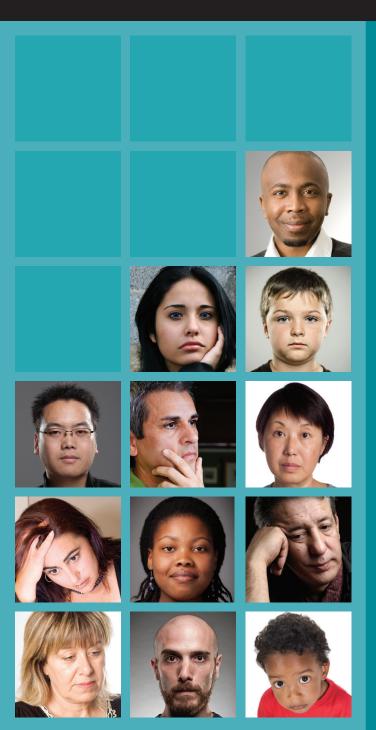


THE UNINSURED A PRIMER



Key Facts About Americans
Without Health Insurance

OCTOBER 2011

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

The number of nonelderly uninsured reached 49.1 million in 2010 due to the weak economy, which contributed to the erosion of job-based coverage. As incomes drop, Medicaid continues to buffer the loss of health insurance for millions.

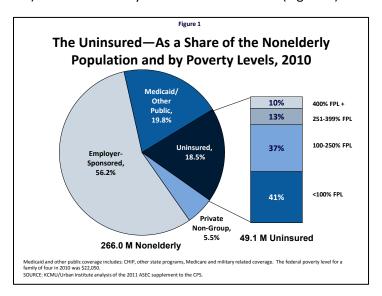
Intr	oduction1
>	How Do Most Americans Obtain Health Insurance?
	More than half of people under the age of 65 obtain health coverage as an employer benefit. While Medicare covers virtually all of the elderly, the nonelderly who do not have access to or cannot afford private insurance go without health coverage unless they qualify for the Medicaid program, the Children's Health Insurance Program (CHIP), or other state-subsidized insurance programs.
	Who Are the Uninsured?6
	Most of the uninsured come from working families and have low incomes. Adults make up a disproportionate share of the uninsured because they are less likely than children to be eligible for Medicaid. Young adults whose low incomes make it more difficult to afford coverage are especially likely to be uninsured.
	How and Why Has the Number of Uninsured Changed?9
	The number of uninsured has increased over the past decade, largely due to the struggling economy and resulting weak job market. Adults have experienced a larger increase in their uninsured rate compared to children. This difference is largely due to limited eligibility for public coverage among adults.
>	How Does Lack of Insurance Affect Access to Health Care?11
	Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. The consequences of reduced access to care over time can be serious, including preventable hospitalizations, poor overall health, disability, and premature death.
>	What Are the Financial Implications of Lack of Coverage?
	For many of the uninsured, the costs of health insurance and medical care are weighed against equally essential needs. Medical bills can mount quickly for the uninsured, and the financial impact, particularly on a low-income family, can be severe. Uninsured families are more likely than those with coverage to exhaust their savings or go into debt to pay for care.

	What is the Role of Employer-Sponsored Coverage?16
	Employer-sponsored health insurance is voluntary for employers and employees. Thirty-eight million people from working families were uninsured in 2010 because not all businesses offer health benefits, not all workers qualify for coverage, and many employees cannot afford their share of the health insurance premium. Other workers have lost their employer-sponsored insurance after being laid-off, a consequence of the weak job market and struggling economy.
	What is Medicaid's Role?19
	Medicaid is the nation's public health insurance program for low-income Americans, providing coverage based not only on a person's or family's income, but also on whether they fit into specific eligibility categories. CHIP complements Medicaid by covering uninsured low-income children with family incomes above Medicaid thresholds. In 2010, federal funding from the American Recovery and Reinvestment Act (ARRA) protected Medicaid coverage for children and families across the states by requiring states to maintain current eligibility levels and providing states with increased matching payments. Many low-income children, families, and people with disabilities would be uninsured without these programs.
>	How Will the Affordable Care Act Affect the Uninsured?22
	The 2010 Patient Protection and Affordable Care Act (ACA) includes several provisions to reduce the number of uninsured. It also makes significant changes to the organization and delivery of health care. The law promotes greater health coverage by building on the existing public-private system for providing health insurance coverage and fills in existing gaps in coverage by expanding the Medicaid program, strengthening employer-based coverage, and providing premium subsidies to make private insurance more affordable. Many of the broader coverage expansions will be implemented in 2014, although some took effect in 2010.
Con	clusion25
Tab	les

Data Note......35

Introduction

The number of nonelderly uninsured Americans reached 49.1 million in 2010, amidst rising unemployment rates and a struggling economy. Nearly all of the elderly are insured by Medicare, yet nearly 792,000 of the elderly were uninsured last year. Because the majority of the nonelderly receive their health insurance as a job benefit, the steady decline in employer-sponsored health coverage since 2000 and the current weak job market largely explain the growing numbers of uninsured. The safety net of Medicaid and the Children's Health Insurance Program (CHIP) has prevented a larger increase in the uninsured and, in particular, buffered children from the full effects of the difficult economic climate. Almost one in five (18.5%) of the nonelderly was uninsured in 2010 (Figure 1).



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 come from working families—four in ten of the uninsured are individuals and families who are poor (incomes less than the federal poverty level of \$22,050 for a family of four in 2010).

Not having health insurance makes a difference in people's access to needed medical care and their financial security. The access barriers the uninsured face 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 already struggle financially to meet basic needs, and medical bills, even for minor problems, can quickly lead to medical debt.

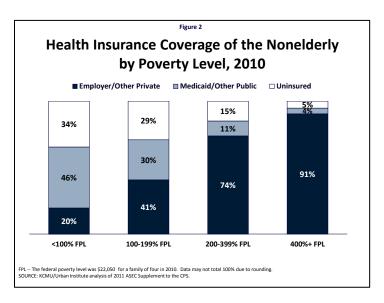
Over the next ten years, the Patient Protection and Affordable Care Act (ACA) of 2010 is expected to reduce the uninsured rate by more than half. The ACA will fill existing gaps in coverage by expanding the Medicaid program to those at or below 138% of the federal poverty level, building on employer-based coverage, and providing premium subsidies to make private insurance more affordable for many between 139% of 400% of poverty.

The Census Bureau reports a total of 49.9 million uninsured in 2010, which includes 792,000 people who are elderly (65+ years old). This primer focuses on the nonelderly uninsured. Our analysis of the Current Population Survey's ASEC supplement differs from estimates by the Census Bureau in several other ways outlined in the Data Notes in the end of this primer.

This primer presents basic information about the uninsured—who they are and why they do not have health coverage—and provides an understanding of the difference health insurance makes in people's lives. *The Uninsured: A Primer* also discusses how and why the number of uninsured has changed and how the ACA will impact the uninsured.

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 over 49 million nonelderly people in the U.S.—18.5% 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.



Employer-Sponsored Health Insurance Coverage

The majority of employers offer group health insurance policies to their employees and to their employees' families. In 2011, 60% of firms offer coverage to their employees. 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%). 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 2011, an average of 79% of their workers are eligible for coverage. 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 5.5% 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. Nationwide, the average monthly premium per person in the individual market in 2010 was \$215, with substantial variation by state. Vermont and Massachusetts both had average per member per month premiums over \$400, as 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.

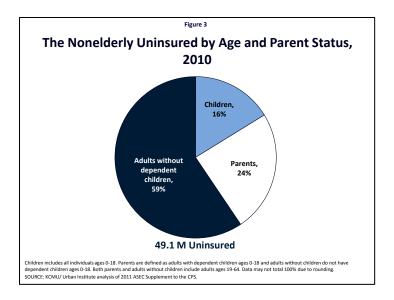
Insurance premiums in the non-group market may vary by age and health status and may be less comprehensive than group plans purchased by employers. Under the current system, applicants with health problems that are offered non-group coverage may be charged a higher premium due to their medical history 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 may also be 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. 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% of the nonelderly population by primarily covering four main categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities. Individuals who do not fall into one of these groups—most notably adults without dependent children—are now generally ineligible for public coverage regardless of their income. While some children and parents are uninsured, adults without dependent children comprise the majority of the uninsured largely because they are the least likely to qualify for Medicaid (Figure 3).

The ACA will extend Medicaid to all individuals at or below 138% of poverty starting in 2014.⁷ 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.⁸



Medicaid and CHIP cover one-third of all children and more than two-thirds of all children in families below the poverty level. Medicaid is the largest source of health insurance for children in the U.S., enrolling 29 million non-disabled children at some point in the 2008 fiscal year (the most recent year of enrollment data available). CHIP supplements Medicaid by covering over 7 million children who are low or moderate income but whose family incomes are too high to qualify for Medicaid. 10

Medicaid finances health and long-term care coverage for 9.2 million nonelderly people with disabilities (2008 estimates).¹¹ 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.

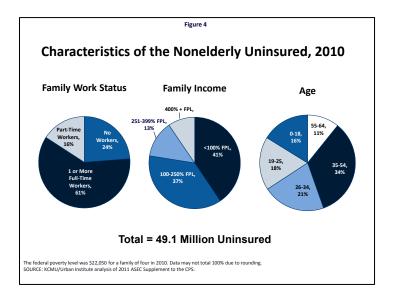
Who Are the Uninsured?

In 2010, 49.1 million people in the U.S. under age 65 lacked health insurance. Most of these individuals come from working families and have low incomes. The weak economy has contributed to significant declines in employer-sponsored coverage. Adults make up a disproportionate share of the uninsured because they are less likely than children to be eligible for Medicaid. Young adults whose low incomes make it more it difficult to afford coverage are especially likely to be uninsured. A high unemployment rate and increases in the number of individuals living below poverty put employer-sponsored coverage out of reach for many individuals.

More than three-quarters of the uninsured are in working families: 61% are from families with one or more full-time workers and 16% are from 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. In 2011, worker contributions for employer-sponsored coverage averaged \$344 per month for family coverage and \$77 for individual coverage.

The vast majority of the uninsured are in low- or moderate-income families (Figure 4). Individuals below poverty are at the highest risk of being uninsured, and this group comprises 41% of the uninsured (the poverty level for a family of four was \$22,050 in 2010). In total, nine in ten of the uninsured are in low- or moderate-income families, meaning they are below 400% of poverty. The ACA targets these individuals through broader Medicaid eligibility and premium subsidies to purchase private coverage.

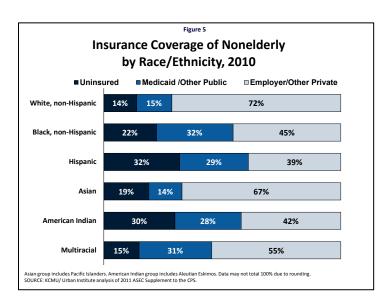
Adults are more likely to be uninsured than children. Adults make up 70% of the nonelderly population but 84% of the uninsured (Figure 4). Most low-income children qualify for Medicaid or the CHIP, but low-income adults under age 65 typically qualify for Medicaid only if they are disabled, pregnant, or have dependent children. Income eligibility levels are generally much lower for parents than for children, and adults without children are generally ineligible. Under the ACA, Medicaid will be expanded in 2014 to provide eligibility to nearly all people under age 65 with income up to 138% of the federal poverty level.¹⁴



Young adults, ages 19 to 25, comprise a disproportionately large share of the uninsured, largely due to their low incomes (Figure 4). Young adults have the highest uninsured rate (30%) of any age group. 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 2010 was less than \$12,000. Beginning September 2010, the health reform law allowed young adults stay on their parent's private health insurance until age 26.

More than half (60%) of nonelderly uninsured adults have no education beyond high school, making them less able to get higher-skilled jobs that are more likely to provide health coverage. Those with less education are also more likely to be uninsured for longer periods of time. ¹⁵

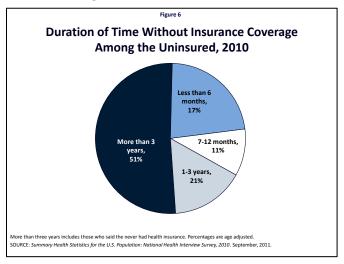
Minorities are much more likely to be uninsured than whites. About one-third of Hispanics and nearly one-quarter of black Americans are uninsured, compared to 14% of non-Hispanic whites (Figure 5). Medicaid and CHIP are important sources of coverage for racial and ethnic minorities, covering over one-quarter of Hispanic and black Americans. However, gaps in eligibility for Medicaid leave large numbers of minorities uninsured.



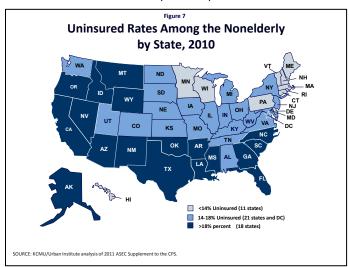
The majority of the uninsured (81%) are native or naturalized U.S. citizens. Although non-citizens (legal and undocumented) are about three times more likely to be uninsured than citizens, they account for less than 20% of the uninsured population. Non-citizens have less access to employer coverage because they are more likely to have low-wage jobs and work for firms that do not offer coverage. Further, until recently, states were precluded from using federal dollars to provide Medicaid or CHIP coverage to 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, 2011, 21 states had adopted the option to eliminate the waiting period for lawfully-residing immigrant children, and 17 states had adopted the option for lawfully-residing pregnant women. ¹⁶ Undocumented immigrants will remain ineligible for federally funded health coverage under the health reform law.

The uninsured tend to be in worse health than the privately insured. Uninsured adults are more than twice as likely to report being in fair or poor health as those with private insurance. Almost half of all uninsured nonelderly adults have a chronic condition.¹⁷ Those with such conditions and others who are not in good health and who do not have access to employer-sponsored coverage may find non-group coverage to be unavailable or unaffordable. The ACA addresses this issue by imposing new regulations 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.¹⁸

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

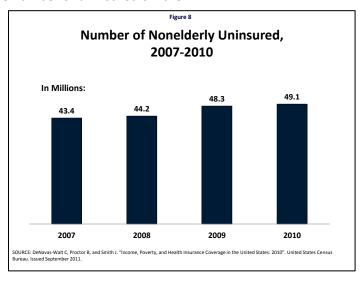


Insurance coverage varies by state depending on the share of families with low incomes, the nature of the state's employment, and the reach of state Medicaid programs. Insurance market regulations and the availability of jobs with employer-sponsored coverage also influence the distribution of health coverage in each state. ¹⁹ Uninsured rates tend to be higher in the southern and western regions of the United States. State-level uninsured rates vary widely. Massachusetts has near universal coverage, with an uninsured rate of 6% due to health reform legislation enacted in 2006. Uninsured rates in states such as New Mexico, Florida, and Texas are 25% or higher (Figure 7).



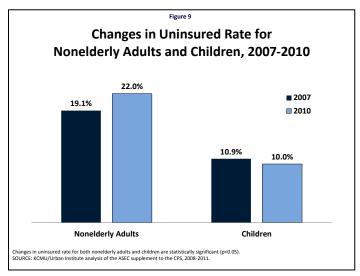
How and Why Has the Number of Uninsured Changed?

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



Broad Medicaid and CHIP eligibility for children has helped maintain health coverage for children.

During the recent economic recession, the percentage of uninsured children actually declined slightly as more children gained coverage through Medicaid or CHIP. Between 2007 and 2010, the uninsured rate for children dropped from 10.9% to 10.0% (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, many became eligible for public insurance.

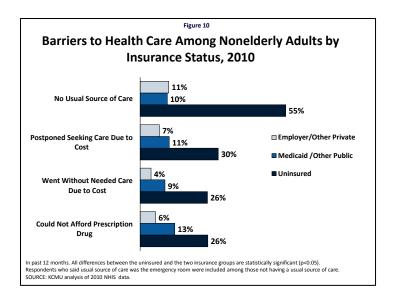


- Public coverage's ability to absorb additional children was bolstered by the reauthorization of the Children's Health Insurance Program in 2009, which enabled states to expand Medicaid and CHIP coverage to more children leading up to the recession. The American Recovery and Reinvestment Act (ARRA) later provided states with temporary increased federal Medicaid funding while requiring states to maintain their eligibility and enrollment policies at the level that was in place on July 1, 2008. This additional funding was originally set to end in December 2010, but was later extended at a lower rate through June 2011.
- In the years preceding the 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 6.3 million more nonelderly adults without coverage. This increase in uninsured adults was largely driven by a decrease in the share of adults with employer-sponsored coverage. Over this period, the unemployment rate increased from 5.0% in January 2008 to 9.4% at the end of 2010,²⁰ which likely caused many adults to lose their employer-sponsored coverage. While a partial federal subsidy for individuals maintaining their previous employer-sponsored coverage was in place for those laid-off between September 2008 and May 2010, uptake of the subsidy was lower than predicted.²¹ Medicaid eligibility for adults is more limited than for children, and therefore the share of adults in the program increased only slightly compared to the changes in the percent of adults with employer-sponsored coverage.
- The uninsured rate among young adults, ages 19 to 25, has improved slightly in the last year. Though still more likely to be uninsured than older adults, the uninsured rate of young adults decreased slightly from 31.7% in 2009 to 30.0% in 2010. Early results from a national health survey indicate that the reduction in uninsured rate for this population continued through the first quarter of 2011. The improvement in coverage for young adults may be attributable to the ACA provision allowing young adults to remain on their parent's private health insurance policies.

How Does Lack of Insurance Affect Access to Health Care?

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

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



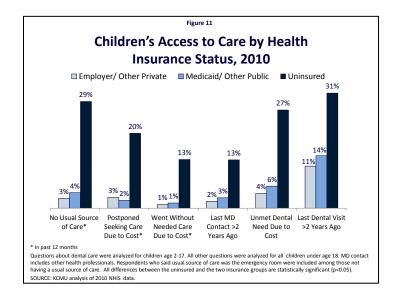
Access to health care has eroded over time for many. Rising health care costs have made health care less affordable, particularly for the uninsured. Between 1997 and 2006, the differences in access to care between the uninsured and insured widened, even among those with chronic conditions. The insurance disparities in access to a usual source of care, annual check-ups, and preventive health care are the greatest and grew the most over the decade. 23,24

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

Anticipating high medical bills, many of the uninsured are not able to follow recommended treatments. More than a quarter of uninsured adults say they did not fill a drug prescription in the past year because they could not afford it. Regardless of a person's insurance coverage, those injured or newly diagnosed with a chronic condition receive similar follow-up care plans; however, the uninsured are less likely than the insured to actually obtain all the services that are recommended.²⁸

Because the uninsured are less likely than the insured to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and experience declines in their overall health. When they are hospitalized, the uninsured receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.^{29, 30}

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. Disparities exist even among children with special needs, including access to specialists.



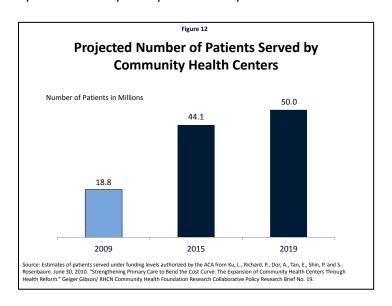
Lack of health coverage, even for short periods of time, results in decreased access to care. Those who have been uninsured for less than six months are already more likely than those with continuous health coverage to report having an unmet need for medical care or a prescription drug in the past year. 33 Children who are uninsured for part of the year have more access problems than those with full-year public or private coverage. 34

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 the uninsured. 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.

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; 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 the uninsured. 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 have access to these providers.³⁶

Increased demand and limited capacity means safety net providers are unable to meet all the health needs of the uninsured. The ability of safety net providers to serve the uninsured has been threatened in recent years due to increased demand and eroding financing.³⁷ 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.³⁸ Further, increasing financial pressures and changing physician practice patterns have contributed to a decline in charity care provided by physicians.³⁹

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 the uninsured. The 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.

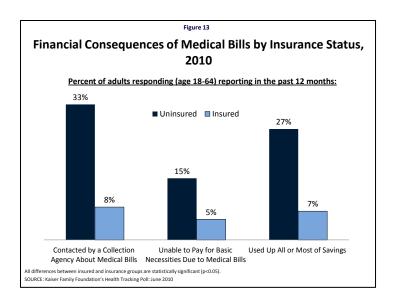


What Are the Financial Implications of Lack of Coverage?

For many of the uninsured, the costs of health insurance and medical care are weighed against equally essential needs. When the uninsured do receive health care, they may be charged for the full cost of that care, which can strain family finances and lead to medical debt. The uninsured 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, were three times as likely as those with higher incomes to report having difficulty paying basic monthly expenses such as rent, food, and utilities.⁴²

- Most of the uninsured do not receive health services for free or at reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services. Slightly less than half of the uninsured know of a provider in their community who charges less to patients without insurance. 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.
- The uninsured are increasingly paying "up front" before services will be rendered. When the uninsured are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or can be turned away.⁴⁶
- The uninsured spend less than half of what the insured 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. ⁴⁷ 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. As 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. Host 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. In 2009, federal grants covered less than half of the cost of caring for uninsured patients in health centers. The cost of care provided by physicians is not directly or indirectly reimbursed by public dollars.
- Being uninsured leaves individuals at an increased risk of amassing unaffordable medical bills.

 Uninsured adults are three times as likely as the insured to have been unable to pay for basic necessities such as housing or food due to medical bills (Figure 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.



Most of the uninsured have few, if any, savings and assets they can easily use to pay health care costs. Half of uninsured households had \$600 or less in total assets (not including their house and cars) in 2004, compared to median assets of \$5,500 for insured households. Moreover, after households' debts are subtracted from assets, the median net worth of uninsured households drops to zero—

leaving many of the uninsured with no financial reserves to pay unexpected medical bills.

significantly less financial strain due to health care costs.⁵²

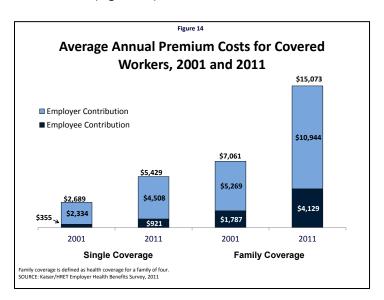
Unprotected from medical costs and with few assets, the uninsured are at risk of being unable to pay off medical debt. Like any bill, when medical bills are not paid or paid off too slowly, they are turned over to a collection agency, and a person's ability to get further credit is significantly limited. In 2010, one-third of uninsured adults reported that a collection agency contacted them about unpaid medical bills in the previous year (Figure 13). When the uninsured gain Medicaid coverage, they are about 25% less likely to have unpaid medical bills sent to a collection agency and report

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 38 million of the uninsured are in families that have at least one worker. The share of the nonelderly population with employer-sponsored coverage has been declining since 2000 and has been exacerbated by the 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 over the next ten years.

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

The cost of employer-sponsored coverage is the most common reason employers cite for not offering health coverage. In 2011, annual employer-sponsored group premiums averaged \$5,429 for individual coverage and \$15,073 for family coverage. Total family premiums have more than doubled since 2001. The employee's share of a family premium has also more than doubled since 2001, averaging \$4,129 in 2011 (Figure 14).



Workers may lose coverage if they become unemployed. Some of the newly unemployed have the option to switch to a spouse's employer-sponsored insurance. The unemployed can also purchase coverage in the non-group market, but high premiums in this market make this option unattainable for those who also struggling with reduced income. Some unemployed individuals may qualify for public coverage, but many do not meet current eligibility requirements. The unemployed who had employer-sponsored coverage while employed may have the opportunity to continue this coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), though the cost of premiums for this coverage is often high. A temporary subsidy reduced the cost of COBRA by 65% for workers laid-off between September 2008 and May 2010. Estimates indicate lower uptake of this subsidy than originally predicted. Without this subsidy, it may be even more difficult for the newly unemployed to remain insured.

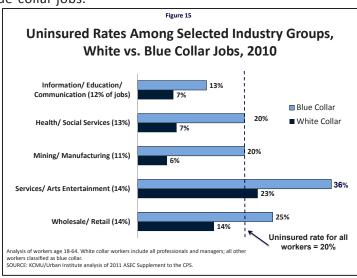
Employer-sponsored health insurance has declined during this decade, and the current economic climate is hastening that trend. Job-based coverage has been gradually declining since 2000, even during years when the economy was stronger and growth in health insurance premiums was slowing. From 2007 to 2010, the percentage of the nonelderly population with employer-sponsored coverage declined by approximately 5%.

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. ⁵⁶

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 than employees of firms with fewer low-wage workers (38% vs. 27% of the premium costs for family coverage). Declines in dependent coverage accounted for more than half of the recent decline in employer-sponsored insurance.

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. ⁵⁹ By comparison, 86% 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.

Health coverage varies both by industry and by type of occupation. Across industries, uninsured rates for workers range from 36% in agriculture to just 6% in public administration. 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.



Small firms are much less likely to offer coverage than large firms. Nearly all businesses (99%) with at least 200 workers offer health benefits to their workers in 2011, but only 59% of firms with less than

200 workers offer these benefits.⁶¹ On average, small firms ask employees to contribute a lower amount annually towards their own health benefits compared to large firms (\$762 vs. \$996 per year). However, small firms ask for larger annual contributions for family coverage (\$4,946 vs. \$3,755).

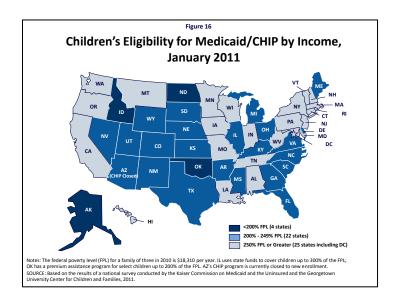
What is Medicaid's Role?

Medicaid is the nation's major public health insurance program for low-income Americans, covering more than 59 million low-income children, families, seniors and people with disabilities. Over the past decade, growth in Medicaid enrollment has helped to buffer losses of job-based coverage, preventing larger increases in the number of uninsured. As the ACA goes into effect, Medicaid will be the base for expanding health care coverage to nearly all of the lowest income Americans.

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

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

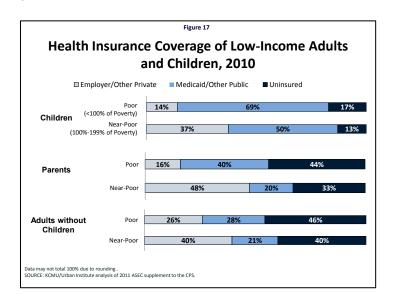
The Children's Health Insurance Program (CHIP) works as a complement to Medicaid by covering low-income children not eligible for Medicaid. CHIP was created in 1997 to expand coverage to children, particularly low-income children. Together Medicaid and CHIP aim to cover low-income children who would otherwise be uninsured. Most states cover children up to or above 200% of the poverty level through Medicaid or CHIP (Figure 16). The reauthorization of CHIP in 2009, in combination with fiscal relief from ARRA, was critical in enabling states to continue their commitment to providing coverage to millions of low-income families.



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, nearly two-thirds (65%) of uninsured children are eligible for Medicaid or CHIP but are not enrolled. Some families are not aware of the availability of the programs or may not believe their children are eligible. For others, burdensome enrollment and renewal requirements still 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.

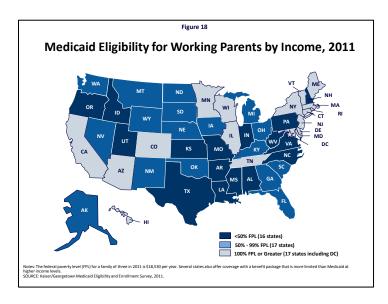
Medicaid covers more than two-thirds of poor children and about half of all low-income children. However, eligibility for adults is more restricted. While all poor children are eligible for Medicaid, many of their parents are not. Most states have much lower income eligibility for parents than for children. In addition, although Medicaid covers some parents and low-income individuals with disabilities, most adults without dependent children—regardless of how poor—are ineligible for Medicaid. As a result, almost half of poor parents and adults without children are uninsured (Figure 17). Many of these parents and childless adults will become eligible for Medicaid in 2014 as a result of the Medicaid expansion in the ACA.



Some states have expanded Medicaid eligibility to cover more poor and near poor parents. About one-third of states have used the flexibility available to them under federal law to extend Medicaid eligibility for parents to 100% of the poverty level or higher. However, in the remaining states, parents still must have income below the poverty level in order to qualify for health coverage (Figure 18). As of January 2011, 33 states limited Medicaid eligibility for parents to 100% of the federal poverty level, with 16 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, as well as to take advantage of the option to use federal matching funds to expand Medicaid to childless adults before the broad expansion to all individuals with income up to 138% of the federal poverty level goes into effect in 2014. As of January 2011, seven states provided Medicaid or Medicaid-comparable coverage to non-disabled adults. ⁶⁴ An additional 18 states provided more limited coverage for adults who meet specified employment-

related requirements. The state programs and coverage expansion for low-income children and adults are a key component of state strategies to address the problem of the uninsured.



Funding from ARRA through the enhanced Federal Matching Assistance Percentage (FMAP) helped states to maintain their Medicaid programs in recent years. Pressure from the recession remained severe throughout Fiscal Year (FY) 2010 and into FY 2011. Fiscal relief funds in ARRA provided critical assistance to states in FYs 2009 and 2010; an extension of these funds through the end of FY 2011 was enacted but at a lower level than those originally approved in ARRA. The ARRA enhanced FMAP reduced state costs for Medicaid and helped to avoid or mitigate provider rate cuts in a time of unprecedented need for access to Medicaid benefits. In addition, the ACA included eligibility protections designed to keep Medicaid coverage steady until broader health reform goes into effect.

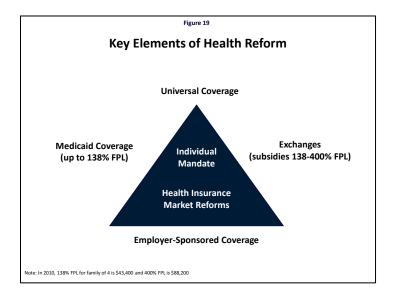
Recent increases in Medicaid and CHIP enrollment helped to offset declines in private coverage.

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 2010, over 4% of children lost employer-sponsored covered while more than 5% gained public coverage, thus preventing the number of uninsured children from increasing.

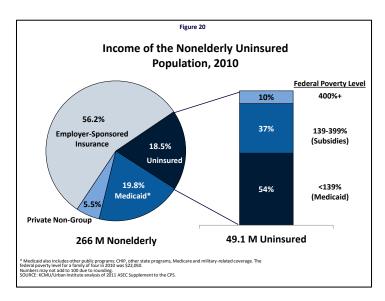
Looking forward, enrollment in Medicaid will likely continue to increase. The Medicaid program is designed as a health coverage safety net, and as such, enrollment in the program increases during economic downturns when people lose their jobs and, therefore, their access to employer-sponsored health insurance. Medicaid was able to play a key role in maintaining coverage partly because of the additional funding to states provided in the ARRA and the requirement that states maintain existing eligibility levels. As the economy rebounds, historically state revenues and reduced pressure on Medicaid have lagged behind the initial economic recovery. In addition, 16 million more people are expected to enroll in Medicaid and CHIP by 2019, mainly due to the ACA's expansion of public coverage.

How Will the Affordable Care Act Affect the Uninsured?

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.



The different coverage provisions in the ACA target the uninsured in different income groups. Among the 49 million nonelderly uninsured in 2010, more than half (54%) have incomes below 139%, a group that would be affected by the expansion of Medicaid in 2014 (Figure 20). Over one-third (37%) of the nonelderly uninsured 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 the uninsured in all income groups will be impacted by new insurance rules and requirements.



Medicaid Expansion

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

Changes in Medicaid enrollment due to implementation of the ACA will vary greatly by state, depending on the state's current Medicaid eligibility and the share of its population that is low income. For example, by 2021, Medicaid enrollment is expected to increase by 38% in Georgia and West Virginia, as compared to 2% or less in Massachusetts and Vermont. The federal government will finance much of the Medicaid expansion defined in the ACA, contributing an estimated \$610 billion toward states' implementation of health reform between 2012 and 2021.

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 for those above the Medicaid eligibility levels, the federal government will make available premium subsidies for individuals and families with incomes from 139% to 400% of the federal poverty level (\$43,400 for an individual and \$88,200 for a family of four in 2010). These subsidies will be offered on a sliding scale basis that will limit the cost of the premium to a share of income up to 9.5 % of income for those with incomes between 300-400% of the poverty level. In addition, cost-sharing subsidies to reduce what people have to pay out-of-pocket to access health services will be available for people with incomes up to 250% of the poverty level.

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.⁶⁷ 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

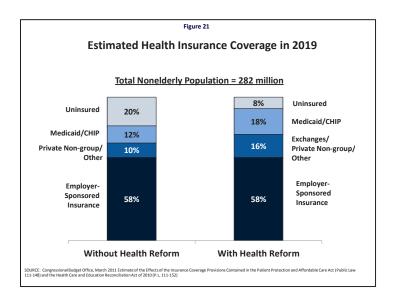
Beginning in 2014, the law will require most individuals to have health insurance. However, this requirement will only apply to those with access to affordable coverage, defined as costing no more than 8% of an individual's or family's income (certain other exemptions to the mandate will also be granted). 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 are available beginning in 2010.

Impact of the Law on the Uninsured

When fully implemented in 2019, the Congressional Budget Office (CBO) estimates the law will expand coverage to 33 million people, cutting the uninsured rate by more than half. According to CBO, the legislation will result in 16 million more people enrolling in Medicaid and CHIP. Another 24 million people (19 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 22 million people will remain uninsured in 2019.⁶⁸ These individuals are likely to include immigrants who are not legal residents and are therefore not eligible for Medicaid coverage or for federal premium subsidies, people who are exempt from the mandate, in most cases because they do not have access to affordable coverage, and people who are subject to the mandate but choose to pay the penalty rather than purchase health insurance. Those than remain uninsured will continue to rely on nation's safety-net hospitals and clinics to access care. Many of the uninsured live in health professional shortage areas,⁶⁹ underscoring the need to continue to develop and support safety-net providers and community health clinics.

Conclusion

The continuing weak economy has laid bare some of the fundamental problems with our health care system. Declines in employer-sponsored coverage, evident since 2000, have been exacerbated by job losses during the recession. For these newly uninsured, 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 offered a safety net of coverage to those facing job displacement and financial hardship and have helped to prevent more people from being uninsured. However, the ability of Medicaid, in particular, to provide broader coverage is limited by low eligibility levels and restrictions on coverage in many states. While these problems reflect systemic failures, they have personal consequences. Being uninsured places people's health at risk and increases financial instability for individuals and families.

With 49.1 million nonelderly people uninsured today, implementing the new coverage provisions in the ACA is increasingly important. 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, Jhamirah Howard, Rachel Licata, and Rachel Garfield of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, and Emily Lawton and Vicki Chen of the Urban Institute.

Tables

- Table 1: Characteristics of the Nonelderly Uninsured, 2010
- Table 2: Characteristics of Uninsured Children, 2010
- Table 3: Health Insurance Coverage of the Nonelderly, 2010
- **Table 4: Health Insurance Coverage of Children, 2010**
- Table 5: Health Insurance Coverage of the Nonelderly by State, 2009-2010
- Table 6: Health Insurance Coverage of Children by State, 2009-2010

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, 2010

29.8% 70.2% 11.1% 13.8%	Uninsured (millions) 49.1 8.0	Percent of Uninsured 100.0%	Uninsured Rate 18.5%
29.8% 70.2% 11.1%	49.1		
29.8% 70.2% 11.1%		100.0%	18.5%
70.2% 11.1%	8.0		
70.2% 11.1%	8.0	1	
11.1%		16.2%	10.0%
	41.2	83.8%	22.0%
13.8%	8.8	18.0%	30.0%
_5.5,5	10.4	21.2%	28.3%
14.9%	8.7	17.7%	22.0%
16.5%	7.9	16.1%	18.0%
13.9%	5.3	10.8%	14.4%
25.5%	24.4	49.7%	36.0%
19.5%	13.5	27.4%	25.9%
55.0%	11.2	22.9%	7.7%
29.2%	26.3	53.6%	33.9%
21.7%	19.9	40.6%	34.5%
7.5%	6.4	13.0%	32.1%
37.4%	18.1	36.9%	18.2%
18.3%	11.9	24.2%	24.4%
19.1%	6.2	12.7%	12.3%
33.4%	4.7	9.5%	5.3%
7.8%	4.4	9.0%	21.3%
12.6%	12.1	24.6%	36.1%
20.7%	8.7	17.6%	15.7%
13.0%	6.6	13.4%	19.0%
40.2%	13.2	26.8%	12.3%
5.8%	4.3	8.7%	27.7%
24.7%	5.0	10.2%	7.6%
			18.3%
			30.9%
14.8%	11.6	23.6%	29.4%
63.20/	22.0	AG 40/	43.00/
			13.8% 22.3%
			22.3% 32.1%
			19.1%
			29.9%
1.7%	0.7	1.4%	14.6%
07.72	26.5	74.204	. ,
			15.7%
			24.3%
			42.9%
5./%	7.3	14.9%	48.4%
68.1%	28.7	58.5%	15.9%
23.0%	15.0	30.6%	24.6%
8.9%	5.3	10.9%	22.5%
	16.5% 13.9% 13.9% 25.5% 19.5% 55.0% 29.2% 21.7% 7.5% 37.4% 18.3% 19.1% 33.4% 7.8% 12.6% 20.7% 13.0% 40.2% 5.8% 24.7% 51.1% 9.3% 14.8% 62.3% 12.7% 17.7% 5.0% 0.6% 1.7% 87.5% 5.0% 1.8% 5.7%	16.5% 7.9 13.9% 5.3 25.5% 24.4 19.5% 13.5 55.0% 11.2 29.2% 26.3 21.7% 19.9 7.5% 6.4 37.4% 18.1 18.3% 11.9 19.1% 6.2 33.4% 4.7 7.8% 4.4 12.6% 12.1 20.7% 8.7 13.0% 6.6 40.2% 13.2 5.8% 4.3 24.7% 5.0 51.1% 24.8 9.3% 7.7 14.8% 11.6 62.3% 22.8 12.7% 7.5 17.7% 15.1 5.0% 2.5 0.6% 0.5 1.7% 0.7 87.5% 36.5 5.0% 3.2 1.8% 2.1 5.7% 7.3	16.5% 7.9 16.1% 13.9% 5.3 10.8% 25.5% 24.4 49.7% 19.5% 13.5 27.4% 55.0% 11.2 22.9% 29.2% 26.3 53.6% 21.7% 19.9 40.6% 7.5% 6.4 13.0% 37.4% 18.1 36.9% 18.3% 11.9 24.2% 19.1% 6.2 12.7% 33.4% 4.7 9.5% 7.8% 4.4 9.0% 12.6% 12.1 24.6% 20.7% 8.7 17.6% 13.0% 6.6 13.4% 40.2% 13.2 26.8% 5.8% 4.3 8.7% 24.7% 5.0 10.2% 51.1% 24.8 50.6% 9.3% 7.7 15.7% 14.8% 11.6 23.6% 62.3% 22.8 46.4% 12.7% 7.5 15.3% 17.7% 15.1 30.7% 5.0%

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

Table 2
Characteristics of Uninsured Children, 2010

	Children (millions)	Percent of Children	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total - Children ^h	79.3	100.0%	8.0	100.0%	10.0%
Age					
<1	4.1	5.2%	0.5	5.9%	11.4%
1-5	21.5	27.1%	1.8	23.2%	8.6%
6-18	53.7	67.8%	5.6	70.9%	10.5%
Family Income					
<\$20,000	20.0	25.2%	3.4	42.8%	17.0%
\$20,000 - \$39,999	15.0	18.9%	2.1	26.6%	14.1%
\$40,000 +	44.3	55.9%	2.4	30.5%	5.5%
Family Poverty Level ^c					
≤138%	28.9	36.4%	4.8	60.0%	16.5%
<100%	22.0	27.8%	3.8	47.7%	17.2%
100-138%	6.9	8.6%	1.0	12.3%	14.3%
139-399%	30.2	38.1%	2.6	32.7%	8.6%
139-250%	15.7	19.7%	1.8	22.4%	11.4%
251-399%	14.6	18.4%	0.8	10.3%	5.6%
400%+	20.2	25.5%	0.6	7.3%	2.9%
Household Type ⁱ					
1 Parent ^d	20.7	26.1%	2.3	29.3%	11.3%
2 Parents ^d	51.5	64.9%	4.1	52.1%	8.0%
Multigenerational/Other ^e	6.5	8.2%	1.3	16.5%	20.1%
Family Work Status					
Talling Work Status				65.3%	
2 Full-time	20.6	26.0%	1.2	14.5%	5.6%
1 Full-time	40.7	51.3%	4.0	50.9%	9.9%
Only Part-time ^f	6.7	8.4%	0.9	11.0%	13.2%
Non-Workers	11.3	14.3%	1.9	23.6%	16.6%
Race/Ethnicity					
White only (non-Hispanic)	43.3	54.6%	3.1	38.7%	7.1%
Black only (non-Hispanic)	11.2	14.1%	1.2	15.1%	10.8%
Hispanic	18.3	23.1%	3.1	38.9%	16.9%
Asian/S. Pacific Islander only	3.6	4.5%	0.3	4.2%	9.2%
Am. Indian/Alaska Native	0.5	0.6%	0.1	1.1%	(17.6%)
Two or More Races ^g	2.4	3.0%	0.2	2.0%	6.7%
Citizenship					
U.S. Citizen	77.1	97.2%	7.2	90.3%	9.3%
Non-U.S. citizen, resident for < 5 years	1.0	1.2%	0.3	3.8%	(30.9%)
Non-U.S. citizen, resident for 5+ years	1.2	1.5%	0.5	5.9%	(38.2%)
Health Status					
Excellent/Very Good	64.5	81.3%	6.0	75.6%	9.3%
Good	13.1	16.5%	1.7	21.9%	13.3%
Fair/Poor	1.7	2.2%	0.2	2.5%	11.5%

^{() =} 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, 2010

			Percent Dist	tribution by Coverage Type			
	Nonelderly	Priv	Private		Public		
	(millions)	Employer	<u>Individual</u>	Medicaid	<u>Other^b</u>		
Total - Nonelderly ^a	266.0	56.2%	5.5%	16.9%	2.9%	18.5%	
Age							
Children - Total	79.3	50.0%	4.2%	34.2%	1.6%	10.0%	
Adults - Total	186.7	58.9%	6.1%	9.6%	3.4%	22.0%	
Adults 19-25	29.5	42.9%	11.7%	13.5%	1.9%	30.0%	
Adults 26-34	36.8	55.3%	4.4%	10.3%	1.7%	28.3%	
Adults 35-44	39.6	63.0%	4.2%	8.8%	2.1%	22.0%	
Adults 45-54	43.9	65.3%	5.2%	8.2%	3.3%	18.0%	
Adults 55-64	37.0	63.1%	6.4%	8.4%	7.7%	14.4%	
Annual Family Income							
<\$20,000	67.8	16.6%	6.4%	36.7%	4.2%	36.0%	
\$20,000 - \$39,999	52.0	42.4%	5.9%	22.4%	3.4%	25.9%	
\$40,000 +	146.3	79.5%	5.0%	5.8%	2.0%	7.7%	
Family Poverty Level ^c							
≤138%	77.8	17.2%	5.6%	39.8%	3.5%	33.9%	
<100%	57.8	14.1%	5.5%	42.7%	3.2%	34.5%	
100-138%	19.9	26.2%	6.0%	31.3%	4.5%	32.1%	
139-399%	99.4	60.4%	6.0%	12.0%	3.4%	18.2%	
139-250%	48.7	47.7%	6.3%	17.7%	3.9%	24.4%	
251-399%	50.7	72.7%	5.8%	6.4%	2.8%	12.3%	
400%+	88.8	85.6%	4.9%	2.5%	1.7%	5.3%	
Household Type							
Single Adults Living Alone	20.7	53.2%	8.5%	11.4%	5.7%	21.3%	
Single Adults Living Together	33.5	40.6%	9.2%	10.8%	3.2%	36.1%	
Married Adults	55.1	68.7%	5.7%	5.4%	4.5%	15.7%	
1 Parent with children ^d	34.6	33.0%	4.5%	42.1%	1.4%	19.0%	
2 Parents with children ^d	106.9	65.8%	4.3%	15.7%	1.8%	12.3%	
Multigenerational/Other with children ^e	15.3	34.9%	3.5%	31.0%	2.8%	27.7%	
Family Work Status							
2 Full-time	65.7	81.8%	3.5%	5.8%	1.3%	7.6%	
1 Full-time	136.0	61.2%	5.4%	13.3%	1.7%	18.3%	
Only Part-time ^f	24.9	26.6%	10.6%	28.5%	3.3%	30.9%	
Non-Workers	39.5	15.0%	5.9%	40.6%	9.1%	29.4%	
Race/Ethnicity							
White only (non-Hispanic)	165.7	64.8%	6.7%	11.8%	3.0%	13.8%	
Black only (non-Hispanic)	33.7	42.0%	3.3%	28.7%	3.7%	22.3%	
Hispanic	47.0	36.6%	2.8%	26.6%	1.9%	32.1%	
Asian/S. Pacific Islander only	13.3	60.3%	6.3%	12.6%	1.7%	19.1%	
Am. Indian/Alaska Native	1.7	37.2%	5.1%	25.4%		29.9%	
Two or More Races ^g	4.5	49.0%	5.8%	26.8%	3.8%	14.6%	
Citizenship							
U.S. citizen - native	232.7	57.9%	5.7%	17.7%	3.0%	15.7%	
U.S. citizen - naturalized	13.4	58.4%	5.6%	9.7%	2.1%	24.3%	
Non-U.S. citizen, resident for < 5 years	4.8	35.0%	6.0%	14.9%	1.2%	42.9%	
Non-U.S. citizen, resident for 5+ years	15.1	34.9%	2.9%	12.5%	1.3%	48.4%	
Health Status							
Excellent/Very Good	181.2	61.6%	6.2%	14.7%	1.7%	15.9%	
Good	61.1	49.3%	4.5%	18.8%	2.8%	24.6%	
						,	

^{() =} 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, 2010

		Percent Distribution by Coverage Type					
	Children	Pri	vate	Pul		Uninsured	
	(millions)	Employer	<u>Individual</u>	Medicaid	<u>Other</u> ^b		
Total - Children ^h	79.3	50.0%	4.2%	34.2%	1.6%	10.0%	
Age							
<1	4.1	41.9%	2.4%	41.6%	2.8%	11.4%	
1-5	21.5	46.5%	3.0%	40.0%	1.9%	8.6%	
6-18	53.7	52.0%	4.8%	31.3%	1.5%	10.5%	
Annual Family Income							
<\$20,000	20.0	11.6%	2.9%	67.0%	1.5%	17.0%	
\$20,000 - \$39,999	15.0	28.0%	3.7%	52.5%	1.7%	14.1%	
\$40,000 +	44.3	74.7%	5.0%	13.1%	1.7%	5.5%	
Family Poverty Level ^c							
≤138%	28.9	14.4%	2.8%	64.7%	1.6%	16.5%	
<100%	22.0	11.4%	2.6%	67.2%	1.6%	17.2%	
100-138%	6.9	24.0%	3.4%	56.9%	1.5%	14.3%	
139-399%	30.2	60.6%	4.8%	24.0%	2.0%	8.6%	
139-250%	15.7	48.1%	4.4%	34.1%	2.1%	11.4%	
251-399%	14.6	74.1%	5.2%	13.2%	1.8%	5.6%	
400%+	20.2	84.9%	5.4%	5.6%	1.3%	2.9%	
Household Type ⁱ							
1 Parent with children d	20.7	29.7%	4.0%	54.0%	1.0%	11.3%	
2 Parents with children d	51.5	61.8%	4.2%	24.0%	1.9%	8.0%	
Multigenerational/Other with children ^e	6.5	23.9%	3.4%	51.2%	1.4%	20.1%	
Family Work Status							
	20.6	75.00/	2.40/	42.00/	1.20/	F C0/	
2 Full-time 1 Full-time	20.6 40.7	75.9% 52.9%	3.4% 4.7%	13.8% 30.7%	1.3% 1.7%	5.6% 9.9%	
Only Part-time ^f	6.7	17.4%	4.7%	62.7%	2.1%	13.2%	
Non-Workers	11.3	11.4%	3.4%	66.8%	1.9%	16.6%	
Race/Ethnicity							
Milita only from Historia	42.2	62.20/	F F0/	22.50/	1.00/	7.40/	
White only (non-Hispanic) Black only (non-Hispanic)	43.3 11.2	62.3% 32.5%	5.5% 2.5%	23.5% 52.5%	1.6% 1.8%	7.1% 10.8%	
Hispanic	18.3	31.0%	1.9%	48.7%	1.6%	16.9%	
Asian/S. Pacific Islander only	3.6	57.9%	5.3%	26.4%	1.2%	9.2%	
Am. Indian/Alaska Native	0.5	(30.6%)				(17.6%)	
Two or More Races ^g	2.4	46.0%	5.0%	39.6%	2.6%	6.7%	
Citizenship							
	77.4	F0.661	4.20/	24.20/	4 701	0.001	
U.S. citizen Non-U.S. citizen, resident for < 5 years	77.1 1.0	50.6%	4.2% 5.2%	34.2%	1.7%	9.3%	
Non-U.S. citizen, resident for < 5 years Non-U.S. citizen, resident for 5+ years	1.0	(29.5%) 27.5%	5.2%	(33.8%) 31.7%		(30.9%) (38.2%)	
Health Status	-					(20.270)	
Excellent/Very Good	64.5	53.8%	4.5%	30.7%	1.7%	9.3%	
Good Fair/Roor	13.1	34.7%	3.0%	47.8%	1.2%	13.3%	
Fair/Poor	1.7	24.4%	2.4%	59.8%	1.8%	11.5%	

^{() =} 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, 2009-2010

	Nonelderly	Priv	rate	Pub	olic	Uninsured
	(thousands) ^a	<u>Employer</u>	Individual	Medicaid	<u>Other</u> ^b	
United States	265,371	56.6%	5.4%	16.8%	2.8%	18.4%
Alabama	4,003	57.3%	3.6%	16.6%	4.2%	18.3%
Alaska	620	57.3%	3.1%	13.6%	6.6%	19.3%
Arizona	5,811	49.4%	5.7%	21.0%	2.7%	21.1%
Arkansas	2,439	49.7%	4.6%	19.1%	5.0%	21.6%
California	32,683	50.7%	6.6%	19.4%	1.8%	21.5%
Colorado	4,441	60.3%	8.3%	12.5%	3.4%	15.5%
	3,023		5.0%			
Connecticut	,	68.7%		12.2%	1.6%	12.5%
Delaware	749	61.7%	4.3%	17.5%	2.6%	14.0%
District of Columbia	530	54.4%	5.9%	24.7%	1.3%	13.8%
Florida	15,245	50.8%	5.7%	14.1%	4.1%	25.3%
Georgia	8,771	54.0%	5.4%	14.4%	4.3%	21.9%
Hawaii	1,035	65.6%	4.5%	17.2%	3.9%	8.8%
Idaho	1,342	54.6%	9.3%	14.2%	2.5%	19.4%
Illinois	11,285	58.6%	5.2%	17.8%	2.1%	16.3%
Indiana	5,500	60.0%	3.5%	18.1%	3.0%	15.6%
lowa	2,612	63.7%	7.0%	14.6%	1.7%	13.1%
Kansas	2,375	61.7%	6.5%	13.1%	4.0%	14.7%
Kentucky	3,735	55.8%	3.8%	19.4%	3.4%	17.5%
Louisiana	3,898	51.7%	5.3%	19.8%	3.7%	19.5%
Maine	1,080	56.5%	4.8%	23.4%	3.7%	11.5%
Maryland	5,009	67.0%	5.3%	11.2%	1.8%	14.7%
Massachusetts	5,636	66.4%	5.0%	21.9%	1.0%	5.7%
Michigan	8,494	60.9%	5.1%	17.6%	1.7%	14.8%
Minnesota	4,501	65.8%	6.3%	15.5%	2.1%	10.2%
		45.9%				22.1%
Mississippi	2,492		5.3%	22.9%	3.8%	
Missouri	5,182	58.8%	6.6%	15.6%	2.5%	16.5%
Montana	817	51.9%	10.2%	14.3%	4.0%	19.6%
Nebraska	1,553	62.4%	8.5%	11.8%	3.4%	13.8%
Nevada	2,322	57.6%	5.7%	10.2%	3.0%	23.5%
New Hampshire	1,135	71.7%	6.3%	7.8%	2.7%	11.5%
New Jersey	7,578	65.0%	4.3%	12.6%	1.3%	16.8%
New Mexico	1,716	45.2%	3.9%	23.3%	3.3%	24.3%
New York	16,687	55.1%	4.5%	22.4%	1.6%	16.4%
North Carolina	8,056	54.2%	4.8%	16.8%	4.3%	19.9%
North Dakota	549	62.0%	11.9%	9.9%	2.8%	13.5%
Ohio	9,898	60.8%	5.4%	15.4%	2.7%	15.7%
Oklahoma	3,135	54.7%	4.2%	16.7%	4.1%	20.3%
Oregon	3,270	57.2%	7.1%	14.3%	2.1%	19.4%
Pennsylvania	10,482	63.6%	5.4%	16.5%	1.7%	12.8%
Rhode Island	892	60.8%	4.4%	19.2%	2.3%	13.3%
South Carolina	3,863	54.8%	4.8%	14.6%	4.2%	21.7%
South Dakota	689	58.6%	8.7%	13.8%	3.7%	15.2%
Tennessee	5,415	54.2%	5.4%	18.3%	4.9%	17.1%
Texas	22,360	49.4%	4.1%	16.4%	2.7%	27.4%
Utah	2,533	67.0%	6.0%	9.8%	1.9%	15.3%
Vermont	538	58.0%	4.4%	24.7%	2.2%	10.7%
Virginia 	6,797	63.7%	5.8%	9.9%	5.4%	15.2%
Washington	5,839	58.3%	6.3%	16.4%	3.9%	15.1%
West Virginia	1,527	57.7%	1.8%	19.9%	4.8%	15.9%
Wisconsin	4,760	64.8%	6.2%	16.8%	1.7%	10.6%
Wyoming	471	59.4%	6.7%	12.4%	2.8%	18.6%

^{() =} Estimate has a large 95% confidence interval of \pm -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, 2009-2010

		Percent Distribution by Coverage Type				
	Children	Priv	/ate	Pub		Uninsured
	<u>(thousands)^h</u>	<u>Employer</u>	<u>Individual</u>	<u>Medicaid</u>	<u>Other</u> ⁵	
United States	79,295	50.6%	4.2%	33.6%	1.5%	10.1%
Alabama	1,195	48.9%	2.1%	38.8%	1.6%	8.6%
Alaska	198	48.4%		27.9%	9.2%	12.1%
Arizona	1,848	42.9%	5.3%	36.3%		14.6%
Arkansas	749	40.2%	3.6%	45.2%		9.8%
California	10,026	45.1%	4.9%	37.9%	1.1%	11.0%
Colorado	1,319	56.6%	6.9%	24.1%	3.7%	8.7%
Connecticut	862	66.1%	5.0%	22.1%		6.5%
Delaware	223	56.5%	3.7%	30.7%	1.7%	7.5%
District of Columbia	118	38.8%		(51.4%)		6.8%
Florida	4,229	45.3%	4.3%	31.9%	2.2%	16.2%
Georgia	2,747	49.2%	4.1%	31.3%	3.9%	11.5%
Hawaii	314	54.4%	3.8%	35.5%	3.6%	
daho	442	48.1%	10.2%	31.2%	J.070 	9.8%
llinois	3,354	50.4%	3.7%	36.8%	0.8%	8.4%
ndiana	1,750	52.6%	2.9%	36.1%	0.8%	7.6%
owa	761	56.2%	5.9%	30.1%	1.1%	6.8%
	750	55.4%	4.7%	29.4%	2.8%	7.7%
(ansas					2.0%	
Kentucky	1,071	49.1%	2.7%	39.4%		8.1%
Louisiana	1,234	41.9%	5.1%	42.6%	1.8%	8.6%
Maine	284	51.1%	4.0%	38.5%		4.6%
Maryland	1,416	62.8%	3.9%	23.9%		8.2%
Massachusetts	1,553	63.2%	3.5%	29.7%		3.4%
Michigan	2,502	56.8%	4.2%	33.3%		5.4%
Minnesota	1,321	62.0%	4.7%	26.5%	1.2%	5.6%
Mississippi	820	36.4%	3.5%	46.7%		12.4%
Missouri	1,507	53.7%	5.6%	30.8%		9.2%
Montana	229	48.8%	7.3%	31.7%		10.1%
Nebraska	480	57.8%	5.8%	25.8%	2.0%	8.6%
Nevada	708	55.3%	5.1%	22.1%	1.9%	15.6%
New Hampshire	301	70.7%	6.1%	17.8%		4.7%
New Jersey	2,192	62.5%	3.0%	25.3%		9.1%
New Mexico	549	36.8%		44.6%		14.5%
New York	4,731	50.0%	3.2%	38.7%	0.4%	7.8%
North Carolina	2,447	46.4%	3.5%	35.3%	3.9%	10.9%
North Dakota	155	61.2%	7.9%	21.2%		8.0%
Ohio	2,858	55.7%	4.3%	30.4%	1.0%	8.6%
Oklahoma	984	43.0%	3.3%	38.9%		12.6%
Oregon	908	50.5%	7.2%	30.4%		11.4%
Pennsylvania	2,949	58.1%	3.3%	30.8%		7.7%
Rhode Island	242	54.0%	2.7%	35.9%		6.6%
South Carolina	1,154	50.1%	5.0%	29.7%		13.5%
South Dakota	209	54.1%	6.1%	30.1%		7.8%
Tennessee	1,572	47.6%	4.6%	36.3%	4.0%	7.6%
Texas	7,358	41.4%	3.0%	37.2%	1.5%	17.0%
Jtah	921	63.9%	5.3%	17.3%	1.8%	11.7%
/ermont	129	49.9%		42.4%		4.4%
/irginia	2,000	61.1%	4.9%	21.0%	5.1%	7.9%
Washington	1,687	47.9%	5.0%	37.8%	3.8%	5.6%
Washington West Virginia	420	47.9% 51.7%	J.U%	40.5%	3.8%	3.0% 4.7%
=			2 20/			
Wisconsin	1,375	62.2%	3.3%	29.3%	 2 F0/	4.7%
Wyoming	142	52.6%	5.6%	29.3%	2.5%	10.0%

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

Table 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.

- Nonelderly includes all individuals under age 65.
- Other includes other public insurance (mostly Medicare and military-related).
 CHIP is included in Medicaid.
- ^c The 2010 federal poverty level for a family of four was \$22,050.
- d Parent includes any person with a dependent child.
- 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.
- 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.
- Nonelderly adults includes all individuals aged 19-64.
- Workers includes all workers aged 18-64.
- 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.
- Other occupations include the following types of jobs: assistants, clerical workers, technicians, repair workers, artists, entertainers, sports-related workers, service workers, laborers, salespersons, operators (equipment, including drivers), skilled trade workers, and assemblers.

Data Notes

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

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

In 2011, the Census Bureau adjusted the imputation methodology for variables related to insurance coverage. As a result, the Census Bureau also revised data collected in previous years. At the time of this publication, detailed revised data for previous years was not available. This analysis applies methodology created by the Urban Institute that aims to replicate the Census Bureau's revision in previous years.

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

- Medicaid: Includes those covered by Medicaid, CHIP, and those who have both Medicaid and another type of coverage, such as dual-eligibles who are also covered by Medicare.
- Employer: Includes employer-sponsored coverage for employees and their dependents.
- Other Public: Includes those covered under the military or Veterans Administration as well as some 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.

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

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

Endnotes

¹ Census revised estimates for previous years to reflect adjustments to the imputation methodology for variable related to insurance coverage. This revision means that the 2009 estimate was 49.0 million, not 50.7 million as previously reported. For more information see: Boudreaux M and Turner J, 2001. "Modifications to the Imputed Routine for Health Insurance in the CPS ASEC: Description and Evaluation." State Health Access Data Assistance Center. Available at: http://www.census.gov/hhes/www/hlthins/data/revhlth/SHADAC.pdf

² Kaiser Family Foundation and Health Research & Educational Trust, 2011. 2011 Kaiser/HRET Employer Health Benefits Survey. Available at: http://ehbs.kff.org.

³ Kaiser Family Foundation and Health Research and Educational Trust, 2011.

⁴ Cox C, Levitt L, Damico A, and Claxton G. 2011. "Mapping Premium Variation in the Individual Market." Kaiser Family Foundation. (#8214; August).

⁵ Schwartz K and Streeter S, 2011. "Health Coverage for the Unemployed." Kaiser Commission on Medicaid and the Uninsured (#8201; June).

⁶ America's Health Insurance Plans. "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits." October 2009. Available at: http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.

⁷ The Patient Protection and Affordable Care Act extends Medicaid eligibility to 133% of poverty, but a special income deduction equal to five percentage points of the poverty level effectively raises the eligibility level to 138% of poverty.

⁸ States have the option to provide Medicaid coverage to immigrant children and pregnant women who have legally been in the United States for less than five years.

⁹ KCMU/Urban Institute analysis of 2008 Medicaid Statistical Information Statistics.

¹⁰ Centers for Medicare & Medicaid Services. "CHIP Ever Enrolled In Year." CHIP Statistical Enrollment Data System (SEDS), February 1, 2011. Available at: https://www.cms.gov/NationalCHIPPolicy/downloads/CHIPEverEnrolledYearGraph.pdf

¹¹ KCMU/Urban Institute analysis of 2008 Medicaid Statistical Information Statistics.

¹² Cunningham P, Artiga S and Schwartz K. 2008 "The Fraying Link Between Work and Health Insurance: Trends in Employer-Sponsored Insurance for Employees, 2000-2007." Kaiser Commission on Medicaid and the Uninsured (#7840; November).

¹³ Kaiser Family Foundation and Health Research and Educational Trust, 2011.

¹⁴ The Patient Protection and Affordable Care Act extends Medicaid eligibility to 133% of poverty, but a special income deduction equal to five percentage points of the poverty level effectively raises the eligibility level to 138% of poverty.

¹⁵ National Center for Health Statistics. 2011. "Health Insurance Coverage: Early Release of Estimates from the National Health Information Survey, 2010." Available at: http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201106.pdf.

¹⁶ Heberlein M, et al. 2011. "Holding Steady, Looking Ahead: Annual Findings of the 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011." Kaiser Commission on Medicaid and the Uninsured (#8130; January)

¹⁷ Davidoff A and Kenney G. 2005. "Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey." The Urban Institute and the University of Maryland. May 2005. Available at: http://www.urban.org/publications/411161.html

¹⁸ Kaiser Family Foundation. "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act." (#8023-R; April). Available at: http://www.kff.org/healthreform/8023.cfm

¹⁹ Marks C, Schwartz T, and Donaldson L, 2009. "State Variation and Health Reform: A Chartbook". Kaiser Commission on Medicaid and the Uninsured. (#7942; July).

²⁰ Bureau of Labor Statistics. Available at: http://data.bls.gov/timeseries/LNS14000000

²¹ Schwartz K and Streeter S, 2011.

²² Cohen R and Martinez ME. "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2011." National Center for Health Statistics. September 2011. Available at: http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201109.pdf.

²³ Hoffman C and Schwartz K. 2008. "Trends in Access to Care Among Working-Age Adults, 1997-2006." Kaiser Commission on Medicaid and the Uninsured (#7824; October).

²⁴ Hoffman C and Schwartz K. 2008. "Eroding Access Among Nonelderly U.S. Adults with Chronic Conditions: Ten Years of Change." *Health Affairs* 27(5):w340-8 (published online July 22, 2008).

²⁵ NewsHour with Jim Lehrer/Kaiser Family Foundation National Survey on the Uninsured. March 2003.

²⁶ Avanian J, et al., 2000. "Unmet Health Needs of Uninsured Adults in the United States." JAMA 284(16):2061-9.

²⁷ Roetzheim R, et al., 2000. "Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes." *American Journal of Public Health* 90(11): 1746-54.

²⁸ Hadley J, 2007. "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition." *JAMA* 297(10):1073-84.

²⁹ Hadley J. 2003. "Sicker and Poorer – The Consequences of Being Uninsured." MCRR 60(2): 3-76.

Wilper, et al., 2009, "Health Insurance and Mortality in US Adults." American Journal of Public Health, 99(12) 2289-2295.

Collins S, et al., 2011. "Help on the Horizon: How the Recession Had Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief" The Commonwealth Fund. Available at: http://www.commonwealthfund.org/Surveys/2011/Mar/2010-Biennial-Health-Insurance-Survey.aspx

³² Institute of Medicine, 2009. "America's Uninsured Crisis, Consequences for Health and Health Care." Washington, DC: National Academies Press. p. 60-63.

³³ Haley J and Zuckerman S. 2003. "Is Lack of Coverage a Short-Term or Chronic Condition?" Kaiser Commission on Medicaid and the Uninsured (#4122; June).

³⁴ Olson LM, et al., 2005, "Children in the United States with Discontinuous Health Insurance Coverage." *The New England Journal of Medicine*. 353: 382-91.

³⁵ Finkelstein A, et al., 2011, "The Oregon Health Insurance Experiment: Evidence From the First Year", National Bureau of Economic Research. Available at http://www.nber.org/papers/w17190.

³⁶ Ein Lewin M and Altman S, Eds. Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, Institute of Medicine. 2000, America's Health Care Safety Net: In Tact but Endangered. (Washington DC: Institute of Medicine).

³⁷ Ibid.

³⁸ Summer L. 2011. "The Impact of the Affordable Care Act on the Safety Net." AcademyHealth. Available at: http://www.academyhealth.org/files/FileDownloads/AHPolicybrief_Safetynet.pdf.

³⁹ Cunningham P and May J. 2006. "A Growing Hole in the Safety Net: Physician Charity Care Declines Again." Center for Studying Health Systems Change Tracking Report.

⁴⁰ Rosenbaum S, Jones E, Shin P and Tolbert J. 2010. Community Health Centers: Opportunities and Challenges of Health Reform. Kaiser Commission on Medicaid and the Uninsured. (#8098; August).

⁴¹ Ibid.

⁴² Collins et al., 2011, "Help on the Horizon: How the Recession Had Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief" The Commonwealth Fund. Available at: http://www.commonwealthfund.org/Surveys/2011/Mar/2010-Biennial-Health-Insurance-Survey.aspx

⁴³ Anderson G. 2007. "From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing." *Health Affairs* 26(4): 780-789.

⁴⁴ Cunningham P, Hadley J, Kenney G, and Davidoff A. 2007. "Identifying Affordable Sources of Medical Care among Uninsured Persons." *Health Services Research* 42(1p1), 265–285.

⁴⁵ Carrier E, Yee T, and Garfield R. 2011. "The Uninsured and Their Health Care Needs: How Have They Changed Since the Recession" Kaiser Commission on Medicaid and the Uninsured. (Forthcoming)

⁴⁶ Asplin B, et al., 2005. "Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments." *JAMA* 294(10):1248-54.

⁴⁷ Hadley J, Holahan J, Coughlin T, and Miller D. 2008. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." *Health* Affairs 27(5):w399-415.

⁴⁸ Hadley J, et al. 2008. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs." Health Affairs. 27(5):w399-415.

⁴⁹ Ibid.

⁵⁰ Shin P, Tolbert J, and Rosenbaum S, 2011. "The Case of Federally Qualified Health Centers." Kaiser Commission on Medicaid and the Uninsured (forthcoming).

⁵¹ Jacobs P and Claxton G. 2008 "Comparing the Assets of Uninsured Households to Cost Sharing Under High Deductible Health Plans," *Health Affairs* 27(3):w214-21 (published online April15, 2008).

⁵² Finkelstein A, et al., 2011.

⁵³ Clemans-Cope L and B Garrett B. 2006. "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 – 2005." Kaiser Commission on Medicaid and the Uninsured (#7599; December), 2006.

⁵⁴ Kaiser Family Foundation and Health Research and Educational Trust, 2011.

⁵⁵ Schwartz K and Streeter S. 2011.

⁵⁶ State Health Access Data Assistance Center (SHADAC). 2011. State Level Trends in Employer Sponsored Health Insurance: A State-by-State Analysis. Available at: http://www.shadac.org/files/shadac/publications/ESI Trends Jun2011.pdf

⁵⁷ Kaiser Family Foundation and Health Research and Educational Trust. 2011.

⁵⁸ State Health Access Data Assistance Center (SHADAC). 2011. State Level Trends in Employer Sponsored Health Insurance: A State-by-State Analysis. Available at: http://www.shadac.org/files/shadac/publications/ESI Trends Jun2011.pdf

⁵⁹ Cunningham P, Artiga S, and Schwartz K. 2008. "The Fraying Link Between Work and Health Insurance: Trends in Employer-Sponsored Insurance for Employees, 2000-2007." Kaiser Commissioner on Medicaid and the Uninsured (#7840; November).

⁶⁰ KCMU/Urban Institute analysis of 2011 ASEC Supplement to the CPS.

⁶¹ Kaiser Family Foundation and Health Research and Educational Trust, 2011.

⁶² KCMU/Urban Institute analysis of 2008 Medicaid Statistical Information Statistics.

⁶³ Kenney G, et al., 2011. Gains for Children: Increased Participation in Medicaid and CHIP in 2009, Available at: http://www.rwjf.org/files/research/20110816coveragegainsforkidsfull.pdf

⁶⁴ Kaiser Commission on Medicaid and the Uninsured. 2011. "Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults." (#7993-02; February)

⁶⁵ Dorn S, Garrett B, Holahan J, and Williams A. 2008. "Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses." Kaiser Commission on Medicaid and the Uninsured. (#7770; April).

⁶⁶ Holahan J, et al., 2011. "House Republican Budget Plan" State-by-State Impact of Changes in Medicaid Financing." Kaiser Commission on Medicaid and the Uninsured. (#8185; May).

⁶⁷ Trish E, et al., 2011. "A Profile of Health Insurance Exchange Enrollees." Kaiser Family Foundation. (#8147; March).

⁶⁸ Congressional Budget Office, March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Available at:

http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf

⁶⁹ Hoffman C, Damico A, and Garfield R. 2011. "Research Brief: Insurance Coverage and Access to Care in Primary Shortage Areas." Kaiser Commission on Medicaid and the Uninsured. (#8161; February).

Select Publications from the Kaiser Commission on Medicaid and the Uninsured

Available at www.kff.org

Reports/Data Books

Health Coverage for the Unemployed, June 2011 (#8201)

Uninsured and Untreated: A look at Uninsured Adults Who Received No Medical Care for Two Years, July 2010 (#8083)

Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage, and Policy Trends—Results From a 50 State Medicaid Budget Survey for State Fiscal Years 2010 and 2011, September 2010 (#8105)

Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011, January 2011 (#8130)

Five Basic Facts on the Uninsured, September 2011 (#7806-04)

The Uninsured and the Difference Health Insurance Makes, October 2011 (#1420-13)

Community Health Centers: Opportunities and Challenges of Health Reform, September 2010 (#8098)

Summary of New Health Reform Law, April 2011 (#8061)

Kaiser Family Foundation Online Resources

State Health Facts, http://www.statehealthfacts.org/

Slides on Health Insurance Coverage and the Uninsured, http://facts.kff.org/results.aspx?view=show&topic=4

Kaiser Family Foundation Health Reform Source, http://healthreform.kff.org/

Kaiser Family Foundation Publications

Employer Health Benefits 2011 Annual Survey, September 2011 (#8225)

Medicaid: A Primer, June 2010 (#7334-04)



THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters 2400 Sand Hill Road Menlo Park, CA 94025 Phone 650-854-9400 Fax 650-854-4800

Washington Offices and Barbara Jordan Conference Center 1330 G Street, NW Washington, DC 20005 Phone 202-347-5270 Fax 202-347-5274

www.kff.org

This publication (#7451-07) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the biggest health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.