-time workers (Figure 4). Workers usually enroll in employer-sponsored health insurance if they are eligible.[6] However, it has become increasingly difficult for many workers to afford coverage. The average annual total cost of employer-sponsored family coverage is $13,770 in 2010, and the share of the premium paid by workers increased to 30% this year.[7]

The vast majority of the uninsured are in low- or moderate-income families. (Figure 4) Individuals below poverty are at the highest risk of being uninsured, and this group comprises 40% of all the uninsured (the poverty level for a family of four was $22,050 in 2010). In total, nine in ten of the uninsured are in low- or moderate-income families, meaning they are below 400% of poverty. The new health reform law targets these individuals through broader Medicaid eligibility and premium subsidies through health insurance exchanges for eligible individuals with incomes up to 400% of poverty who do not have access to employer sponsored insurance.

Adults are more likely to be uninsured than children. Adults make up 70% of the nonelderly population, but more than 80% of the uninsured (Figure 4). Most low-income children qualify for Medicaid or the Children's Health Insurance Program (CHIP), 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, and adults without children are generally ineligible. Under the Patient Protection and Affordable Care Act (ACA), Medicaid will be expanded in 2014 to provide eligibility to nearly all people under age 65 with income under 138%[8] of the federal poverty level.

Figure 4

Characteristics of the Uninsured, 2009



Total = 50.0 million uninsured

The federal poverty level was $22,050 for a family of four in 2009. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2010 ASEC Supplement to the CPS.

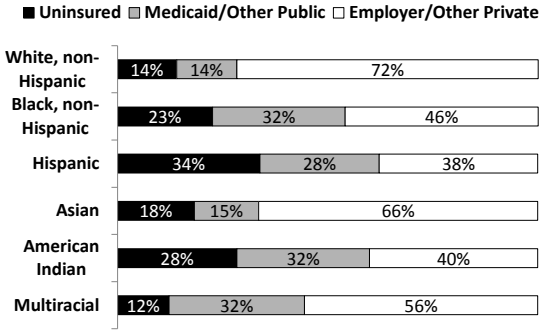
Young adults, ages 19 to 29, comprise a disproportionately large share of the uninsured, largely due to their low incomes. Young adults have the highest uninsured rate (32%) of any age group. More than half of uninsured young adults are families with at least one full-time worker, but their low incomes make it more difficult for them to afford coverage.[9] The median income of uninsured young adults in 2008 was $15,000. Starting in September 2010, the health reform law will let young adults stay on their parent's private health insurance until they are 26.

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.[10]

Minorities are much more likely to be uninsured than whites. About one third of Hispanics are uninsured compared to 14% of whites. The uninsured rate among African-Americans (23%) 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, 2009



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 2010 ASEC Supplement to the CPS.

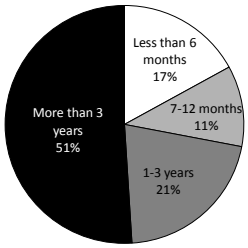
The majority of the uninsured (81%) are native or naturalized U.S. citizens. Although non-citizens (legal and undocumented) are about three times more likely to be uninsured than citizens they are not the primary cause of the uninsured problem. Non-citizens have less access to employer coverage because they are more likely to have low-wage jobs and work for firms that do not offer coverage. Further, until recently, states were precluded from using federal dollars to provide Medicaid or CHIP coverage to most recent legal immigrants who have been in the U.S. less than five years. However, in 2009 states were given the option of extending Medicaid coverage to children and pregnant women who previously would have been subject to the five-year ban. Undocumented immigrants will remain ineligible for federally funded health coverage under the health reform law.

The uninsured tend to be in worse health than the privately insured. Uninsured adults are more than twice as likely to report being in fair or poor health as those with private insurance. Almost half of all uninsured nonelderly adults have a chronic condition.[11] 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. The ACA addresses this issue by imposing new regulations on all health plans that will prevent health insurers from denying coverage to people for any reason including health status, and from charging higher premiums based on health status or gender.[12]

More than seventy percent of the uninsured have gone without health coverage for more than a year (Figure 6). Because health insurance is primarily obtained as an employment benefit, health coverage is disrupted when people change or lose their 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 Insurance Coverage Among the Uninsured, 2009

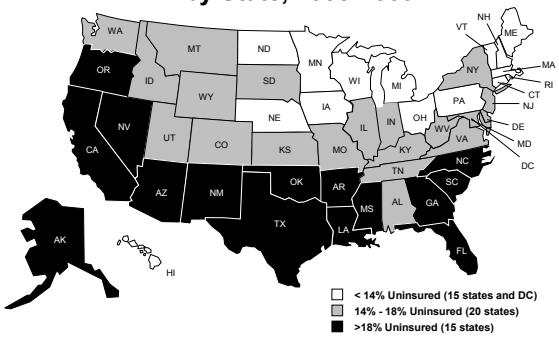


More than three years includes those who said they never had health insurance. Percentages are age adjusted.
SOURCE: *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2009.* 2010.

Insurance coverage varies by state depending on the share of families with low incomes, the nature of the state's employment, and the reach of state Medicaid programs. Insurance market regulations and the availability of jobs with employer-sponsored coverage also influence the distribution of health coverage in each state.[13] Uninsured rates tend to be higher in the southern and western regions of the United States; however in 2009 the Midwest saw the greatest increase in uninsured rates of any region in the country. At the state level uninsured rates vary widely. Massachusetts has near universal coverage, with an uninsured rate of less than 5% due to landmark health reform legislation enacted in 2006. While uninsured rates in states such as New Mexico, Florida, and Texas exceed 25% (Figure 7).

Figure 7

Uninsured Rates Among Nonelderly by State, 2008-2009



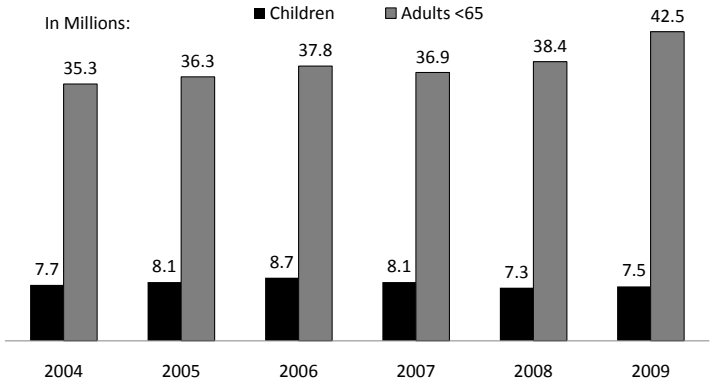
SOURCE: Kaiser Commission on Medicaid and the Uninsured/ Urban Institute analysis of 2009 and 2010 ASEC Supplements to the CPS, two-year pooled data.

How and Why Has the Number of Uninsured Changed?

The number of uninsured has increased over the past decade and jumped sharply in the past year largely due to the economic recession and resulting weak job market (Figure 8). While some of those who lose private coverage are able to gain public coverage through Medicaid or CHIP, others become uninsured. Employer-sponsored coverage remains the most common form of health insurance, and therefore trends in the availability and cost of this coverage are key factors in how the number of uninsured has changed over time. Additionally, the availability of public coverage has also had an effect on the number of uninsured and has been instrumental in preventing further increases in the number of uninsured children.

Figure 8

Number of Uninsured Children and Non-Elderly Adults, 2004-2009



SOURCE: KCMU/Urban Institute analysis of ASEC Supplement to the CPS, 2005-2010.

Broad Medicaid and CHIP eligibility for children has helped maintain health coverage for children. During the recent economic recession, the percentage of uninsured children actually declined slightly as more children gained coverage through Medicaid or CHIP. From 2007 to 2009, the uninsured rate for children dropped from 11.3% to 10.4%. This decline occurred despite a decrease in the share of children with employer-sponsored coverage. As the weakening economy caused more children to lose the coverage they had through a parent's employer, many were eligible for public insurance.

Public coverage's ability to absorb additional children was bolstered by the reauthorization of the Children's Health Insurance Program in 2009, which enabled states to expand Medicaid and CHIP coverage to more children leading up to the recession. The American Recovery and Reinvestment Act later provided states with temporary increased federal Medicaid funding while requiring states to maintain their eligibility and enrollment policies at the level that was in place on July 1, 2008. This additional funding was originally set to end in December 2010, but was later extended at a lower rate through June 2011.

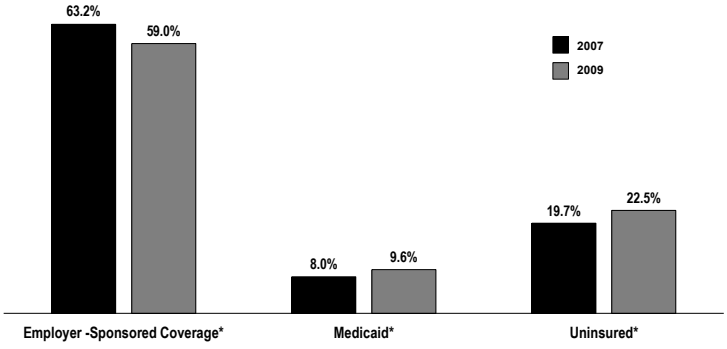
The uninsured rate for adults increased sharply during the recent recession, resulting in 5.6 million more adults without coverage. This increase in uninsured adults was largely driven by a decrease in the share of adults with employer-sponsored coverage (Figure 9). Over this period, the unemployment rate increased from 4.6% in January 2007 to 10.0% at the end of 2009, which likely caused many adults to lose their employer-sponsored coverage. While a partial federal subsidy for individuals maintaining their previous employer-sponsored coverage was in place for those laid-off from September 2008 until May 2010, the increase in unemployment likely still contributed to the decrease in employer-sponsored coverage. Medicaid eligibility for adults is more limited than for children and

therefore the share of adults on the program increased only slightly compared to the changes in the percent of adults with employer-sponsored coverage. The uninsured rate for adults increased from 19.7% to 22.5% from 2007 to 2009, which represents a 5.6 million increase in the number of uninsured adults.

In the years preceding the recent recession, the uninsured rate for adults rose due to a decrease in employer-sponsored coverage. Although the economy was relatively strong from 2004 to 2006, employer-sponsored coverage rates declined. The share of adults on Medicaid remained relatively steady and did not compensate for the drop in employer-sponsored coverage.

Figure 9

Changes in Coverage for Nonelderly Adults, 2007-2009



* Statistically significant change. Medicaid includes CHIP and other state programs.
SOURCE: KCMU/Urban Institute analysis of ASEC Supplement to the CPS, 2008-2010.

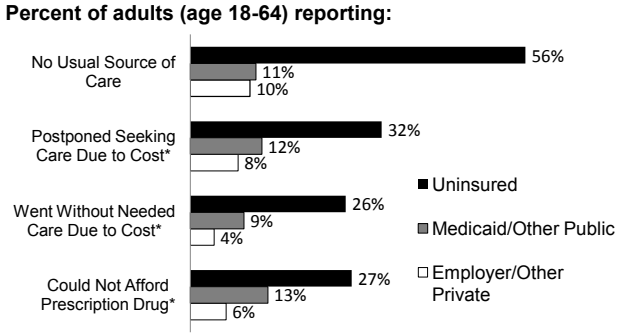
How Does Lack of Insurance Affect Access to Health Care?

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. About one-quarter of uninsured adults say that they have forgone care in the past year because of its cost—compared to 4% of adults with private coverage. Part of the reason for this is that more than half of uninsured adults do not have a regular place to go when they are sick or need medical advice (Figure 10).

Figure 10

Barriers to Health Care Among Nonelderly Adults, by Insurance Status, 2009



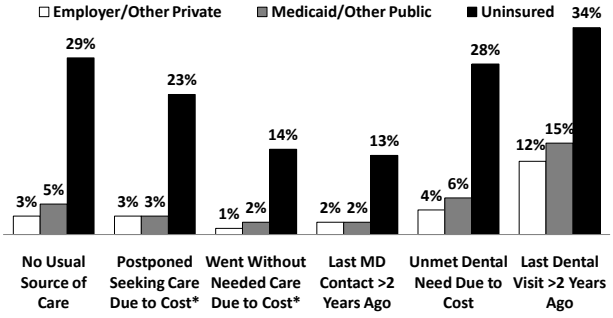
*In past 12 months.
Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.
All differences between uninsured and insurance groups are statistically significant ($p<0.05$).
SOURCE: KCMU analysis of 2009 NHIS data.

Anticipating high medical bills, many of the uninsured are not able to follow recommended treatments. More than 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.[14]

Problems getting needed care also exist among uninsured children. Uninsured children are significantly more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance (Figure 11). Uninsured children with common childhood illnesses and injuries do not receive the same level of care as others. As a result, they are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.[15] Disparities exist even among children with special needs, including access to specialists.[16]

Figure 11

Children's Access to Care by Health Insurance Status, 2009



*** 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. All differences between the uninsured and the two insurance groups are statistically significant ($p<0.05$).

SOURCE: KCMU analysis of 2009 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.[17] Children who are uninsured for part of the year have more access problems than those with full-year public or private coverage.[18]

The uninsured are less likely to receive timely preventive care. Silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. Uninsured nonelderly adults, compared to those with coverage, are far less likely to have had regular preventive care, including cancer screenings.[19] Consequently, uninsured patients are diagnosed in later stages of diseases, including cancer, and die earlier than those with insurance.[20,21]

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 receive fewer diagnostic and therapeutic services and also are more likely to die in the hospital than insured patients.[22,23] Among those injured in severe automobile accidents, the uninsured receive less care and have a higher mortality rate.[24]

Research demonstrates that gaining health insurance restores access to health care considerably and diminishes the adverse effects of having been uninsured. Middle-aged adults who are continuously uninsured are much more likely to experience a decline in their health than those who are continuously insured.[25] However among previously uninsured adults who acquire Medicare coverage at age 65, use of preventive care increases, their access to physician and hospital care improves, and they experience improved health and functional status. When uninsured children gain health coverage, they receive more timely diagnosis, fewer preventable hospitalizations, and miss fewer days of school.[26]

Access to health care has eroded over time for many. Rising health care costs have made health care less affordable, particularly for the uninsured. Between 1997 and 2006, the differences in access to care between the uninsured and insured widened, even among those with chronic conditions. The insurance 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.[27,28]

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 basic monthly expenses such as rent, food, and utilities.[29] 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.

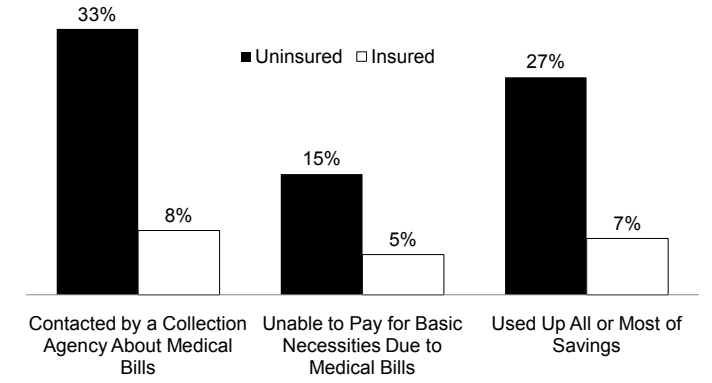
Most of the uninsured do not receive health services for free or at reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.[30] Slightly less than half of the uninsured know of a provider in their community who charges less to patients without insurance.[31] 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.[32]

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.[33]

Being uninsured leaves individuals at an increased risk of amassing unaffordable medical bills. Uninsured adults are three times as likely as the insured to have been unable to pay for basic necessities such as housing or food due to medical bills (Figure 12). Medical bills may also force uninsured adults to exhaust their savings. In 2010, 27% of uninsured adults used up all or most of their savings paying medical bills.

Figure 12

Financial Consequences of Medical Bills, by Insurance Status, 2010



All differences between uninsured and insurance groups are statistically significant ($p<0.05$).
SOURCE: Kaiser Family Foundation's Health Tracking Poll: June 2010.

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.[34] 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.

Unprotected from medical costs and with few assets, 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. One-third of uninsured adults report that a collection agency has contacted them about unpaid medical bills in the past year.

How Is Uncompensated Care Financed?

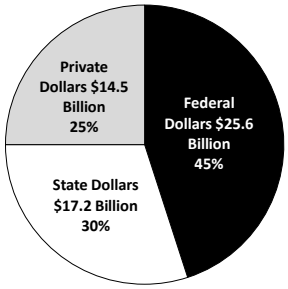
When the uninsured are unable to pay for the health care they receive, that uncompensated care is paid for through a patchwork of federal, state, and private funds. The bulk of such care is funded by the government and is crucial to the strength of the nation's safety-net hospitals and clinics. Despite coverage expansions and improvements to the health system health reform will leave an estimated 23 million persons without access to affordable coverage in 2019, so health centers will likely continue to play a central—and perhaps increasingly critical—role in caring for the uninsured.[35]

The uninsured spend less than half of what the insured spend on health care. In 2008, the average person who was uninsured for a full-year incurred $1,686 in total health care costs compared to $4,463 for the nonelderly with coverage.[36] The uninsured will pay for about a third of this care out of pocket, 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.[37]

The remaining costs of their care, the uncompensated costs, amounted to about $57 billion in 2008. About 75% of this total ($42.9 billion) was paid by federal, state, and local funds appropriated for care of the uninsured (Figure 13). Nearly half of all funds for uncompensated care come from the federal government, with the majority of federal dollars flowing through Medicare and Medicaid. While substantial, these government dollars amount to a small slice (2%) of total health care spending in the U.S.

Figure 13

Payment Sources for Uncompensated Care, 2008



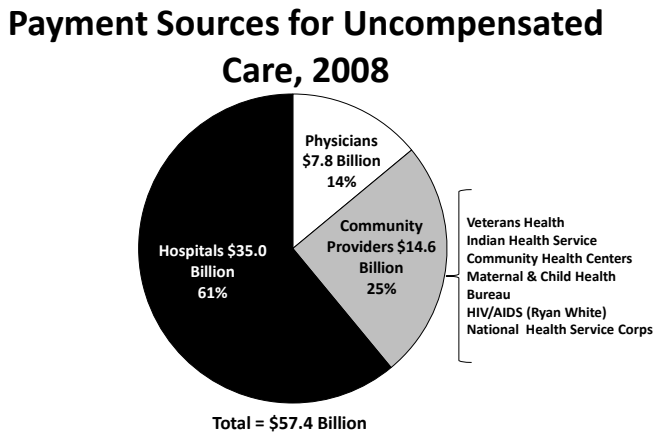
Total = $57.4 billion

SOURCE: Hadley J. et al. 2008. "Covering the Uninsured in 2009: 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 costs are incurred in hospitals because medical needs requiring hospitalization are the most expensive (Figure 14).[38] Most government dollars for uncompensated care are paid to hospitals based indirectly on the share of uncompensated care they may provide.

The cost of uncompensated care provided by physicians is not directly or indirectly reimbursed by public dollars.[39] 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.[40]

Figure 14

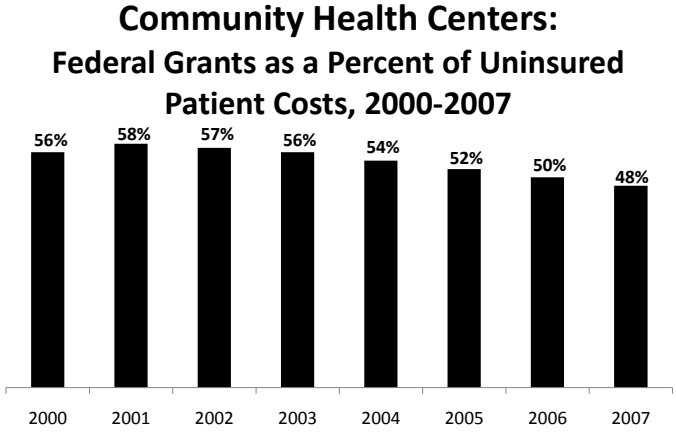


SOURCE: Hadley J. et al. 2008. "Covering the Uninsured in 2009: Current Costs, Sources of Payment, and Incremental Costs." *Health Affairs Web-Exclusive*, Aug 25, 2008.

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. More than 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.[41]

In recent years federal funding for community health centers (CHCs) has been increasing, however it has not kept pace with the growing numbers of uninsured and the costs of caring for them.[42] 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 15). Less than $1 billion out of $26 billion of federal spending for uncompensated care went to community health centers in 2008.[43] Recognizing the growing need for CHC services, the American Recovery and Reinvestment Act passed in 2009 provided over $2 billion to expand the number of sites, increase services at existing CHCs, and provide supplemental payments for spikes in the number of uninsured they serve as a result of the recession. Additionally, the Affordable Care Act allocates $11 billion over five years for broad health center expansion.

Figure 15



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

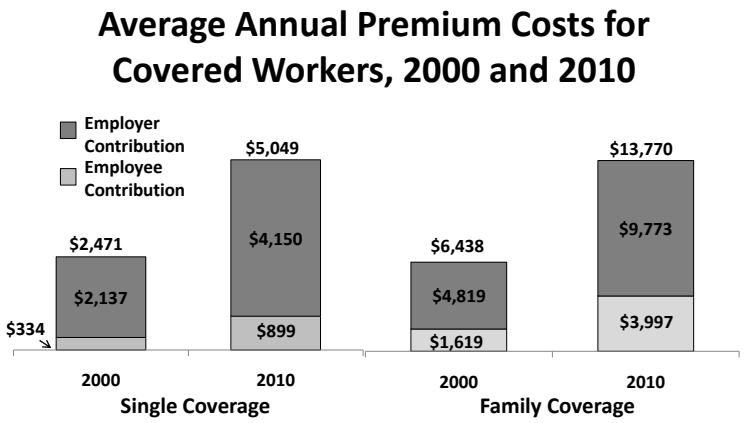
Why Doesn't Employer-Sponsored Insurance Cover More Americans?

Almost 60% of people in the U.S. under the age of 65 get their health insurance through an employer, making it the most common form of health coverage. However, having a job does not guarantee a person will have access to employer-sponsored coverage; in fact, about 39 million of the uninsured are in families that have at least one worker. The share of the nonelderly population with employer-sponsored coverage has been declining since 2000 and has been exacerbated by the two recessions the U.S. faced this decade. From 2007 to 2009, the recent recession contributed to a decline of almost 10 million in the number of people with employer-sponsored coverage.

Many workers do not have access to employer-sponsored insurance. The majority of uninsured workers are not offered health insurance by their employer.[44] Other workers are not eligible for coverage, often because they have not worked for their employer for a sufficient amount of time or they do not work enough hours. During the recent recession, high unemployment rates put employer-sponsored coverage at risk for millions of workers and their families.

The cost of employer-sponsored coverage is the most common reason employers cite for not offering health coverage.[45] In 2010, annual employer-sponsored group premiums averaged $5,049 for individual coverage and $13,770 for family coverage. Total family premiums have more than doubled since 2000. The employee's share of a family premium has also more than doubled since 2000, averaging $3,997 in 2010 (Figure 16).[46]

Figure 16



Family coverage is defined as health coverage for a family of four.
SOURCE: Kaiser/HRET Employer Health Benefits Survey, 2010.

Workers may lose coverage if they become unemployed. When an individual is laid-off, health coverage may be at risk for both the worker and his or her family. A temporary subsidy for unemployed individuals continuing their previous employer-sponsored coverage through Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was in place for workers laid-off between September 2008 and May 2010. This federal subsidy covered 65% of the cost of maintaining employer-sponsored coverage through COBRA for up to 15 months. Without the subsidy, individuals have to pay the full cost of employer-sponsored coverage (both the employer and employee share) to maintain their previous coverage. No official numbers have been released regarding how many people took advantage of the subsidized coverage, however, one survey of 200 large employers found that monthly

COBRA enrollment rates increased from 19% to 38% once the subsidy was in place.[47] Individuals who are now being laid-off are not eligible for this subsidy and others are finding that their 15-month eligibility period is ending. Without this subsidy, it will be even more difficult for the newly unemployed to remain insured.

Employer-sponsored health insurance has declined during this decade and the current recession is hastening that trend. Job-based coverage has been gradually declining since 2000, even during years when the economy was stronger and growth in health insurance premiums was slowing. From 2007 to 2009, the percentage of the nonelderly population with employer-sponsored coverage declined from 61% to 57% as the number of people with this type of insurance declined by 10 million.

Low-income workers are less likely to be offered employer-sponsored coverage than those with higher incomes. In 2007, 58% of employees below 200% of poverty were offered and eligible for employer-sponsored coverage through their own or their spouse's employer.[48] By comparison, 86% of employees with family incomes at or above 400% of poverty had access to employer-sponsored coverage.[49] The majority (62%) of employees below 200% of poverty with access to coverage through an employer enrolled in this coverage.[50]

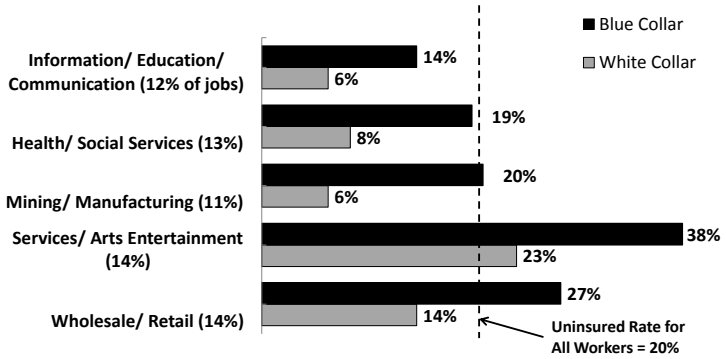
The majority of employees in low-income families participate in their employer's health plan when they are offered coverage. Despite having lower incomes and thus typically fewer resources to pay for necessities, nearly two-thirds of low-income employees who are eligible for employer-sponsored coverage choose to enroll. Employees who do not participate may not be able to afford the premium. Workers in low-wage firms are typically asked to contribute a larger share of the insurance premium, paying 35% of the premium costs for family coverage compared to 29% paid by employees in higher-wage firms in 2010.[51]

Small firms are much less likely to offer coverage than large firms. Nearly all businesses (99%) with at least 200 workers offer health benefits to their workers in 2010, but only 68% of firms with fewer than 200 workers offer these benefits.[52] On average, small firms ask employees to contribute a similar amount towards their own health benefits compared to large firms ($865 vs. $917 per year). However, small firms ask for larger annual contributions for family coverage ($4,665 vs. $3,652).

Health coverage varies both by industry and by type of occupation. Across industries, uninsured rates for workers range from 37% in agriculture to just 6% in public administration.[53] But even in industries where uninsured rates are lower, the gap in health coverage between blue and white-collar workers is often two-fold or greater (Figure 17). More than 80% of uninsured workers are in blue-collar jobs.

Figure 17

Uninsured Rates Among Selected Industry Groups, White vs. Blue Collar Jobs, 2009



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 2010 ASEC Supplement to the CPS.

What is Medicaid's Role?

Medicaid is the nation's major public health insurance program for low-income Americans, covering 58 million low-income children, families, seniors and people with disabilities. Over the past decade, growth in Medicaid enrollment has helped to buffer losses of job-based coverage, preventing larger increases in the number of uninsured from occurring. As the ACA goes into effect Medicaid will be the base for expanding health care coverage to nearly all of the lowest income Americans.

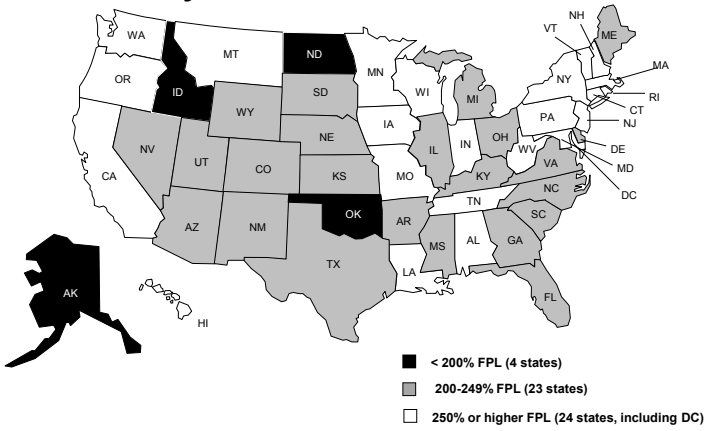
Medicaid is a federal-state partnership, and under current law a person must meet financial criteria and belong to one of the "categorically eligible" groups to qualify for coverage. Medicaid covers four main groups of nonelderly, low-income people: children, their parents, pregnant women, and people with disabilities—with the program playing its broadest role among children. Federal law requires states to cover school age children up to 100% of the poverty level (133% for preschool children), but states are only required to cover parents below states' 1996 welfare eligibility levels (often below 50% of the federal poverty level).

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.

The Children's Health Insurance Program (CHIP) works as a complement to Medicaid by covering low-income children not eligible for Medicaid. CHIP was created in 1997 to expand coverage to children, particularly low-income children. Together Medicaid and CHIP aim to cover low-income children who would otherwise be uninsured. Most states cover children up to or above 200% of the poverty level through Medicaid or CHIP (Figure 18). The reauthorization of CHIP in 2009 in combination with fiscal relief from ARRA was critical in enabling states to continue their commitment to providing coverage to millions of low-income families.

Figure 18

Children's Eligibility for Medicaid/CHIP by Income, December 2009

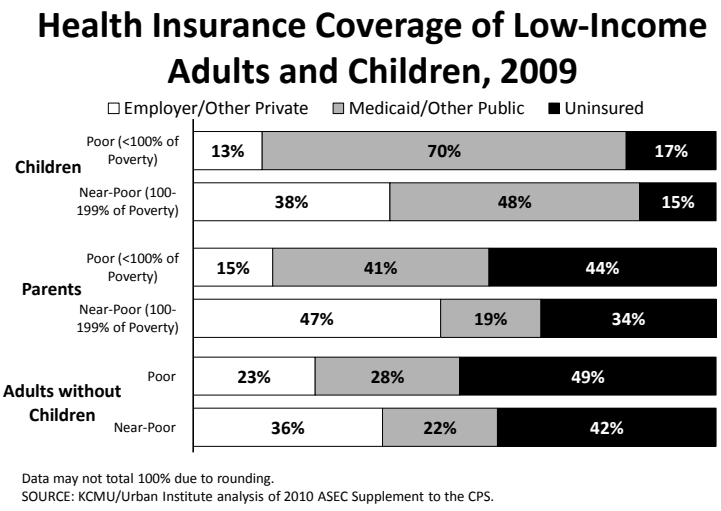


*The federal poverty line (FPL) for a family of three in 2009 is $18,310 per year.
**IL uses state funds to cover children above 200% FPL. MA uses state funds to 400% FPL.
SOURCE: Based on a national survey conducted by KCMU with the Center on Budget and Policy Priorities, 2009.

Medicaid and CHIP cover more than half of all low-income children. These programs have played a critical role in improving access to care for children. Still, three quarters of uninsured children are eligible for Medicaid or CHIP but are not enrolled.[54] Some families are not aware of the availability of the programs or may not believe their children are eligible. In addition, despite major improvements made over the past decade, burdensome enrollment and renewal requirements still pose major obstacles to participation.

In contrast to coverage for children, the role of Medicaid for nonelderly adults is more limited. Medicaid covers more than two-thirds of poor children and about half of all low-income children. However, eligibility for adults is more restricted. While all poor children are eligible for Medicaid, many of their parents are not. Most states have much lower income eligibility for parents than for children. In addition, although Medicaid covers some parents and low-income individuals with disabilities, 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). Many of these parents and childless adults will become eligible for Medicaid in 2014 as a result of the Medicaid expansion in the ACA.

Figure 19

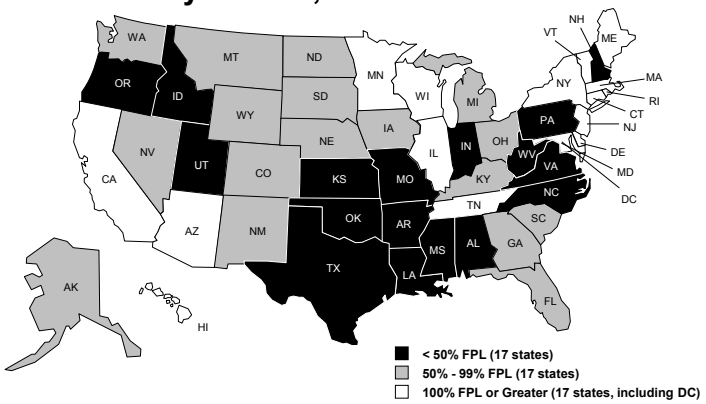


Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2010 ASEC Supplement to the CPS.

Some states have expanded Medicaid eligibility to cover more poor and near poor parents. About 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 20). In fact, 17 states set income eligibility levels for working parents below 50% of the poverty level. As a result, millions of poor parents are ineligible for Medicaid.

Figure 20

Medicaid Eligibility for Working Parents by Income, December 2009



*The federal poverty line (FPL) for a family of three in 2009 is $18,310 per year.
SOURCE: Based on a national survey conducted by KCMU with the Center on Budget and Policy Priorities, 2009.

In recent years, states have used their Medicaid and CHIP programs as a foundation for broader health care coverage expansions. States have built on these public programs to take advantage of the existing delivery and administrative systems as well as federal matching funds to help finance the expansions. In addition, eighteen states have obtained waivers of federal requirements to expand coverage to childless adults through their Medicaid programs.[55] 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. Although the dampened economic climate has put the future of many state coverage expansions in question, ARRA helped to protect Medicaid eligibility in 2009, and even with tight budgets some states reported eligibility expansions.[56]

Funding from ARRA through the enhanced FMAP helped states to maintain their Medicaid programs. Pressure from the recession remained severe throughout FY 2010 and into FY 2011. Fiscal relief funds in ARRA provided critical assistance to states in FYs 2009 and 2010; an extension of these funds through the end of FY 2011 was enacted but at a lower level than those originally approved in ARRA. The ARRA enhanced FMAP reduced state costs for Medicaid and helped to avoid or mitigate provider rate cuts in a time of unprecedented need for access to Medicaid benefits.

Increases in Medicaid and CHIP enrollment in 2009 helped to offset declines in private coverage. In 2009, an increase in Medicaid coverage helped to offset declines in private insurance. Medicaid's role in covering children was particularly important. While 2 million children lost private coverage in 2009, about 2.8 million gained Medicaid coverage, thus preventing the number of uninsured children from increasing significantly.

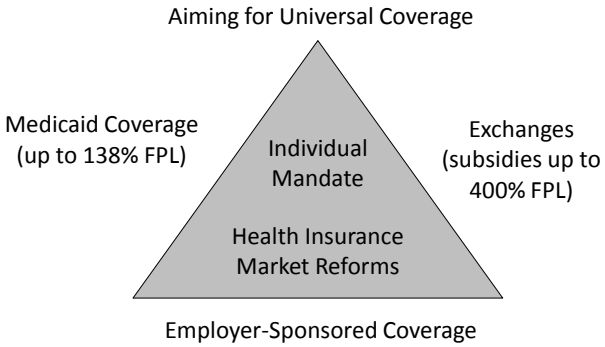
Looking forward, even when the economy moves toward economic recovery, enrollment in Medicaid will likely continue to increase. The Medicaid program is designed as a health coverage safety net, and as such, enrollment in the program increases during economic downturns when people lose their jobs and, therefore, their access to employer-sponsored health insurance.[57] Medicaid was able to play a key role in maintaining coverage partly because of the additional funding to states provided in the American Reinvestment and Recovery Act, and the requirement that states maintain existing eligibility levels. As the economy rebounds, historically state revenues and reduced pressure on Medicaid have lagged behind the initial economic recovery.

Expanding Health Insurance through Health Reform

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA) that provides new strategies to reduce the number of uninsured and makes significant changes to the organization and delivery of health care. The law promotes greater health coverage by building on the existing public-private system for providing health insurance coverage and fills in existing gaps in coverage by expanding the Medicaid program, building on employer-based coverage, and providing premium subsidies to make private insurance more affordable (Figure 21). The major coverage expansions will be implemented in 2014, although some improvements take effect earlier.

Figure 21

Health Coverage under Health Reform



Key Coverage Provisions

Medicaid Expansion

Beginning in 2014, Medicaid will be expanded to nearly all individuals under age 65 with incomes up to 138% of the federal poverty level.† This expansion will create a uniform minimum Medicaid eligibility threshold across states and will provide a new avenue for coverage for many low-income adults without dependent children who are currently not eligible for Medicaid in most states. To ensure that people do not lose Medicaid coverage before the expansion takes effect, states are required to maintain current Medicaid eligibility levels for adults until 2014, and eligibility levels for children in Medicaid and CHIP until 2019.

New Health Insurance Exchanges and Premium Subsidies

Also in 2014, states will set up Health Insurance Exchanges, which are essentially new marketplaces where individuals and small employers can purchase insurance. These new marketplaces are designed to ensure a more level competitive environment for insurers and to provide consumers with information on cost and quality to enable them to choose among plans.

To help ensure that coverage in these new Exchanges is affordable for those above the Medicaid eligibility levels, the federal government will make available premium subsidies for individuals and families with incomes from 138% to 400% of the federal poverty level ($43,400 for an individual and $88,200 for a family of four in 2010). These subsidies will be offered on a sliding scale basis that will limit the cost of the premium to a share of income up to 9.5 % of income for those with incomes between 300-400% of the

† The ACA expands Medicaid eligibility to 133% of the federal poverty level and also includes an automatic 5% income disregard, which raises the effective eligibility level to 138% of the federal poverty level.

poverty level. In addition, cost-sharing subsidies to reduce what people have to pay out-of-pocket to access health services will be available for people with incomes up to 250% of the poverty level.

Changes to Private Insurance

The law will improve the availability of health insurance by adopting new rules for insurers beginning in 2014 that will prevent them from denying coverage to people for any reason, including their health status, and from charging people who are sick more. However, the law will continue to allow insurers to charge older people more for coverage, though how much extra they can charge will be limited. The law will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage.

While most of the more significant coverage expansions do not occur until 2014, the law does make some important changes to private coverage that begin immediately. It creates a new Pre-existing Condition Insurance Program to provide coverage to people with pre-existing medical conditions who have been uninsured for at least six months. This coverage will be available through state high risk pools. In addition, beginning for new plans and when existing plans renew on or after September 23, 2010, young adults will be allowed to remain on their parent's health insurance until they turn 26.

Employer Requirements and Incentives

The law does not include a mandate that employers provide coverage to their employees; however, beginning in 2014, employers with more than 50 employees will be assessed a fee of up to $2,000 per full-time employee (in excess of 30 employees) if they do not offer affordable coverage and if they have at least one employee who receives a premium credit through an Exchange. This requirement does not apply to small employers.

Recognizing the challenges that small employers, especially those with low-wage workers, face in providing coverage to their employees, the law provides tax credits to the smallest employers (those with fewer than 25 workers and average annual wages of less than $50,000) to offset the cost of that coverage. These tax credits are available beginning in 2010.

Individual Mandate

Beginning in 2014, the law will require most individuals to have health insurance. However, this individual mandate will only apply to those with access to affordable coverage, defined as costing no more than 8% of an individual's or family's income (certain other exemptions to the mandate will also be granted). Greater access to Medicaid and the availability of new premium subsidies will increase the availability of affordable coverage options enabling more people to gain coverage. Still, those who choose not to have coverage and who are not exempt from the requirement will be required to pay a yearly financial penalty through their taxes.

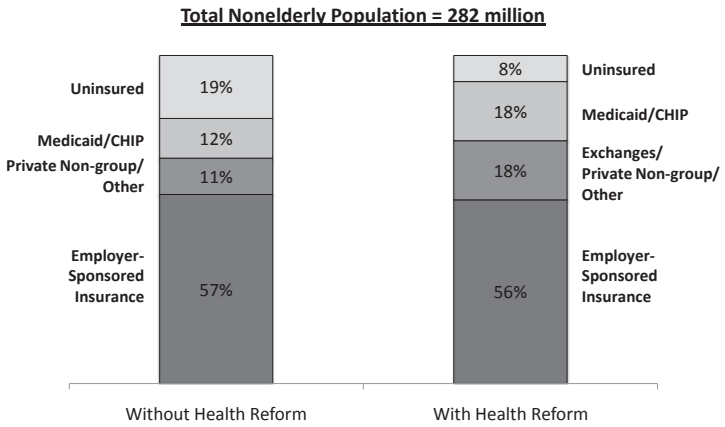
Impact of the Law on Coverage

When fully implemented in 2019, the Congressional Budget Office (CBO) estimates the law will expand coverage to 32 million people, cutting the uninsured rate in that year by more than half. According to CBO, the legislation will result in 16 million more people enrolling in Medicaid and the Children's Health Insurance Program. Another 24 million people (19 million of whom will receive federal premium subsidies) will obtain coverage in the newly created state health insurance Exchanges, including some who previously purchased coverage on their own in the individual market (Figure 22).

While the new law will make important strides in reducing the number of uninsured, an estimated 23 million people will remain uninsured in 2019. These individuals are likely to include immigrants who are not legal residents and are therefore not eligible for Medicaid coverage or for federal premium subsidies, people who are exempt from the mandate, in most cases because they do not have access to affordable coverage, and people who are subject to the mandate but choose to pay the penalty rather than purchase health insurance.

Figure 22

Estimated Health Insurance Coverage in 2019



SOURCE: Congressional Budget Office, March 20, 2010

Conclusion

The recent recession has laid bare some of the fundamental problems with our health care system. Declines in employer-sponsored coverage, evident since 2000, have been exacerbated by job losses during the current recession, leaving 4.3 million more people uninsured. For these newly uninsured, obtaining insurance through the individual market is not an option either because they are denied coverage outright or they are charged premiums they cannot afford. The Medicaid and CHIP programs have offered a safety net of coverage to those facing job displacement and financial hardship and have helped to prevent more people from being uninsured. However, the ability of Medicaid, in particular, to provide broader coverage is limited by low eligibility levels and restrictions on coverage in many states. While these problems reflect systemic failures, they have personal consequences. Being uninsured places people's health at risk and increases financial instability for individuals and families.

With 50 million uninsured today, implementing the new coverage provisions in the health reform law is more imperative than ever. The law will create new affordable coverage options in 2014 and provides more immediate mechanisms to stem further erosions in coverage. Importantly, once these changes are in place, far fewer individuals and families will face the health and financial consequences of not having health insurance.

This report was co-authored by Karyn Schwartz, Jhamirah Howard, and Jennifer Tolbert of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, and Emily Lawton and Vicki Chen of the Urban Institute.

Tables

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

Table 1
Characteristics of the Nonelderly Uninsured, 2009

	Nonelderly (millions)	Percent of Nonelderly	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total - Nonelderly[a]	**264.7**	**100.0%**	**50.0**	**100.0%**	**18.9%**
Age					
Children - Total	**79.3**	**30.0%**	**8.3**	**16.6%**	**10.4%**
Adults - Total	**185.4**	**70.0%**	**41.7**	**83.4%**	**22.5%**
Adults 19-25	29.1	11.0%	9.6	19.2%	33.0%
Adults 26-34	36.4	13.8%	10.5	21.0%	28.8%
Adults 35-44	40.2	15.2%	8.8	17.5%	21.8%
Adults 45-54	44.3	16.7%	7.9	15.8%	17.8%
Adults 55-64	35.4	13.4%	4.9	9.9%	13.9%
Annual Family Income					
<$20,000	66.2	25.0%	25.0	50.1%	37.8%
$20,000 - $39,999	52.1	19.7%	13.7	27.4%	26.3%
$40,000 +	146.5	55.3%	11.2	22.5%	7.7%
Family Poverty Level[c]					
≤138%	**74.1**	**28.0%**	**25.9**	**51.8%**	**34.9%**
...<100%	55.6	21.0%	19.8	39.7%	35.7%
...100-138%	18.5	7.0%	6.1	12.1%	32.8%
139-399%	**101.9**	**38.5%**	**19.4**	**38.7%**	**19.0%**
...139-250%	51.0	19.3%	12.9	25.8%	25.3%
…251-399%	50.9	19.2%	6.5	13.0%	12.7%
400%+	**88.7**	**33.5%**	**4.8**	**9.5%**	**5.4%**
Household Type					
Single Adults Living Alone	19.5	7.4%	4.1	8.2%	20.9%
Single Adults Living Together	33.5	12.6%	12.5	25.0%	37.3%
Married Adults	54.5	20.6%	8.9	17.7%	16.3%
1 Parent with children[d]	33.4	12.6%	6.7	13.3%	19.9%
2 Parents with children[d]	108.6	41.0%	13.5	27.0%	12.4%
Multigenerational/Other with children[e]	15.2	5.7%	4.4	8.8%	29.0%
Family Work Status					
2 Full-time	68.2	25.8%	5.3	10.5%	7.7%
1 Full-time	135.4	51.1%	25.4	50.8%	18.8%
Only Part-time[f]	24.1	9.1%	8.0	16.1%	33.4%
Non-Workers	37.1	14.0%	11.3	22.6%	30.5%
Race/Ethnicity					
White only (non-Hispanic)	166.0	62.7%	23.4	46.8%	14.1%
Black only (non-Hispanic)	33.5	12.7%	7.6	15.2%	22.6%
Hispanic	46.0	17.4%	15.6	31.2%	33.9%
Asian/S. Pacific Islander only	12.9	4.9%	2.4	4.7%	18.3%
Am. Indian/Alaska Native	1.8	0.7%	0.5	1.0%	28.4%
Two or More Races[g]	4.4	1.7%	0.5	1.1%	12.3%
Citizenship					
U.S. citizen - native	231.8	87.5%	37.4	74.7%	16.1%
U.S. citizen - naturalized	12.8	4.8%	2.9	5.9%	23.0%
Non-U.S. citizen, resident for < 5 years	4.1	1.5%	1.8	3.6%	44.5%
Non-U.S. citizen, resident for 5+ years	16.1	6.1%	7.9	15.7%	48.9%
Health Status					
Excellent/Very Good	178.0	67.2%	28.8	57.6%	16.2%
Good	63.3	23.9%	15.8	31.6%	24.9%
Fair/Poor	23.5	8.9%	5.4	10.8%	23.0%

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

Table 2
Characteristics of Uninsured Children, 2009

	Children (millions)	Percent of Children	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total - Children[h]	**79.3**	**100.0%**	**8.3**	**100.0%**	**10.4%**
Age					
<1	4.2	5.3%	0.5	5.9%	11.6%
1-5	21.3	26.9%	1.9	22.5%	8.7%
6-18	53.8	67.8%	5.9	71.6%	11.0%
Family Income					
<$20,000	20.0	25.2%	3.6	43.1%	17.9%
$20,000 - $39,999	14.6	18.4%	2.1	25.4%	14.4%
$40,000 +	44.7	56.4%	2.6	31.5%	5.8%
Family Poverty Level[c]					
≤138%	**28.2**	**35.6%**	**4.8**	**57.8%**	**17.0%**
...<100%	21.5	27.1%	3.7	44.5%	17.2%
...100-138%	6.7	8.5%	1.1	13.4%	16.4%
139-399%	**30.8**	**38.8%**	**2.8**	**34.3%**	**9.2%**
...139-250%	16.0	20.2%	1.8	22.1%	11.4%
…251-399%	14.8	18.6%	1.0	12.2%	6.8%
400%+	**20.3**	**25.6%**	**0.7**	**7.9%**	**3.2%**
Household Type[i]					
1 Parent[d]	20.0	25.3%	2.5	29.7%	12.3%
2 Parents[d]	52.0	65.6%	4.2	51.3%	8.2%
Multigenerational/Other[e]	6.4	8.1%	1.3	16.1%	20.7%
Family Work Status					
2 Full-time	21.5	27.1%	1.3	15.2%	5.9%
1 Full-time	40.5	51.1%	4.1	49.5%	10.1%
Only Part-time[f]	6.4	8.0%	0.9	11.3%	14.7%
Non-Workers	11.0	13.8%	2.0	24.0%	18.2%
Race/Ethnicity					
White only (non-Hispanic)	43.7	55.1%	3.2	38.5%	7.3%
Black only (non-Hispanic)	11.3	14.2%	1.3	16.2%	11.9%
Hispanic	17.9	22.6%	3.1	37.8%	17.5%
Asian/S. Pacific Islander only	3.5	4.5%	0.4	4.5%	10.6%
Am. Indian/Alaska Native	0.6	0.8%	0.1	1.3%	(18.3%)
Two or More Races[g]	2.3	2.9%	0.1	1.6%	5.8%
Citizenship					
U.S. Citizen	76.8	96.9%	7.5	90.0%	9.7%
Non-U.S. citizen, resident for < 5 years	1.0	1.2%	0.3	3.7%	(31.8%)
Non-U.S. citizen, resident for 5+ years	1.5	1.9%	0.5	6.3%	34.8%
Health Status					
Excellent/Very Good	63.6	80.2%	6.2	74.4%	9.7%
Good	13.9	17.5%	2.0	23.6%	14.1%
Fair/Poor	1.8	2.2%	0.2	2.0%	9.3%

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

Table 3
Health Insurance Coverage of the Nonelderly, 2009

	Nonelderly (millions)	Percent Distribution by Coverage Type				
		Private		**Public**		**Uninsured**
		Employer	Individual	Medicaid	Other[b]	
Total - Nonelderly[a]	**264.7**	**56.5%**	**5.2%**	**16.7%**	**2.7%**	**18.9%**
Age						
Children - Total	**79.3**	**50.9%**	**4.0%**	**33.2%**	**1.4%**	**10.4%**
Adults - Total	**185.4**	**59.0%**	**5.7%**	**9.6%**	**3.2%**	**22.5%**
Adults 19-25	29.1	41.0%	10.8%	13.5%	1.6%	33.0%
Adults 26-34	36.4	54.7%	4.5%	10.4%	1.6%	28.8%
Adults 35-44	40.2	63.3%	4.1%	8.9%	1.9%	21.8%
Adults 45-54	44.3	66.1%	4.7%	8.0%	3.3%	17.8%
Adults 55-64	35.4	64.2%	5.8%	8.5%	7.6%	13.9%
Annual Family Income						
<$20,000	66.2	14.7%	6.2%	37.2%	4.1%	37.8%
$20,000 - $39,999	52.1	43.4%	5.1%	21.7%	3.4%	26.3%
$40,000 +	146.5	80.1%	4.8%	5.6%	1.8%	7.7%
Family Poverty Level[c]						
≤138%	**74.1**	**15.3%**	**5.5%**	**40.8%**	**3.5%**	**34.9%**
...<100%	55.6	12.3%	5.5%	43.4%	3.1%	35.7%
...100-138%	18.5	24.2%	5.3%	33.0%	4.8%	32.8%
139-399%	**101.9**	**60.8%**	**5.5%**	**11.6%**	**3.1%**	**19.0%**
...139-250%	51.0	47.9%	6.0%	17.1%	3.7%	25.3%
…251-399%	50.9	73.8%	5.0%	6.1%	2.4%	12.7%
400%+	**88.7**	**86.1%**	**4.6%**	**2.4%**	**1.6%**	**5.4%**
Household Type						
Single Adults Living Alone	19.5	55.4%	7.8%	10.6%	5.2%	20.9%
Single Adults Living Together	33.5	40.2%	8.5%	10.7%	3.2%	37.3%
Married Adults	54.5	68.2%	5.4%	5.7%	4.3%	16.3%
1 Parent with children[d]	33.4	33.1%	4.1%	41.5%	1.4%	19.9%
2 Parents with children[d]	108.6	66.4%	4.3%	15.3%	1.6%	12.4%
Multigenerational/Other with children[e]	15.2	33.3%	2.9%	31.8%	2.9%	29.0%
Family Work Status						
2 Full-time	68.2	81.9%	3.3%	5.9%	1.2%	7.7%
1 Full-time	135.4	60.9%	5.1%	13.5%	1.8%	18.8%
Only Part-time[f]	24.1	25.8%	10.7%	27.5%	2.7%	33.4%
Non-Workers	37.1	14.0%	5.6%	41.2%	8.7%	30.5%
Race/Ethnicity						
White only (non-Hispanic)	166.0	65.3%	6.4%	11.5%	2.8%	14.1%
Black only (non-Hispanic)	33.5	43.1%	2.8%	27.8%	3.8%	22.6%
Hispanic	46.0	35.2%	2.5%	26.8%	1.6%	33.9%
Asian/S. Pacific Islander only	12.9	59.4%	7.0%	13.3%	2.0%	18.3%
Am. Indian/Alaska Native	1.8	38.4%	---	29.1%	2.5%	28.4%
Two or More Races[g]	4.4	51.0%	4.5%	28.2%	4.0%	12.3%
Citizenship						
U.S. citizen - native	231.8	58.5%	5.3%	17.2%	2.8%	16.1%
U.S. citizen - naturalized	12.8	58.4%	5.5%	10.6%	2.5%	23.0%
Non-U.S. citizen, resident for < 5 years	4.1	30.8%	4.6%	18.8%	1.3%	44.5%
Non-U.S. citizen, resident for 5+ years	16.1	33.1%	3.2%	13.8%	1.0%	48.9%
Health Status						
Excellent/Very Good	178.0	62.2%	5.9%	14.2%	1.6%	16.2%
Good	63.3	49.3%	4.2%	18.7%	2.8%	24.9%
Fair/Poor	23.5	33.1%	3.0%	29.9%	11.1%	23.0%

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

Table 4
Health Insurance Coverage of Children, 2009

	Children (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
Total - Children[h]	**79.3**	**50.9%**	**4.0%**	**33.2%**	**1.4%**	**10.4%**
Age						
<1	4.2	43.9%	2.4%	40.6%	1.6%	11.6%
1-5	21.3	47.6%	2.7%	39.3%	1.5%	8.7%
6-18	53.8	52.7%	4.7%	30.2%	1.4%	11.0%
Annual Family Income						
<$20,000	20.0	10.8%	2.7%	67.4%	1.3%	17.9%
$20,000 - $39,999	14.6	29.4%	3.3%	51.4%	1.5%	14.4%
$40,000 +	44.7	75.8%	4.9%	12.0%	1.5%	5.8%
Family Poverty Level[c]						
≤138%	**28.2**	**13.8%**	**2.7%**	**65.2%**	**1.3%**	**17.0%**
...<100%	21.5	10.7%	2.5%	68.3%	1.4%	17.2%
...100-138%	6.7	23.8%	3.1%	55.5%	1.2%	16.4%
139-399%	**30.8**	**61.8%**	**4.8%**	**22.5%**	**1.7%**	**9.2%**
...139-250%	16.0	49.3%	4.5%	32.9%	1.9%	11.4%
…251-399%	14.8	75.3%	5.1%	11.2%	1.5%	6.8%
400%+	**20.3**	**85.9%**	**4.7%**	**4.9%**	**1.2%**	**3.2%**
Household Type[i]						
1 Parent with children[d]	20.0	29.9%	3.7%	53.2%	1.0%	12.3%
2 Parents with children[d]	52.0	62.8%	4.2%	23.2%	1.6%	8.2%
Multigenerational/Other with children[e]	6.4	23.1%	2.7%	52.2%	1.3%	20.7%
Family Work Status						
2 Full-time	21.5	76.3%	3.4%	13.2%	1.2%	5.9%
1 Full-time	40.5	53.2%	4.5%	30.6%	1.6%	10.1%
Only Part-time[f]	6.4	18.5%	5.0%	60.6%	1.2%	14.7%
Non-Workers	11.0	11.1%	2.9%	66.2%	1.5%	18.2%
Race/Ethnicity						
White only (non-Hispanic)	43.7	63.4%	5.3%	22.6%	1.4%	7.3%
Black only (non-Hispanic)	11.3	34.5%	2.0%	49.6%	2.0%	11.9%
Hispanic	17.9	30.4%	2.0%	49.0%	1.1%	17.5%
Asian/S. Pacific Islander only	3.5	57.7%	6.2%	24.4%	---	10.6%
Am. Indian/Alaska Native	0.6	(28.9%)	---	(49.4%)	---	(18.3%)
Two or More Races[g]	2.3	47.8%	3.0%	40.0%	3.4%	5.8%
Citizenship						
U.S. citizen	76.8	51.6%	4.0%	33.2%	1.5%	9.7%
Non-U.S. citizen, resident for < 5 years	1.0	(28.3%)	---	(36.5%)	---	(31.8%)
Non-U.S. citizen, resident for 5+ years	1.5	27.4%	3.8%	33.4%	---	34.8%
Health Status						
Excellent/Very Good	63.6	55.2%	4.4%	29.3%	1.5%	9.7%
Good	13.9	34.6%	2.7%	47.4%	1.2%	14.1%
Fair/Poor	1.8	26.0%	2.9%	59.9%	1.8%	9.3%

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

Table 5
Health Insurance Coverage of the Nonelderly by State, 2008-2009

	Nonelderly	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
	(thousands)[a]	Employer	Individual	Medicaid	Other[b]	
United States	**263,743**	**58.1%**	**5.2%**	**15.8%**	**2.7%**	**18.1%**
Alabama	3,994	59.6%	3.0%	17.4%	3.2%	16.8%
Alaska	610	56.0%	3.8%	12.6%	7.0%	20.6%
Arizona	5,757	49.6%	5.7%	20.6%	2.5%	21.6%
Arkansas	2,445	50.5%	5.0%	17.8%	5.4%	21.2%
California	32,574	52.1%	6.5%	18.4%	1.6%	21.4%
Colorado	4,388	61.2%	7.1%	10.7%	3.6%	17.4%
Connecticut	2,994	69.0%	5.0%	11.8%	1.7%	12.6%
Delaware	742	63.4%	4.4%	15.6%	2.6%	14.0%
District of Columbia	528	57.2%	6.3%	23.0%	1.2%	12.4%
Florida	15,069	52.7%	5.9%	12.2%	3.8%	25.3%
Georgia	8,674	57.2%	4.2%	13.5%	4.1%	21.0%
Hawaii	1,027	66.7%	3.9%	15.5%	4.5%	9.4%
Idaho	1,332	59.0%	8.5%	13.0%	2.1%	17.4%
Illinois	11,266	61.4%	5.1%	15.9%	2.2%	15.5%
Indiana	5,481	62.3%	3.6%	16.7%	2.2%	15.1%
Iowa	2,619	65.1%	7.2%	13.9%	1.9%	11.8%
Kansas	2,391	62.6%	7.1%	12.2%	3.6%	14.5%
Kentucky	3,709	56.4%	4.3%	17.8%	3.1%	18.4%
Louisiana	3,837	54.0%	5.5%	16.7%	3.4%	20.3%
Maine	1,096	57.4%	4.6%	22.1%	3.7%	12.2%
Maryland	4,938	68.1%	4.9%	10.6%	1.9%	14.6%
Massachusetts	5,566	68.8%	3.7%	20.5%	1.3%	5.7%
Michigan	8,565	63.3%	4.6%	16.0%	1.7%	14.4%
Minnesota	4,485	66.7%	6.4%	15.0%	2.0%	9.9%
Mississippi	2,486	47.9%	4.6%	23.5%	3.8%	20.2%
Missouri	5,135	60.0%	5.7%	14.7%	3.6%	16.0%
Montana	826	54.9%	9.1%	13.0%	4.5%	18.6%
Nebraska	1,552	63.9%	7.6%	12.5%	2.7%	13.4%
Nevada	2,303	61.5%	4.1%	9.8%	2.6%	22.1%
New Hampshire	1,141	72.2%	4.9%	8.6%	2.6%	11.7%
New Jersey	7,512	67.0%	3.7%	11.0%	1.5%	16.8%
New Mexico	1,713	45.7%	4.2%	19.9%	4.5%	25.7%
New York	16,722	55.9%	4.4%	21.8%	1.6%	16.2%
North Carolina	8,054	56.0%	5.5%	15.4%	4.1%	19.1%
North Dakota	546	64.6%	10.6%	9.3%	2.5%	12.9%
Ohio	9,897	62.7%	5.0%	14.8%	2.7%	14.8%
Oklahoma	3,069	56.2%	4.7%	16.3%	4.2%	18.6%
Oregon	3,292	59.0%	6.2%	13.3%	1.9%	19.6%
Pennsylvania	10,419	64.8%	5.5%	15.7%	1.7%	12.4%
Rhode Island	898	61.6%	4.9%	18.0%	1.8%	13.7%
South Carolina	3,836	58.2%	4.5%	14.0%	4.2%	19.1%
South Dakota	683	59.7%	8.2%	13.2%	3.7%	15.2%
Tennessee	5,308	53.7%	5.6%	18.4%	4.6%	17.8%
Texas	21,897	49.2%	4.1%	15.6%	2.9%	28.1%
Utah	2,528	67.8%	6.8%	8.4%	1.6%	15.3%
Vermont	529	60.4%	4.1%	22.4%	2.2%	10.9%
Virginia	6,749	65.2%	5.0%	10.1%	5.3%	14.4%
Washington	5,809	60.3%	6.3%	15.5%	3.6%	14.2%
West Virginia	1,497	58.2%	2.4%	17.8%	4.3%	17.2%
Wisconsin	4,787	65.5%	5.5%	16.1%	1.9%	11.0%
Wyoming	465	60.8%	7.4%	11.6%	3.3%	16.9%

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

Table 6
Health Insurance Coverage of Children by State, 2008-2009

	Children	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
	(thousands)[h]	Employer	Individual	Medicaid	Other[b]	
United States	**78,991**	**52.6%**	**4.1%**	**31.5%**	**1.5%**	**10.4%**
Alabama	1,188	51.0%	2.4%	38.6%	---	6.5%
Alaska	194	49.2%	3.9%	23.9%	10.6%	12.4%
Arizona	1,821	42.8%	4.7%	36.7%	---	15.0%
Arkansas	746	41.3%	3.6%	42.6%	---	11.0%
California	9,999	47.2%	4.5%	36.2%	1.0%	11.1%
Colorado	1,296	57.8%	6.4%	21.1%	3.2%	11.4%
Connecticut	862	66.0%	4.9%	21.9%	---	6.8%
Delaware	223	59.2%	3.7%	26.1%	---	9.5%
District of Columbia	117	42.0%	---	(47.7%)	---	7.5%
Florida	4,243	48.6%	5.0%	26.5%	2.0%	17.8%
Georgia	2,702	52.5%	2.7%	30.3%	3.1%	11.5%
Hawaii	309	54.9%	3.7%	31.5%	5.3%	4.6%
Idaho	443	54.5%	7.7%	27.3%	---	9.7%
Illinois	3,369	55.5%	3.4%	32.4%	---	8.1%
Indiana	1,716	53.9%	2.9%	35.0%	---	7.7%
Iowa	762	58.6%	6.4%	28.6%	---	5.8%
Kansas	750	55.6%	5.0%	26.4%	3.0%	10.0%
Kentucky	1,071	49.3%	3.6%	36.9%	---	9.6%
Louisiana	1,200	47.5%	5.2%	36.1%	---	10.3%
Maine	292	52.4%	4.2%	36.5%	---	5.3%
Maryland	1,415	64.3%	4.2%	23.5%	---	6.8%
Massachusetts	1,552	65.0%	2.5%	29.0%	---	3.3%
Michigan	2,526	59.3%	4.0%	30.8%	---	5.6%
Minnesota	1,300	63.3%	4.5%	25.4%	---	6.1%
Mississippi	833	39.6%	2.8%	44.0%	---	12.3%
Missouri	1,519	55.4%	5.4%	29.6%	---	8.5%
Montana	230	52.1%	6.1%	28.2%	2.6%	11.1%
Nebraska	478	58.6%	5.2%	25.8%	2.0%	8.4%
Nevada	712	58.6%	3.8%	19.8%	---	16.6%
New Hampshire	308	70.4%	4.7%	20.2%	---	3.9%
New Jersey	2,186	65.0%	2.8%	20.9%	---	10.4%
New Mexico	544	38.0%	3.3%	39.2%	3.8%	15.6%
New York	4,684	50.7%	3.5%	37.9%	---	7.6%
North Carolina	2,440	49.5%	4.5%	31.1%	3.8%	11.0%
North Dakota	154	63.7%	6.3%	21.0%	---	7.3%
Ohio	2,885	58.5%	4.1%	28.8%	1.2%	7.5%
Oklahoma	971	44.9%	3.6%	38.2%	3.0%	10.4%
Oregon	921	52.6%	6.3%	28.5%	---	11.9%
Pennsylvania	2,976	59.4%	3.4%	29.7%	---	7.3%
Rhode Island	247	54.9%	3.1%	33.7%	---	7.4%
South Carolina	1,147	54.4%	4.1%	26.8%	1.8%	12.9%
South Dakota	212	52.7%	6.0%	28.8%	2.5%	9.9%
Tennessee	1,560	47.8%	3.5%	36.2%	3.9%	8.6%
Texas	7,232	42.1%	3.4%	34.8%	1.7%	18.0%
Utah	916	67.4%	6.0%	14.7%	---	11.0%
Vermont	135	51.2%	2.4%	40.8%	---	4.9%
Virginia	2,004	63.1%	4.0%	21.2%	4.2%	7.5%
Washington	1,652	52.2%	5.2%	33.1%	3.5%	6.1%
West Virginia	411	51.4%	2.0%	39.3%	---	6.2%
Wisconsin	1,399	61.9%	3.6%	28.3%	---	5.5%
Wyoming	142	56.2%	6.3%	25.2%	3.0%	9.3%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with larger margins of error or with 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] Other includes other public insurance (mostly Medicare and military-related). CHIP is included in Medicaid.

[c] The 2009 federal poverty level for a family of four was $22,050.

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

[e] 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).

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

[g] 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.

[h] Children includes all individuals under age 19.

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

[j] Nonelderly adults includes all individuals aged 19-64.

[k] Workers includes all workers aged 18-64.

[l] Worker's income only; does not include income from other family members or other sources.

[m] Self-employed includes only the self-employed who are working in firms with fewer than 25 workers.

[n] A small percentage (<1%) of workers are former military and are included in the "Other Occupations" and "Total Workers" totals.

[o] Other occupations include the following types of jobs: assistants, clerical workers, technicians, repair workers, artists, entertainers, sports-related workers, service workers, laborers, salespersons, operators (equipment, including drivers), skilled trade workers, and assemblers.

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, CHIP, 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 half 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 as a percent 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.

Endnotes

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