KAISER COMMISSION ON MEDICAID AND THE UNINSURED

THE HENRY J. KAISER FAMILY FOUNDATION

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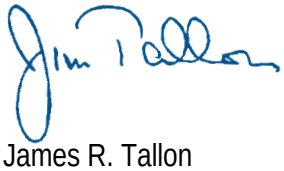
THE UNINSURED: A PRIMER

KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE

January 2006

Over 45 million Americans were without health insurance in 2004. Since 2000 the number of uninsured under the age of 65 has grown by six million. Employer-sponsored health insurance has decreased by five full percentage points, covering 66 percent of the nonelderly in 2000, but just 61 percent in 2004. Public insurance, both Medicaid and the State Children's Health Insurance Program, has filled this gap for children but not for adults – who accounted for all of the growth in the number of uninsured since 2000. Two-thirds of this growth in uninsured adults occurred among the poor or near-poor.

It is the Commission's hope that by updating this primer, the fundamentals of how health insurance is provided in our country will be understood by more, as well as how important insurance is in accessing health services, and why the number of uninsured Americans continues to grow.



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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 bi-partisan group of national leaders and experts in health care and public policy.

The Uninsured: A Primer
Key Facts About
Americans Without Health Insurance

Overview

Over 45 million Americans under age 65 lacked health insurance coverage in 2004, an increase of 800,000 in a single year and over six million people since 2000. While the majority of Americans obtain health insurance through their employer as a benefit, being employed does not guarantee that a worker will have insurance. The uninsured come primarily from working families with low and moderate incomes, families for whom coverage is not available in the workplace or is unaffordable.

Medicare covers virtually all those 65 and older, while Medicaid and the State Children's Health Insurance Program (S-CHIP) help provide coverage for millions of low-income people. However, there still remains a significant gap in coverage—so large that 18% of the population under age 65 lacks health insurance. Employer-sponsored health insurance, sensitive to both the general economy and changes in health insurance premiums, has decreased markedly from covering 66% of the nonelderly in 2000 to 61% by 2004.

Health Insurance Matters

There is a strong relationship between health insurance coverage and access to medical services. Health insurance makes a substantial difference in the amount and kind of health care people are able to afford, as well as where they obtain care. Research has consistently shown that the lack of insurance ultimately compromises persons' health because they are less likely to receive preventive care, are more likely to be hospitalized for avoidable health problems, and are more likely to be diagnosed in the late stages of disease. Having insurance improves health overall and could reduce mortality rates for the uninsured by 10 to 15%.

Health insurance also affects the financial well-being of families. Insurance helps reduce the financial uncertainty associated with health care, as illness and health care needs are not always predictable and care can be very expensive. Therefore, those lacking coverage are more financially vulnerable to the high cost of care, are exposed to higher out-of-pocket costs compared to the insured, and are more often burdened by medical bills.

The Public Safety Net

Medicaid and the S-CHIP provide coverage to certain low-income populations that meet eligibility requirements. The programs play a particularly important role for children, aiming to cover nearly all low-income uninsured children. The role of Medicaid for adults is far more limited however, covering only some low-income parents and disabled individuals, leaving most childless adults ineligible, regardless of how poor they are. Recent growth in Medicaid and S-CHIP enrollment of children has filled in the sizable gap created by decreased employer-sponsored insurance since 2000. The share of children who are uninsured actually decreased between 2000 and 2004, but little progress was made in expanding public insurance to more low-income adults. Consequently, adults accounted for all of the growth in the number of uninsured since 2000.

Options for Health Insurance Reform

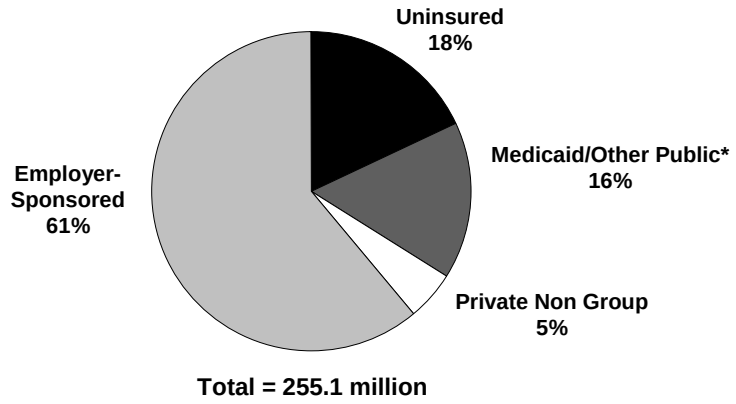
When surveyed, Americans consistently support guaranteeing health insurance for more people. Options for reforming the current health insurance system and decreasing the number of uninsured continue to be debated. Most proposals recognize that in order to make health insurance affordable for the majority of the uninsured, premiums will need to be subsidized for the lowest income groups. However, rising health care costs and fiscal constraints to expanding public coverage, pose a significant challenge for reform. In the absence of national reform, Governors and legislatures are seeking practical solutions and proposing a diverse mix of strategies to address the growing numbers of uninsured in their own states.

How Do Most Americans Obtain Health Insurance?

Most Americans under the age of 65 receive health insurance coverage as an employer benefit—61% in 2004. While Medicare covers virtually all those who are 65 years or older, the nonelderly who do not have access to or cannot afford private insurance go without health coverage unless they qualify for the Medicaid program, S-CHIP, or other state-subsidized insurance programs. The gaps in our private and public health insurance systems left 45.5 million nonelderly Americans – 18% of those under age 65 – without health coverage in 2004.

Figure 1

Health Insurance Coverage of the Nonelderly Population, 2004



Total = 255.1 million

*Medicaid/Other Public includes Medicaid, SCHIP, other state programs, Medicare and military-related coverage.
SOURCE: Kaiser Commission on Medicaid and the Uninsured (KCMU) and Urban Institute analysis of the March 2005 Current Population Survey.

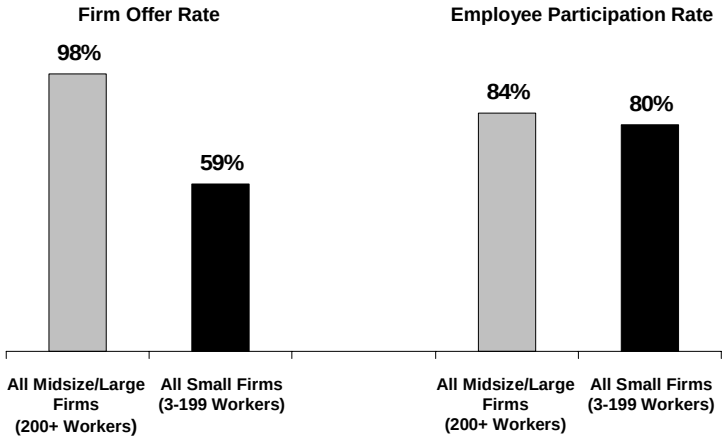
Private Health Insurance Coverage

- Many, but not all, employers offer group health insurance policies to their employees as a benefit and also often extend coverage to their employees' families. About half of Americans insured through employer-sponsored health plans are covered by their own employer (51%) and half are covered as a worker's dependent (49%). Employer-sponsored group plans cost on average $4,024 per year for individual coverage and $10,880 for coverage for a family of four in 2005. The employee's share of a family premium in 2005 averaged $2,713, increasing roughly $1,000 since 2000.[1]

- Employer-sponsored health insurance is voluntary; businesses are not legally required to offer a health benefit, and employees can choose not to participate. While virtually all midsize and large businesses (i.e., more than 200 workers) offer health benefits, 41% of smaller businesses (3 – 199 workers) did not offer health benefits to their employees in 2005. Even when businesses offer health benefits, some employees are ineligible because they are part-time employees or recent hires and some do not sign up because of the required employee share of the premium. However, participation rates do not differ dramatically between workers in small versus large businesses.[2]

Figure 2

Health Insurance Offer and Participation Rates by Firm Size, 2005



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.

- Private policies directly purchased in the non-group market (i.e., outside of employer-sponsored benefits) cover only 5% of nonelderly Americans. Private non-group insurance premiums are based on individual health risk and are substantially more expensive than group plans purchased by employers, with cost varying by age and health status. Insurance companies in the non-group market can deny or limit coverage to persons in poor health or with chronic conditions. The share of the nonelderly with private non-group insurance has changed very little over time.

- 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 by employers. Those who are self-employed are now allowed to deduct all of the costs of their insurance premiums from their taxes. In addition, persons with unusually high health care expenses (exceeding 7.5% of their adjusted gross income) can deduct the costs, including premiums, on their tax returns. Tax advantages are also available for health savings accounts (HSAs) and flexible spending accounts.

Public Health Insurance Coverage

- The Medicaid program provides coverage to some, but not all, of the low-income and disabled uninsured. Covering 13% of the nonelderly, Medicaid is larger than any single private health insurer. It provides health coverage based on both income and categories of eligibility, primarily covering three main groups of nonelderly low-income people: children, their parents, and individuals with disabilities. Medicaid also assists low-income Medicare beneficiaries by paying Medicare premiums and the costs of services not covered by Medicare.

Who Are the Uninsured?

In 2004, 45.5 million Americans under the age of 65 lacked health insurance. While the number of uninsured Americans has been growing, who the uninsured are and the social and economic factors that place a person at risk of being uninsured, have not changed substantially over time. The uninsured are largely low-income adult workers for whom coverage is either unavailable or unaffordable.

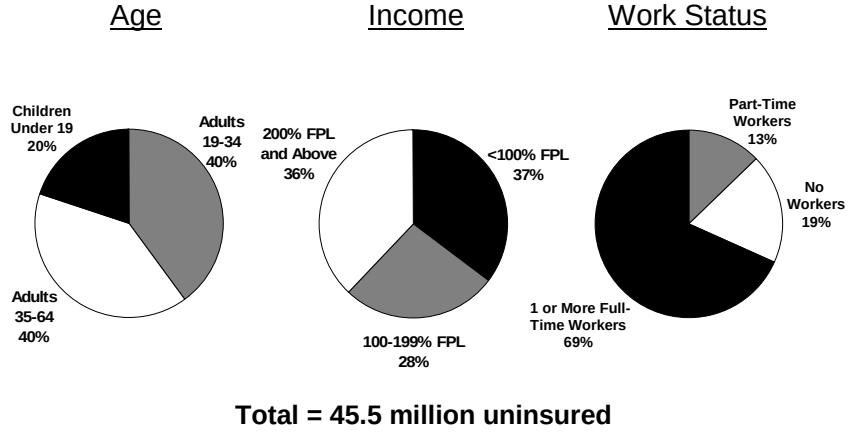
- In 2004, over 8 in 10 uninsured came from working families—almost 70% from families with one or more full-time workers and 13% from families with part-time workers. Only 19% of the uninsured are from families that have no connection to the workforce. Even at lower income levels, the majority of the uninsured have workers in their family. Fifty-five percent of the uninsured who are poor have at least one worker in the family. (Poor is defined as an income less than 100% of the federal poverty level – $19,307 for a family of four in 2004).

- Because of the high cost of health insurance, the poor and near-poor have the greatest risk of being uninsured. The uninsured rate among the nonelderly poor is twice as high as the national average (37% vs.18%). Were it not for the Medicaid program, many more of the poor would be uninsured. The near-poor (those with incomes between 100% and 199% of poverty) also run a high risk of being uninsured (29%) because they are not likely to be eligible for Medicaid.

- Two-thirds of the uninsured are low-income individuals or from low-income families, making less than 200% of the poverty level, or $38,614 for a family of four in 2004. Over a third of the uninsured (37%) are poor and another 28% are near-poor.

Figure 3

Characteristics of the Uninsured, 2004



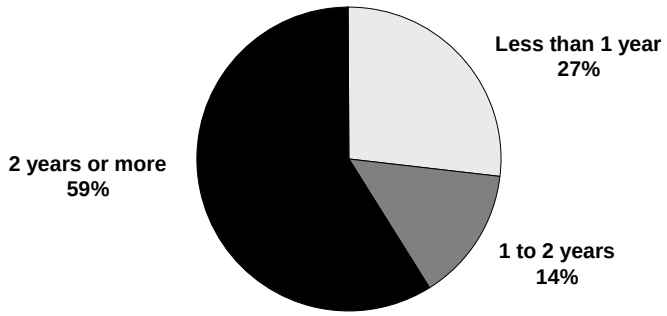
Total = 45.5 million uninsured

Note: The federal poverty level was $19,307 for a family of four in 2004.
SOURCE: KCMU and Urban Institute analysis of the March 2005 Current Population Survey.

- The majority of uninsured adults (59%) have gone without coverage for a period of at least two years.[3] Because health insurance is primarily obtained as an employment benefit, health coverage can be disrupted when people change jobs. This, as well as other changes in income and family composition, can cause temporary gaps in health insurance. While most adults go without coverage for years, this varies across states and those states where more of the uninsured have short periods without coverage also tend to have lower uninsured rates in general.[4]

Figure 4

Duration of Periods Without Health Insurance Among the Uninsured, 2003



SOURCE: Kaiser Family Foundation, Kaiser 2003 Health Insurance Survey (unpublished data).

- Adults are more likely to be uninsured than children. Adults make up about 70% of the nonelderly population, but nearly 80% of the uninsured. Most low-income children qualify for either Medicaid or S-CHIP, though many eligible children are not enrolled, often because they do not know they qualify. However, low-income adults under age 65 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.

- Minorities are much more likely to be uninsured than white Americans. More than a third of the Hispanic population and over a quarter of Native Americans are uninsured compared to 13% of whites. The uninsured rates among African Americans (21%) and Asian Americans (18%) are also much higher than that of whites. These differences are only partly explained by income disparities—insurance disparities exist at both lower and higher income levels.

- The large majority of the uninsured (79%) are American citizens. While non-citizens have high uninsured rates (roughly 40% to 50%) due to their employment in low-wage jobs that are less likely to offer health coverage and restrictions on their eligibility for public coverage, studies show that new immigrants are not primarily responsible for the growth in the overall uninsured population, mainly because their numbers are still small compared to the U.S. population as a whole.[5]

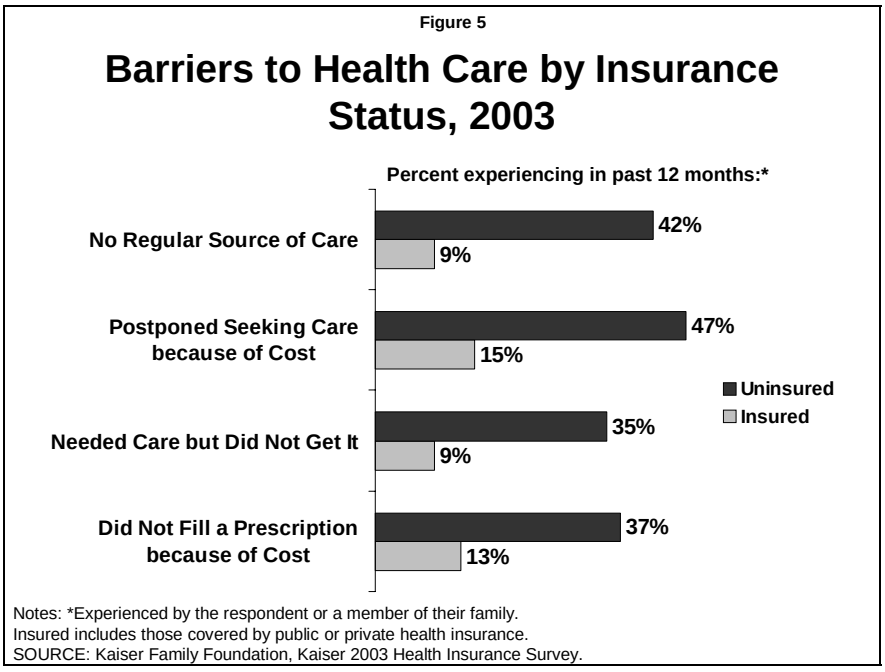
How Does Lack of Insurance Affect Access to Health Care Services?

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 and less able to afford prescription drugs or follow through with recommended treatments. Problems getting needed care are less common among children, who are generally healthy, but disparities in access to care between uninsured and insured children are as great as the adult differences. The consequences of reduced access to care can be severe, particularly when preventable conditions go undetected.

- The uninsured are up to three times more likely than those with insurance to report problems getting needed medical care, even for serious conditions. Part of the reason many of the uninsured postpone or forgo needed care is because over 40% do not have a regular place to go when they are sick or need medical advice, compared to just 9% of those with coverage. About 20% of the uninsured (vs. 3% of those with coverage) say their usual source of care is an emergency room.[6]

- Anticipating high medical bills, many of the uninsured are not able to follow recommended treatment. Over a third of uninsured adults say they did not fill a drug prescription in the past year and over a third went without a recommended medical test or treatment due to cost.[7] Insured nonelderly adults are at least 50% more likely to have had preventive care such as pap smears, mammograms, and prostate exams compared to uninsured adults.[8]

Figure 5



- 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 less likely than those with continuous health coverage to have a usual source of care and more likely to report having an unmet need for medical care or a prescription drug in the past year. As the period without coverage lengthens, more of the uninsured face these kinds of access problems.[9]

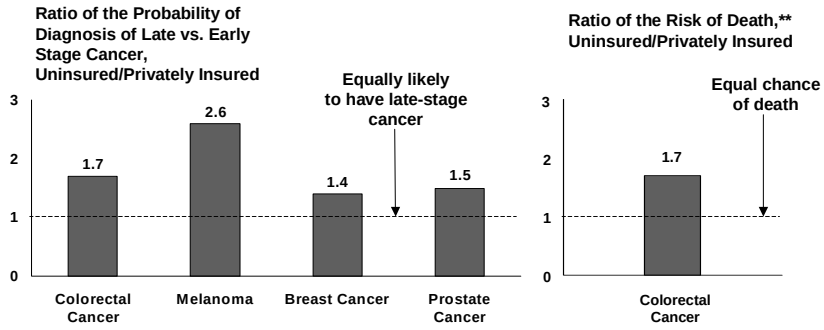
- Access to health care improves after an uninsured person obtains health insurance; similarly, losing coverage, whether it is private insurance or Medicaid, substantially decreases access to care. For example, persons who have lost Medicaid coverage are two to three times more likely than Medicaid beneficiaries to report going without medical care because it is too expensive and they are worried about medical bills.[10]

- 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. When they are hospitalized, they are more likely to receive fewer services and to die in the hospital than are insured patients.[11]

- The uninsured are also less likely to receive timely preventive care. For example, people with insurance are significantly more likely to have had recent mammograms and colon and cervical cancer screening. Consequently, uninsured cancer patients are diagnosed in later stages of the disease and die earlier than those with insurance.

Figure 6

Diagnosis of Late-Stage Cancer, Uninsured vs. Privately Insured*



Notes: * Privately insured all had commercial indemnity plans.
** Among cancer cases identified in 1994; mortality follow-up through 1997.
All differences are statistically significant after adjusting for age, sex, race/ethnicity, comorbidity, marital status (when appropriate), smoking status, socioeconomic status, education, stage at diagnosis, and treatment.
SOURCE: Roetzheim RG, et. al., 1999, 2000 from Hadley, J., *Sicker and Poorer: The Consequences of Being Uninsured,* 2003, prepared for KCMU.

- Private insurance covers only a minority of people who are not in good health and the uninsured are not as healthy as those who have health insurance. Medicaid covers 55% of children and over a quarter of adults who are in fair or poor health. Still, 12% of children and 20% of adults in fair or poor health remain uninsured.

- Having insurance improves health overall and could reduce mortality rates for the uninsured by 10-15%. It has been estimated that the number of excess deaths among uninsured adults age 25-64 is in the range of 18,000 a year.[12]

How Do the Uninsured Pay for Medical Care?

For many of the uninsured, the costs of health insurance and medical care are weighed against equally essential needs. The uninsured are twice as likely as those with health coverage to live in a household that is having difficulty paying monthly bills as basic as rent, food, and utilities. Medical bills can mount quickly for the uninsured, even for relatively minor problems like dental care, and the financial impact on a family can be serious.

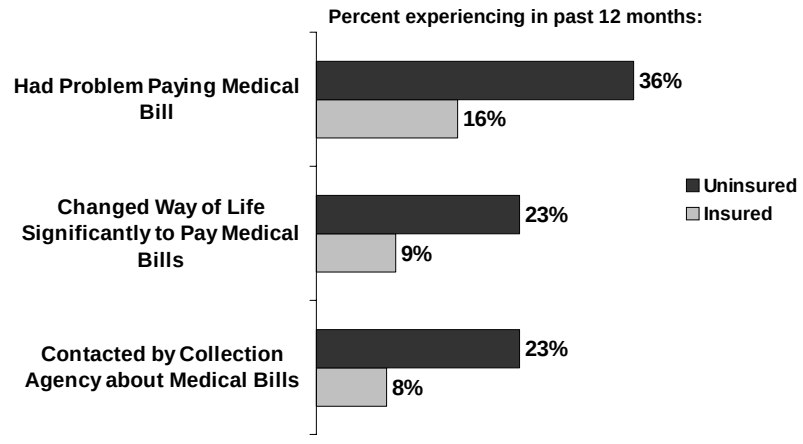
- Among the nonelderly in 2004, the costs of medical care received by those uninsured for the full year were just over half that of those with insurance. Their per capita costs were $1,629 compared to $2,975 for the insured. Over a third (35%) of the costs of care received by the full-year uninsured are paid for themselves out-of-pocket. Most of the remaining costs not paid by the individuals themselves are referred to as uncompensated care costs.[13]

- Having health insurance makes a difference in the debt individuals and families face because of medical bills. The uninsured are more than twice as likely to have had problems paying medical bills in the past year as those who have coverage. In addition, the impact of these bills is much greater on uninsured families. Nearly a quarter (23%) of the uninsured reported changing their way of life significantly in order to pay medical bills.[14]

- Having health insurance makes a difference to a person's credit history. 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. Nearly a quarter (23%) of the uninsured report that they were contacted by a collection agency about unpaid medical bills in just the past year.[15]

Figure 7

Financial Burden of Medical Bills by Insurance Status, 2003



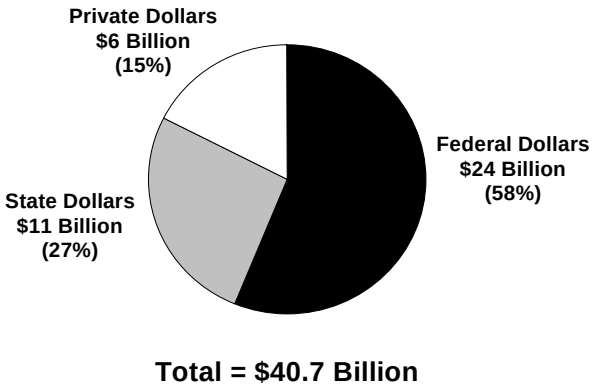
Note: Insured includes those with public or private insurance coverage.
SOURCE: Kaiser Family Foundation, Kaiser 2003 Health Insurance Survey.

- The costs of uncompensated care are estimated to be about $41 billion in 2004. Projected government spending available to pay for the care of the uninsured in 2004 is $34.6 billion—about 85% of the total uncompensated care bill. More than half of all funds for uncompensated care come from the federal government, with the majority (70%) of federal dollars flowing through Medicare and Medicaid. Most government dollars for uncompensated care goes for hospital care—which is paid indirectly to hospitals based partly on the share of uncompensated care they provide. Uncompensated care costs in direct service programs, such as community health centers (CHCs) and the VA health system, are funded almost completely by public dollars.[16]

  Federal spending has not kept up with the recent growth in the number of uninsured. Although federal support for CHCs increased by more than 50% between 2001 and 2004 (from $430 million to $670 million), these expenditures account for only a small share of total federal spending for uncompensated care (less than 3%). As the number of uninsured increased by 11% between 2001 and 2004, federal spending per uninsured person decreased by 9%—from an average of $546 per uninsured person in 2001 to $498 in 2004.[17]

Figure 8

Projected Government vs. Private Dollars as Share of Total Uncompensated Care in 2004



Total = $40.7 Billion

SOURCE: Derived from Hadley J. and J. Holahan. 2004. "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? KCMU, Issue Update, May 2004.

- Uncompensated care provided by physicians outside of these settings (estimated at $5 billion in 2001) is not directly or indirectly reimbursed by public dollars. In the current environment of competitive managed care systems coupled with Medicare and Medicaid fee schedules, the amount of uncompensated care that a provider can absorb is diminished and their willingness to care for the uninsured may be less.[18]

- 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 be turned away, or they either negotiate a payment schedule with the doctor's office, clinic, or hospital or pay with credit cards (typically with high interest rates).[19]

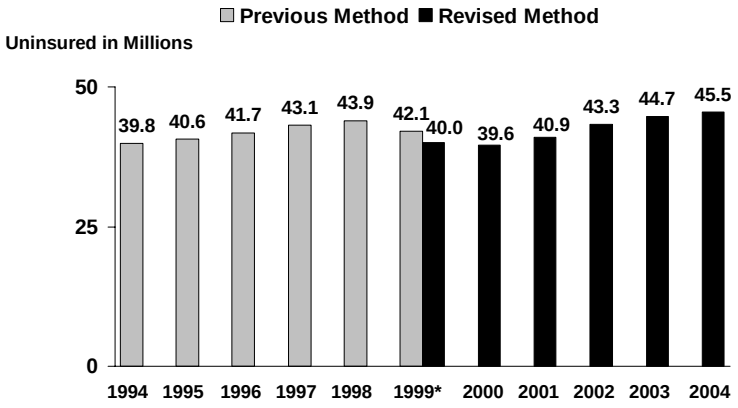
- Most of the uninsured do not receive health services for free or at reduced charge. In the case of hospital bills, charges for services may actually be higher for the uninsured in comparison to fees negotiated by managed care organizations or set by public payers. Among families with at least one uninsured member, less than a quarter report they have received care for free or at reduced rates in the past year.[20]

How and Why Has the Number of Uninsured Changed Recently?

Lack of health insurance coverage is a problem for many more Americans today than it was 10 years ago. Even through most of the 1990s, when the economy was rapidly growing and competition for workers was high, the number of uninsured increased by about one million a year—leveling off only at the end of the economic boom. The 2001 recession, brief as it was, triggered a sharp downtick in job-based coverage and it continued to affect health insurance coverage even in 2004, as employment was slow to recover, job opportunities shifted, and family incomes declined. Between 2000 and 2004 the number of uninsured Americans increased by over 6 million.

Figure 9

Number of Nonelderly Uninsured Americans, 1994 - 2004



*Revised method estimates for 1999 are comparable to later years, except they are based on a smaller sample.
SOURCE: KCMU and Urban Institute analysis of March Current Population Survey data.

- In the mid- and late-1990s, employer-sponsored coverage gradually increased—fueled by a robust economy, low unemployment rates, increases in real wages, and slower growth in health premiums. However, until 1999, the increases had not been enough to offset the declines in Medicaid enrollment that began following welfare reforms implemented in the mid-1990s. As families moved into the workforce, they often found low-paying jobs that were not likely to offer health benefits. In addition, as the link between welfare assistance and Medicaid was severed, many eligible families were not enrolled in Medicaid. Changes in immigration policy at the same time restricted Medicaid coverage for non-citizens and discouraged some potentially eligible families from enrolling themselves or their children. The number of uninsured grew by four million between 1994 and 1998.

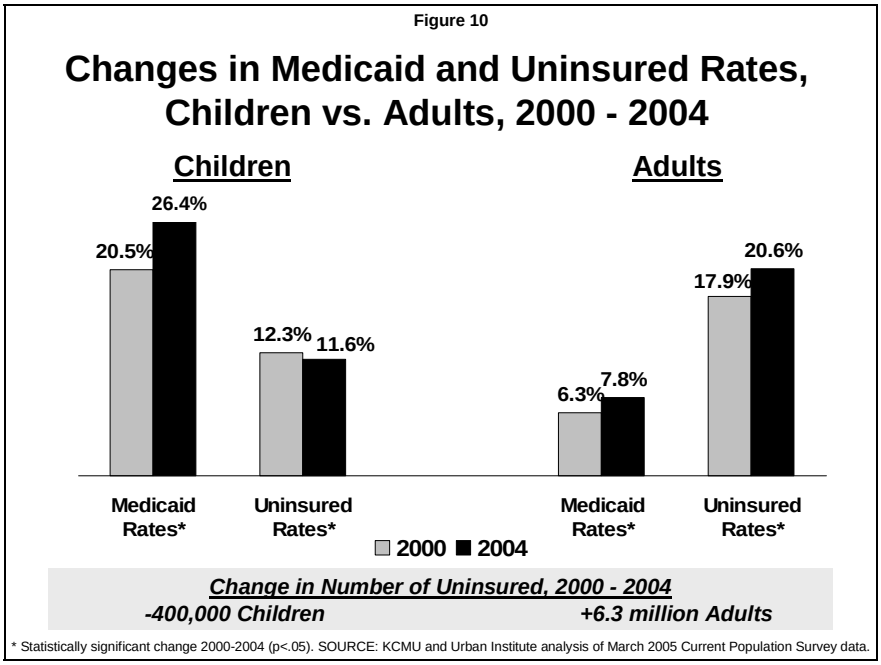
- By 1999, the percentage of people covered by Medicaid stabilized, and modest increases in private coverage helped to decrease the number of uninsured for the first time in over a decade. As more Americans moved into higher income levels, job-based coverage became more affordable. In addition, more people gained coverage as states implemented S-CHIP and improved Medicaid enrollment. Expanded public coverage of children in 2000 accounted for another small decline in the number of uninsured that year.[21]

- The decline in the uninsured did not last long however, as economic growth stalled in 2001. The share of nonelderly Americans with employer-sponsored health insurance declined for the first time since 1993 in 2001, decreasing from 66% in 2000 to 61% by 2004. Family incomes shifted downward. As the population grew by 10 million people between 2000 and 2004, 7 million moved into poverty—where uninsured rates are highest. In addition, employment continued to shift—more workers in 2004 were either self-employed or were working in small firms (< 25 workers) and more jobs moved into the service sector for example, where more workers are uninsured.

- Enrollment in both Medicaid and S-CHIP has been increasing in response to greater numbers who qualify and also because of improved outreach efforts. Declines in employer-sponsored insurance among children since 2000 have been fully offset by increases in Medicaid and S-CHIP enrollment. Children's uninsured rates actually decreased slightly between 2000 and 2004 and the number of uninsured children has not grown.[22]

- Public coverage has also increased among adults, but with Medicaid's limits on adult eligibility, it has not been enough to buffer the recent loss of job-based coverage. Adults accounted for all of the growth in the number of uninsured since 2000—increasing by 6.3 million while 400,000 children gained coverage. Two-thirds of the growth in uninsured adults was among low-income adults.

Figure 10



* Statistically significant change 2000-2004 (p<.05). SOURCE: KCMU and Urban Institute analysis of March 2005 Current Population Survey data.

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

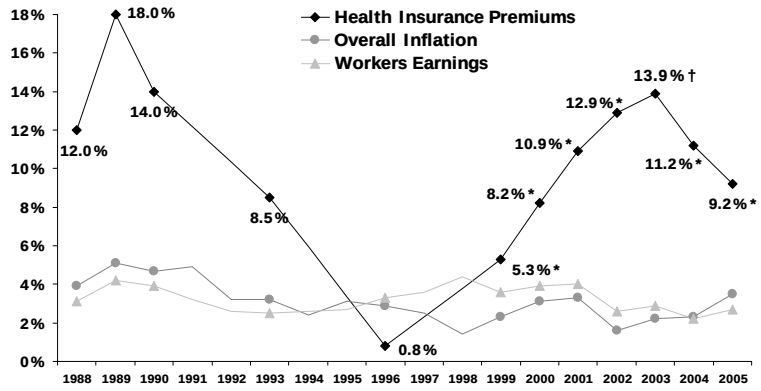
Employer-sponsored health insurance covered 156 million Americans – (61%) of the nonelderly population – in 2004. Yet, 27 million workers were uninsured in that year because not all businesses offer health benefits, not all workers qualify for coverage, and many employees cannot afford their share of the health premium. The strength of the economy and growth rate of health insurance premiums are the primary factors influencing the proportion of Americans insured through employer-sponsored benefits.

- Employer-sponsored health insurance is sensitive to sharp changes in health insurance premiums. Between 1988 and 1993, health insurance premiums grew by at least 8% annually, and the proportion of workers covered by job-based insurance decreased. By 1996, premiums had stabilized, even dropping below the overall rate of inflation as insurers competed to increase their market share. Low premium growth combined with the prospering economy very gradually reversed the trend in employer-sponsored coverage, and the percent of the population covered by employer-sponsored coverage grew slightly. However, job-based insurance did not return to the higher levels of the late 1980s.

- The economic downturn which began in early 2001, coupled with the return of double-digit inflation in health insurance premiums, decreased employer-sponsored coverage again. Both factors also adversely affect the type of health benefits offered and the amount employees are required to contribute towards their health benefits. Although the rate of growth of health insurance premiums has declined for the second straight year in 2005, employer-sponsored coverage continues to erode.

Figure 11

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2005



* Estimate is statistically different from the previous year shown at p<0.05. † Estimate is statistically different from the previous year shown at p<0.1. Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

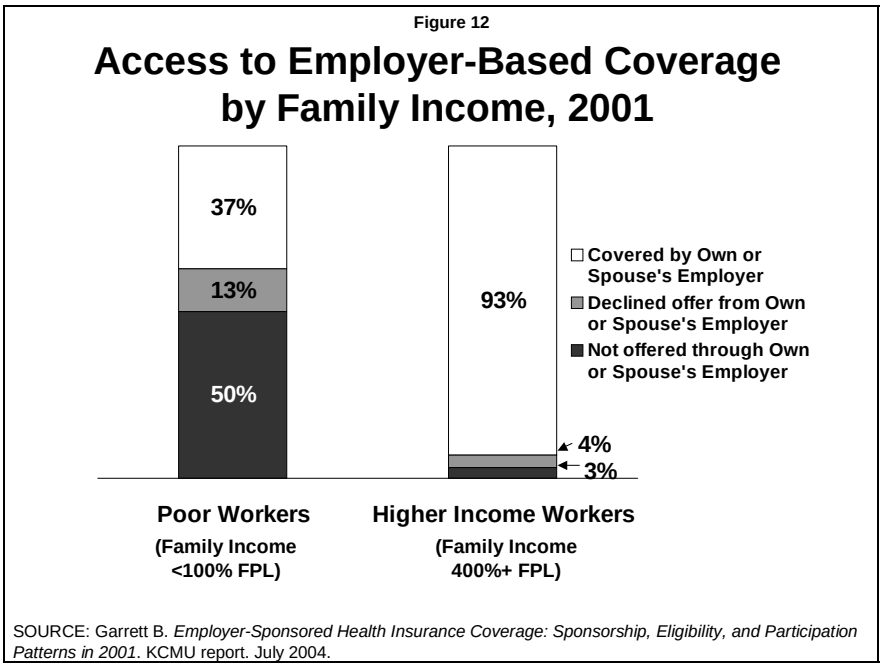
SOURCE: KFF/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; HIAA, 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation, 1988-2005; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2005.

- Almost all midsize and large businesses (with more than 200 workers) offer health benefits, but 41% of all workers are employed in smaller businesses, where less than two-thirds of firms now offer health benefits to their employees. The percentage of small firms offering health insurance to employees increased between 1996 and 2000 (from 59% to 68%) but dropped to 59% by 2005 as health insurance premiums grew. [23]

- Most uninsured workers are not offered employer-sponsored health insurance. In 2001, 64% of uninsured workers were not offered health benefits through their own job; 17% worked in firms that offered benefits, but they were not eligible for them. Twenty percent of uninsured workers had health benefits available to them, but declined to participate.[24]

- Workers from low-income families have less access to job-based insurance, even when benefits from a spouse's job are considered. In 2001, 50% of workers from poor families did not have employer-sponsored insurance available to them, either through their own job or a family member's job, compared to only 3% of workers from higher income families (400% or more of the poverty level).[25]

Figure 12



SOURCE: Garrett B. *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001*. KCMU report. July 2004.

- Employee contributions to premiums make employer-sponsored coverage unaffordable for some, particularly low-wage workers. Low-wage workers (earning less than $7/hour) compared to higher-wage workers ($15 or more/hour) are less likely to participate when health benefits are offered (71% vs. 89%).[26] Besides the fact that low-wage workers are less able to afford premiums compared to high-wage workers, they often work in firms where employees pay a larger share of the premium for family coverage. In 2005, lower-wage employers paid only 64% of premiums for family coverage compared to 75% paid by higher-wage employers.[27]

- Health coverage varies both by industry and by type of occupation. By industry, uninsured rates range from a high of 37% in agriculture to just 5% in public administration. But even in industries where health benefits are better than average, the gap in health coverage between blue and white collar employees is over two-fold on average. Over 80% of uninsured workers are in blue-collar jobs.

What is Medicaid's Role?

Medicaid is the nation's major public health insurance program for low-income Americans, providing health coverage based not only on income levels, but also eligibility categories. As a federal-state program, Medicaid's combination of federal rules and state options for coverage have created different eligibility rules for different groups across the country.

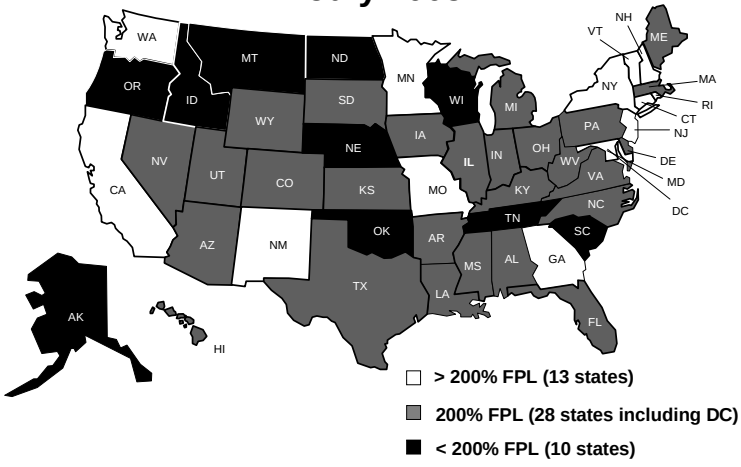
Medicaid covers three main groups of nonelderly low-income people: children, their parents, and persons with disabilities—with the program playing its broadest role among children. Half of all Medicaid beneficiaries are children.

- Federal law requires states to cover children under age 19 who come from poor families (with incomes less than the poverty level). The threshold is higher (133% of the poverty level) for children under age 6 and pregnant women, and states have the option to expand coverage beyond these federal minimum requirements. Still, not all those who qualify for the program are enrolled, leaving nearly a quarter of poor children uninsured.

- S-CHIP works as a complement to Medicaid by covering low-income children not eligible for Medicaid. The two programs together aim to cover nearly all low-income children. S-CHIP gives states the option to cover children through their existing Medicaid program or a separate child health program. Most states cover children up to 200% of the poverty level through Medicaid or S-CHIP.

Figure 13

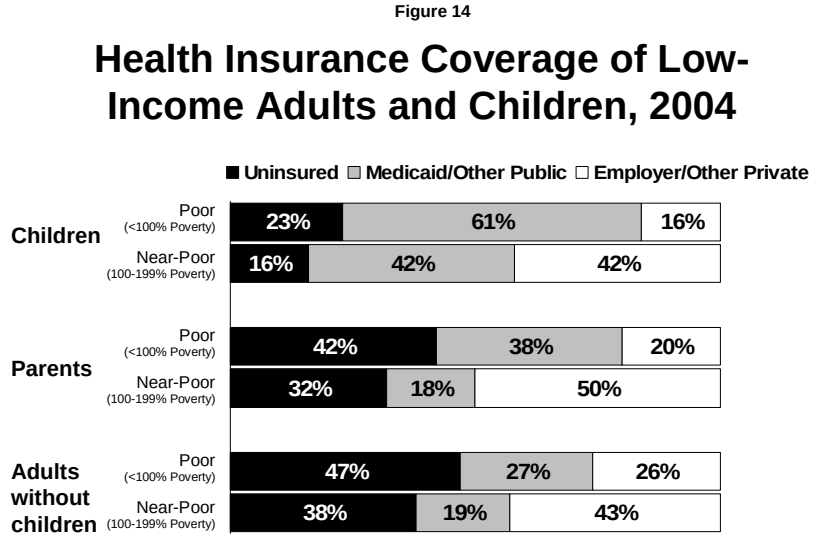
Medicaid/SCHIP Eligibility Levels for Children, July 2005



SOURCE: Cohen Ross and Cox, 2005.

- In contrast, the role of Medicaid for nonelderly adults is far more limited. Medicaid covers some parents and low-income disabled individuals, but most adults without dependent children – regardless of how poor – are ineligible for Medicaid. Parents of dependent children qualify for Medicaid, though income eligibility levels are set much lower than congressionally mandated standards for children. These eligibility restrictions, coupled with barriers to Medicaid enrollment, leave 45% of poor adults under age 65 uninsured.

Figure 14



Notes: Medicaid also includes SCHIP and other state programs, Medicare and military-related coverage. The federal poverty level was $19,307 for a family of four in 2004.
SOURCE: KCMU and Urban Institute analysis of March 2005 Current Population Survey.

- Some states have expanded Medicaid eligibility for low-income parents, but most states continue to tie income eligibility levels for parents to former welfare assistance levels. 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 line or higher. However, in the remaining states, parents still must have income below the poverty line in order to qualify for health coverage. As a result, millions of poor parents are ineligible for Medicaid. For example, a parent in a family of three working full-time at the minimum wage cannot qualify for Medicaid in 25 states in 2005.[28]

- Recent growth in Medicaid/S-CHIP enrollment since 2000 has contributed in large part to the decrease in the share of children who are uninsured, while the proportion of adults who are uninsured has increased. Medicaid and S-CHIP have the potential to cover the 6.5 million uninsured low-income children that remain; however, the ability to expand coverage to more adult beneficiaries is limited given the recent state budget situation. Although most states are emerging from an extended period of extreme fiscal stress due to the most recent economic downturn, states are continuing to implement cost control actions designed to limit Medicaid spending growth. For example, 8 states implemented restrictions on Medicaid eligibility in FY 2005 and 14 are planning to restrict or cut eligibility in FY 2006. These actions mostly affect coverage for adults.[29]

What Can Be Done to Decrease the Number of Uninsured?

Public opinion surveys over time show that the majority of Americans believe decreasing the number of uninsured is an important policy priority. However, there is little agreement on how to achieve this goal. Policy options that have been proposed to guarantee universal coverage range from: a single public plan that covers all Americans to more targeted strategies that extend employer-based coverage; some build on public coverage while others require individuals to purchase coverage directly. Most strategies recognize the need to subsidize the cost for the lowest income groups.

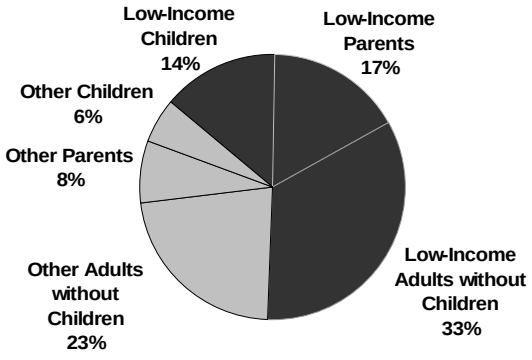
Many of the recent proposals however, have taken approaches that combine strategies in order to expand health insurance coverage incrementally. Building on the nation's mixed system of public and private insurance, the strategies being discussed vary not only by the means of insuring more Americans, but also who is targeted for coverage. The uninsured population is diverse; therefore, applying different strategies may be necessary to meet the needs of a growing uninsured population. Components of proposed strategies include:

- Expanding public coverage for the low-income uninsured by building on Medicaid and S-CHIP. With the administrative means to enroll beneficiaries and pay providers already in place, these public programs currently provide comprehensive benefits with no or minimal cost-sharing to all who qualify. These programs are explicitly designed to cover those most at risk of being uninsured—low-income families and the disabled. However, they have not reached their full enrollment potential and the recent fiscal situation in the states has made further expansions difficult.

  Increasing federal and state funding to expand public coverage offers the potential (as shown in Figure 15) to reach nearly two-thirds of the uninsured population, if coverage is extended to low-income adults without children, as well as to more parents.

Figure 15

The Nonelderly Uninsured, by Age and Income Groups, 2004



Total = 45.5 Million Uninsured

Note: Low-income includes those with family incomes less than 200% of the federal poverty level ($38,614 for a family of four in 2004).
SOURCE: KCMU and Urban Institute analysis of the March 2005 Current Population Survey.

- Expanding private group coverage by bolstering the current employer-sponsored system and/or building new group insurance options. While the majority of Americans obtain their health insurance through the workplace, over 80% of the uninsured are working themselves or have a connection to the workforce. Proposals aimed at increasing coverage through the workplace range from encouraging more job-based coverage with financial incentives for employers, including tax credits, to mandating that businesses provide health coverage.

  Some proposals would set up new group insurance options for individuals or businesses, usually modeled after the Federal Employee Health Benefits Program, providing a wide range of health plans with a large risk pool. Others make it easier for small employers and the self-employed to band into larger insurance purchasing pools, potentially giving them large group negotiating power when buying insurance. Both types of strategies could lower premiums and broaden the choice of policies available to the uninsured, but many experts believe the government will need to subsidize the premiums for low-wage workers or some small firms, or at least, provide some form of federal reinsurance for high cost enrollees to reduce employer premiums.

- Subsidizing the purchase of private individual health insurance, making coverage more affordable with tax credits or deductions delivered through the federal income tax system. Some believe job-based coverage is an outdated approach in a country where workers change employers several times during their lives and are unable to maintain their health benefits across jobs. Letting individuals choose their own health plans and helping with costs through tax credits provides an alternative to employment-linked coverage. However, the success of these options depends on whether the individual health insurance market can evolve to meet the needs of people with higher health needs. Most people with health problems or a chronic condition currently are either excluded from non-group insurance or find policies unaffordable.

  Proposals that offer tax credits/deductions to individuals vary by whom they would assist. Some would target tax provisions to the low-income; others would assist all uninsured. The cost to the government of tax-based approaches could be high, since those least able to afford insurance would require substantial financial assistance to pay their premiums. Moreover, such tax credits are likely to also be used by many who are already insured, providing greater tax equity, but also increasing the cost of expanded coverage.

  Another set of proposals would make it easier for people to take advantage of HSAs, which are both tax-free and bear interest. Health savings accounts are available only to those with high-deductible policies, allowing people to set aside money for their uncovered medical expenses. While HSAs could potentially make people more cost-conscious, they may be unaffordable to most of the uninsured and could attract only healthy people, driving up the cost of coverage for others.

In the absence of national reform, two states have enacted health coverage expansions aside from their Medicaid and S-CHIP programs. In 2003 Maine began offering discounted premiums to low and middle income individuals (less than 300% of the poverty level) through a pooled health plan, that also encourages small businesses to offer health benefits. This year the state of Illinois enacted a program to provide coverage for all the state's uninsured children, funded from anticipated managed care system savings. As more state budgets return to healthy balances, many more Governors and state legislators are seeking practical solutions to address their state's growing number of uninsured—and proposing a diverse mix of strategies.

TABLES

Table 1
Characteristics of the Nonelderly Uninsured, 2004

	Nonelderly (millions)	Percent of Nonelderly	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total - Nonelderly[a]	**255.1**	**100.0%**	**45.5**	**100.0%**	**17.8%**
Age					
Children - Total	**77.8**	**30.5%**	**9.0**	**19.9%**	**11.6%**
Adults - Total	**177.3**	**69.5%**	**36.5**	**80.1%**	**20.6%**
Adults 19-24	23.8	9.3%	8.0	17.6%	33.6%
Adults 25-34	39.0	15.3%	10.2	22.4%	26.1%
Adults 35-44	43.1	16.9%	8.1	17.8%	18.8%
Adults 45-54	41.9	16.4%	6.3	13.8%	15.0%
Adults 55-64	29.5	11.6%	3.9	8.6%	13.3%
Annual Family Income					
<$20,000	62.5	24.5%	23.0	50.6%	36.8%
$20,000 - $39,999	55.0	21.6%	12.9	28.4%	23.5%
$40,000 +	137.6	53.9%	9.6	21.1%	7.0%
Family Poverty Level[c]					
<100%	**45.8**	**18.0%**	**16.7**	**36.8%**	**36.5%**
100-199%	**43.9**	**17.2%**	**12.5**	**27.5%**	**28.5%**
...100-149%	21.3	8.4%	6.5	14.4%	30.7%
...150-199%	22.6	8.9%	6.0	13.2%	26.5%
200-399%	**74.8**	**29.3%**	**11.0**	**24.1%**	**14.7%**
...200-299%	40.3	15.8%	7.4	16.2%	18.3%
...300-399%	34.4	13.5%	3.6	7.9%	10.5%
400%+	**90.6**	**35.5%**	**5.3**	**11.5%**	**5.8%**
Household Type					
Single Adults Living Alone	18.7	7.3%	3.1	6.8%	16.7%
Single Adults Living Together	28.4	11.1%	10.2	22.4%	35.8%
Married Adults	51.7	20.3%	8.7	19.0%	16.7%
1 Parent with children[d]	31.6	12.4%	6.0	13.1%	18.9%
2 Parents with children[d]	111.3	43.6%	13.6	29.9%	12.2%
Multigenerational/Other with children[e]	13.4	5.2%	4.0	8.7%	29.7%
Family Work Status					
2 Full-time	69.6	27.3%	6.0	13.2%	8.6%
1 Full-time	137.6	54.0%	25.3	55.5%	18.4%
Only Part-time[f]	18.1	7.1%	5.7	12.6%	31.8%
Non-Workers	29.7	11.7%	8.5	18.7%	28.6%
Race/Ethnicity					
White only (non-Hispanic)	166.1	65.1%	21.9	48.1%	13.2%
Black only (non-Hispanic)	32.3	12.7%	6.8	15.0%	21.2%
Hispanic	39.6	15.5%	13.6	29.8%	34.3%
Asian/S. Pacific Islander only	11.6	4.5%	2.1	4.7%	18.5%
Am. Indian/Alaska Native	1.5	0.6%	0.4	0.9%	29.1%
Two or More Races[g]	4.1	1.6%	0.7	1.4%	16.1%
Citizenship					
U.S. citizen - native	223.7	87.7%	33.8	74.3%	15.1%
U.S. citizen - naturalized	10.8	4.2%	2.3	5.0%	21.1%
Non-U.S. citizen, resident for < 6 years	7.3	2.9%	3.6	8.0%	49.8%
Non-U.S. citizen, resident for 6+ years	13.3	5.2%	5.8	12.7%	43.4%
Health Status					
Excellent/Very Good	177.1	69.4%	28.2	62.0%	15.9%
Good	56.9	22.3%	13.0	28.6%	22.9%
Fair/Poor	21.1	8.3%	4.2	9.3%	20.2%

Table 2
Health Insurance Coverage of the Nonelderly, 2004

	Nonelderly (millions)	Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
Total - Nonelderly[a]	**255.1**	**61.0%**	**5.4%**	**13.4%**	**2.3%**	**17.8%**
Age						
Children - Total	**77.8**	**56.3%**	**4.4%**	**26.4%**	**1.3%**	**11.6%**
Adults - Total	**177.3**	**63.1%**	**5.8%**	**7.8%**	**2.7%**	**20.6%**
Adults 19-24	23.8	43.1%	11.1%	10.7%	1.5%	33.6%
Adults 25-34	39.0	59.8%	4.1%	8.8%	1.2%	26.1%
Adults 35-44	43.1	67.8%	4.5%	7.3%	1.6%	18.8%
Adults 45-54	41.9	70.7%	5.1%	6.2%	3.0%	15.0%
Adults 55-64	29.5	66.1%	6.6%	6.9%	7.1%	13.3%
Annual Family Income						
<$20,000	62.5	19.8%	6.8%	32.5%	4.1%	36.8%
$20,000 - $39,999	55.0	52.6%	5.4%	16.0%	2.6%	23.5%
$40,000 +	137.6	83.2%	4.7%	3.7%	1.4%	7.0%
Family Poverty Level[c]						
<100%	**45.8**	**15.0%**	**6.1%**	**39.1%**	**3.3%**	**36.5%**
100-199%	**43.9**	**38.8%**	**5.9%**	**23.0%**	**3.7%**	**28.5%**
...100-149%	21.3	30.2%	6.0%	28.7%	4.4%	30.7%
...150-199%	22.6	46.9%	5.8%	17.7%	3.1%	26.5%
200-399%	**74.8**	**71.8%**	**5.4%**	**6.1%**	**2.0%**	**14.7%**
...200-299%	40.3	65.9%	5.5%	7.9%	2.3%	18.3%
...300-399%	34.4	78.6%	5.3%	3.9%	1.7%	10.5%
400%+	**90.6**	**86.3%**	**4.7%**	**1.9%**	**1.3%**	**5.8%**
Household Type						
Single Adults Living Alone	18.7	61.4%	8.4%	9.0%	4.6%	16.7%
Single Adults Living Together	28.4	43.9%	8.8%	9.0%	2.5%	35.8%
Married Adults	51.7	69.7%	5.4%	4.3%	4.0%	16.7%
1 Parent with children[d]	31.6	37.9%	4.8%	36.9%	1.5%	18.9%
2 Parents with children[d]	111.3	70.8%	4.3%	11.3%	1.3%	12.2%
Multigenerational/Other with children[e]	13.4	37.4%	3.5%	26.8%	2.5%	29.7%
Family Work Status						
2 Full-time	69.6	82.7%	3.2%	4.5%	1.0%	8.6%
1 Full-time	137.6	63.8%	5.4%	11.1%	1.4%	18.4%
Only Part-time[f]	18.1	29.8%	12.1%	23.0%	3.3%	31.8%
Non-Workers	29.7	16.6%	6.3%	39.4%	9.1%	28.6%
Race/Ethnicity						
White only (non-Hispanic)	166.1	68.9%	6.3%	9.3%	2.4%	13.2%
Black only (non-Hispanic)	32.3	48.0%	2.9%	24.8%	3.1%	21.2%
Hispanic	39.6	39.8%	2.8%	21.7%	1.4%	34.3%
Asian/S. Pacific Islander only	11.6	62.9%	7.5%	9.3%	1.7%	18.5%
Am. Indian/Alaska Native	1.5	39.2%	2.4%	25.8%	3.5%	29.1%
Two or More Races[g]	4.1	54.3%	5.8%	20.2%	3.6%	16.1%
Citizenship						
U.S. citizen - native	223.7	63.1%	5.5%	13.8%	2.4%	15.1%
U.S. citizen - naturalized	10.8	62.4%	6.3%	7.9%	2.3%	21.1%
Non-U.S. citizen, resident for < 6 years	7.3	33.2%	4.2%	12.4%	0.5%	49.8%
Non-U.S. citizen, resident for 6+ years	13.3	40.0%	3.7%	11.7%	1.1%	43.4%
Health Status						
Excellent/Very Good	177.1	65.9%	5.9%	10.9%	1.4%	15.9%
Good	56.9	54.7%	4.5%	15.6%	2.4%	22.9%
Fair/Poor	21.1	37.8%	3.3%	28.6%	10.1%	20.2%

Table 3
Health Insurance Coverage of the Nonelderly by State, 2003-2004

	Nonelderly (thousands)[a]	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
United States	**253,891**	**61.5%**	**5.3%**	**13.1%**	**2.3%**	**17.8%**
Alabama	3,928	62.3%	3.9%	14.3%	3.8%	15.7%
Alaska	593	55.4%	4.2%	15.4%	5.5%	19.5%
Arizona	4,927	54.9%	6.9%	15.9%	2.8%	19.6%
Arkansas	2,306	53.5%	5.7%	17.4%	3.6%	19.7%
California	31,705	54.7%	7.0%	16.0%	1.5%	20.6%
Colorado	4,076	63.4%	7.0%	7.6%	3.2%	18.8%
Connecticut	2,992	70.2%	3.9%	11.5%	1.6%	12.7%
Delaware	719	68.2%	3.1%	11.2%	2.9%	14.6%
District of Columbia	484	57.1%	5.6%	20.3%	1.5%	15.5%
Florida	14,293	56.2%	6.1%	11.8%	3.2%	22.7%
Georgia	7,803	61.3%	4.5%	13.4%	2.2%	18.6%
Hawaii	1,052	69.4%	3.3%	11.0%	4.6%	11.6%
Idaho	1,231	58.8%	8.1%	12.7%	1.6%	18.8%
Illinois	11,050	66.5%	5.6%	10.1%	1.8%	16.0%
Indiana	5,435	66.6%	4.2%	11.4%	2.0%	15.8%
Iowa	2,510	68.4%	7.9%	10.0%	1.7%	12.0%
Kansas	2,345	66.9%	7.2%	9.9%	3.5%	12.5%
Kentucky	3,533	60.4%	5.0%	15.0%	3.2%	16.3%
Louisiana	3,873	54.3%	5.6%	16.0%	2.6%	21.5%
Maine	1,096	59.6%	4.9%	21.0%	2.6%	12.0%
Maryland	4,862	69.2%	4.4%	8.2%	2.1%	16.1%
Massachusetts	5,582	67.7%	4.8%	13.5%	1.2%	12.7%
Michigan	8,733	67.7%	4.4%	13.7%	1.5%	12.7%
Minnesota	4,555	72.0%	7.8%	9.3%	1.1%	9.8%
Mississippi	2,511	53.5%	4.0%	19.4%	3.3%	19.9%
Missouri	4,856	65.1%	5.4%	13.8%	2.1%	13.6%
Montana	789	52.1%	8.8%	13.2%	3.7%	22.2%
Nebraska	1,509	65.0%	9.0%	10.4%	2.6%	12.9%
Nevada	2,048	64.3%	4.9%	7.4%	2.3%	21.0%
New Hampshire	1,132	76.1%	3.3%	6.3%	1.9%	12.4%
New Jersey	7,580	70.9%	3.1%	8.2%	1.3%	16.5%
New Mexico	1,647	47.9%	4.5%	19.6%	3.5%	24.5%
New York	16,544	60.6%	3.8%	17.7%	1.3%	16.7%
North Carolina	7,329	58.8%	5.5%	12.7%	4.4%	18.6%
North Dakota	541	63.6%	10.8%	9.3%	3.5%	12.8%
Ohio	9,915	69.5%	3.6%	11.8%	1.8%	13.3%
Oklahoma	2,917	55.8%	4.4%	12.1%	4.0%	23.7%
Oregon	3,108	61.0%	6.5%	11.6%	1.7%	19.3%
Pennsylvania	10,328	68.2%	5.3%	11.3%	1.5%	13.7%
Rhode Island	915	65.0%	4.5%	16.6%	1.6%	12.3%
South Carolina	3,538	59.4%	4.8%	15.3%	3.8%	16.8%
South Dakota	645	60.8%	9.8%	12.3%	3.1%	14.0%
Tennessee	5,137	57.6%	6.3%	16.7%	3.9%	15.6%
Texas	19,922	53.4%	4.2%	13.0%	2.1%	27.3%
Utah	2,189	67.0%	8.0%	9.3%	1.3%	14.5%
Vermont	530	60.5%	5.6%	19.5%	2.6%	11.9%
Virginia	6,474	67.0%	5.2%	7.6%	4.7%	15.5%
Washington	5,409	61.1%	5.9%	14.4%	2.6%	16.0%
West Virginia	1,507	57.2%	3.2%	16.0%	4.2%	19.4%
Wisconsin	4,755	67.6%	6.0%	12.5%	1.7%	12.1%
Wyoming	430	60.1%	8.2%	11.1%	3.6%	17.1%

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).

[a] Nonelderly includes all individuals under age 65.

[b] Other includes other public insurance (mostly Medicare and military-related). S-CHIP is included in Medicaid.

[c] The 2004 federal poverty level for a family of four was $19,307.

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

[e] Multigenerational/other families with children include families with at least three generations in a household, plus families in which adults are caring for children other than their own (e.g., a niece living with her aunt).

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

[g] For the first time in 2003, respondents could identify themselves in more than one racial group. Since there is no way of knowing how people who reported more than one race previously reported their race, comparisons in health insurance coverage by race/ethnicity can only be made between 2003 and 2004.

Data Notes

Much of the health insurance coverage information in this primer (including data in the tables) is based on a collaborative analysis of the Census Bureau's March Current Population Survey (CPS; Annual Social and Economic Supplement) 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. The CPS' large sample size ensures that many social and economic subgroups relevant to health insurance policy can be studied each year. In addition, it is the only federal survey able to provide annual estimates for all fifty states. 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.

Endnotes

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