

medicaid
and the **uninsured**

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**The Uninsured and Their Health Care Needs:
How Have They Changed Since the Recession?**

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Introduction

As the nation's economy continues to struggle, many Americans are losing their private health insurance coverage and joining the ranks of the uninsured. In 2010, more Americans were uninsured than at any time in the previous decade.¹ While the Patient Protection and Affordable Care Act (ACA) will expand health coverage to millions of uninsured Americans, understanding the uninsured population and its needs remains an important concern for policymakers, as major coverage provisions of ACA do not go into effect until 2014. As high rates of unemployment are expected to continue for the foreseeable future, high rates of uninsurance are likely to continue—and perhaps increase further—until the full implementation of health reform in 2014. Thus, there are immediate policy concerns about meeting the current needs of the large and growing uninsured population.

In addition, those who have recently lost their employer-sponsored insurance and become uninsured may have different health needs or characteristics than the previously uninsured population. Since previous analyses of the impact of health reform by the Congressional Budget Office (CBO) and other researchers were made largely based on characteristics of the uninsured prior to the recession, it is important to understand how the uninsured population has changed to assess the effects of the ACA and to prepare for health reform implementation.

Last, even after ACA is fully implemented, many people are expected to remain uninsured. Understanding the health care needs of those who remain uninsured is important to efforts to structure a safety net beyond 2014.

This analysis uses the Center for Studying Health System Change's (HSC) 2010 Health Tracking Household Survey, the 2007 HSC Health Tracking Household Survey and the 2003 HSC Community Tracking Household Survey to describe the uninsured population and how it has changed over the past decade, especially between 2007 and 2010 when the recession caused many with previously stable coverage to become uninsured. It finds that, while the uninsured population remains disproportionately made up of younger people, the poor, and racial/ethnic minorities, uninsurance rose the fastest among the near-elderly, whites, and those with higher incomes. Many of these demographic shifts may be attributed to the great recession that began in late 2007, while other trends in the characteristics of the uninsured have been longstanding and show little change.

Background

Most nonelderly Americans receive health insurance coverage as a fringe benefit linked to either their own or a family member's job. As a result, when people lose their jobs, they often lose their health insurance. Further, having a job does not guarantee health coverage. Currently, employers are not required to offer coverage, and even if they do, some employees may be ineligible for coverage or may not be able to afford their share of the premium. Those without employer-sponsored coverage can try to purchase coverage directly from insurance companies, but such coverage is often prohibitively expensive and many do not qualify based on medical history. Medicaid and the Children's Health Insurance Program (CHIP) provide public coverage to some low-income individuals, but gaps in eligibility for these programs—particularly for adults without children—leave many without access to insurance.

Over the last decade, the United States experienced an economic slowdown (2000-2004), followed by a brief recovery (2004-2007)² and then, at the end of 2007, a significant recession.³ While there have been brief periods of improvement in employment during that time, rates of insurance (particularly employer-sponsored insurance) have fallen consistently.⁴ An estimated 5 million Americans lost employment-sponsored health coverage between 2007 and 2009.⁵ The decline in employer-sponsored coverage is a result of several factors: employment rates dropped, incomes fell, and those workers who remained employed were more likely to work in industries where fewer jobs come with insurance. These employment changes were most pronounced among low-income people. Federal subsidies for COBRA premiums slightly blunted the effect of job loss on insurance, but take up of these subsidies was low.⁶ Medicaid and CHIP filled in gaps for many low-income families, particularly children, but most uninsured adults are ineligible for coverage under current program rules. As states struggled to balance their budgets, few enacted Medicaid expansions to cover more adults. By the end of the decade, the unemployment rate had risen to 9.6 percent,⁷ and the number of uninsured continued to grow.

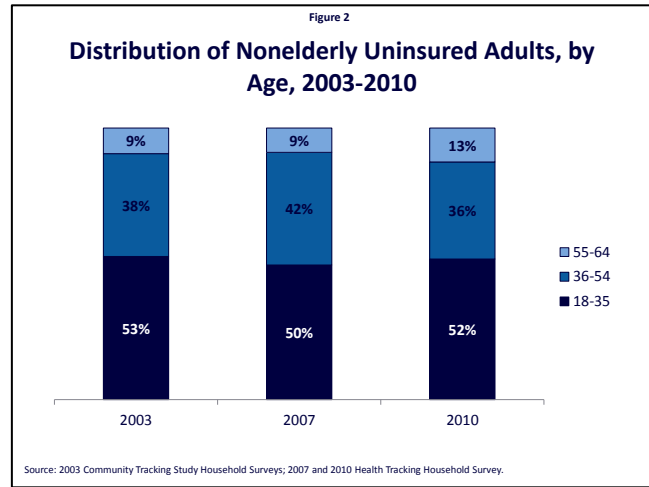
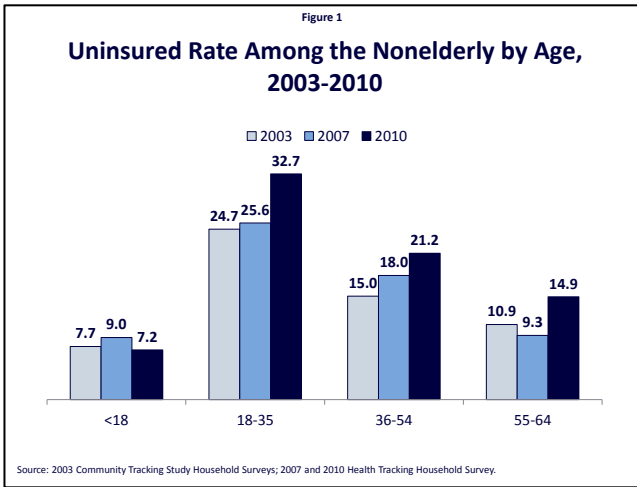
Key Findings

The Health Tracking Household Survey finds that the share of the nonelderly population that lacks insurance coverage has grown over the study period. In 2010, 19.5 percent of the population under age 65 lacked insurance coverage, up from 15.0 percent in 2003 and 16.3 percent in 2007 (see Table 1). This translates to 51.5 million uninsured nonelderly in 2010, an increase of more than 14 million uninsured since 2003 (see Appendix Table A). Most of the growth in the uninsured was in the second half of the study period, from 2007 to 2010.*

Compared to adults, children remain relatively protected from rising uninsured rates. In recent years, the uninsured rate has risen fastest among young adults and the near-elderly, changing the age composition of the uninsured. 7.2 percent of children (or 5.4 million children) and 24.4 percent of nonelderly adults (or 45.5 million adults) were uninsured in 2010. The uninsured rate among children has remained relatively stable since 2003 (see Figure 1), as this group is protected from uninsurance by the safety nets of Medicaid and CHIP. In contrast, the uninsured rate has risen among adults since 2003, with rates increasing more rapidly between 2007 and 2010. In recent years (2007-2010), the most rapid growth in the uninsured rate was among young adults (ages 18-35) and the near-elderly (ages 55-64).

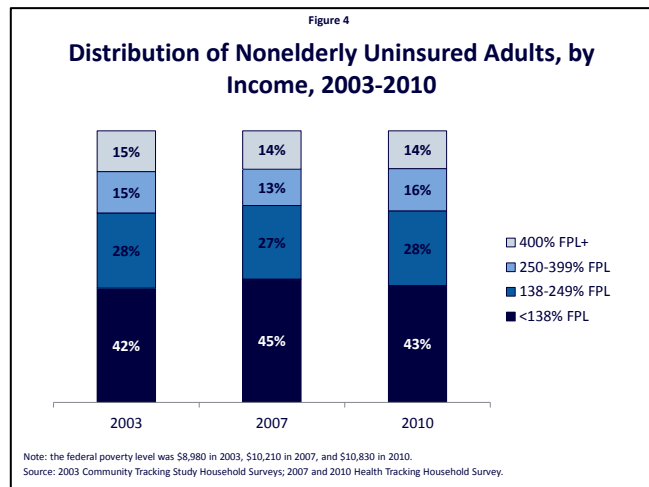
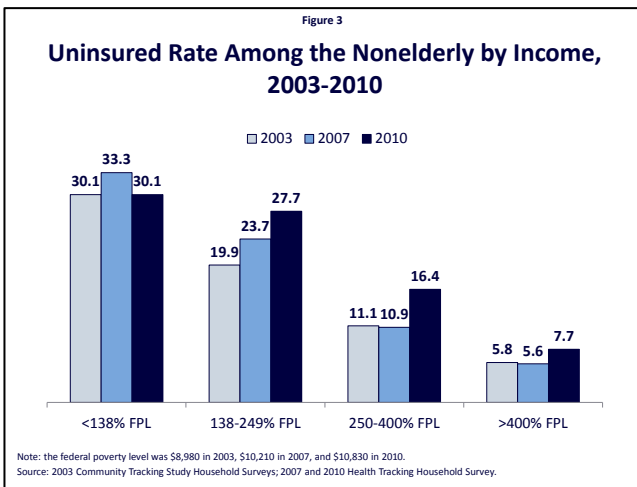
* Estimates from the HSC Health Tracking Household Survey of trends in the number of uninsured are consistent with other national surveys, such as the Current Population Survey (CPS), although there may be slight differences in estimates for specific years.

As a result of changing uninsured rates among adults, near-elderly adults accounted for a larger share of the uninsured adult population in 2010 than in earlier survey periods (see Figure 2 and Table 3). However, the uninsured are still relatively young, with young adults accounting for about half of uninsured adults throughout the study period.



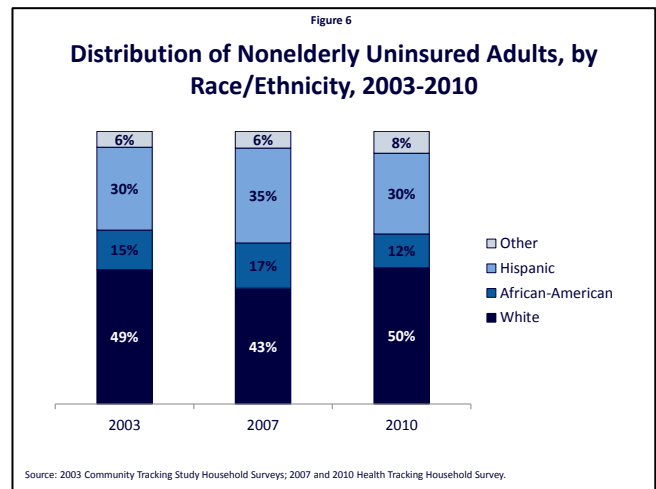
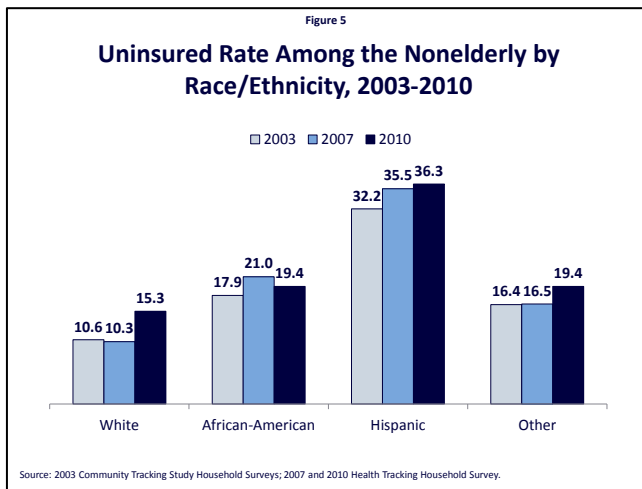
While the uninsured population is still disproportionately low income, uninsured rates have risen fastest among those in middle- and upper-income groups. Those in the lowest income group (below 138% of the federal poverty level (FPL), or \$25,268 for a family of three in 2010) have the highest uninsured rate, with over 30 percent lacking coverage in 2010 (see Figure 3). While much higher than the uninsured rate for other income groups, the uninsured rate among the lowest income group did not change significantly over the study period. In contrast, the uninsured rates for middle-income groups (138-249% FPL and 250-400% FPL) increased significantly over the study period of 2003 to 2010, from 19.9 to 27.7 percent and from 11.1 to 16.4 percent, respectively. In the most recent period studied (2007-2010), the uninsured rate increased significantly among those in the higher-income ranges (250-400% FPL and 400% FPL and up).

Despite the increase in the risk of being uninsured among those reporting income between 138% and 400% FPL, those with incomes below 138% FPL still accounted for more than 40 percent of uninsured adults in 2010 (see Figure 4 and Table 3). And respondents in the highest-income group (>400% FPL) still comprised only around 14 percent of uninsured adults despite their rising rate of uninsurance.



Though racial and ethnic minorities remain more likely to be uninsured than whites, the uninsured rate among whites is increasing. In all three waves of the survey, racial and ethnic minorities had higher uninsured rates than whites. In 2010, nearly one in five African Americans and more than one in three Hispanics was uninsured. However, the rate of uninsurance among minorities has not changed significantly over time. In contrast, the uninsured rate among whites increased in the most recent period (2007-2010), from about 10 percent to more than 15 percent (see Figure 5).

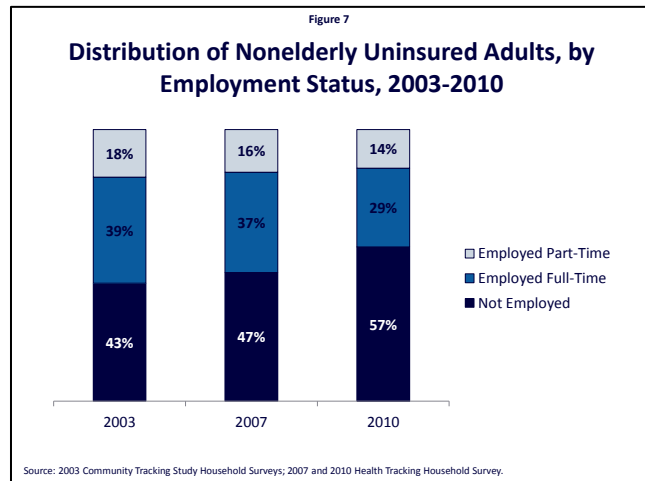
Because the uninsured rate for whites is still low relative to other racial and ethnic groups, this trend has not changed the racial and ethnic composition of the uninsured. In 2010, nearly half of the uninsured adult population was white, around one-third was Hispanic, and the remainder African Americans (around 12%) and other racial/ethnic groups (see Figure 6 and Table 3).



In recent years, the uninsured rate has converged for urban and rural areas. While previous rounds of the survey found significant differences in the uninsured rate for urban versus rural areas, in 2010 there was no significant difference in the uninsured rate by urban or rural status. This convergence is a result of particularly rapid increases in uninsurance in small metropolitan and rural areas. The changing geography of the uninsured is also seen in regional data, which show a significant increase in the uninsured rate for the Midwest (see Table 1).

Immigrants are at higher risk of being uninsured than non-immigrants, but the uninsured rate is rising among those born in the United States. In 2010, more than half of non-citizen adults were uninsured (see Table 2), compared to about a quarter of adults naturalized as citizens and a fifth of adults born in the United States. However, only adults born in the United States had a significant increase in the uninsured rate, up from about 15 percent in 2003.

An increasing share of uninsured adults is not working. In 2010, 57 percent of the nonelderly adult uninsured population were not working, up from 43 percent in 2003 and 47 percent in 2007 (see Figure 7 and Table 3).[†] (This measure includes those who may be retired, out of the workforce for other reasons, not looking for work, or unemployed and looking for work.) Correspondingly, fewer uninsured adults were working at a single job (either part time or full time).



Among uninsured adults who are working, almost half (47%) do not have access to employer-sponsored coverage, either through their own job or through a spouse (see Table 4). The distribution of uninsured workers across firm size and type (e.g., private or government organization) has not changed significantly over time. An increasing share of the working uninsured is in industries that have traditionally offered health coverage, but this shift is not statistically significant. Notably, an increasing share of uninsured working adults lives in households with union membership, a group that has traditionally had stable insurance coverage.

The health status of uninsured adults has fluctuated over the study period but is not significantly worse now than it was in 2003. Despite changes in the composition of the uninsured population since 2003, roughly the same proportion (around 24%) reported fair or poor health status in 2010 as did in 2003 (around 22%) (see Table 5). However, at the mid-point of our analysis (2007), a larger share of uninsured adults (32%) reported that they were in fair or poor health. Similarly, the share of uninsured adults who report having a chronic health condition rose in 2007 but then fell back toward prior levels. This pattern could be explained by economic trends, as the relatively healthy may have moved out of the uninsured pool in the middle period of the decade (as they gained employment) and then back into the uninsured pool at the end of the decade (as they lost employment).

When looking at the prevalence of specific diseases among uninsured adults, no clear pattern emerges (data not shown). Between 2003 and 2010, more uninsured adults reported having hypertension or diabetes, while there was no significant change in the prevalence of depression. These figures likely reflect national trends suggesting that the nation as a whole has experienced worsening health over the past decade, with increased rates of obesity, diabetes and other chronic conditions.⁸

Health care utilization patterns for uninsured adults track health status, rising slightly mid-decade and dropping by the end of the study period. In 2010, more than half of uninsured adults reported using some combination of outpatient, emergency department or hospital care over the previous 12 months (see Table 5). All types of utilization (outpatient, emergency care and inpatient hospitalization) rose slightly from 2003 to 2007 and then fell slightly by 2010. Most notably, the share of uninsured adults

[†] To note, our measures of employment status are distinct from the CPS measures, which calculates unemployment rate as the percentage of the work force that is unemployed at any given date, and also examines employment status at the family level; our data examines at the individual level and includes retirees and those that are not currently part of the work force.

with a doctor's visit in the past year rose from 2003 to 2007 (from 44.5% to 51.3%) then dropped significantly in 2010 (to 43.5%). In addition to this decline in the likelihood of use, there was also a significant drop in the intensity of use in 2010, with the number of visits (among those with a visit) dropped from 4.3 visits/year to 3.2 visits/year. Utilization patterns for non-physician providers, such as nurse practitioners and physician assistants (not shown) are similar, indicating that the uninsured were not simply substituting other outpatient care for physician services.

Of note, despite public perceptions that the uninsured crowd emergency departments seeking basic health care, around twice as many uninsured reported at least one outpatient physician's visit over the prior 12 months compared with the proportion reporting at least one emergency department visit. Overall, the uninsured use emergency care at around the same rate as the insured but are much less likely to use outpatient care (data not shown).

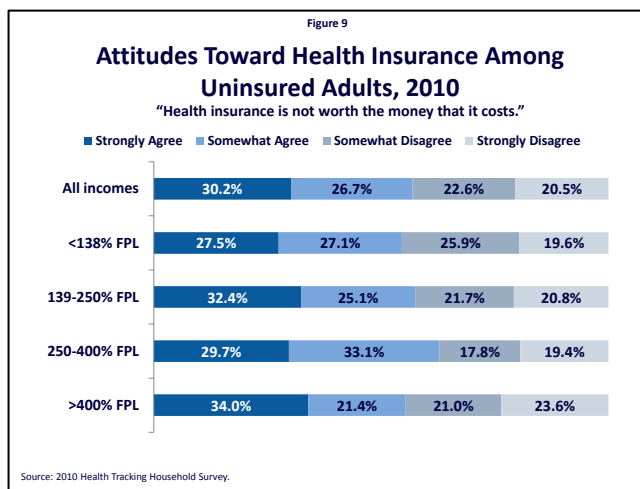
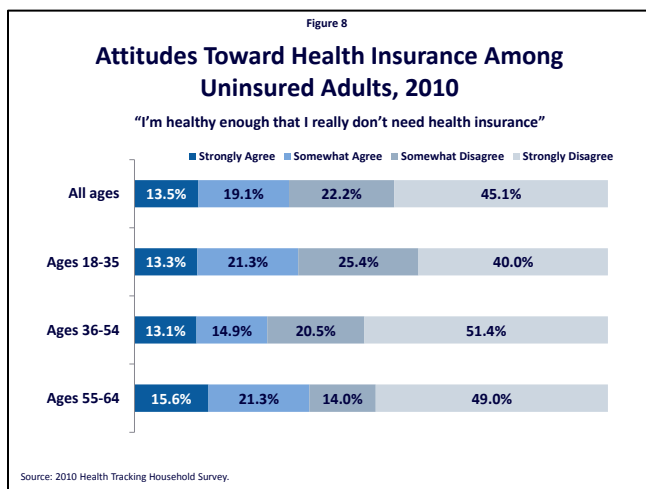
In addition, the utilization patterns in Table 5 may reflect differences in elasticity of demand for different services. The changes in hospital use and emergency use were not significant over time, while changes in doctor's visits (which are likely for lower acuity problems) did significantly change over time. Among those with chronic illnesses, such as hypertension or diabetes, there was no significant change in the likelihood of an office visit for their illness. In contrast, among those with depression, the pattern (of an increase in use in 2007 followed by a decline in use in 2010) was significant. Research has found that mental health services are more elastic—that is, more responsive to price and availability—than other types of services, which may explain the recent decrease in office visits for depression.⁹

Out-of-pocket health care spending among uninsured adults tracks utilization, and many uninsured adults report problems paying medical bills. In 2010, nearly two-thirds of uninsured adults paid for medical care in the past year (see Table 5). The share of uninsured adults who reported paying out of pocket for medical care rose between 2003 and 2007 and declined in 2010. This trend appears to reflect utilization patterns for this population rather than other factors (such as the likelihood of being charged), since out-of-pocket spending among those with a visit was stable over the study period (data not shown). More than 82 percent of uninsured adults who used a medical service in the past year paid some amount out-of-pocket for health care.

An increasing share of uninsured adults reported problems paying medical bills in the past year (31.2% in 2010 vs. 26.0% in 2003). Interestingly, the share of uninsured adults reporting that they receive a discount for medical care has remained stable over time, indicating that the uninsured are not more likely to negotiate for lower prices as their numbers increase, or perhaps that providers are not more willing to offer discounts.

Most uninsured adults believe they need health insurance. However, they are concerned about the cost. Under ACA, individuals will be required to have health insurance, with an exception if no affordable premium is available. This requirement is primarily to engage younger, healthier consumers whose participation is necessary to maintain a balanced risk pool.¹⁰ Previous research has found that the main reason that people are uninsured is because of cost rather than lack of desire to have coverage.¹¹ The Health Tracking Survey findings similarly suggest that many uninsured adults value insurance coverage, with less than a third agreeing with the statement that they are too healthy to need insurance coverage (see Table 6). These views hold even among those who reported good, very good or excellent health and are fairly consistent across age, income and race/ethnicity. Of note, the near-elderly (55-64) were just as likely as young adults (18-35) to feel that they were healthy enough not to need insurance (37% vs. 35%) (see Figure 8). Not surprisingly, those in poor or fair health were least

likely to agree that they were healthy enough not to need coverage.



However, a majority of the uninsured (57%) agreed that health insurance is not worth the money it costs. Again, this result held across age, gender and race. Compared to those with excellent, very good or good health, uninsured adults in fair or poor health were somewhat more likely to agree that coverage was not worth the cost. These individuals may face higher premiums for coverage in the current market. As of 2014, ACA will end the medical underwriting that raises the cost of insurance for the sickest consumers purchasing non-group coverage.

In addition, those of low to moderate income (138%-400% of FPL) were somewhat more likely to believe coverage is not worth the cost than those at the lowest and highest income levels (see Figure 9). These differences may reflect the idea that those with moderate incomes struggle to afford insurance without the safety-net services available to some of the poorest. ACA includes income-adjusted subsidies to make private coverage affordable for those who do not qualify for free coverage through Medicaid. These subsidies limit what people will be required to pay for health insurance to a percentage of their income, ranging from 3 percent of income for people with incomes at 133 percent of the federal poverty level to 9.5 percent of income for people with incomes between 300 and 400 percent of the poverty level. It remains to be seen whether the cost of coverage with these subsidies will meet the uninsured populations' expectations of affordability.

Discussion

The slow economy has led millions of Americans to lose their health insurance coverage: by 2010, 51.5 million nonelderly Americans were uninsured, an increase of more than 14 million since 2003. The growth in the uninsured is concentrated among adults, who are less likely than children to be protected from coverage loss by the availability of Medicaid or CHIP. In many states Medicaid coverage for parents targets those with very low incomes, and most states do not extend coverage to adults without children regardless of income level. Under ACA, Medicaid will be expanded to all individuals up to 138% of the poverty level, expanding the safety net for low-income adults.

In contrast to current coverage levels for adults, all states have expanded Medicaid or CHIP coverage for children well beyond the federal minimum levels in Medicaid, and maintenance of eligibility (MOE) requirements tied to increased federal funding have led states to maintain eligibility despite mounting budget pressures. Without the MOE requirements and enhanced federal funding, many states almost

certainly would have needed to turn to cutbacks in eligibility in 2010, and it is possible that coverage rates for children would have declined similarly to those for adults.

The current economic climate also has reshaped the uninsured population, bringing relatively higher-income respondents into the uninsured population. While most of the uninsured still fall within the income range for either Medicaid coverage (<139% FPL) or premium subsidies (139-400% FPL) under ACA, the growing share of the uninsured with incomes above 400 percent of FPL will be ineligible for subsidies. Interestingly, these individuals are about as likely as those in the lowest-income group to feel that health insurance is not worth the cost. Since the uninsured of all incomes report they would like to have insurance, implementing the affordability provisions in the law will be important.

Reflecting declining employment rates in the nation, the proportion of uninsured adults who are not working has increased in recent years. The unemployed face many challenges in finding coverage. Both COBRA continuation coverage and individually purchased coverage are often prohibitively expensive, particularly for those struggling with reduced income, and many adults do not meet eligibility criteria for Medicaid coverage. If current economic conditions persist, the changing work composition of the uninsured could alter the pathways through which people gain coverage under ACA; specifically, fewer uninsured would be covered through provisions that build on employer-sponsored coverage and more would be covered through provisions that target individuals directly.

In addition, an increasing share of the uninsured is near-elderly, a group that is more likely to have chronic conditions and other health problems requiring care than their younger counterparts. Despite this shift, the self-reported health status of uninsured adults in 2010 was similar to what it was in 2003. However, in 2007, a larger proportion of uninsured adults reported being in fair or poor health.

Uninsured adults' health care utilization patterns over time likely reflect patterns of health status described above, increasing when more uninsured are in poor health or have chronic conditions and declining when the health profile of the uninsured improves. Another possible explanation for the recent decline in utilization is the growth in unemployment and drop in incomes, which could lead the uninsured to be less likely to seek care, knowing they cannot afford the cost or have reduced access to credit.

When uninsured people do use services, most pay for their care. While the amount that the uninsured pay has not changed significantly over time, an increasing share of uninsured people report problems paying their medical bills. Further, there is no change in the likelihood of the uninsured being able to negotiate for a lower or discounted rate for their services. Like others, providers (and particularly safety net providers that serve the uninsured) are facing severe budget constraints, and most cannot afford to substantially expand their uncompensated services. These figures indicate that millions of uninsured Americans face immediate challenges in affording their medical care.

The CBO estimates that more than 30 million uninsured people will obtain coverage under ACA provisions starting in 2014, which could markedly decrease the share of total uninsured, as well as the share of individuals with problems paying medical bills.¹² Until then, many Americans will continue to struggle with increasing health care costs and difficulties obtaining care. Looking forward, ease of enrollment in Medicaid coverage and affordability in state health insurance exchanges will likely be crucial to whether those who will qualify for coverage obtain insurance. As this and other studies have found,¹³ the majority of the uninsured feel that they need insurance regardless of their health status.

Appendix: Description of Data Sources

The estimates in this report are based on analyses of the 2010 and 2007 Health Tracking Household Surveys and the 2003 Community Tracking Study Household Survey. All three surveys were sponsored by the Robert Wood Johnson Foundation and conducted by the Center for Studying Health System Change and Mathematica Policy Research, Inc. All three surveys are telephone-based surveys and include nationally representative samples of the civilian, noninstitutionalized population. Questionnaire design, survey administration, and the question wording of all measures in this report were virtually identical across all three surveys. Total sample sizes for the surveys were about 47,000 persons for the 2003 survey, 17,800 persons for the 2007 survey, and 16,700 for the 2010 survey. Sample sizes for the uninsured population are 4,800 for the 2003 survey, 1,850 for the 2007 and 2,250 for the 2010 survey.

There are some differences in sample design between the three surveys. The sample for the 2003 survey was based on 60 randomly selected communities, while the 2007 and 2010 surveys were based on a strictly random sample of the nation. Survey weights and standard errors of the estimates take into account these design differences, including the clustering of the sample for the 2003 survey into 60 sites.

In addition, the 2003 and 2007 surveys were based entirely on a sample of landline telephones. However, given the growth in the number of households without landline telephones (about 30 percent by 2010), one-fourth of the sample for the 2010 survey consisted of cell phone numbers.¹⁴ Population weights for the 2010 survey account for both the overlap of landline and cell phone households (i.e. many households have both landline and cell phones) as well as differences in the characteristics of the cell phone and landline samples. While the 2003 and 2007 surveys did not include cell phone samples, survey weights for the 2007 survey were post-stratified to population totals from the 2006 National Health Interview Survey, which includes detailed information on households without landline telephones, as well as the Current Population Survey.

Despite the adjustments in the sample weights, it is possible that the change in sample design between 2007 and 2010 may affect some estimates of change. For example, sensitivity analyses indicate that the improvements in health status between 2007 and 2010 were somewhat smaller when the 2010 sample was restricted to persons with landline telephones, indicating that cell phone respondents are somewhat healthier on average than landline telephone respondents. In addition, the large increase in the percent of young adults (ages 18-34) who were uninsured between 2007 and 2010 may be due in part to the inclusion of the cell phone sample in 2010, as they are disproportionately more likely to have cell phones but no landline phones. Determining the effect of the cell phone sample on estimates of change is difficult, however, since the large decrease in households with landline telephones means that the characteristics of these households has likely changed between 2007 and 2010.

Response rates for the surveys were 57 percent in 2003 and 43 percent in 2007. For 2010, the response rates were 45 percent for the landline sample and 29 percent for the cell phone sample. Survey weights in all three surveys were post-stratified to account for survey nonresponse based on age, sex, race/ethnicity, and education.

Acknowledgement

The survey data used for the analysis was sponsored by the Robert Wood Johnson Foundation.

	2003	2007	2010
Total nonelderly population	249.1 million	259.6 million	263.9 million
Share uninsured:	15.0%	16.3%	19.5% *§
Share uninsured by characteristic:			
<i>Gender</i>			
Male	16.4	17.6	21.1 *§
Female	13.7	15.1	17.9 *§
<i>Age</i>			
<18	7.7	9.0	7.2
18-35	24.7	25.6	32.7 *§
36-54	15.0	18.0 *	21.2 *§
55-64	10.9	9.3	14.9 *§
<i>Family Poverty Level</i>			
<138%	30.1	33.3	30.1
138-249%	19.9	23.7	27.7 *
250-400%	11.1	10.9	16.4 *§
>400%	5.8	5.6	7.7 §
<i>Race/Ethnicity</i>			
White	10.6	10.3	15.3 *§
African-American	17.9	21.0	19.4
Hispanic	32.2	35.5	36.3
Other	16.4	16.5	19.4
<i>Rural/Urban</i>			
Large Metropolitan Area	15.4	15.2	18.0 *§
Small Metropolitan Area	12.3	15.7	21.2 *
Rural Area	14.4	21.7 *	20.3 *
<i>Census Region</i>			
Northeast	10.6	10.3	11.7
Midwest	10.3	11.2	16.7 *§
South	18.6	20.6	21.7 *
West	17.5	18.8	21.6
Notes: Includes everyone under age 65.			
* Value is significantly different from 2003 value (p<0.05)			
§ 2010 Value is significantly different from 2007 value (p<0.05)			
Source: 2003 Community Tracking Study Household Survey, 2007 and 2010 Health Tracking Household Surveys.			

Table 2: Uninsured Rates Among the Adult Nonelderly Population, 2003-2010			
	2003	2007	2010
Adult nonelderly population	176.4 million	185.7 million	189.3 million
Share uninsured	18.1%	19.2%	24.4% *§
Share uninsured by characteristic:			
Gender			
Male	20.3	20.8	27.3 *§
Female	15.9	17.7	21.5 *§
Age			
18 – 35	24.7	25.6	32.7 *§
36 – 54	15.0	18.0 *	21.2 *§
55 – 64	10.9	9.3	14.9 *§
Family Poverty Level			
<138%	40.8	43.1	41.3
138-249%	25.4	29.6	35.5 *§
250-400%	13.2	12.7	19.8 *§
>400%	6.6	6.5	9.3 *§
Race/Ethnicity			
White	12.9	12.4	18.9 *§
African-American	22.2	25.5	24.2
Hispanic	39.6	43.4	46.7 *
Other	19.7	18.8	25.0
Immigration Status			
Born a Citizen	15.1	15.4	20.4 *§
Naturalized As a Citizen	20.8	16.2	24.6
Non-Citizen	47.3	54.7	54.0
Rural/Urban			
Large Metropolitan Area	18.2	17.7	22.6 *§
Small Metropolitan Area	14.8	18.5	26.0 *
Rural Area	18.4	26.6 *	24.8 *
Census Region			
Northeast	13.1	12.2	15.0
Mideast	12.3	14.3	21.0 *§
South	22.5	24.2	26.8 *
West	20.7	21.1	26.6 *§
Notes: Includes those ages 18-64.			
* Value is significantly different from 2003 value (p<0.05)			
§ 2010 Value is significantly different from 2007 value (p<0.05)			
Source: 2003 Community Tracking Study Household Surveys; 2007 and 2010 Health Tracking Household Survey.			

Table 3: Characteristics of Uninsured Nonelderly Adults, 2003-2010			
	2003	2007	2010
Uninsured Nonelderly Adults	31.9 million 100%	35.7 million 100%	46.1 million 100%
Distribution of uninsured nonelderly adults by:			
Gender			
Male	55.3	53.4	55.5
Female	44.7	46.6	44.5
Age			
18-35	52.7	49.6	51.8
36-54	37.9	41.5	35.7§
55-64	9.4	8.9	12.5*§
Family Poverty Level			
<138%	42.1	45.4	43.1
138-249%	27.7	27.1	27.5
250-400%	15.2	13.4	15.5
>400%	15.0	14.1	13.9
Race/Ethnicity			
White	49.3	42.5	50.0
African-American	14.6	16.6	12.4
Hispanic	30.4	34.8	29.6
Other	5.8	6.1	8.0
Rural/Urban			
Large Metropolitan Area	75.7	69.6	73.2
Small Metropolitan Area	4.8	7.1	7.3
Rural Area	19.5	23.3	19.5
Census Region			
Northeast	14.4	10.5	13.3
Midwest	14.2	17.4	20.1
South	42.9	46.3	40.0§
West	28.5	25.8	26.7
Employment Status			
Not Employed	43.4	47.3	56.9*§
One Job, Full-Time (> 35 Hours Per Week)	33.6	31.1	23.3*§
One Job, Part-Time	16.7	14.8	12.8*
Multiple Jobs, At Least One Full-Time	5.4	5.8	5.7
Multiple Jobs, Part-Time Only	0.8	0.9	1.4
Notes: Includes uninsured ages 18-64.			
* Value is significantly different from 2003 value (p<0.05)			
§ 2010 Value is significantly different from 2007 value (p<0.05)			
Source: 2003 Community Tracking Study Household Surveys; 2007 and 2010 Health Tracking Household Survey.			

Table 4: Characteristics of Uninsured Nonelderly Adult Workers, 2003-2010			
	2003	2007	2010
Uninsured Nonelderly Adult Workers	18.0 million 100%	18.8 million 100%	19.9 million 100%
Distribution by:			
Access to Employer-Sponsored Insurance¹			
Offered And Eligible	30.0	33.1	34.4
Offered, Not Eligible	19.8	18.6	18.1
Not Offered	50.2	48.3	47.4
Firm Size And Type			
Private Company, Firm Size <50	44.1	40.2	39.2
Private Company, Firm Size >50-100	4.7	5.6	4.6
Private Company, Firm Size >100	25.3	25.6	27.3
Government	6.8	8.8	8.5
Self-Employed	19.1	19.8	20.4
Industry			
Low ESI Coverage Firms ²	61.5	62.5	56.5
High ESI Coverage Firms	38.5	37.5	43.6
Union Membership In Household			
Yes	3.4	4.8	6.3*
No	96.6	95.2	93.7*
Notes:			
* Value is significantly different from 2003 value (p<0.05)			
§ 2010 Value is significantly different from 2007 value (p<0.05)			
¹ Includes access through self or through spouse. "Offered, Not Eligible" indicates that the employer offers insurance to some employees, but the respondent does not qualify for that coverage.			
² Low ESI coverage firms include the following industries: agriculture, forestry, fishing, construction, retail trade, and personal, business, and repair services.			
Source: 2003 Community Tracking Study Household Surveys; 2007 and 2010 Health Tracking Household Survey.			

Table 5. Health status , health services utilization, and expenditures of uninsured adults, 2003-2010

	2003	2007	2010
Uninsured Nonelderly Adults	31.9 million 100%	35.7 million 100%	46.1 million 100%
Distribution of uninsured nonelderly adults by:			
Health Status			
Excellent, Very Good, Or Good	77.8	68.1*	76.2§
Fair Or Poor	22.2	31.9*	23.8§
Prevalence Of Chronic Conditions			
None	65.7	56.8*	59.9*
1-2	28.9	34.2*	33.2*
3 Or More	5.4	9.0*	6.8
Health Services Utilization in Past 12 Months			
Any Medical Visit			
Any Medical Visit	54.6	60.5*	56.2
Doctor's Office Visit			
1 Or More	44.5	51.3*	43.5§
Average # Of Visits (among those with any MD visit)	4.1	4.3	3.2*§
Hospital Stay			
1 Or More	6.5	7.0	5.3
Average # Hospitalizations (among those with any)	1.3	1.8	1.3
Emergency Department Visit			
1 Or More	22.6	26.2	22.7
Average # Of Visits (among those with any ED visit)	1.9	2.2	2.0
Medical Expenditures In Past 12 Months			
Out-Of-Pocket Spending			
No Out-Of-Pocket Spending	40.7	29.6*	36.4§
<\$500	33.5	39.2*	33.3§
\$500 - \$1,999	16.4	19.2	18.8
\$2,000 - \$2,999	4.1	5.7	4.5
\$3,000 - \$4,999	2.4	3.1	3.5
>\$5,000	2.9	3.3	3.5
Problems Paying Medical Bills	26.0	35.3*	31.2*
Ability To Receive Discounts At Usual Source Of Care			
Pay Full Price	53.5	52.1	53.8
Pay Discounted/Lower Amount	46.5	47.9	46.2
Notes:* Value is significantly different from 2003 value (p<0.05)			
§ 2010 Value is significantly different from 2007 value (p<0.05)			
Source: 2003 Community Tracking Study Household Surveys; 2007 and 2010 Health Tracking Household Survey.			

Table 6. Attitudes about health insurance coverage among uninsured adults, 2010		
	% Strongly or Somewhat Agree	% Strongly or Somewhat Disagree
<i>"I'm healthy enough that I really don't need health insurance."</i>		
All Uninsured Adults	32.6	67.3
Age		
18 – 35 (R)	34.6	65.4
36 – 54	28.0*	71.9*
55 – 64	36.9	63.0
Gender		
Male (R)	38.4	61.6
Female	25.5*	74.6*
Race/Ethnicity		
White (R)	31.5	68.6
African-American	29.2	70.8
Hispanic	33.5	66.5
Other	42.9	57.1
Family Poverty Level		
< 138% (R)	31.7	68.4
138-249%	34.1	66.0
250-400%	33.0	67.0
>400%	32.4	67.5
Health Status		
Excellent/Very Good/Good (R)	36.7	63.3
Poor/Fair	20.3*	79.7*
<i>"Health insurance is not worth the money that it costs."</i>		
All Uninsured Adults	56.9	43.1
Age		
18 – 35 (R)	52.8	47.2
36 – 54	63.3*	36.7*
55 – 64	56.8	43.3
Gender		
Male (R)	57.6	42.4
Female	56.0	43.9
Race/Ethnicity		
White (R)	59.7	40.4
African-American	54.7	45.4
Hispanic	51.8*	48.2*
Other	62.7	37.2
Family Poverty Level		
< 138% (R)	54.6	45.5
138-249%	57.5	42.5
250-400%	62.8	37.2
>400%	55.4	44.6
Health Status		
Excellent/Very Good/Good (R)	56.1	43.9
Poor/Fair	59.4	40.6
(R) = Reference group; * Value is significantly different from reference group (p<0.05)		
Source: 2010 Health Tracking Household Survey		

Appendix Table A: Number of Nonelderly Uninsured by Key Characteristics, 2003-2010			
	2003	2007	2010
Total Nonelderly Uninsured	37.4 million	42.3 million	51.5 million
Number of Uninsured by Characteristic (millions)			
Gender			
Male	20.3	22.8	27.8
Female	17.2	19.6	23.6
Age			
<18	5.6	6.6	5.4
18-35	16.8	17.7	23.9
36-54	12.1	14.8	16.5
55-64	3.0	3.2	5.8
Family Poverty Level			
<138%	15.8	19.3	22.2
138-249%	10.6	11.7	14.4
250-400%	5.76	5.9	8.0
>400%	5.3	5.5	6.9
Race/Ethnicity			
White	18.0	17.2	25.5
African-American	5.4	6.8	6.5
Hispanic	11.9	15.7	15.5
Other	2.1	2.6	4.0
Rural/Urban			
Large Metropolitan Area	28.7	30.0	34.1
Small Metropolitan Area	1.7	3.0	3.4
Rural Area	7.0	9.3	9.2
Census Region			
Northeast	5.2	4.4	5.9
Midwest	5.4	6.7	9.1
South	15.7	19.1	18.6
West	11.2	11.6	12.5
Note: Numbers may not sum to totals due to rounding.			
Source: 2003 Community Tracking Study Household Surveys; 2007 and 2010 Health Tracking Household Survey			

This brief was prepared by Emily Carrier and Tracy Yee of the Center for Studying Health System Change and Rachel Garfield of the Kaiser Commission on Medicaid and the Uninsured.

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