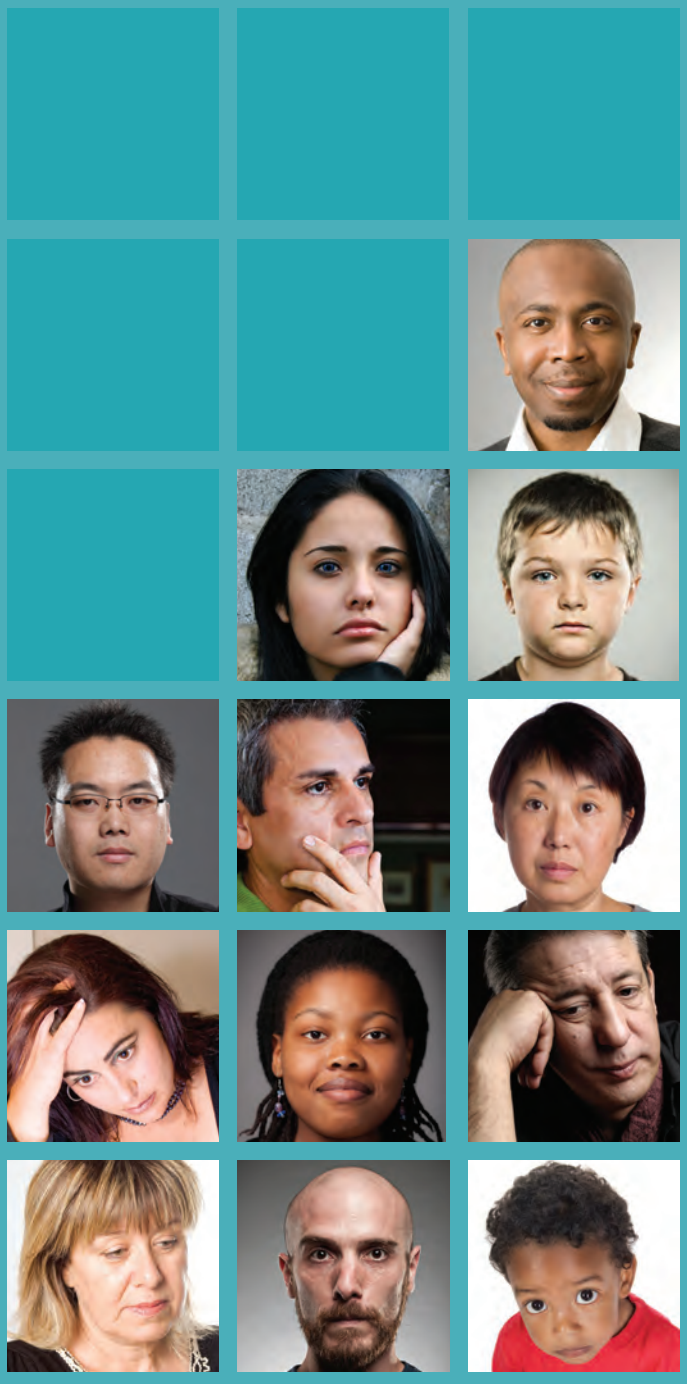
THE UNINSURED
A PRIMER



Key Facts About Americans Without Health Insurance

OCTOBER 2012

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

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.

The Uninsured: A Primer

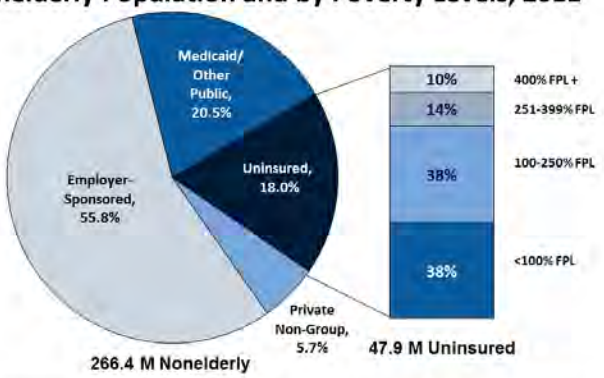
In 2011, 48 million nonelderly Americans were uninsured, a decrease of over 1.3 million uninsured people since 2010. This change resulted from stability in private coverage and the availability of Medicaid to buffer loss of health insurance for the low-income population. While the first decrease in the number of uninsured since 2007 is promising, the number of uninsured has grown by more than 4.5 million people since the recession began in 2007.

Introduction

In 2011, 48 million nonelderly Americans were uninsured. Nearly all of the elderly are insured by Medicare, yet nearly 690,000 of the elderly were uninsured in 2011.* A majority of the nonelderly receive their health insurance as a job benefit, but not everyone has access to or can afford this type of coverage. Few people can afford to purchase coverage on their own through the non-group market. Medicaid and the Children's Health Insurance Program (CHIP) fill in gaps in the availability of coverage for millions of people, in particular, children. More than one in six (18%) of the nonelderly was uninsured in 2011 (Figure 1).

Figure 1

The Uninsured Population—As a Share of the Nonelderly Population and by Poverty Levels, 2011



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 2011 was $22,350.
SOURCE: KCMU/Urban Institute analysis of the 2012 ASEC supplement to the CPS.

The gaps in our health insurance 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 population live in working families—almost four out of ten of the uninsured are individuals and families who are poor (incomes less than the federal poverty level of $22,350 for a family of four in 2011).

Being uninsured affects people's access to needed medical care and their financial security. The access barriers facing uninsured people mean 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 struggle financially to meet basic needs and medical bills can quickly lead to medical debt.

Over the next five years, the Affordable Care Act (ACA) of 2010 is expected to reduce the uninsured rate by more than half.[1] The ACA will fill existing gaps in coverage by providing for an expansion of Medicaid for adults with incomes at or below 138% of poverty, building on employer-based coverage, and providing premium subsidies to make private insurance more affordable for many with incomes less than 400% of poverty.[2]

This primer presents basic information about the uninsured population—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 people has changed and how the ACA will impact those without health coverage.

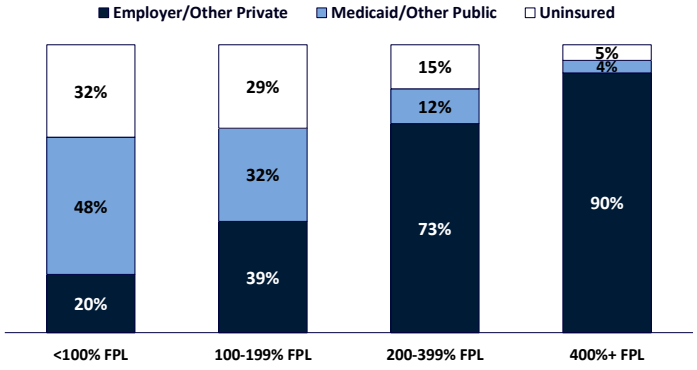
* Our analysis of the Current Population Survey's ASEC supplement differs from estimates by the Census Bureau in several ways outlined in the Data Notes in the end of this primer.

How Do Most Americans Obtain Health Insurance?

More than half (56%) 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 almost 48 million nonelderly people in the U.S.—18% of those under age 65—without health coverage. The Patient Protection and Affordable Care Act of 2010 (ACA) is designed to expand access to health coverage, and most of the law's key provisions regarding the expansion of coverage will take effect in 2014. The risk of being uninsured is greatest for those with the lowest incomes (Figure 2), and the ACA targets this population through federal subsidies to help purchase private insurance coverage and expanded eligibility for Medicaid.

Figure 2

Health Insurance Coverage of the Nonelderly by Poverty Level, 2011



FPL -- The federal poverty level was $22,350 for a family of four in 2011. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Employer-Sponsored Health Insurance Coverage

The majority of employers offer group health insurance policies to their employees and to their employees' families. In 2012, 61% of firms offer coverage to their employees.[3] Among individuals with employer-sponsored coverage, about half are covered by their own employer (51%) and half are covered as an employee's dependent (49%).[4] Health insurance offer rates vary among businesses, with large firms and those with more high-wage workers being more likely to offer coverage.

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 health benefits in 2012, an average of 77% of their workers are eligible for coverage.[5] The ACA aims to expand access to employer-sponsored coverage through both temporary subsidies for the smallest firms and, starting in 2014, penalties for larger firms that do not offer adequate coverage.

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.

Non-Group Health Insurance Coverage

Private policies directly purchased in the non-group market (i.e., outside of employer-sponsored benefits) cover only 5.7% of people under age 65. The share of the nonelderly population with private non-group insurance has changed very little over time.

Non-group insurance premiums can be more expensive for the enrollee than group plans purchased by employers. Though, on average, non-group insurance premiums are lower than for employer-sponsored coverage, enrollees pay 100% of the cost because they cannot share that premium expense with an employer. Nationwide, the average monthly premium per person in the non-group market in 2010 was $215, with substantial variation by state.[6] Vermont and Massachusetts both had average per member per month premiums over $400, compared to less than $160 in Alabama and California. Beginning in 2014, most people with incomes up to 400% of the federal poverty level who cannot access affordable employers-sponsored insurance will be able to purchase coverage through Health Insurance Exchanges with the assistance of premium and cost-sharing subsidies.

Insurance premiums in the non-group market may vary by age and health status and may be less comprehensive than group plans purchased by employers.[7] Under the current system, applicants with health problems that are offered non-group coverage may be charged a higher premium due to their medical history or their policy may exclude specific conditions through an elimination rider. In addition, many states allow non-group policies to exclude coverage for maternity care or limit prescription drug coverage. Deductibles and other cost sharing in non-group plans are often higher than in employer-sponsored coverage.

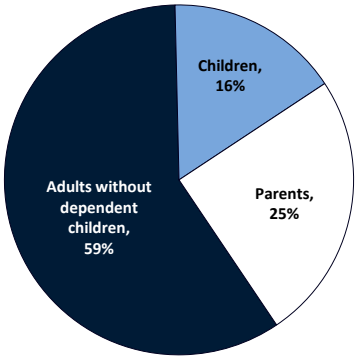
Obtaining coverage in the individual market can be difficult, particularly for those who are older or have had health problems. In 2008, 29% of individuals age 60 to 64 who applied for non-group insurance were denied coverage based on their health status.[8] Starting in 2014, insurers will be barred from taking pre-existing conditions into account when issuing policies for adults. Beginning in September 2010, the ACA prohibited individual and group health plans from denying children coverage based on pre-existing medical conditions and from including pre-existing condition exclusions for children.

Public Health Insurance Coverage

Medicaid and CHIP currently provide coverage to some, but not all, low-income individuals and people with disabilities. Medicaid and CHIP cover 17.6% 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. Adults without dependent children comprise the majority of the uninsured population largely because they are the least likely to qualify for Medicaid (Figure 3).

Figure 3

The Nonelderly Uninsured Population by Age and Parent Status, 2011



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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 does not total 100% due to rounding.
SOURCE: KCMU/ Urban Institute analysis of 2012 ASEC Supplement to the CPS.

The ACA will extend Medicaid to many individuals at or below 138% of poverty starting in 2014.[9] This will expand public coverage to childless adults as well as 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.[10]

Medicaid and CHIP cover one-third of all children and more than two-thirds of children in families below the poverty level. Medicaid is the largest source of health insurance for children in the U.S., enrolling 31 million non-disabled children at some point in the 2009 fiscal year (the most recent year of enrollment data available).[11] CHIP supplements Medicaid by covering almost 8 million children who are low or moderate income but whose family incomes are too high to qualify for Medicaid.[12]

Medicaid finances health and long-term care coverage for 9.5 million nonelderly people with disabilities (2009 estimates).[13] Its role is especially important 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.

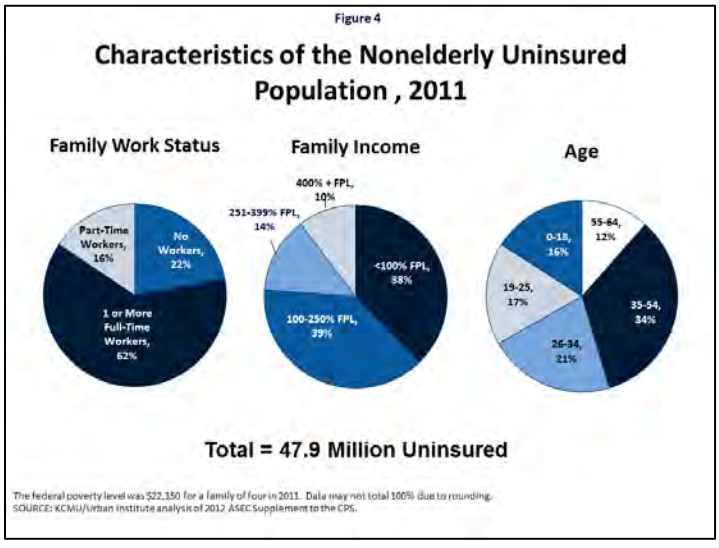
Who Is the Uninsured Population?

In 2011, 47.9 million people in the U.S. under age 65 lacked health insurance. Most of these individuals are in working families but do not have access to or cannot afford employer-sponsored coverage. The majority of the uninsured has very low income, making it difficult for them to afford coverage on their own. The main reason that people say they are uninsured is because they cannot afford coverage. Adults make up a disproportionate share of the uninsured population because they are less likely than children to be eligible for Medicaid.

More than three-quarters of the uninsured population are in working families: 62% are in families with one or more full-time workers and 16% are in families with part-time workers (Figure 4). Many uninsured workers are not offered coverage by their employers. Workers that are offered coverage will usually enroll in employer-sponsored health insurance; however, it has become increasingly difficult for many workers to afford their share of the cost.[14] In 2012, worker contributions for employer-sponsored coverage averaged $360 per month for family coverage and $79 for individual coverage.[15]

The vast majority of uninsured people are in low- or moderate-income families (Figure 4). Individuals below poverty are at the highest risk of being uninsured, and this group comprises 38% of the uninsured population (the poverty level for a family of four was $22,350 in 2011). In total, nine out of ten uninsured people are in low- or moderate-income families, meaning they are below 400% of poverty. The ACA targets these individuals through broader Medicaid eligibility and premium subsidies to purchase private coverage.

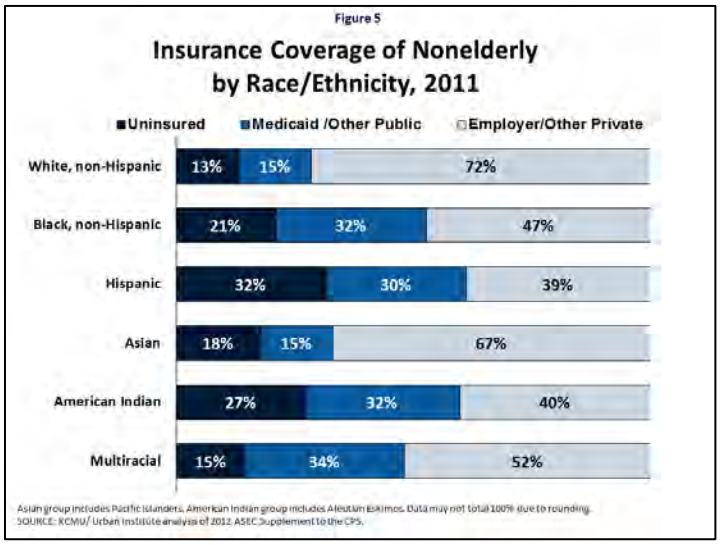
Adults are more likely to be uninsured than children. Adults make up 71% of the nonelderly population but 84% of people without health coverage (Figure 4). Most low-income children qualify for Medicaid or CHIP, but low-income adults under age 65 typically qualify for Medicaid only if they are disabled, pregnant, or have dependent children. Income eligibility levels are generally much lower for parents than for children, and adults without children are generally ineligible.



Beginning in 2014, the ACA expands Medicaid eligibility to adults with incomes up to 138% FPL, which would make millions of currently uninsured adults newly eligible for the program. If all states implement the Medicaid expansion, eligibility would increase in nearly 40 states for parents and in nearly every state for other adults.[16] If a state does not implement the expansion, poor uninsured adults will be left out of coverage.

Young adults, ages 19 to 25, have historically been at particularly high risk of being uninsured, largely due to their low incomes (Figure 4). More than half of uninsured young adults are from families with at least one full-time worker, but their low incomes make affording coverage difficult. The average income of uninsured young adults in 2011 was approximately $12,000. Beginning September 2010, the health reform law allowed young adults stay on their parent's private health insurance until age 26, and approximately 3 million people ages 19 to 25 have gained coverage under this provision.[17] Still, young adults account for a disproportionately large share of the uninsured.

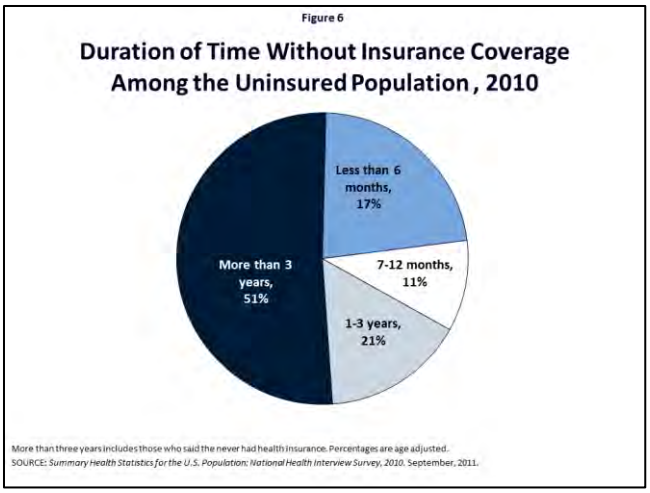
Minorities are much more likely to be uninsured than whites. About one-third of Hispanics and over one-fifth of black Americans are uninsured, compared to 13% of non-Hispanic whites (Figure 5). Medicaid and CHIP are important sources of coverage for racial and ethnic minorities, covering over one-quarter of Hispanic and black Americans. However, gaps in eligibility for Medicaid leave large numbers of minorities uninsured.



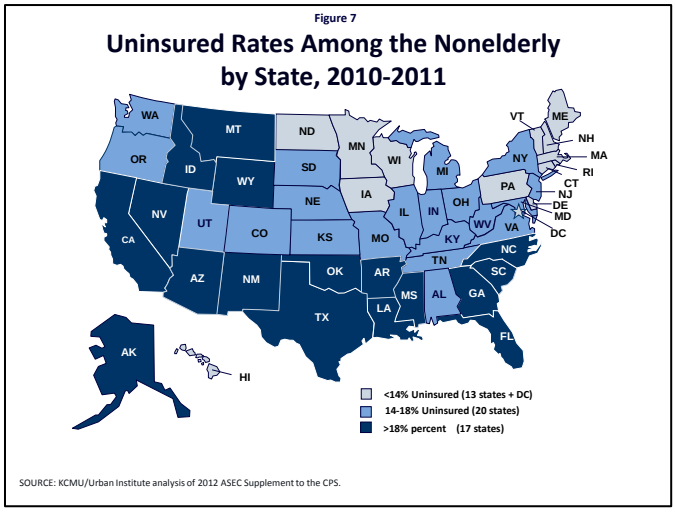
The majority of uninsured people (80%) are native or naturalized U.S. citizens. Although non-citizens (legal and undocumented) are about three times more likely to be uninsured than citizens, they account for less than 20% of the uninsured population. Non-citizens have poor access to employer coverage because they likely 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 legal immigrants who have been in the U.S. less than five years. 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. By January 1, 2012, 24 states had adopted the option to eliminate the waiting period for lawfully-residing immigrant children, and 18 states had adopted the option for lawfully-residing pregnant women.[18] Undocumented immigrants will remain ineligible for federally funded health coverage under the health reform law.

The uninsured population is in worse health than the privately insured population. Uninsured adults are almost twice as likely to report being in fair or poor health as those with private insurance.[19] More than a third of all uninsured nonelderly adults have a chronic condition.[20] People who have chronic conditions or poor 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 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.[21]

More than seventy percent of uninsured people have gone without health coverage for more than a year (Figure 6). Most uninsured adults believe they need health insurance, but do not have coverage because of the cost, rather than a lack of desire to have coverage.[22] Also, 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 or they work in an industry that has low offer rates.



Insurance coverage varies by state depending on the share of families with low incomes, the nature of employment in the state, and the reach of state Medicaid programs. Insurance market regulations and the availability of jobs with employer-sponsored coverage also influence the insurance rate in each state.[23] Massachusetts has near universal coverage, with an uninsured rate of 5% due to health reform legislation enacted in 2006. Hawaii also has relatively low uninsured rate of 9%. Uninsured rates in states such as Nevada, Florida, and Texas are 24% or higher (Figure 7).

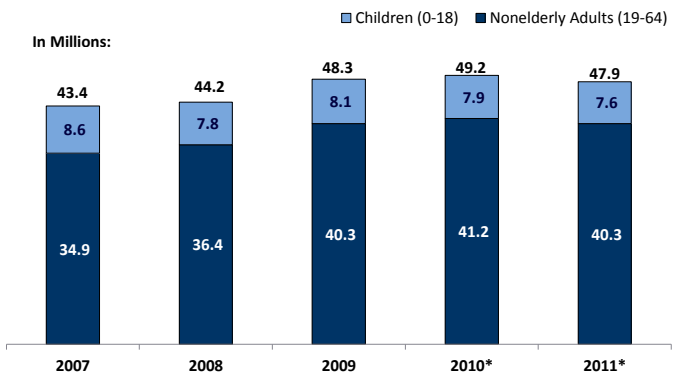


How and Why Has the Number of Uninsured People Changed?

The recent recession and ongoing weak job market led to a steep rise in the number of uninsured people between 2007 and 2010 (Figure 8). This trend was driven by a decline in employer-sponsored coverage that resulted from the high jobless rate. In December 2010, the unemployment rate was 9.4%, close to double the rate in December 2007 when the recession began. While some of those who lost private coverage were able to gain public coverage through Medicaid or CHIP, others became uninsured. Throughout 2011, the unemployment rate improved slightly. In the same year, the uninsured rate declined slightly, in part due to stability in employer-sponsored coverage, which remains the most common form of health insurance and in part due to the availability of Medicaid for the low-income.

Figure 8

Number of Nonelderly Uninsured Individuals, 2007-2011



* Applied Census 2010-based population controls.
NOTE: May not sum to totals due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2009 through 2012 ASEC Supplement to the CPS. Holahan J and Chen V. "Changes in Health Insurance Coverage in the Great Recession, 2007-2010." Kaiser Commission on Medicaid and the Uninsured. December 2011.

In the years preceding the 2007 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.

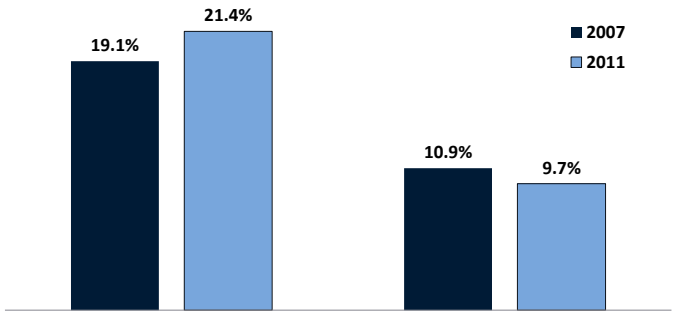
The uninsured rate for adults further increased between 2007 and 2010, resulting in 5.8 million more nonelderly adults without coverage (Figure 8). This increase in uninsured adults was largely driven by a decrease in the share of adults with employer-sponsored coverage and an increase in the number of people living in poverty.[24] Over this period, the unemployment rate nearly doubled from 5.0% in December 2007, when the recession began, to 9.4% in December 2010.[25] While a partial federal subsidy for individuals maintaining their previous employer-sponsored coverage was in place for those laid-off between September 2008 and May 2010, uptake of the subsidy was lower than predicted.[26] Medicaid eligibility for adults is more limited than for children, and therefore the share of adults in the program increased only slightly compared to losses in the percent of adults with employer-sponsored coverage.

In 2011, almost 48 million nonelderly Americans were uninsured, a decrease of over 1.3 million people from the previous year. The change in the number of uninsured represents the first decrease since 2007, before the recession began. The decrease is, in part, a result of increased stability in employer-based coverage. In addition, the number of people coverage by Medicaid and CHIP increased from 16.9% in 2010 to 17.6% in 2011.

Broad Medicaid and CHIP eligibility for children has helped maintain health coverage for children despite the economic downturn and slow recovery. During the recent economic recession and slow recovery, the percentage of uninsured children actually declined slightly as more children gained coverage through Medicaid or CHIP. Between 2007 and 2011, the uninsured rate for children dropped from 10.9% to 9.7% (Figure 9). 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 and incomes dropped, many became eligible for public insurance.

Figure 9

Uninsured Rate for Nonelderly Adults and Children, 2007 and 2011



SOURCE: KCMU/Urban Institute analysis of the 2012 ASEC supplement to the CPS. Holahan J and Chen V, December 2011.

The uninsured rate among young adults, ages 19 to 25, has improved slightly in the last year. The share of young adults that were uninsured decreased from 30.0% in 2010 to 27.9% in 2011, due in part to the ACA provision allowing them to remain on a parent's private health plan until age 26.[27] The change in coverage for this age group accounted for about 40% of the overall decline in the number of uninsured. However, young adults continue to have a high uninsured rate.

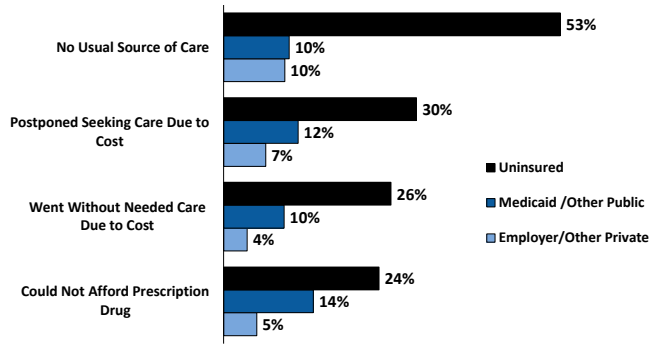
How Does Lack of Insurance Affect Access to Health Care?

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 those with insurance to postpone or forgo health care altogether. The consequences can be severe, particularly when preventable conditions go undetected.

Uninsured people are far more likely than those with insurance to report problems getting needed medical care. More than one-quarter of adults without coverage (26%) 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 poor access among the uninsured is that more than half of uninsured adults (53%) 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, 2011



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 2012 NHIS.

Access to health care has eroded over time for many. Rising health care costs have made health care less affordable, particularly for uninsured people. Between 2000 and 2010, the differences in access to care between those with and without coverage widened.[28] Compared to adults with private or public coverage, uninsured adults were less likely to have a usual source of care or an office visit, and more likely to have unmet need for prescription drugs, eye care, or mental health care.

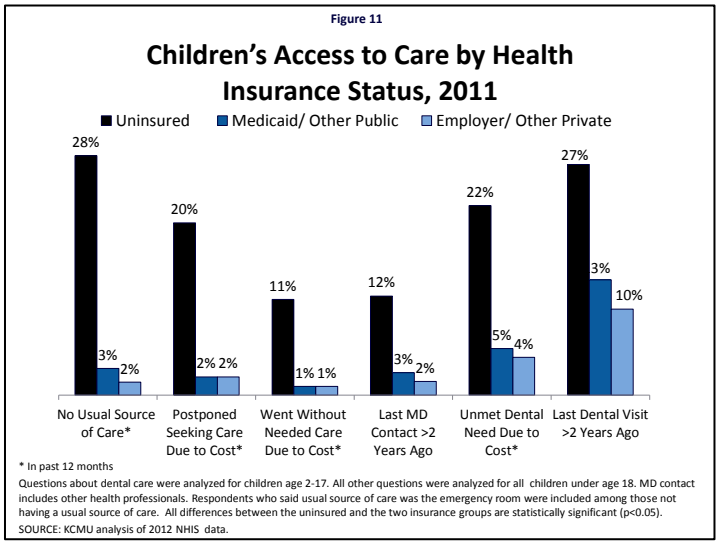
Uninsured people are less likely than those with coverage to receive timely preventive care. Silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. Uninsured nonelderly adults, compared to those with coverage, are far less likely to have had regular preventive care, including blood pressure, cholesterol checks, and cancer screenings.[29,30] Consequently, uninsured patients have increased risk being diagnosed in later stages of diseases, including cancer, and die earlier than those with insurance.[31, 32,33]

Anticipating high medical bills, many of uninsured people are not able to follow recommended treatments. More than a quarter of uninsured adults say they did not fill a prescription drug 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, people without health coverage are less likely than those with coverage to actually obtain all the services that are recommended.[34]

Because people without health coverage are less likely than those with insurance 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, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.[35,36,37,38]

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.[39] Disparities exist even among children with special needs, including access to specialists.[40]

Figure 11



* 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 2012 NHIS data.

Lack of health coverage, even for short periods of time, results in decreased access to care. Adults with gaps in their health insurance coverage in the previous year were less likely to have a regular source of care or to be up to date with blood pressure or cholesterol checks than those with continuous coverage.[41] Children who are uninsured for part of the year have more access problems than those with full-year public or private coverage.[42]

Research demonstrates that gaining health insurance restores access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of health insurance in Oregon found that newly insured Medicaid enrollees were more likely to receive care from a hospital or doctor than uninsured people.[43] Gaining Medicaid coverage was associated with approximately 35% increased likelihood of having an outpatient visit and a 15% increased likelihood of taking a prescription. New enrollees in Medicaid also reported improvements in physical and mental health status. A separate study of three other states (New York, Maine, and Arizona) found that expansions in Medicaid eligibility for adults were associated with reduced mortality, as well as improvements in access to care and self-reported health status.[44]

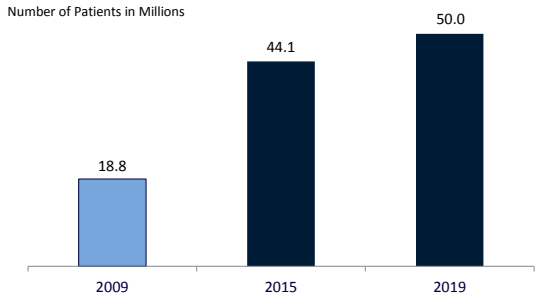
The safety net of public hospitals, community clinics, and local service providers that provides health services to vulnerable populations is crucial in caring for the uninsured population; however, such services are unable to fully substitute for the access to care that insurance provides. Safety net providers, such as public hospitals, community health centers, rural health centers, and local health departments, provide care to people without health coverage. In addition, private, office-based physicians provide some charity care, as do nearly all hospitals. However, the safety net is a "patchwork" system, and not all uninsured people have access to these providers.[45]

Increased demand and limited capacity means safety net providers are unable to meet all the health needs of the uninsured population. The ability of safety net providers to serve uninsured people has been threatened in recent years due to increased demand and eroding financing.[46] Both health centers and public hospitals report an increase in demand in recent years, and many clinics report that they are at full capacity and cannot accept new patients.[47] Further, increasing financial pressures and changing physician practice patterns have contributed to a decline in charity care provided by physicians.[48]

In recognition of the growing need for services, federal funding for clinics has increased in recent years but still falls below need. Community health centers (CHCs) play an important role in caring for individuals without health coverage.[49] The American Recovery and Reinvestment Act (ARRA) provided $2 billion to expand the number of CHC sites, increase services at existing centers, and provide supplemental payments for spikes in the number of uninsured they serve as a result of the recession. The ACA allocated $11 billion over five years for broad health center expansion, though legislation in April 2011 reduced the first year of new ACA investment by $600 million. The additional funding in the ACA was estimated to add CHC service capacity in order to reach up to 44 million patients by 2015 and up to 50 million patients in 2019 (Figure 12). ACA also provides new funds for nurse-managed health centers and school-based clinics. While the number of uninsured patients is projected to drop significantly nationwide as a result of health reform, the share of uninsured patients cared for by CHCs is expected to remain relatively high compared to other primary health care providers.[50]

Figure 12

Projected Number of Patients Served by Community Health Centers



Source: Estimates of patients served under funding levels authorized by the ACA from Ku, L., Richard, P., Dor, A., Tan, E., Shin, P. and S. Rosenbaum. June 30, 2010. "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform." Geiger Gibson/ RHCN Community Health Foundation Research Collaborative Policy Research Brief No. 19.

What Are the Financial Implications of Lack of Coverage?

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs. When people without health coverage 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. Uninsured people are more likely to report problems with high medical bills than those with insurance. Low-income individuals, who comprise a large share of the uninsured population, were three times as likely as those with higher incomes to report having difficulty paying basic monthly expenses such as rent, food, and utilities.[51]

Most uninsured people 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.[52] Slightly less than half of the uninsured population knows of a provider in their community who charges less to patients without insurance.[53] More than half of uninsured adults paid full price for their usual source of care, with 82% of uninsured adults who used any medical services in the previous year paying some amount out-of-pocket for health care.[54]

Uninsured people often pay "up front" before services will be rendered. When people without health coverage 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.[55]

People without health coverage spend less than half of what those with coverage spend on health care, but pay for a larger portion of their care out-of-pocket. 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.[56] The uninsured pay for about a third of this care out-of-pocket, totaling $30 billion in 2008. This included the health care costs for those uninsured all year and the costs incurred during the months the part-year uninsured have no health coverage.

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 population.[57] 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.

The burden of uncompensated care varies across providers. Hospitals incur 60% of the cost of uncompensated care because of the high cost of medical needs requiring hospitalization, despite the fact that physicians and community clinics see more uninsured patients.[58] Most government funding of uncompensated care is paid to hospitals based indirectly on the share of uncompensated care they provide. The cost of uncompensated care provided by physicians is not directly or indirectly reimbursed by public dollars.

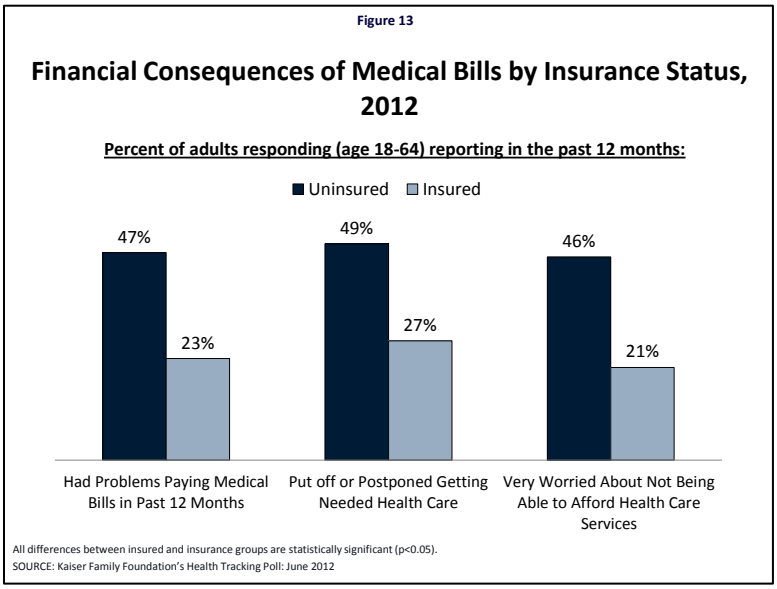
Safety net hospitals that serve a large number of uninsured individuals will receive a reduction in the federal disproportionate share (DSH) payments beginning in 2014. DSH payments are intended to cover the extra cost experienced by hospitals serving a large number of low-income and uninsured patients relative to other hospitals. The amount of DSH subsidies currently received by each state varies considerably, from $998 million for Texas to $207 million for Florida.[59] In 2014, when many

states will expand Medicaid eligibility to 138% of poverty, the ACA will begin reducing DSH payments, with total reductions by 2022 estimated to be more than $22 billion.[60] However, some states may elect not to expand Medicaid eligibility, which would leave uninsured residents with few low-cost coverage options and the hospitals that serve these individuals with less federal DSH funding.

Being uninsured leaves individuals at an increased risk of amassing unaffordable medical bills. Uninsured people are almost twice as likely (47% versus 23%) as those with health insurance coverage to report having trouble paying medical bills (Figure 13). 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, as compared with 7% of those with coverage.[61]

Figure 13

Financial Consequences of Medical Bills by Insurance Status, 2012



All differences between insured and insurance groups are statistically significant (p<0.05).
SOURCE: Kaiser Family Foundation's Health Tracking Poll: June 2012

Most of uninsured people have few, if any, savings and assets they can easily use to pay health care costs. Half of uninsured families living below 200% of poverty have no savings at all.[62] In fact, half of uninsured families with incomes over 400% of poverty have less than $4,100 in financial assets. Uninsured people also have far fewer financial assets than those with insurance coverage. A recent survey found that almost half (46%) of uninsured people are not confident that they can pay for the health care services they think they need, compared to 21% of people with insurance (Figure 13).

Unprotected from medical costs and with few assets, uninsured people 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. Almost one-quarter (23%) of uninsured nonelderly individuals have medical bills that they are unable to pay at all, compared to 6% of those with private insurance.[63] When the uninsured people gain Medicaid coverage, they are about 25% less likely to have unpaid medical bills sent to a collection agency and report significantly less financial strain due to health care costs.[64]

What is the Role of Employer-Sponsored Coverage?

More than half (56%) 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 37 million uninsured people are from families with at least one worker. The share of the nonelderly population with employer-sponsored coverage has declined since 2000 and has been exacerbated by the multiple recessions the U.S. has faced this decade. Despite this trend, employer-sponsored coverage is expected to continue playing a dominant role in the health insurance market in the future.

Employer-sponsored health insurance has declined during this decade, and the current economic climate hastened that trend. The share of the nonelderly population with employer-sponsored coverage declined steadily between 2000 and 2010, even during years when the economy was stronger and growth in health insurance premiums was slowing. In 2011, this trend ended as the share with employer-sponsored coverage held nearly constant at 56%.

Workers may lose coverage if they become unemployed. Two-thirds of uninsured adults that lost employer-sponsored coverage in the previous year stated that this was because they or their spouse had lost or changed jobs or started working part-time.[65] Some of the newly unemployed have the option to switch to a spouse's employer-sponsored insurance. Others may qualify for public coverage, but many do not meet current eligibility requirements. The unemployed who had employer-based insurance while employed may be able to continue this coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), though premium requirements for this coverage is often high. Purchasing coverage in the non-group market is another option, but high premiums make this option unattainable for those who also struggling with reduced income.

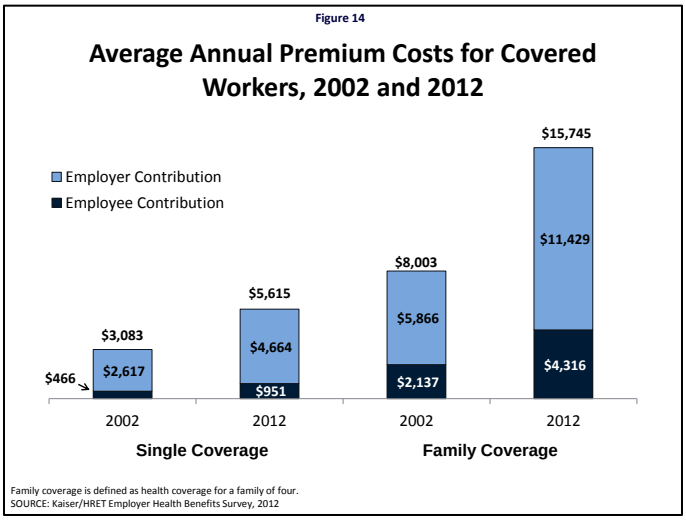
Many workers do not have access to employer-sponsored insurance. The majority of uninsured workers are not offered health insurance by their employer.[66] Some people work in firms that cover some employees but are not themselves eligible for coverage, often because they have not worked for their employer for a sufficient amount of time or they do not work enough hours.

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.[67] By comparison, 87% of employees with family incomes at or above 400% of poverty had access to employer-sponsored coverage. The majority (62%) of employees below 200% of poverty with access to coverage through an employer enrolled in this coverage.

Small firms are less likely to offer coverage than large firms. Nearly all businesses (98%) with at least 200 workers offer health benefits to their workers in 2012, but only 61% of firms with less than 200 workers offer these benefits.[68] On average, small firms ask employees to contribute a lower amount annually towards their own health benefits compared to large firms ($848 vs. $1,001 per year). However, small firms ask for larger annual contributions for family coverage ($5,134 vs. $3,926).

The cost of employer-sponsored coverage is the most common reason employers cite for not offering health coverage.[69] In 2012, annual employer-sponsored premiums averaged $5,615 for individual coverage and $15,745 for family coverage (Figure 14). Total family premiums, as well as the employee's share of those premiums, have more than in the last ten years.

Figure 14

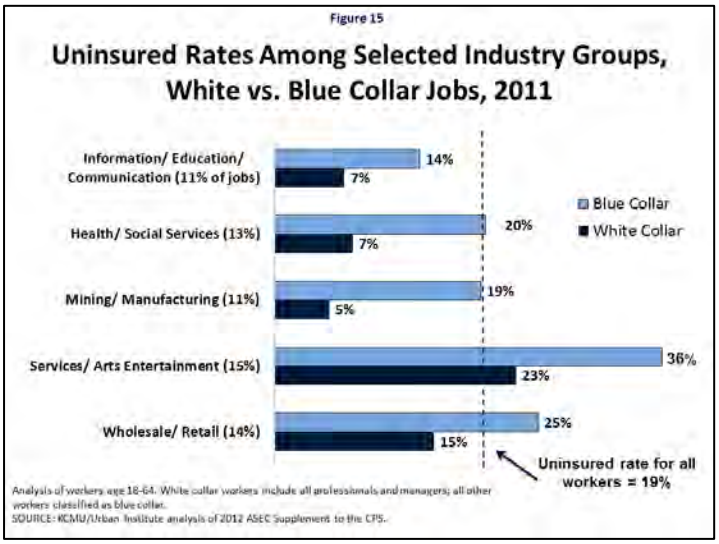


The majority of employees participate in their employer's health plan when they are offered coverage. Approximately three-quarters of employees eligible for employer-sponsored insurance enrolled in 2008 and 2009, though the take-up rate of employer-sponsored coverage decreased slightly over the last ten years.[70]

Employer-sponsored coverage is unaffordable for many families. Even when workers can afford coverage for themselves, the cost of health insurance for their families is often prohibitive. Employees in firms with many low-wage workers are typically asked to contribute a larger share of the insurance premium for family coverage than employees of firms with fewer low-wage workers (34% vs. 28% of the premium costs for family coverage).[71] Declines in dependent coverage accounted for more than half of the decline in employer-sponsored insurance in the last decade.[72]

Health coverage varies both by industry and by type of occupation. Across industries, uninsured rates for workers range from 37% in agriculture to just 7% in public administration.[73] 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 15). More than 80% of uninsured workers are in blue-collar jobs.

Figure 15



What is Medicaid's Role?

Medicaid is the nation's major public health insurance program for low-income Americans, covering more than 62 million low-income children, families, seniors and people with disabilities.[74] 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 people. As the ACA goes into effect, Medicaid will be the base for expanding health care coverage to many of the lowest income Americans.

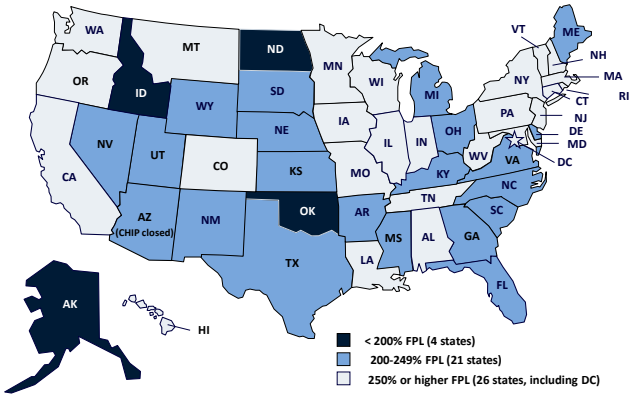
Medicaid is a federal-state partnership, and under current law a person must meet financial criteria and belong to one of the "categorically eligible" groups to qualify for coverage. Medicaid covers four main groups of nonelderly, low-income people: children, their parents, pregnant women, and people 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 poorer and in 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 and to report being in fair or poor health.[75] 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 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 16). The reauthorization of CHIP in 2009, in combination with fiscal relief from ARRA, enabled states to continue providing coverage to millions of low-income families.

Figure 16

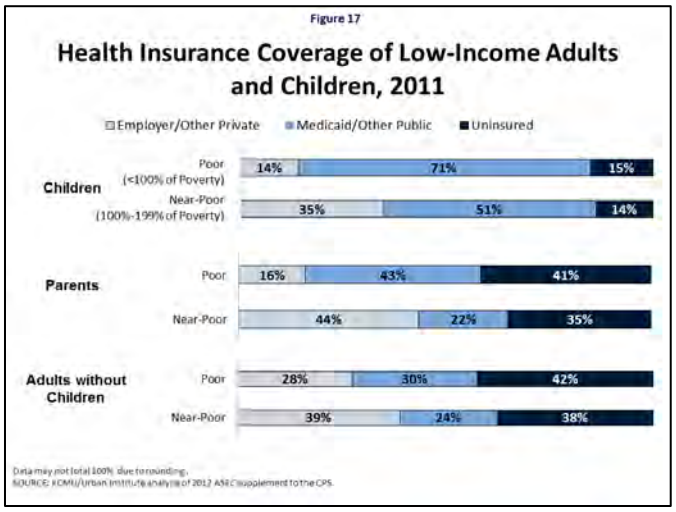
Children's Eligibility for Medicaid/CHIP by Income, January 2012



NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

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, as of 2009, nearly two-thirds (65%) of uninsured children were eligible for Medicaid or CHIP but not enrolled.[76] Some families are not aware of the availability of the programs or their eligibility. For others, burdensome enrollment and renewal requirements pose major obstacles to participation, despite major improvements made over the past decade.

In contrast to coverage for children, the role of Medicaid for nonelderly adults is more limited. Medicaid covers more than two-thirds (71%) of poor children and about half (51%) of near-poor children (Figure 17). 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, four out of ten (42%) poor parents and adults without children are uninsured. The Medicaid expansion in the ACA provides a new coverage pathway for millions of currently uninsured adults.

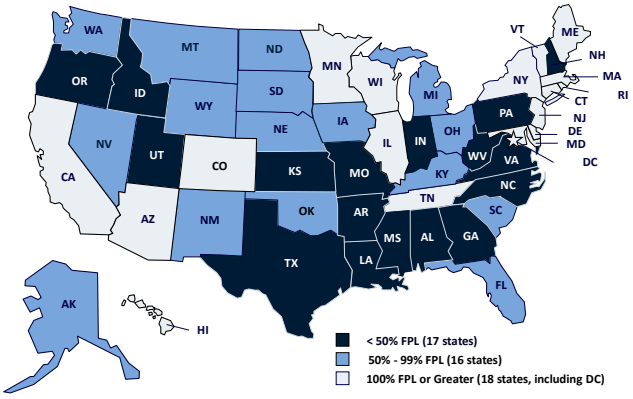


Some states have expanded Medicaid eligibility to cover more poor and near-poor parents. About one-third of states have used the flexibility available to them under federal law to extend Medicaid eligibility for parents to 100% of the poverty level or higher (Figure 18). However, in the remaining states, parents still must have income below the poverty level in order to qualify for health coverage. As of January 2012, 33 states limited Medicaid eligibility for parents to 100% of the federal poverty level, with 17 states limiting eligibility to below 50% of the federal poverty level. As a result, millions of poor parents are ineligible for Medicaid.

In recent years, many 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 leverage existing delivery and administrative systems. Between Fiscal Years (FY) 2009 and 2011, funding from ARRA through the enhanced Federal Matching Assistance Percentage (FMAP) helped states to maintain their Medicaid programs. In addition, some states have taken advantage of the option to use federal matching funds to expand Medicaid to childless adults before the broad ACA Medicaid expansion to individuals with income up to 138% of poverty goes into effect in 2014. As of July 2012, eight states (including the District of Columbia) provided Medicaid or Medicaid-comparable coverage to non-disabled adults.[77] An additional 17 states provided more limited coverage for adults who meet specified employment-related requirements.

Figure 18

Medicaid Eligibility for Working Parents by Income, January 2012



NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid to parents at higher income levels through waiver or state-funded coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

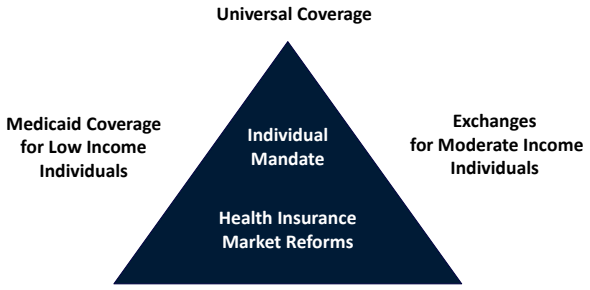
Recent increases in Medicaid and CHIP enrollment helped to offset declines in private coverage. Increases in public coverage in recent years helped to offset declines in private insurance. The role of Medicaid and CHIP in covering children was particularly important. Between 2007 and 2011, the share of children with employer-sponsored coverage dropped by 10 percentage points, while the share with public coverage increased by more than 11 percentage points, thus preventing the number of uninsured children from increasing.[78,79] At the same time, Medicaid played a smaller role in buffering the loss of health insurance coverage for nonelderly adults. The share of nonelderly adults with employer-sponsored insurance dropped by just over four percentage points and the share of with Medicaid increased by close to four percentage points.

How Will the Affordable Care Act Affect the Uninsured Population?

The Patient Protection and Affordable Care Act (ACA) of 2010 promotes greater health coverage by building on the existing public-private system for providing health insurance coverage. The ACA 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 19). The major coverage expansions will be implemented in 2014, although some provisions take effect earlier.

Figure 19

Key Elements of Health Reform

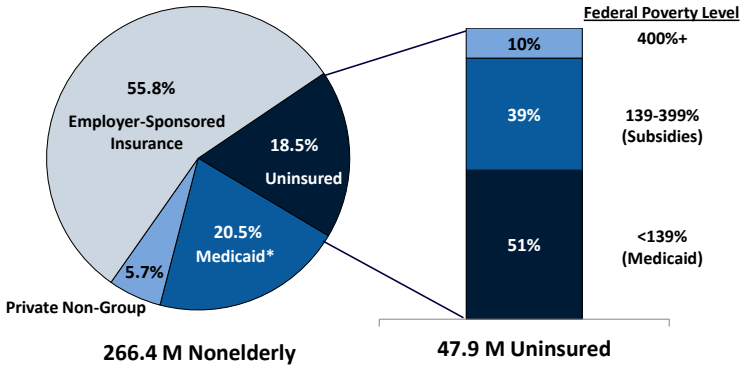


NOTE: In 2011, 100% of the federal poverty level (FPL) is $10,890 for an individual and $22,350 for a family of four and 400% FPL is $43,560 for an individual and $89,400 for a family of four

The different coverage provisions in the ACA target the uninsured population in different income groups. Among the 48 million nonelderly uninsured people in 2011, roughly half (51%) have incomes below 139%. This group would be affected by the expansion of Medicaid in 2014 in states that implement the expansion (Figure 20). Over one-third (39%) of the nonelderly uninsured people have incomes between 139% and 399% of the federal poverty level, the income level targeted by subsidies for coverage purchased through a Health Insurance Exchange. Coverage for uninsured individuals in all income groups will be impacted by new insurance rules and requirements.

Figure 20

Income of the Nonelderly Uninsured Population, 2011



* Medicaid also includes other public programs: CHIP, other state programs, Medicare and military-related coverage. The federal poverty level for a family of four in 2011 was $22,350.
Numbers may not add to 100 due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Medicaid Expansion
Beginning in 2014, the ACA provides for the expansion of Medicaid eligibility to adults with incomes up to 138% of poverty, largely with federal funding. With the Supreme Court ruling in 2012, the federal government's authority to require states to implement the expansion was restricted. Thus, some states may not expand their Medicaid programs under the ACA. If a state does not expand Medicaid, adults in that state with incomes between 100% and 138% of poverty will still be eligible for subsidies to purchase coverage through new health insurance exchanges, while those with incomes below 100% of poverty will be ineligible for these subsidies and will be left out of coverage expansions under ACA. To ensure that people do not lose Medicaid coverage before key ACA provisions takes effect, all states are required to maintain current Medicaid eligibility levels for adults until 2014 and eligibility levels for children in Medicaid and CHIP until 2019.

If all states implement the Medicaid expansion, eligibility for parents would increase in nearly 40 states and in nearly every other state for low income adults without dependent children.[80] Changes in Medicaid enrollment due to the Medicaid expansion under ACA will vary greatly by state, depending on the state's current Medicaid eligibility and the share of its population that is low income. The share of uninsured adults with incomes below the Medicaid expansion income limit varies across states from about 60% in Alabama and Hawaii to approximately one-third in Vermont and New Hampshire. The federal government will finance much of the Medicaid expansion defined in the ACA, contributing an estimated $930 billion toward states' implementation of health reform over the next ten years.[81]

Health Insurance Exchanges and Premium Subsidies
The ACA also establishes Health Insurance Exchanges, which are essentially new marketplaces where individuals and small employers can purchase insurance, starting in 2014. 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, the federal government will provide premium subsidies for individuals and families with incomes from 100% of the federal poverty level ($10,890 for an individual and $22,350 for a family of four in 2011) to 400% of poverty ($43,560 for an individual and $89,400 for a family of four in 2011). These subsidies will limit the cost of the premium to a share of income and will be offered on a sliding scale basis. In addition, the federal government will make available cost-sharing subsidies to reduce what people with incomes between 100% and 250% of poverty will have to pay out-of-pocket to access health services. The cost-sharing subsidies will also be available on a sliding scale based on income.

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.

Those who enroll in private insurance through an Exchange are projected to be relatively older, less educated, lower income, and more racially diverse than current privately-insured populations.[82] An estimated 65% of individuals that are expected to purchase health insurance through the Exchange will transition from being uninsured. These new enrollees will have experienced access barriers and may have a large pent-up need for medical care once they gain insurance.

Requirements and Incentives for Coverage
Beginning in 2014, the law will require most individuals to have health insurance. However, this requirement 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.

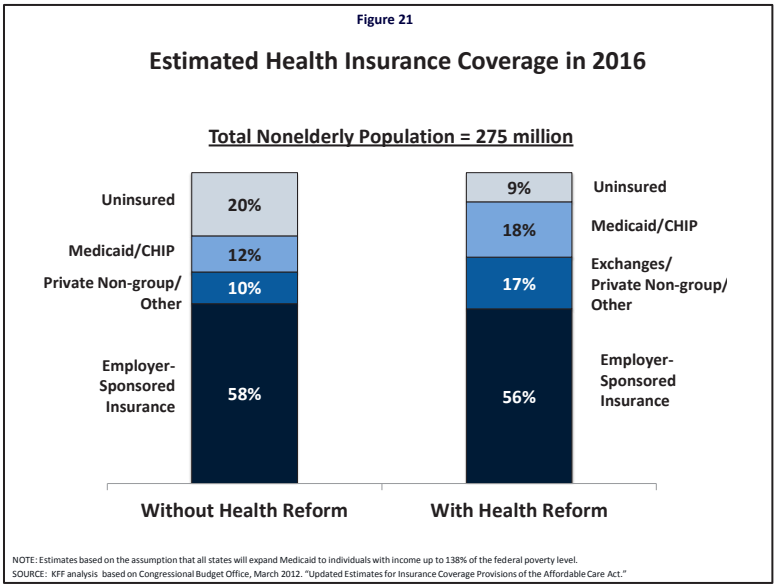
Beginning in 2014, employers with more than 50 employees will be assessed a fee of up to $2,000 per full-time employee (in excess of 30 employees) if they do not offer affordable coverage and if they have at least one employee who receives a premium credit through an Exchange. This requirement does not 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 were available beginning in 2010.

Impact of the Law on the Uninsured Population

By 2016, the Congressional Budget Office (CBO) estimates the law will expand coverage to 30 million people, cutting the uninsured rate by more than half (Figure 21). According to CBO, the law will result in 17 million more people enrolling in Medicaid and CHIP. Another 20 million people (16 million of whom will receive federal premium subsidies) will obtain coverage in the newly created Health Insurance Exchanges, including some who previously purchased coverage on their own in the individual market.

Figure 21



While the ACA will make important strides in reducing the number of uninsured, an estimated 26 million people will remain uninsured in 2016.[83] 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; people who are subject to the mandate but choose to pay the penalty rather than purchase health insurance. The number of uninsured people may be higher if states do not implement the Medicaid expansion. Those than remain uninsured will continue to rely on nation's safety-net hospitals and clinics to access care. Many uninsured people live in health professional shortage areas, underscoring the need to continue to develop and support safety-net providers and community health clinics.[84]

Conclusion

The nation's system of health insurance has many gaps that currently leave millions of people without coverage. Many workers, particularly low-wage workers, do not have access to coverage through their jobs or cannot afford their share of the premiums, and the recent economic downturn has led millions to lose employer-sponsored coverage. For uninsured people, obtaining insurance through the individual market is often not an option, either because they are denied coverage outright or they are charged premiums they cannot afford. The Medicaid and CHIP programs have helped to prevent more people from being uninsured. However, the ability of Medicaid to provide broader coverage is limited by low eligibility levels for adults and restrictions on coverage in many states. These problems reflect systemic failures but have personal consequences. Being uninsured places people's health at risk and increases financial instability for individuals and families.

With 47.9 million nonelderly people uninsured today, implementing the new coverage provisions in the ACA is increasingly important to reducing the number of Americans without health insurance. 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 Sonya Streeter, Rachel Licata, Vann Newkirk, and Rachel Garfield of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, and Emily Lawton and Megan McGrath of the Urban Institute.

Tables

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

Table 1
Characteristics of the Nonelderly Uninsured Population, 2011

	Nonelderly (millions)	Percent of Nonelderly	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total - Nonelderly[a]	**266.4**	**100.0%**	**47.9**	**100.0%**	**18.0%**
Age					
Children - Total	**78.4**	**29.4%**	**7.6**	**15.9%**	**9.7%**
Adults - Total	**188.0**	**70.6%**	**40.3**	**84.1%**	**21.4%**
Adults 19-25	29.7	11.1%	8.3	17.3%	27.9%
Adults 26-34	36.8	13.8%	10.2	21.4%	27.8%
Adults 35-44	39.7	14.9%	8.4	17.5%	21.2%
Adults 45-54	43.9	16.5%	7.9	16.4%	17.9%
Adults 55-64	38.0	14.3%	5.5	11.5%	14.6%
Annual Family Income					
<$20,000	66.4	24.9%	22.6	47.1%	34.0%
$20,000 - $39,999	52.7	19.8%	13.6	28.3%	25.7%
$40,000 +	147.3	55.3%	11.8	24.6%	8.0%
Family Poverty Level[c]					
≤138%	**76.6**	**28.7%**	**24.5**	**51.2%**	**32.0%**
…<100%	56.3	21.1%	18.1	37.7%	32.1%
…100-138%	20.3	7.6%	6.4	13.4%	31.8%
139-399%	**99.3**	**37.3%**	**18.5**	**38.6%**	**18.6%**
…139-250%	48.7	18.3%	12.0	25.1%	24.6%
…251-399%	50.6	19.0%	6.5	13.5%	12.8%
400%+	**90.5**	**34.0%**	**4.9**	**10.3%**	**5.4%**
Household Type					
Single Adults Living Alone	20.7	7.8%	4.3	9.0%	20.9%
Single Adults Living Together	34.0	12.8%	11.4	23.7%	33.5%
Married Adults	56.5	21.2%	8.9	18.5%	15.7%
1 Parent with children[d]	35.7	13.4%	6.5	13.6%	18.3%
2 Parents with children[d]	105.4	39.6%	13.1	27.4%	12.5%
Multigenerational/Other with children[e]	14.2	5.3%	3.7	7.7%	26.1%
Family Work Status					
2 Full-time	65.0	24.4%	5.1	10.5%	7.8%
1 Full-time	138.4	51.9%	24.8	51.7%	17.9%
Only Part-time[f]	23.7	8.9%	7.5	15.6%	31.4%
Non-Workers	39.3	14.8%	10.6	22.2%	27.1%
Race/Ethnicity					
White only (non-Hispanic)	161.6	60.7%	21.4	44.7%	13.2%
Black only (non-Hispanic)	33.5	12.6%	7.0	14.7%	21.0%
Hispanic	49.2	18.5%	15.5	32.4%	31.6%
Asian/S. Pacific Islander only	14.7	5.5%	2.6	5.5%	17.9%
Am. Indian/Alaska Native	1.9	0.7%	0.5	1.1%	27.3%
Two or More Races[g]	5.6	2.1%	0.8	1.7%	14.5%
Citizenship					
U.S. citizen - native	231.4	86.9%	35.1	73.2%	15.2%
U.S. citizen - naturalized	14.3	5.4%	3.3	7.0%	23.4%
Non-U.S. citizen, resident for < 5 years	3.9	1.5%	1.4	2.8%	35.0%
Non-U.S. citizen, resident for 5+ years	16.8	6.3%	8.2	17.0%	48.6%
Health Status					
Excellent/Very Good	182.4	68.5%	28.4	59.3%	15.6%
Good	60.0	22.5%	14.3	29.9%	23.9%
Fair/Poor	24.0	9.0%	5.2	10.9%	21.6%

( ) = 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, 2011

	Children (millions)	Percent of Children	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total - Children[h]	**78.4**	**100.0%**	**7.6**	**100.0%**	**9.7%**
Age					
<1	3.9	5.0%	0.4	5.8%	11.3%
1-5	20.4	26.0%	1.6	21.3%	8.0%
6-18	54.1	69.0%	5.6	73.0%	10.3%
Family Income					
<$20,000	19.2	24.4%	3.1	40.0%	15.9%
$20,000 - $39,999	15.0	19.1%	2.0	26.7%	13.6%
$40,000 +	44.3	56.5%	2.5	33.4%	5.8%
Family Poverty Level[c]					
≤138%	**27.9**	**35.6%**	**4.3**	**56.7%**	**15.5%**
…<100%	21.0	26.7%	3.2	42.2%	15.4%
…100-138%	7.0	8.9%	1.1	14.6%	15.9%
139-399%	**29.8**	**38.0%**	**2.7**	**34.8%**	**8.9%**
…139-250%	15.5	19.8%	1.8	23.5%	11.6%
…251-399%	14.3	18.2%	0.9	11.3%	6.0%
400%+	**20.7**	**26.4%**	**0.6**	**8.5%**	**3.1%**
Household Type[i]					
1 Parent[d]	21.3	27.2%	2.4	31.5%	11.3%
2 Parents[d]	50.3	64.2%	3.9	51.1%	7.8%
Multigenerational/Other[e]	6.1	7.7%	1.1	15.0%	18.9%
Family Work Status					
2 Full-time	20.1	25.6%	1.1	14.0%	5.3%
1 Full-time	41.4	52.8%	4.1	53.4%	9.8%
Only Part-time[f]	6.2	7.9%	0.8	10.9%	13.4%
Non-Workers	10.7	13.7%	1.7	21.7%	15.5%
Race/Ethnicity					
White only (non-Hispanic)	41.5	53.0%	2.9	37.9%	7.0%
Black only (non-Hispanic)	10.8	13.8%	1.1	15.0%	10.6%
Hispanic	18.6	23.7%	2.9	38.2%	15.7%
Asian/S. Pacific Islander only	3.9	4.9%	0.4	4.7%	9.2%
Am. Indian/Alaska Native	0.6	0.8%	0.1	1.3%	(16.8%)
Two or More Races[g]	3.0	3.8%	0.2	2.8%	7.2%
Citizenship					
U.S. Citizen	76.2	97.2%	7.0	91.1%	9.1%
Non-U.S. citizen, resident for < 5 years	0.8	1.1%	0.2	2.6%	(24.0%)
Non-U.S. citizen, resident for 5+ years	1.4	1.7%	0.5	6.2%	34.9%
Health Status					
Excellent/Very Good	64.4	82.2%	5.9	77.1%	9.1%
Good	12.3	15.7%	1.6	20.6%	12.8%
Fair/Poor	1.7	2.2%	0.2	2.3%	10.4%

( ) = 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, 2011

	Nonelderly (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
Total - Nonelderly[a]	**266.4**	**55.8%**	**5.7%**	**17.6%**	**2.9%**	**18.0%**
Age						
Children - Total	**78.4**	**49.9%**	**4.0%**	**34.9%**	**1.4%**	**9.7%**
Adults - Total	**188.0**	**58.3%**	**6.4%**	**10.4%**	**3.5%**	**21.4%**
Adults 19-25	29.7	43.1%	13.1%	14.3%	1.7%	27.9%
Adults 26-34	36.8	54.7%	4.5%	11.1%	1.9%	27.8%
Adults 35-44	39.7	63.0%	4.4%	9.5%	1.9%	21.2%
Adults 45-54	43.9	64.0%	5.2%	9.2%	3.7%	17.9%
Adults 55-64	38.0	62.0%	6.5%	9.2%	7.8%	14.6%
Annual Family Income						
<$20,000	66.4	16.4%	7.1%	38.1%	4.5%	34.0%
$20,000 - $39,999	52.7	41.5%	5.8%	23.5%	3.4%	25.7%
$40,000 +	147.3	78.7%	5.0%	6.3%	2.0%	8.0%
Family Poverty Level[c]						
≤138%	**76.6**	**16.7%**	**6.1%**	**41.5%**	**3.7%**	**32.0%**
...<100%	56.3	14.0%	6.2%	44.5%	3.1%	32.1%
...100-138%	20.3	24.1%	5.6%	33.1%	5.4%	31.8%
139-399%	**99.3**	**59.0%**	**6.2%**	**12.9%**	**3.3%**	**18.6%**
...139-250%	48.7	46.0%	6.3%	19.0%	4.0%	24.6%
...251-399%	50.6	71.6%	6.0%	7.0%	2.7%	12.8%
400%+	**90.5**	**85.4%**	**4.9%**	**2.6%**	**1.7%**	**5.4%**
Household Type						
Single Adults Living Alone	20.7	52.6%	8.7%	11.9%	5.8%	20.9%
Single Adults Living Together	34.0	41.5%	10.2%	11.5%	3.4%	33.5%
Married Adults	56.5	67.3%	6.0%	6.5%	4.6%	15.7%
1 Parent with children[d]	35.7	33.3%	4.7%	42.2%	1.4%	18.3%
2 Parents with children[d]	105.4	65.6%	4.1%	16.2%	1.7%	12.5%
Multigenerational/Other with children[e]	14.2	33.1%	3.7%	34.1%	3.0%	26.1%
Family Work Status						
2 Full-time	65.0	81.9%	3.4%	5.8%	1.1%	7.8%
1 Full-time	138.4	60.3%	5.7%	14.3%	1.8%	17.9%
Only Part-time[f]	23.7	26.2%	10.5%	29.2%	2.6%	31.4%
Non-Workers	39.3	14.8%	6.6%	41.8%	9.7%	27.1%
Race/Ethnicity						
White only (non-Hispanic)	161.6	64.6%	6.9%	12.2%	3.1%	13.2%
Black only (non-Hispanic)	33.5	43.6%	3.6%	28.1%	3.7%	21.0%
Hispanic	49.2	35.9%	3.0%	27.9%	1.6%	31.6%
Asian/S. Pacific Islander only	14.7	59.9%	7.1%	13.2%	1.8%	17.9%
Am. Indian/Alaska Native	1.9	35.7%	4.6%	29.2%	3.2%	27.3%
Two or More Races[g]	5.6	47.1%	4.8%	29.2%	4.4%	14.5%
Citizenship						
U.S. citizen - native	231.4	57.6%	5.8%	18.3%	3.1%	15.2%
U.S. citizen - naturalized	14.3	57.5%	5.8%	11.0%	2.4%	23.4%
Non-U.S. citizen, resident for < 5 years	3.9	36.3%	9.1%	18.8%	--	35.0%
Non-U.S. citizen, resident for 5+ years	16.8	33.6%	3.5%	13.3%	1.0%	48.6%
Health Status						
Excellent/Very Good	182.4	61.4%	6.4%	15.1%	1.6%	15.6%
Good	60.0	48.4%	4.6%	19.9%	3.2%	23.9%
Fair/Poor	24.0	32.1%	3.2%	31.5%	11.6%	21.6%

( ) = 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, 2011

	Children (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
Total - Children[h]	**78.4**	**49.9%**	**4.0%**	**34.9%**	**1.4%**	**9.7%**
Age						
<1	3.9	43.0%	2.1%	41.2%	2.4%	11.3%
1-5	20.4	46.8%	2.6%	40.8%	1.8%	8.0%
6-18	54.1	51.6%	4.6%	32.2%	1.2%	10.3%
Annual Family Income						
<$20,000	19.2	11.0%	3.0%	68.9%	1.2%	15.9%
$20,000 - $39,999	15.0	27.6%	3.0%	54.2%	1.6%	13.6%
$40,000 +	44.3	74.3%	4.7%	13.7%	1.5%	5.8%
Family Poverty Level[c]						
≤138%	**27.9**	**13.8%**	**2.7%**	**66.8%**	**1.2%**	**15.5%**
...<100%	21.0	11.0%	2.7%	69.8%	1.2%	15.4%
...100-138%	7.0	22.4%	2.4%	57.8%	1.5%	15.9%
139-399%	**29.8**	**58.9%**	**4.8%**	**25.6%**	**1.8%**	**8.9%**
...139-250%	15.5	45.7%	4.3%	36.5%	1.9%	11.6%
...251-399%	14.3	73.3%	5.3%	13.6%	1.7%	6.0%
400%+	**20.7**	**85.8%**	**4.6%**	**5.3%**	**1.2%**	**3.1%**
Household Type[i]						
1 Parent with children[d]	21.3	29.7%	3.9%	54.2%	0.9%	11.3%
2 Parents with children[d]	50.3	62.1%	4.0%	24.5%	1.7%	7.8%
Multigenerational/Other with children[e]	6.1	22.6%	3.2%	53.7%	1.5%	18.9%
Family Work Status						
2 Full-time	20.1	77.1%	3.0%	13.4%	1.1%	5.3%
1 Full-time	41.4	51.6%	4.4%	32.4%	1.7%	9.8%
Only Part-time[f]	6.2	16.4%	4.9%	64.4%	0.9%	13.4%
Non-Workers	10.7	11.8%	3.5%	67.8%	1.4%	15.5%
Race/Ethnicity						
White only (non-Hispanic)	41.5	62.2%	5.2%	24.0%	1.7%	7.0%
Black only (non-Hispanic)	10.8	35.3%	2.5%	50.5%	1.1%	10.6%
Hispanic	18.6	30.7%	2.1%	50.6%	0.9%	15.7%
Asian/S. Pacific Islander only	3.9	60.2%	4.5%	24.8%	1.3%	9.2%
Am. Indian/Alaska Native	0.6	(26.0%)	--	(53.1%)	--	(16.8%)
Two or More Races[g]	3.0	43.1%	3.5%	42.9%	3.3%	7.2%
Citizenship						
U.S. citizen	76.2	50.5%	4.0%	34.9%	1.5%	9.1%
Non-U.S. citizen, resident for < 5 years	0.8	(30.4%)	7.5%	(37.2%)	--	(24.0%)
Non-U.S. citizen, resident for 5+ years	1.4	28.9%	--	33.6%	--	34.9%
Health Status						
Excellent/Very Good	64.4	54.0%	4.3%	31.1%	1.4%	9.1%
Good	12.3	31.8%	2.8%	51.0%	1.5%	12.8%
Fair/Poor	1.7	25.1%	--	61.9%	--	10.4%

( ) = 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, 2010-2011

	Nonelderly (thousands)[a]	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
United States	**266,123**	**56.0%**	**5.6%**	**17.3%**	**2.9%**	**18.2%**
Alabama	4,087	57.1%	5.3%	16.5%	4.9%	16.2%
Alaska	634	56.3%	3.3%	14.4%	6.1%	19.9%
Arizona	5,668	52.0%	5.0%	19.4%	3.2%	20.4%
Arkansas	2,445	49.5%	4.8%	20.4%	4.7%	20.6%
California	33,029	50.2%	6.7%	19.5%	1.9%	21.7%
Colorado	4,406	58.7%	9.0%	13.2%	2.9%	16.1%
Connecticut	3,043	67.4%	5.2%	14.3%	1.9%	11.2%
Delaware	762	62.3%	4.6%	18.0%	2.8%	12.3%
District of Columbia	535	54.1%	7.5%	25.2%	1.4%	11.7%
Florida	15,511	50.7%	5.9%	15.3%	3.9%	24.2%
Georgia	8,627	52.9%	5.4%	15.3%	4.9%	21.5%
Hawaii	1,112	63.1%	4.2%	19.4%	4.4%	8.9%
Idaho	1,352	52.7%	9.2%	14.9%	2.7%	20.6%
Illinois	11,100	57.1%	5.3%	18.8%	2.1%	16.7%
Indiana	5,478	60.6%	3.5%	18.3%	3.0%	14.6%
Iowa	2,617	62.8%	7.1%	15.7%	1.8%	12.6%
Kansas	2,372	60.2%	6.3%	14.3%	3.9%	15.4%
Kentucky	3,726	55.6%	4.6%	19.6%	3.5%	16.7%
Louisiana	3,875	47.5%	4.2%	21.5%	3.7%	23.1%
Maine	1,101	56.7%	5.1%	23.1%	3.6%	11.5%
Maryland	5,058	65.2%	5.4%	12.5%	1.9%	15.0%
Massachusetts	5,584	66.6%	5.8%	21.6%	0.9%	5.0%
Michigan	8,352	58.6%	5.7%	19.3%	1.9%	14.5%
Minnesota	4,543	66.1%	5.8%	15.2%	2.0%	10.8%
Mississippi	2,531	49.5%	5.4%	20.4%	3.5%	21.3%
Missouri	5,089	58.2%	6.8%	15.3%	2.9%	16.7%
Montana	810	48.9%	10.1%	15.0%	4.2%	21.8%
Nebraska	1,578	61.6%	8.8%	12.0%	3.1%	14.6%
Nevada	2,348	55.4%	6.0%	10.1%	3.4%	25.0%
New Hampshire	1,119	70.4%	6.2%	7.6%	2.8%	13.1%
New Jersey	7,514	62.3%	4.8%	13.5%	1.8%	17.7%
New Mexico	1,724	44.2%	4.9%	23.9%	3.1%	23.8%
New York	16,651	55.7%	4.6%	22.7%	1.7%	15.4%
North Carolina	8,130	54.0%	5.0%	17.7%	4.0%	19.3%
North Dakota	571	63.3%	10.8%	10.1%	2.8%	13.0%
Ohio	9,733	59.3%	5.2%	17.0%	2.7%	15.7%
Oklahoma	3,189	53.7%	4.9%	17.2%	4.3%	19.9%
Oregon	3,267	56.9%	7.4%	16.3%	2.2%	17.3%
Pennsylvania	10,595	62.6%	6.4%	16.2%	1.9%	12.8%
Rhode Island	880	59.5%	5.0%	19.4%	2.4%	13.7%
South Carolina	3,927	51.8%	4.8%	17.0%	3.4%	22.9%
South Dakota	692	56.8%	8.9%	15.9%	3.4%	15.1%
Tennessee	5,468	54.1%	5.9%	19.2%	4.9%	15.9%
Texas	22,692	50.3%	4.2%	16.1%	2.7%	26.7%
Utah	2,499	66.0%	6.3%	9.9%	2.0%	15.7%
Vermont	532	56.7%	5.6%	25.6%	1.8%	10.4%
Virginia	6,836	62.8%	5.9%	9.6%	5.9%	15.7%
Washington	5,837	56.5%	6.1%	16.6%	4.6%	16.2%
West Virginia	1,569	57.1%	1.7%	19.5%	5.5%	16.3%
Wisconsin	4,829	62.6%	6.5%	17.8%	1.7%	11.5%
Wyoming	491	58.5%	5.7%	13.2%	2.7%	19.8%

( ) = 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, 2010-2011

	Children (thousands)[h]	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
United States	**78,584**	**49.9%**	**4.1%**	**34.5%**	**1.5%**	**9.9%**
Alabama	1,216	51.1%	3.0%	36.6%	--	8.0%
Alaska	201	48.8%	2.4%	29.0%	6.9%	12.9%
Arizona	1,733	46.6%	4.1%	33.5%	--	14.8%
Arkansas	733	38.3%	3.8%	49.0%	--	7.8%
California	9,881	45.1%	4.8%	37.8%	1.1%	11.3%
Colorado	1,316	56.0%	7.3%	24.7%	2.5%	9.6%
Connecticut	875	63.7%	4.1%	25.9%	--	6.0%
Delaware	222	55.9%	3.6%	32.9%	--	6.5%
District of Columbia	110	(40.3%)	4.2%	(49.4%)	--	5.0%
Florida	4,188	44.7%	4.3%	35.3%	1.6%	14.1%
Georgia	2,660	46.8%	3.8%	34.0%	4.6%	10.9%
Hawaii	330	51.4%	2.9%	38.1%	4.2%	3.4%
Idaho	452	45.9%	9.4%	33.0%	--	11.0%
Illinois	3,278	48.8%	3.9%	39.4%	0.8%	7.2%
Indiana	1,737	54.5%	2.6%	36.0%	--	6.2%
Iowa	773	56.3%	5.4%	30.3%	--	6.4%
Kansas	757	53.6%	4.4%	30.6%	2.6%	8.8%
Kentucky	1,077	48.8%	3.2%	40.1%	--	6.7%
Louisiana	1,206	38.2%	3.2%	46.7%	1.7%	10.3%
Maine	288	52.2%	3.4%	37.4%	--	5.5%
Maryland	1,433	59.2%	3.8%	25.9%	--	9.7%
Massachusetts	1,536	64.5%	3.8%	28.5%	--	3.0%
Michigan	2,470	54.5%	4.0%	35.5%	--	5.4%
Minnesota	1,354	63.6%	4.5%	24.6%	--	6.6%
Mississippi	809	39.3%	4.2%	43.7%	--	11.8%
Missouri	1,486	54.9%	5.1%	29.0%	--	10.2%
Montana	230	46.2%	6.6%	34.3%	2.0%	10.9%
Nebraska	486	57.6%	5.0%	25.8%	2.1%	9.5%
Nevada	695	52.2%	4.6%	21.9%	1.9%	19.3%
New Hampshire	300	68.4%	6.0%	18.3%	--	6.6%
New Jersey	2,173	58.1%	4.3%	27.1%	1.0%	9.6%
New Mexico	539	36.7%	2.9%	47.0%	--	12.3%
New York	4,584	51.2%	2.6%	38.2%	--	7.6%
North Carolina	2,462	46.1%	3.5%	37.3%	3.6%	9.5%
North Dakota	163	61.3%	8.0%	21.8%	--	7.7%
Ohio	2,843	52.7%	3.6%	34.3%	0.9%	8.6%
Oklahoma	992	44.2%	4.3%	39.6%	2.2%	9.7%
Oregon	903	49.9%	5.5%	34.8%	--	9.3%
Pennsylvania	2,905	56.1%	3.9%	31.6%	--	8.0%
Rhode Island	240	55.5%	2.8%	35.0%	--	6.0%
South Carolina	1,138	45.0%	4.4%	34.9%	--	14.4%
South Dakota	211	50.8%	6.2%	34.2%	1.6%	7.2%
Tennessee	1,571	46.4%	5.0%	38.3%	3.3%	7.0%
Texas	7,305	41.8%	3.3%	37.1%	1.2%	16.6%
Utah	918	63.9%	5.3%	17.6%	2.0%	11.2%
Vermont	132	48.6%	3.8%	42.8%	--	4.2%
Virginia	1,979	60.8%	5.0%	20.5%	6.1%	7.6%
Washington	1,733	46.4%	4.8%	37.0%	4.3%	7.4%
West Virginia	415	51.2%	1.9%	38.7%	2.1%	6.3%
Wisconsin	1,405	58.1%	3.3%	32.3%	--	5.4%
Wyoming	145	52.9%	4.2%	30.2%	2.0%	10.7%

( ) = 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 2011 federal poverty level for a family of four was $22,350.

[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

The data in the tables is based on analysis of the Census Bureau's March Supplement to the Current Population Survey (the CPS Annual Social and Economic Supplement or ASEC) by 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.

With the release of 2011 data, the Census Bureau implemented population controls based on the 2010 Census and applied them to data collected in 2010 and 2011. While the impact of this change on most estimates was minimal, data in this report may not be directly comparable to that in reports from earlier years.

The ASEC asks respondents about their health insurance coverage throughout the previous calendar year. Respondents may report having more than one type of coverage. In this analysis, individuals are sorted into only one category of insurance coverage using the following hierarchy:

- **Medicaid**: Includes those covered by Medicaid, the Children's Health Insurance Program (CHIP), and those who have both Medicaid and another type of coverage, such as dual-eligibles who are also covered by Medicare.
- **Employer**: Includes those covered by employer-sponsored coverage either through their own job or as a dependent.
- **Other Public**: Includes those covered under the military or Veterans Administration as well as nonelderly Medicare enrollees.
- **Individual**: Includes those covered by private insurance other than employer-sponsored coverage.
- **Uninsured**: Includes those without health insurance and those who have coverage under the Indian Health Service only.

For example, a person having Medicaid coverage in the first half of the year but employer-based coverage in the last months of the year would be categorized as having Medicaid coverage in this analysis.

In this analysis, income (mostly categorized as a percent of the federal poverty level) 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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