

**Delawareans Without Health Insurance
2008**

**prepared for
the Delaware Health Care Commission**

by

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Executive Summary

Delawareans are doing better than the nation and the region in obtaining health insurance. Some 11.2 percent of Delaware's residents were without health insurance in 2008. This rate is the lowest observed in the last four reporting periods. Currently 101,000 people are estimated to be without health insurance. The uninsured rate for the region, which includes Maryland, Pennsylvania, New Jersey and New York is higher (12.7%) than that for Delaware as is the national rate (15.3%). Delaware currently ranks 33rd among the states and the District of Columbia (Massachusetts has the lowest rate and is ranked 51st). This year's ranking is slightly higher than in 2007 when Delaware ranked 31st.

Research suggests that the uninsured are more likely to delay seeking primary care. They are also less likely to be screened for cancer and cardiovascular disease and as a result are apt to be diagnosed in the later stages of the disease. Currently, 55.8% of uninsured adults have had a physical in the last year compared with 80.1% of insured adults.

Uninsured adults are five times more likely than those that have health insurance to say they could not see a doctor because of the cost. However, uninsured adults assess their current health only slightly lower than those that have health insurance. Some 66.3% of uninsured adults have a primary care physician compared with 90.3% of those that are insured.

Over the past five years, the percentage of Delawareans who are uninsured has risen from 9.9% to 11.2%. While the overall rate is well below the national rate and that of the surrounding states, the trend is not favorable and deserves careful monitoring.

Who are the 101,000 uninsured?

- 23% are under the age of 19
- 56% are working adults
- 54% are male
- 69% are White
- 22% are Hispanic
- 21% live alone
- 34% with household income over \$50,000
- 59% own or are buying their home
- 9% are self-employed
- 21% are non-citizens
- 80% are above the poverty line

Introduction

The Delaware Health Care Commission has, since its inception, been concerned about access to health care for all Delawareans. While that is not its only focus, since the Commission's mandate is broad, improving access to health care is a primary goal. Access to health care has several dimensions. One of those dimensions is covered in this report, and that is health insurance coverage. Those with health insurance typically enjoy greater access to health care providers than do those who are without it.

Persons who do not have health insurance are still likely to require medical care at some point in time. When they do require such services, their condition may be significantly worse than had it been detected and addressed at an earlier stage. In addition, the uninsured will tend to use one of the most expensive providers, the emergency room. Ultimately, providers must cover all of their costs. Services delivered to the insured and the uninsured alike, figure into that cost. As a result, some of the cost of services provided to the uninsured is shifted to the insured population. This raises the overall cost of fringe benefits to employers.

To better understand the nature of the uninsured population, the Delaware Health Care Commission has been monitoring its size and structure for a number of years. This report is a significant update and offers both new information and analysis. **It adds information for the year 2008 to the database and recently revised data sets for 2005, 2006, and 2007.** The primary source of the data is the Current Population Survey conducted by the US Bureau of Census. The survey is conducted annually in March and in 2008 some 1,116 households were selected to be interviewed in Delaware. In contrast to most household surveys, data is collected for all persons living in the household (3,008) making it possible to obtain data about children.

The report has three major sections. In the first section, the current status of the uninsured in Delaware and the region (DE, MD, PA, NJ, and NY) is discussed. A time series, beginning in 1982 and ending in 2008 is used to show any trends. The second section focuses on the labor market in Delaware and existing and future trends that might affect employer provided health coverage. The third section contains information on health insurance coverage for a variety of demographic variables. The implications of current demographic trends are also considered in this section. With few exceptions, three-year moving averages are used to measure the variables. The final section is expanded further this year and contains a more focused look at the uninsured.

The Uninsured

Background

Two primary sources of data are available for measuring access to health insurance in Delaware. The first source is the March Current Population Survey (CPS), conducted annually by the U.S. Bureau of Census. The second source is the Behavioral Risk Factor Surveillance System, conducted monthly for the U.S. Centers for Disease Control and Prevention by the Center for Applied Demography & Survey Research at the University of Delaware, through the Delaware Division of Public Health. Both sources are valuable in their own right, but each has associated advantages and disadvantages.

The CPS is conducted monthly throughout the nation and is designed to measure the unemployment rate and other employment related statistics for the 50 states and the nation. Some 75,872 households were interviewed in the sample in March 2008 and data was gathered on 206,404 persons in those households. Each month, the basic employment information is gathered along with optional information that changes from month to month. The March CPS is usually referred to as the annual demographic file, since it captures a broad array of demographic information along with basic employment data. Part of that demographic information concerns health insurance coverage.

In Delaware, the 2008 March CPS involved 1,236 households. Of those households selected 1,116 (90.3%) participated. Some 3,008 persons resided in those households. This sample size is sufficient for producing statewide estimates on a wide variety of demographic indicators. When measuring the percentage of the population without health insurance, for example, the accuracy is approximately +/- 0.8%. Three-year averages can be reported reliably at the county level although the accuracy is less.

The health insurance questions were added to the CPS in 1982. There were modifications to the questions in 1989, again in 1995, and verification questions were added in 2000. However, a consistent data series can be constructed in spite of the changes. One aspect of the health insurance questions, time frame, is important to understand, since it differs between the two primary sources of data. The questions on the CPS are asked with reference to the previous year. Thus, in March 2008, respondents were asked about health insurance coverage in 2007.

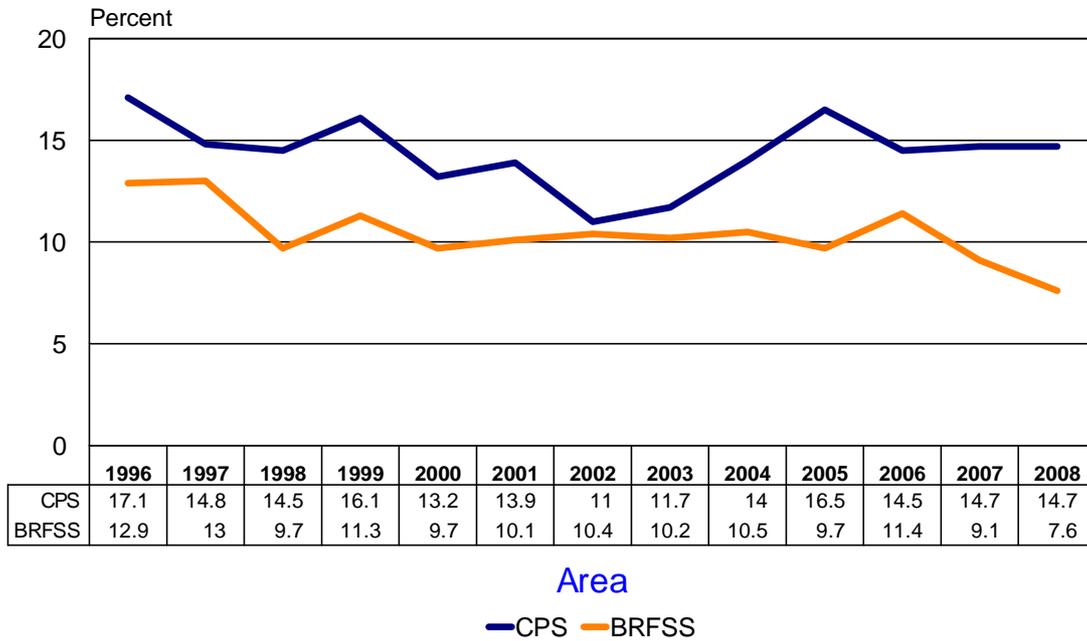
However, there is considerable evidence to suggest that the responses given are highly correlated with their current health insurance status or at least to the current quarter. The U.S. Bureau of Census conducted significant parallel testing between the Survey of Income and Program Participation (SIPP) and the Current Population Survey. The SIPP sample of households is part of a panel that is re-interviewed quarterly for more than two years. Thus, the survey is able to more accurately follow the respondent's health insurance status over time. The comparisons of estimates of health insurance coverage obtained from the CPS show a strong relationship between the SIPP responses and the CPS responses at the time the questions were asked. Thus, for purposes of this report, the year referenced in the tables and text always refers to the year in which the survey was conducted.

The second source of health insurance information is the Behavioral Risk Factor Surveillance System (BRFSS). The survey has been carried out by the Center for Applied Demography & Survey Research since 1990. The sample consists of residents of the state who are 18 years old or older. Each month approximately 333 households are contacted statewide and then an adult respondent is randomly chosen from within each household to be interviewed. The survey is wide-ranging. Among the questions asked are whether the person being interviewed currently has health coverage. If they are not covered, they are asked how much time has elapsed since they were covered. The limitation of BRFSS is that it only represents adults. However, the sample size is sufficient to obtain county level estimates that are more accurate than those that can now be obtained from the CPS.

Together the BRFSS and the CPS provide a powerful set of data for understanding the health insurance problems in Delaware today. A comparison of the two measurements of the uninsured among Delaware's adults is provided in Figure 1-1.

The figure clearly shows that the CPS estimates of uninsured adults have been above those of BRFSS during this ten-year period. The CPS estimates appeared to be converging with those of BRFSS until 2003. In 2004 and 2005 the estimates of the two series diverged. This trend, if it is real, is troublesome. The difference is twice any difference observed over the decade. This suggests that the 2005 CPS estimate was a statistical anomaly and was corrected by a re-release of the data set. As the graph shows, the 2007 CPS estimate and the BRFSS 2007 estimate are much closer.

**Figure 1-1
Comparison of the Uninsured Measured by Alternative Data Sources
Adults 18-64**



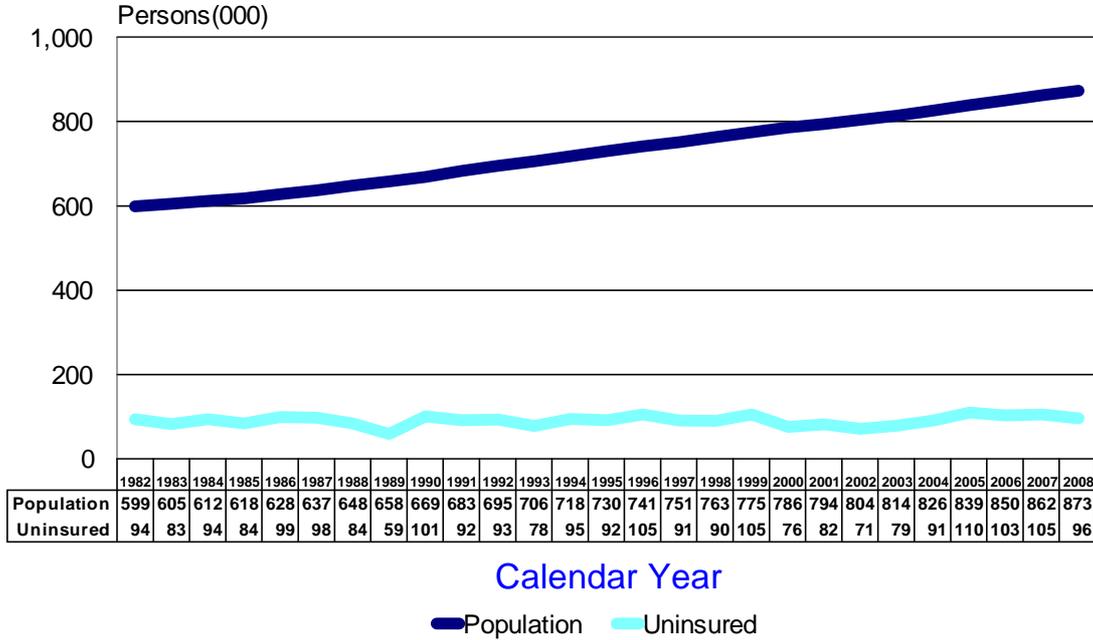
Source: Center for Applied Demography & Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1996-2008
Delaware Health and Social Services, 1996-2008 Behavioral Risk Factor Surveillance System

In the balance of this section, the current estimates of the uninsured will be presented. In addition, time series information will be used to show trends contained within those estimates. Finally, county level estimates will be provided along with a comparison of Delaware with the larger region.

The Uninsured 1982-2008

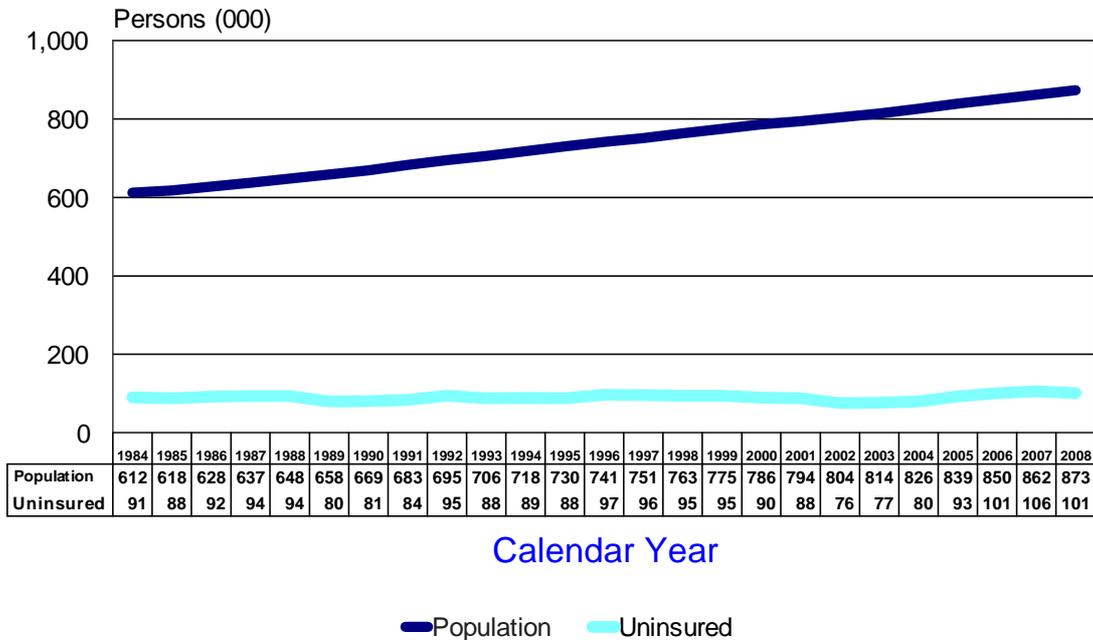
The point estimates for the number of persons without health insurance from 1982 to 2008 are shown in Figure 1-2. The term “point estimate” is used here to describe the results obtained from the CPS for a single year. There are several general observations that can be made about the information contained in this figure. First, the number of persons without health insurance in 2008 (96,000) decreased during the past year. The decrease in the point estimate for 2008, coupled with a revision downward of the 2006 estimate from 110,000 to 103,000 suggest that the recent rapid increases may be slowing.

Figure 1-2
Estimated Persons without Health Insurance
State of Delaware



Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 1982-2008

Figure 1-3
Estimated Persons without Health Insurance
State of Delaware (3-year average)

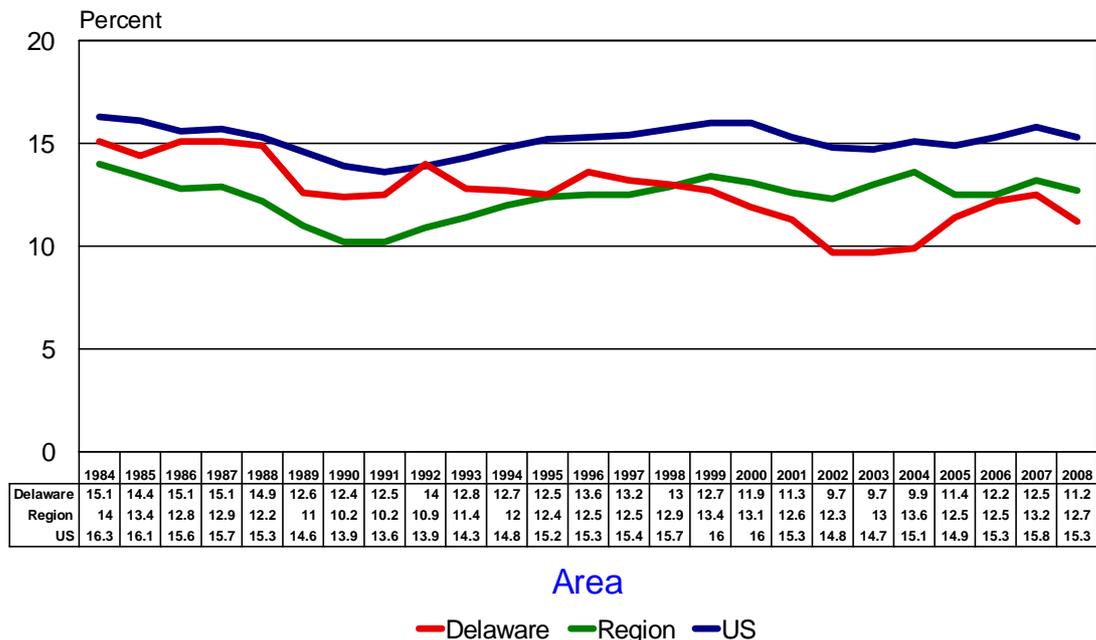


Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 1982-2008

Second, while the number of uninsured has averaged 91,000 over the 27 years, the population of Delaware has increased by more than 274,000 since 1982. Had the number of uninsured kept pace with population growth, there would have been more than 41,000 additional persons without health insurance in 2008 based on the one-year estimate. Clearly, there are other factors operating that impact the number of uninsured apart from population growth.

Figure 1-3 shows the same information as a three-year moving average. This tends to remove some of the year-to-year fluctuations that are due to random variation associated with sample surveys. The number of uninsured varies between 76,000 and 106,000 over the entire period, a relatively small range given that the standard error is about 13,000. The sudden increase in the 1996 estimate appears to have been a statistical artifact that was not confirmed in either 1997 or 1998 (see Figure 1-2). A similar pattern occurred in 1999-2001. The 3-year average tends to moderate those movements.

Figure 1-4
Percent of Persons without Health Insurance
US, Delaware, and the Region (3 year average)



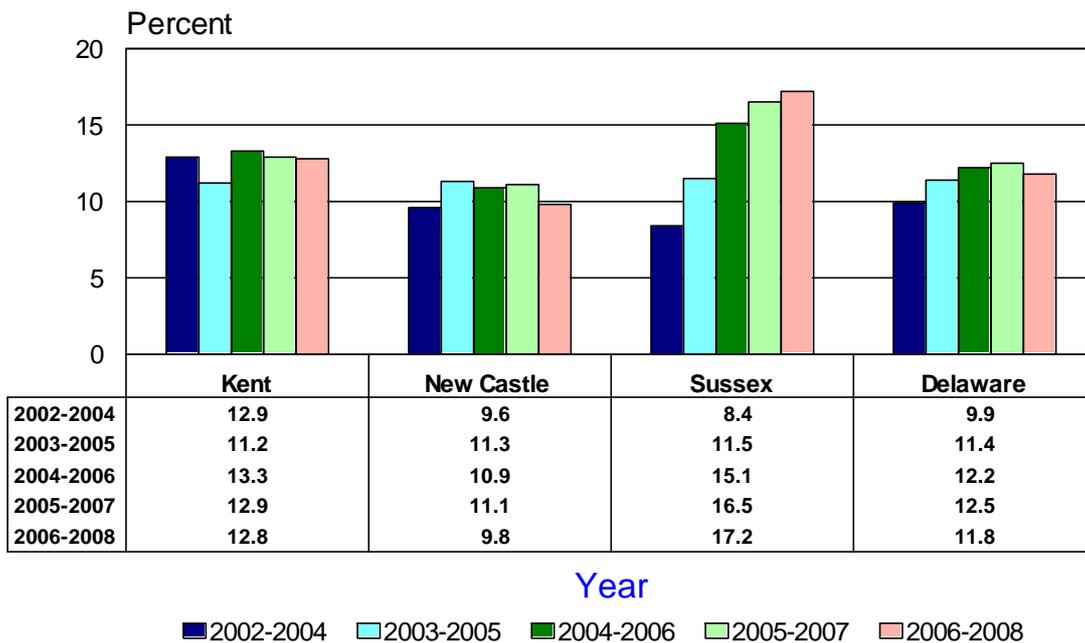
Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 1982-2008

The estimates for the proportion of the population in Delaware without health insurance, shown in Figure 1-4, have also shown distinct improvement since their recent peak in 1996. The rate has fallen from about 15.1% in 1986-1988 to approximately 11.2% in the 2008. Some of this

is undoubtedly due to legislative and policy initiatives, but at least some of the shift may be attributed to favorable demographics. In either case, Delaware is better off.

Also found in Figure 1-4 are comparative rates for the region which include Maryland, Pennsylvania, New Jersey, and New York. From 1982 through 1992 Delaware’s percentage of uninsured tended to be about 2% higher than that calculated for the entire region. However, as the graph shows, the percentage in the region began to rise after 1989 and has risen higher until very recently. Delaware’s rate although more variable, tended to fall during the same period but moved much higher during the past two years. At least part of this has to do with Delaware’s economy, until recently a job creation machine that was even able to absorb the impact of major job cuts by some of the state’s larger employers. The CHIP program and the liberalization of Medicaid also contributed to the decline. The reason for the recent increases is not as yet apparent although the challenges faced by employers and the cost of health insurance are the most likely culprits.

Figure 1-5
Percent of Persons without Health Insurance in Delaware
by County (3-year average)

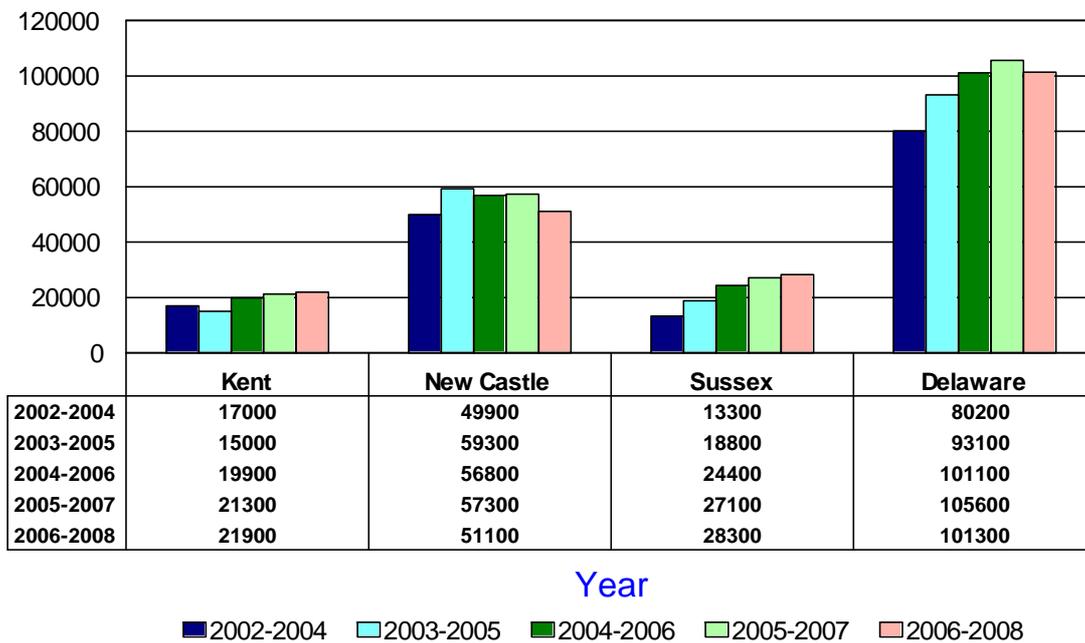


Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Since 1996, the Census Bureau has provided county level identifiers on the CPS data. The sample sizes are sufficient to produce some rudimentary estimates at the county level. Since the sample sizes are small in Kent and Sussex counties, more random variation can be expected. The percentage of uninsured in each county is found in Figure 1-5. These three-year averages

show significant differences between the county rates. Residents of New Castle County enjoyed the lowest rate consistently during the three-year period; however, the rate has been higher recently. Sussex County is highest, with the percentage of uninsured averaging over 16% in the most recent period. This is, in part, due to in-migration. Kent County has also experienced an increase in the percentage of uninsured although the increases are more modest.

**Figure 1-6
Persons without Health Insurance in Delaware
by County (3-year average)**

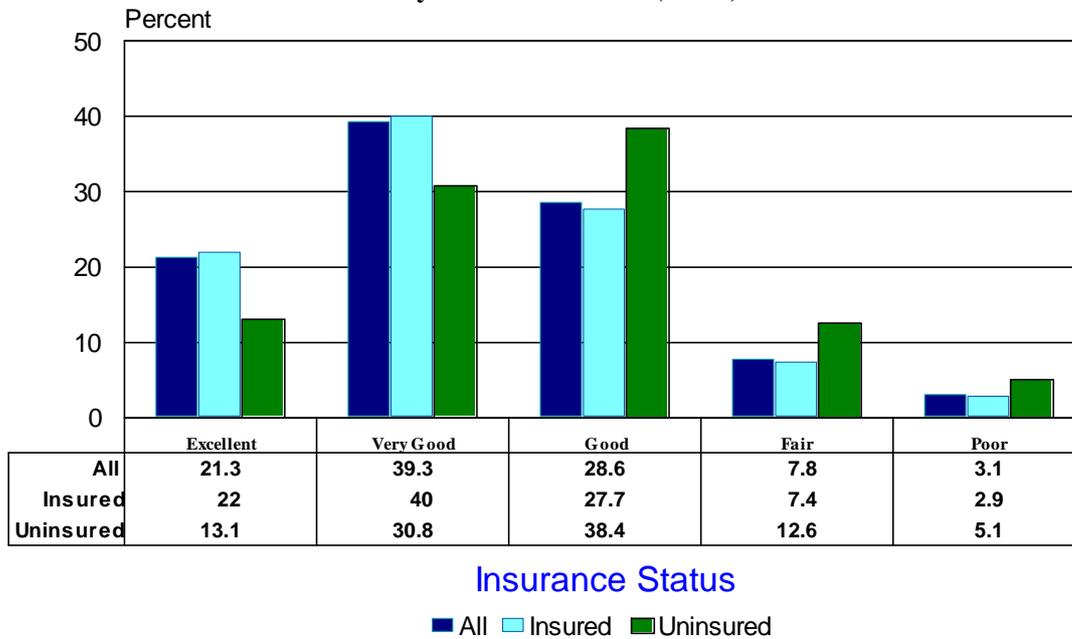


Source: Center for Applied Demography & Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 2002-2008

The estimates of uninsured persons by county are provided in Figure 1-6. New Castle County residents are the most numerous even though the rate is slightly lower. Almost 51% of the uninsured reside in New Castle County. The only major change is a substantial increase in the number of uninsured living in Sussex County.

There are several interesting questions that can be addressed by BRFSS. First, the Health Status of Insured is compared to that of the Uninsured in Figure 1-7. There are modest differences between the two groups. More of the Insured see themselves of being in Excellent or Very Good health as compared with the Uninsured. In contrast, the Uninsured are far more likely to simply classify their health as just Good.

**Figure 1-7
Health Status in 2008
by Insurance Status (18-64)**



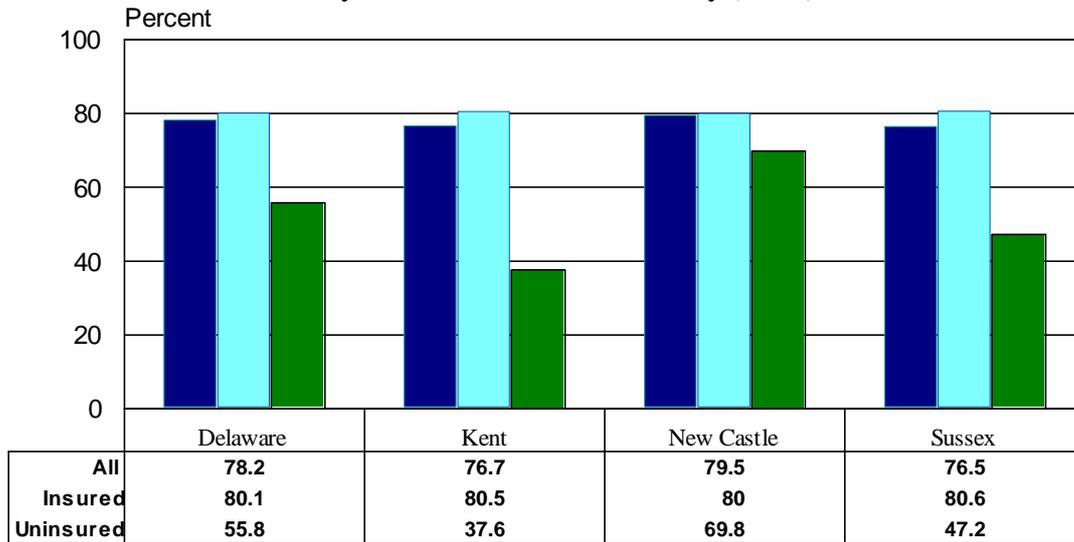
Source: Center for Applied Demography & Survey Research, University of Delaware
Delaware Health and Social Services, 2008 Behavioral Risk Factor Survey

One of the most frequently mentioned problems with the uninsured is that they avoid seeking medical assistance because they lack health insurance. As a result, their medical condition could deteriorate and the cost of correcting the problem could increase. The chart above is suggestive of that hypothesis and the one below further supports it.

Respondents were asked how long it had been since their last physical. The responses to that question for the Insured and the Uninsured are displayed in Figure 1-8. The chart shows that about half of the Uninsured have had a physical in the last six months. That compares with about 80% for insured respondents. The three counties mirror that result.

While there is a difference between the two groups, it is perhaps not as large as one might expect. First, about half of the uninsured were likely to have had health insurance last year. Second, some uninsured are able to pay out-of-pocket for doctor’s visits. Finally, if the person had a long term relationship with a physician, the physician may have simply treated the visit as uncompensated care. The latter two issues are addressed in Figures 1-9 and 1-10.

Figure 1-8
Physical Within Last Twelve Months in 2008
by Insurance Status and County (18-64)



Insurance Status

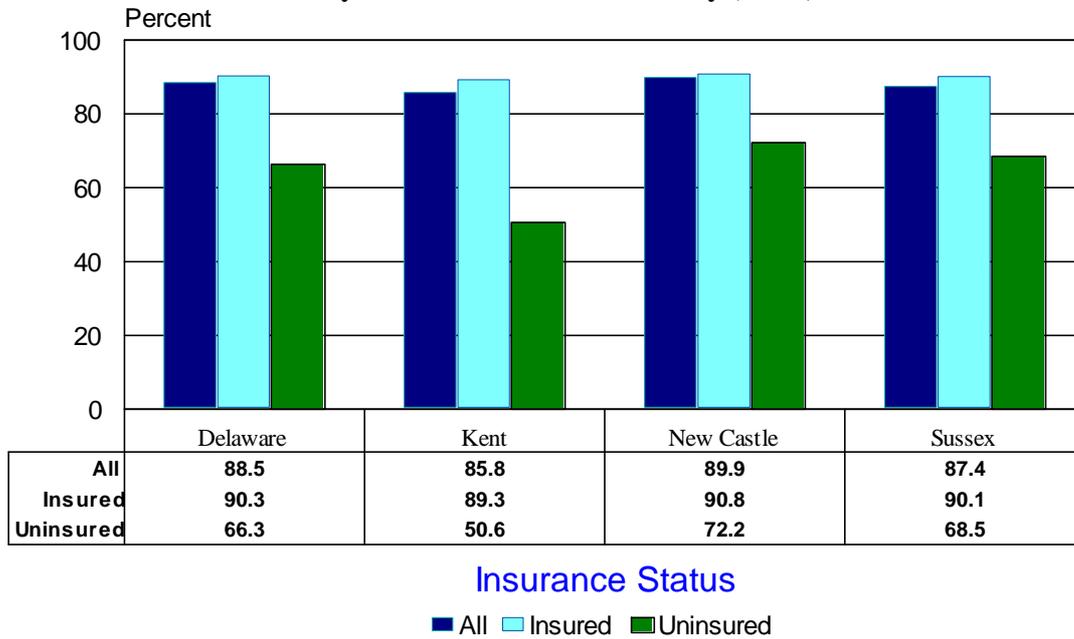
■ All ■ Insured ■ Uninsured

Source: Center for Applied Demography & Survey Research, University of Delaware
 Delaware Health and Social Services, 2008 Behavioral Risk Factor Survey

Respondents were asked if they had a “personal doctor(s)”. The intent of this question is to measure the degree of connectedness to the health care system. Theoretically this should lead to better and more cost effective care and provide a relationship that can carry one through a period when one lacks health insurance.

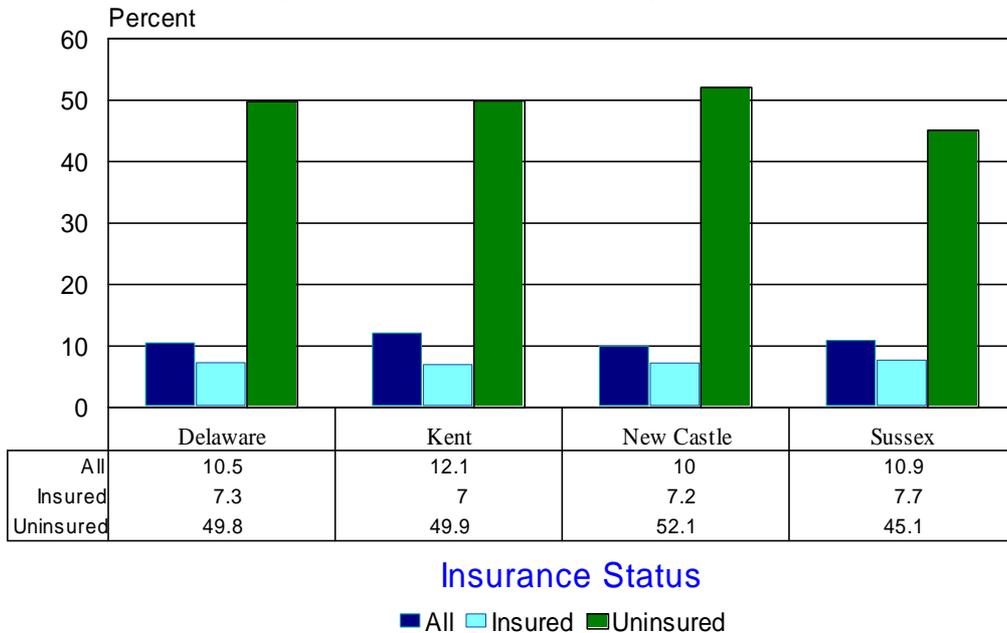
The chart in Figure 1-9, shows the difference between the Insured and the Uninsured with respect to connectedness to the health care system. Overall, 90% of Delawareans have a relationship with one or more physicians. However, the Uninsured are far less likely to have such a relationship. There is a substantial difference between the counties as well. In Sussex County, the Uninsured are far more likely to have a personal doctor than in either Kent or New Castle County. This probably reflects the age difference between the counties. Certainly the 50+ age-group will be more concerned with health care than those who are in the 18-29 age-group. The chart is also strikingly similar to Figure 1-8.

Figure 1-9
Have a Personal Doctor in 2008
by Insurance Status and County (18-64)



Source: Center for Applied Demography & Survey Research, University of Delaware
 Delaware Health and Social Services, 2008 Behavioral Risk Factor Survey

Figure 1-10
Needed a Doctor but too Costly in 2008
by Insurance Status and County (18-64)

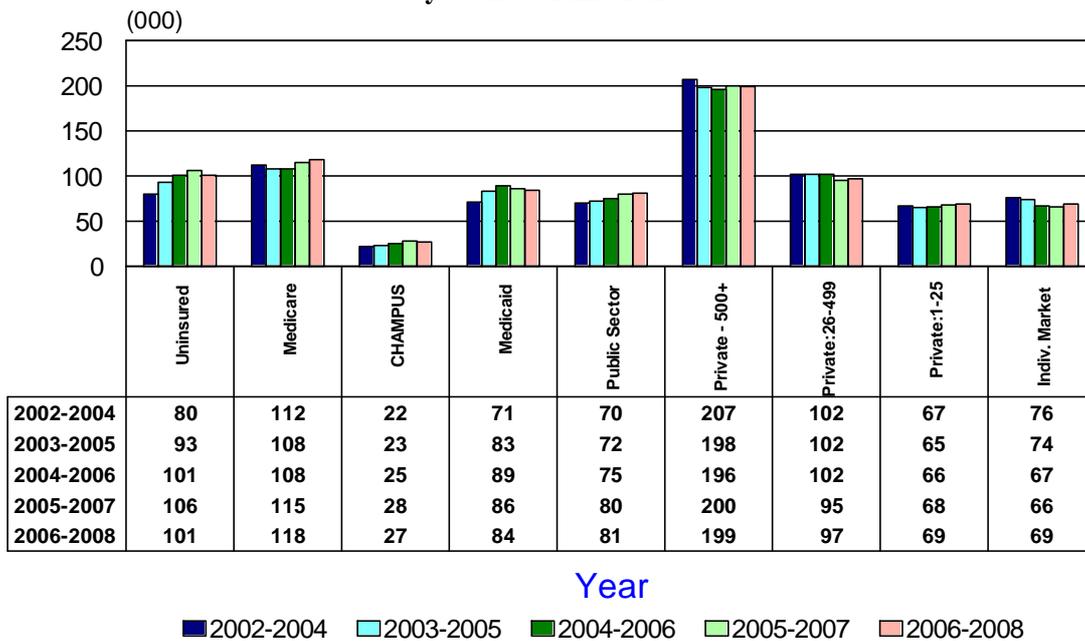


Source: Center for Applied Demography & Survey Research, University of Delaware
 Delaware Health and Social Services, 2008 Behavioral Risk Factor Survey

The final figure in the series, Figure 1-10, addresses the issue of being uninsured and needing health care services and not being able to afford it. The Uninsured are far more likely to be in this position although perhaps 25-30% of the Uninsured can pay out-of-pocket for many services. Another subset of the uninsured may simply not need to access care and still another portion can delay care without harming their health. The insured population also experiences cost pressures as well. This may be an indicator of the size of the underinsured population as well.

Finally, it is useful to understand something about how people obtain their health coverage. This can be particularly important in determining the amount of influence government policy can have on Delaware’s population. Figure 1-11 shows that Delawareans get their health insurance in many different ways.

Figure 1-11
Number of Persons in Delaware
by Source of Insurance



Source: Center for Applied Demography & Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 2002-2008

Excluding the 101,000 uninsured, about 229,000 people receive their health insurance through one of three government programs, Medicare, Medicaid, or one of several military sources (CHAMPUS). Medicaid estimates are lower than what the state actually has enrolled (over 145,000). The difference is partly from the fact that people use multiple sources of

insurance during the year and a recognized tendency of the CPS to underestimate this number. It is also apparent that Medicaid recipients, who receive their benefits as the result of a program other than one related to poverty, may not report being a Medicaid recipient. In 2006 Delaware had the twelfth lowest poverty rate in the US and as a result only 90,000 people would have been qualified for Medicaid without other programs being involved. TANF and long-term care are two examples. Finally, research also indicates that people tend not to report government-provided health benefits if they received them for less than six months.

The public sector at all levels insures some 81,000 residents. There is some state data that suggests this number is closer to 90,000. If it is, the numbers covered by the private sector are probably too high. Within the private sector there are two distinct groups. The large employers (more than 500 employees) are largely self-insured and don't utilize the insurance market in a conventional way. These account for the largest single group of residents numbering more than 199,000. The balance, some 235,000 obtain their insurance through smaller employers who purchase various group plans in the insurance market or obtain insurance as individuals.

One interesting feature of this information, not found in Figure 1-11, is that many people report having multiple sources of health insurance over the year. For example in 2008, 14.9% of the population reported receiving Medicare, but only 4.7% say that Medicare was the only source of insurance that they had during the year. Similarly, 12.4% reported Medicaid as a source of coverage, but only 4.8% said that it was their only means of coverage. These two situations probably represent two different dynamics. Medicare recipients are quite often carrying additional insurance to cover any medical services not handled by that program. Medicaid recipients, on the other hand, seem to be more likely to move from some type of group coverage to Medicaid and back again as their life situations change.

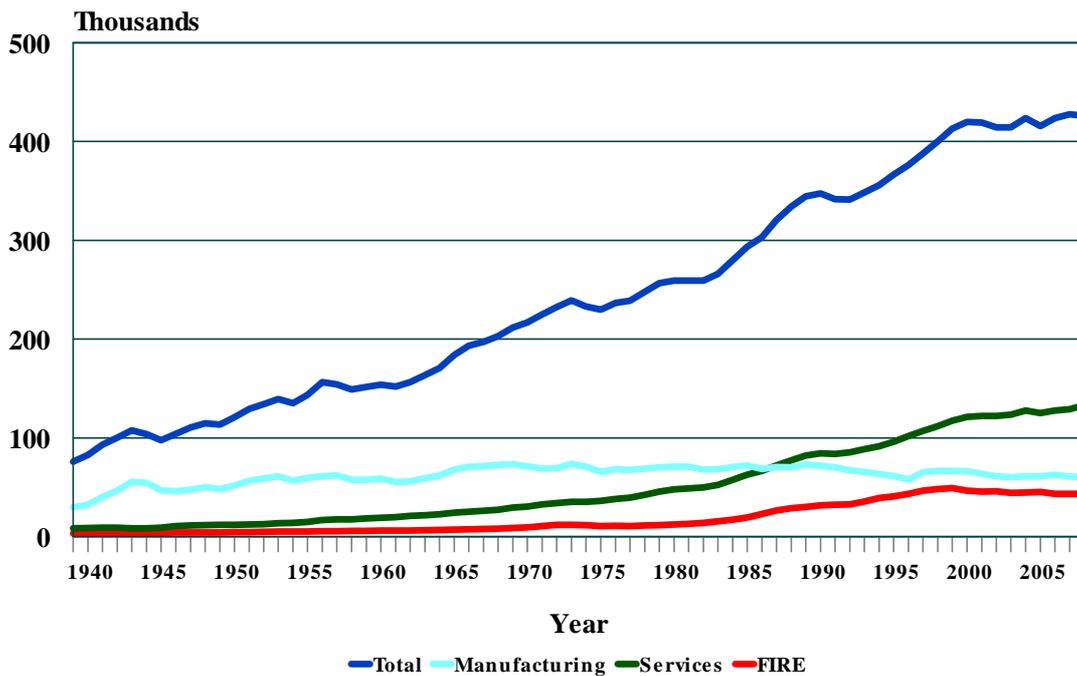
In conclusion, it should be noted that, while at any point there are approximately 11.2% of Delawareans uninsured, the proportion that is uninsured at some point during the year is closer to 18.6% based on national statistics. The same statistic derived from the Survey of Income and Program Participation, points to a median time without coverage of six months. Overall, it appears that health insurance coverage in Delaware continues in the right direction and, with the addition of Medicaid managed care and the Children's Health Insurance Program, the proportion of uninsured Delawareans will at least be stable absent changes in other demographic and economic variables.

Labor Market Issues

Background

Health care coverage is inexorably linked to an individual's employment status along with the type and size of firm for which they work. Many Delawareans have recently experienced more instability in their labor market activity and this has, inevitably, affected aspects of their coverage. The factors producing this increased instability are varied and are both national and international in scope. There are, however, some basic trends that are important to understand since they are affecting and will continue to affect health care coverage in the years to come.

Figure 2-1
Delaware Non-Agricultural Employment:
Selected Sectors 1939-2008

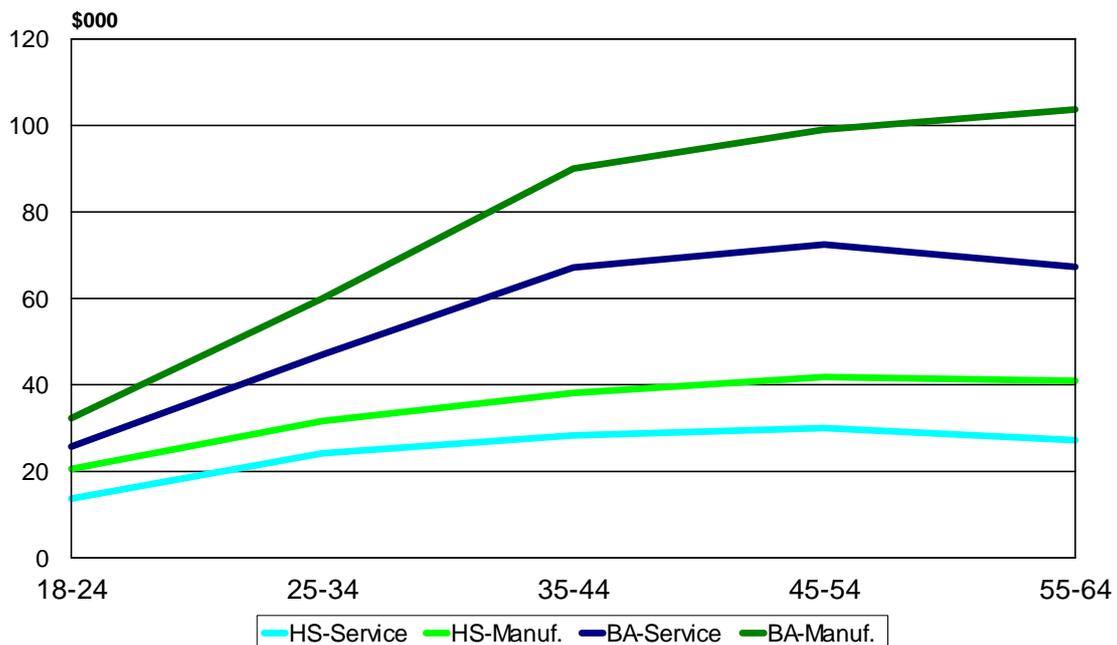


Source: Center for Applied Demography & Survey Research, University of Delaware
US Bureau of Labor Statistics

In Figure 2-1, the total employment for Delaware from 1939 through 2008 is shown along with three of the ten employment sectors namely: manufacturing, services, and FIRE (finance, insurance, and real estate). The graph clearly shows the impact that the business cycle has had on total employment in the mid-1970s, the early 1980s, the early 1990s, and in the current crisis. All of these economic events are likely to affect the percentage of persons without

health coverage. The more subtle influence is related to the change in the structure of employment. Manufacturing employment reached its peak in 1989 and has been in a steady but very shallow decline for the most part. Service industry employment increased steadily over the entire period and began accelerating its growth when manufacturing employment was at its peak. In 1986, service sector employment surpassed manufacturing employment and today it accounts for nearly twice as much employment as manufacturing. This trend will probably continue unabated for the foreseeable future. Employment in the FIRE sector clearly exploded after the passage of the Financial Center Development Act in the early 1980s. It continued to grow dramatically until the 1990-1991 recession. To most observers' surprise, the growth re-ignited in 1992 and continued until 2000 when the economic downturn began. The recent financial crisis coupled with the merger of MBNA with Bank America has produced a further decline largely centered in FIRE.

Figure 2-2
Average Annual Earnings by
Sector, Age, and Education



Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census Current Population Survey, March 2008

The importance of these inter-sector employment shifts is shown in Figure 2-2. Figure 2-2 shows the average annual earnings by age, education, and industrial sector. The top two lines represent annual earnings for college graduates in the manufacturing and service sector

respectively. The bottom two lines depict the same information for high school graduates in the same two sectors.

The graph shows a difference of more than \$30,000 in annual earnings between the two sectors for the higher level of education. The spread for high school education is now about \$10,000. If the same health care benefits were offered in both sectors, the cost to employers would be a much larger proportion of the annual salary in the service sector than in manufacturing. This suggests that employees in the service sector will likely be offered fewer benefits.

In addition, those employed in manufacturing are much more likely to be represented in a collective bargaining unit, a union. They are also more likely to work full-time with significant overtime, which further reduces the impact of the cost of benefits on total compensation. In contrast, service sector workers are more likely to be employed by non-union companies and are much more likely to work part-time. These factors, coupled with the increasing number of service sector workers relative to the number of manufacturing workers will tend to increase the number of uninsured or under-insured people.

Firm Sector and Size

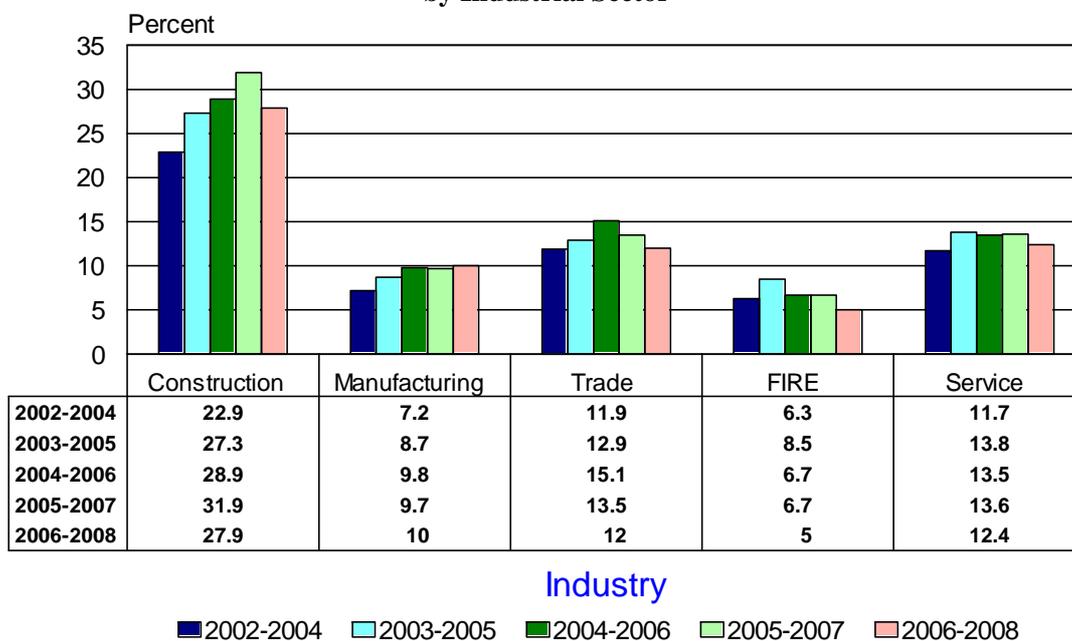
There are significant differences in both the level and pattern of the uninsured, depending upon the type of industry in which an individual is employed. For instance, according to Figure 2-3, construction workers frequently report being uninsured. Although it may be noted that some construction workers are unionized, and are usually provided health coverage, many more are either employed by a non-union company or are self-employed. Overall, it is estimated that about 32% of all construction workers are uninsured.

Many persons employed in the trade industry (retail and wholesale) also find themselves without health coverage. Because this sector is not heavily unionized and is reliant on a large number of part-time workers (most of whom do not qualify for a typical health insurance package), it is not unexpected that an estimated 13.5% of those employed in the trade industry currently lack health coverage. The data since 2000 suggest that the trend for this industry that had been improving has now reversed.

Of the other industries represented in Figure 2-3, approximately 14% of all those employed in the service industry are not offered or do not accept health insurance as part of a benefits package. This number appears to be increasing somewhat over the period. This probably reflects the changing nature of the service industry.

Roughly 9% of those currently employed in manufacturing and 7% in FIRE do not have health coverage. However, the proportion uninsured in most of the sectors is increasing during the period.

Figure 2-3
Percent of Persons without Health Insurance in Delaware
by Industrial Sector

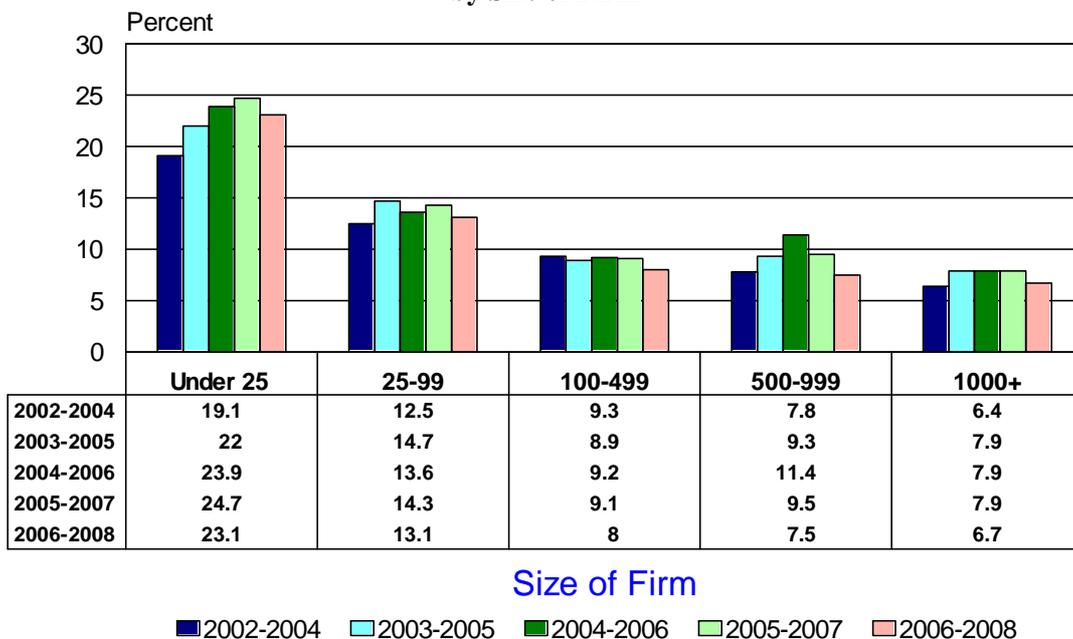


Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Finally, it also should be pointed out that the differences in coverage between industries are among the largest observed for any variable in this report. The importance of this information relates to the changing structure of the economy. As employment shifts from manufacturing to the service sector, the percentage of uninsured workers increases by about 2%. The importance of the FIRE sector in Delaware cannot be overestimated at least with respect to health coverage. As the percentage of uninsured in the region has risen, Delaware’s rate was falling until 2004 and generally rising until 2008. This appears, in large part, to be related to the importance of the FIRE sector and to a less rapidly growing service sector compared to the nation.

The other important inter-sector shift that is subtler is associated with the nature of downsizing in Delaware’s manufacturing sector. A significant portion of those employees who were “downsized” belonged to headquarters support operations as opposed to the factory floor. In many cases, those same employees started or joined firms that supplied services to their previous employer who simply wanted to “out-source” those functions. Many of these new jobs are classified as business services, part of the service sector, and are far from the typical “hamburger flipper” often discussed in the media. This has produced increases in annual earnings in the service sector that bodes well for benefit programs in the future.

Figure 2-4
Percent of Persons without Health Insurance in Delaware
by Size of Firm



Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Employees who work for small firms (under 25 employees) are far less likely to have health insurance than those that work for large firms (more than 1,000 employees). Figure 2-4 shows this relationship.

The graph shows that there are two distinct groupings: (1) firms with less than 25 employees where the percentage without health insurance is 23% and (2) firms with more than 500 employees where the percentage of those without health insurance is about 7%. The larger firms are perhaps more likely to be unionized at least to the extent that larger firms have a higher

probability of being in sectors such as manufacturing. They are also more likely to pay higher wages, which makes the relative cost of health insurance more tolerable. From a tax perspective, the provision of health insurance also provides a convenient way to increase total compensation.

It appears that those working for the smallest firms are now less likely to have health insurance coverage in comparison with five years ago. Those firms with employees in the range 100-999 have also showed stability. The larger firms with 1,000 or more employees have deteriorated somewhat over the time series.

In conclusion, these data suggest that any effort to increase coverage must focus on smaller firms. Those firms will tend to provide lower levels of compensation, will probably use more part-time employees, and may offer less stable employment. However, they are growing faster and becoming a bigger part of the economy. This fact may tend to mitigate some of the negative factors over time. On the other hand, the large firms with better coverage are becoming smaller and that does not help the long-term outlook. There is no doubt, however, that all of these factors will tend to make the goal of better access to health care a challenge for the foreseeable future.

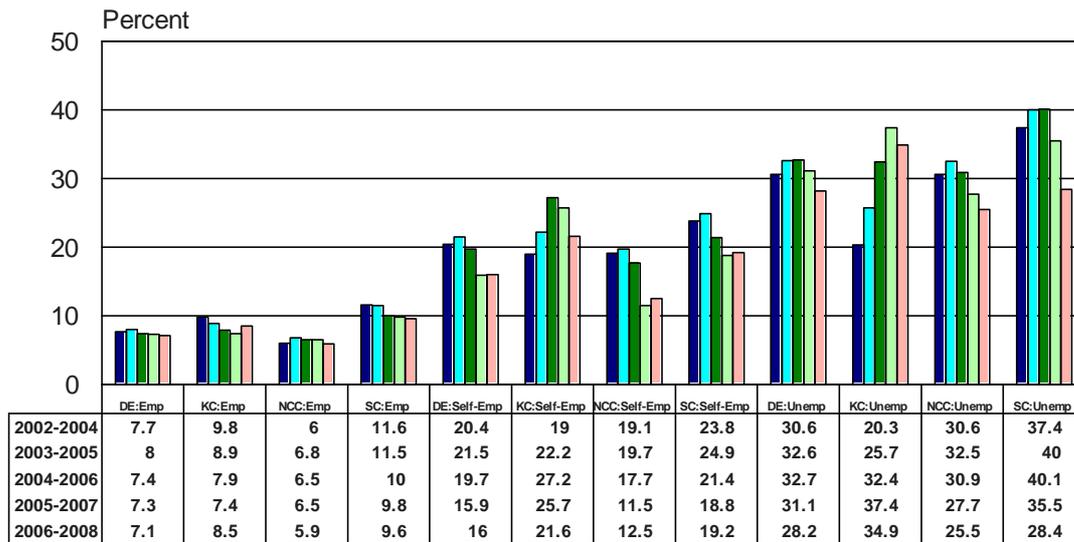
Employment Status and Class

Some form of group health insurance (including ERISA plans) covers approximately 70% of all Delawareans. The majority of them are covered through their employer and therefore any disruption in employment will undoubtedly increase the likelihood that coverage will lapse. Coverage may not automatically lapse since another worker in the family may also cover them, or the employees may extend the coverage through payments themselves, or the individual may qualify for some government plan like Medicaid or Medicare. Still, the disruption is significant as is shown in Figure 2-5.

The information reported in Figure 2-5 shows that the probability of being without health insurance increases by nearly a factor of four when the individual is unemployed. The percentage on the average rises from about 7% to in the vicinity of 33% as the individual's employment status changes. There is considerably more volatility in the estimates in Kent and Sussex counties because of small sample sizes, but the relationship mirrors that in New Castle County where sample size is not a problem. While those that are self-employed are also found in relatively small numbers in the BRFSS survey, the lack of health insurance is 50% more prevalent as that

of those with traditional employment. This finding exhibits little change over the time series and is found in all three counties.

Figure 2-5
Percent of Adults without Health Insurance in Delaware
by County and Employment Status



Employment Status by County

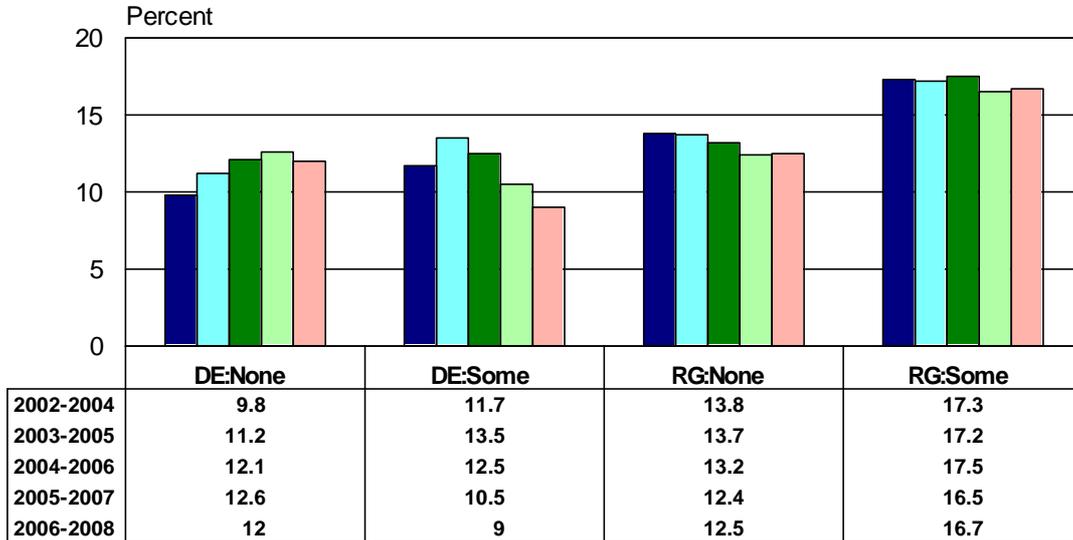
■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 Delaware Health and Social Services, 2002-2008 Behavioral Risk Factor Survey

The other piece of information that deserves comment is the relative differences between the coverage for employed workers in the three counties. The rate in New Castle County (NCC) is lower than those observed in Kent (KC) and Sussex (SC) counties. Following the earlier argument, this probably arises from differences in the economic base, since larger firms with higher wages and more stable employment are located primarily in the northern part of the state.

In Figure 2-6, further evidence is found about the relationship between insurance coverage and employment status. In this analysis, the receipt of unemployment compensation is used as an indicator of an interruption of employment at some point during the year. In both Delaware (DE) and the region (RG), there is a rise in the lack of health coverage associated with receiving benefits. While the effect is more muted than in Figure 2-5, where a more direct measure was available, the percentage is always higher in the region where the sample size permits a better estimate.

Figure 2-6
Percent of Persons without Health Insurance
by Receipt of Unemployment Compensation and Area



Unemployment Compensation by Area

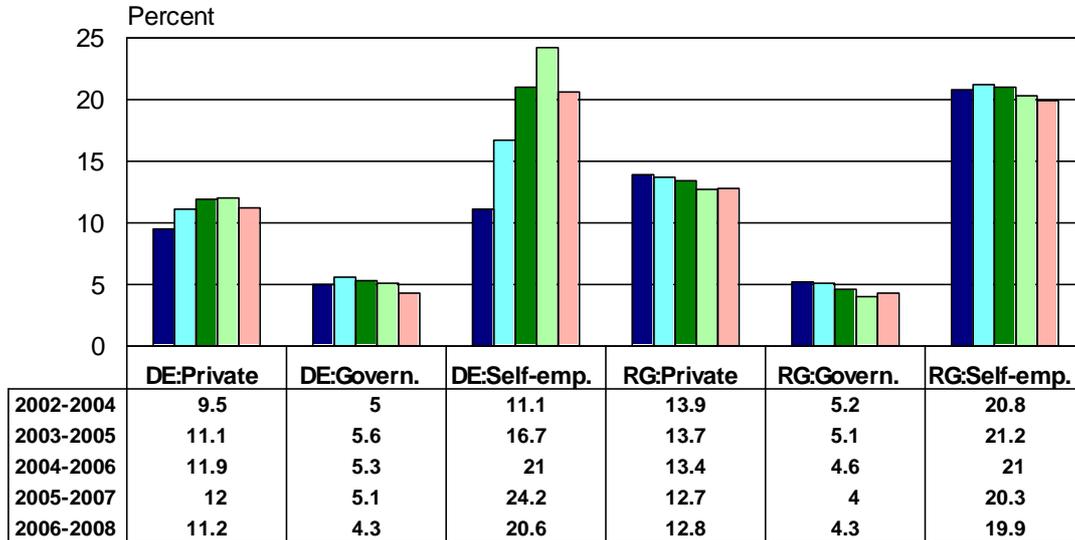
■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

The final graph in this section of the report represents the percentage of workers without health insurance in Delaware and the region as indicated by three broad classes namely: private sector workers, government workers, and the self-employed. In Figure 2-7, Delaware workers in the private sector average somewhat fewer uninsured than those in the region. Within the private sector, Delaware seems to be losing ground over the time series. The rates in the region, for the private sector, exhibit a more stable trend.

It is no surprise that government employees both in Delaware and the region are far more likely to have health insurance than the private sector in general. Government rates are comparable with very large private sector firms operating in a unionized work place. The only government workers who are likely to lack coverage are temporary/part-time workers or private contractors.

Figure 2-7
Percent of Persons without Health Insurance
by Class of Worker and Area



Class of Worker by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

A more interesting structural shift, which has been underway for some time, is that government workers are representing a smaller proportion of the labor force, since that sector is growing less rapidly than employment overall. This implies that the percentage of uninsured workers will tend to rise, even if all the rates within these classes remain constant.

The information about the self-employed corroborates the information from the BRFSS discussed earlier. The data for the region (RG), however, shows that the significant upward trend previously identified has moderated. There is a variety of potential explanations. One reason, which is consistent with other data, is that tight labor markets have allowed many of those previously classified as “self-employed” to find work and to gain benefits. Those that remain self-employed are likely to be financially stronger and better able to obtain health insurance.

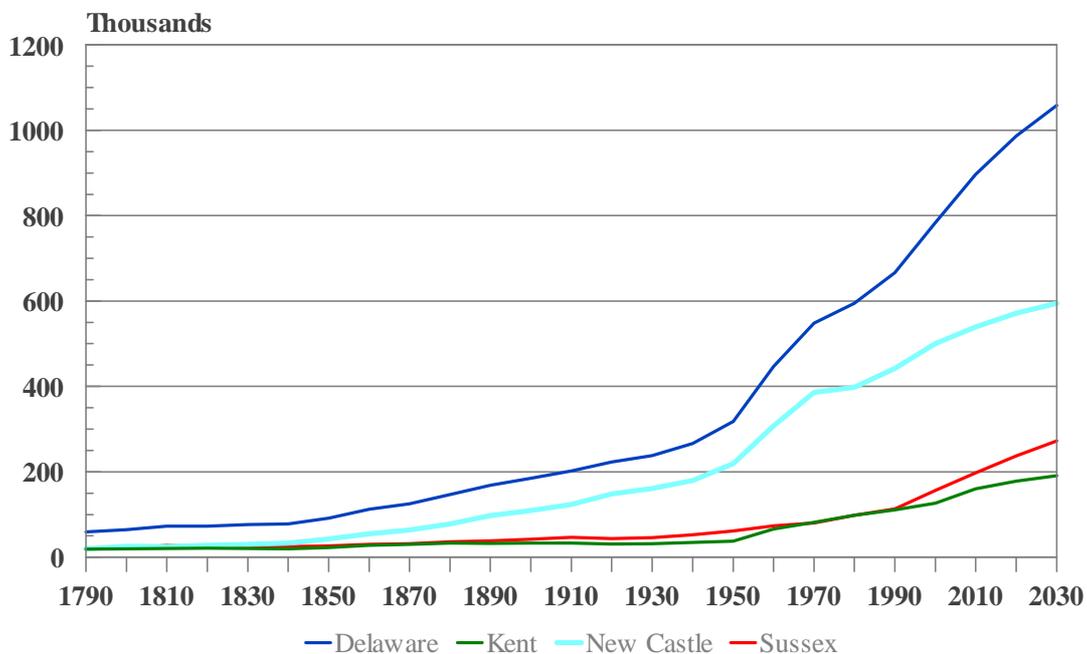
Demographic Characteristics

Background

Labor market characteristics are only some of the variables that play a role in influencing the proportion of people without health insurance. Demographic variables also may help explain a population's lack of health insurance. Others simply provide a convenient method for describing this condition among subsets of the population. Both will be addressed in this section.

Before returning to the health insurance issue, a few important factors driving population growth need to be addressed. In the first section of the report, it was reported that the number of uninsured had remained reasonably stable while the population increased substantially. There are, however, some recent indications, also discussed in the previous section, that future population increases could be accompanied by increasing numbers of uninsured. For that reason, it is important to understand how Delaware is growing.

Figure 3-1
Population of Delaware and Counties

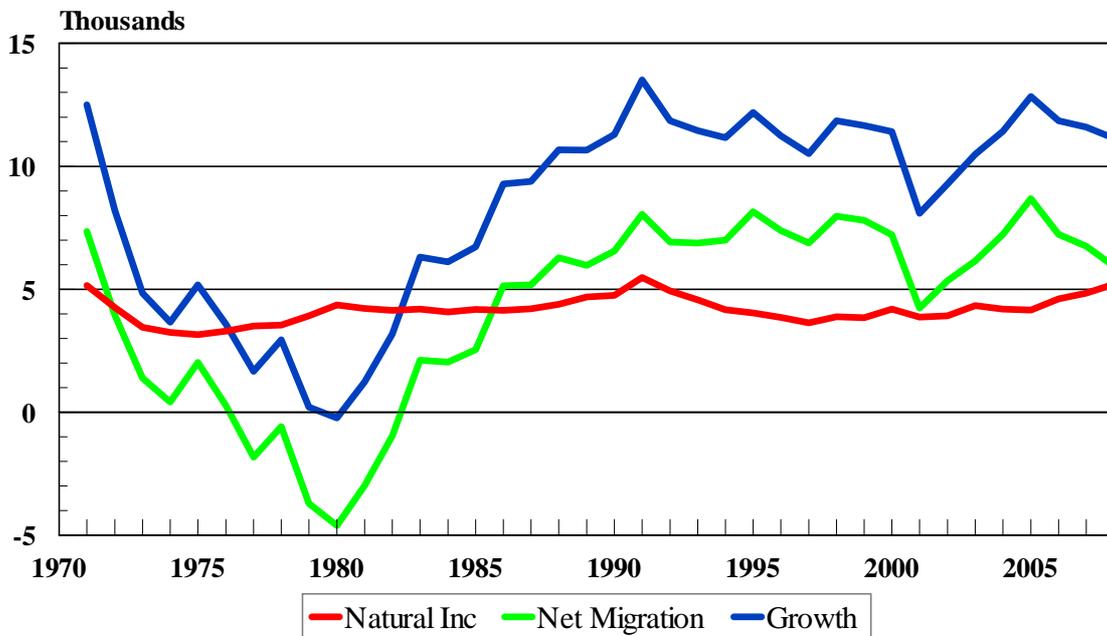


Source: Center for Applied Demography & Survey Research, University of Delaware
US Bureau of Census, Decennial Census 1790-2030
Delaware Population Consortium, October 2008

In Figure 3-1, the pattern of population growth for the state and for each county is shown from the first U.S. census in 1790 through the current 30-year projection in 2030. The state grew at a fairly steady rate from 1840 to 1950, when population growth began to explode. This pattern continued unabated for 20 years until the oil-crisis induced recession and the migration to the “sun-belt” began. Population growth resumed in 1980, although at a much slower rate, and is predicted to continue to grow at rates around 1.3% annually. Kent County continues to grow more rapidly in the short-term (2.5%) and then will grow at rates that are consistent with those observed in the last 50 years. Sussex County has been growing at a rate of 2.2% per year while New Castle County has slowed to 0.7% during this decade.

If current conditions continue, this population growth would likely generate another 17,000 uninsured persons over the next 30 years. But, current conditions, especially those in the labor market, are unlikely to continue. In fact, global competition and pressure on production costs may cause employers to rethink the total compensation package. The structural changes in the labor market alone will probably lead to an increase in the uninsured. Legislative changes and innovative government programs may also act to mitigate any increase in those numbers. However, it is difficult to speculate as to how these different factors will average out.

Figure 3-2
Sources of Population Growth in Delaware



Source: Center for Applied Demography & Survey Research, University of Delaware

Figure 3-2 illustrates the components of Delaware's population growth since 1970. The darkest (blue) line in the graph represents annual population growth. It has been as little as 0 persons in 1980, at the end of the recession, and as much as 13,000 persons just after the economy peaked in 1990.

Overall growth is dependent upon two components: natural increase and net migration. Natural increase is the number of births to Delaware residents less the number of Delaware residents that die. That quantity is represented by the lightest (red) curve in Figure 3-2 and has been around 4,500 per year until the "baby boomlet" started in 1985 and ended in 1991.

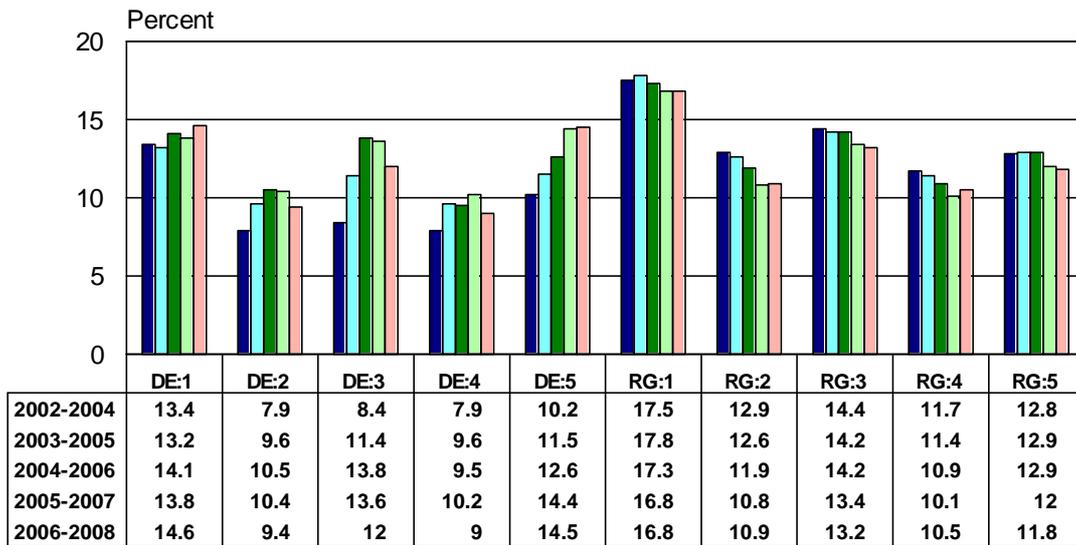
Net migration, which is the result of persons moving into Delaware less persons moving out of Delaware, is clearly the volatile component of the growth picture. It has moved from net out-migration in 1980 of -5000 to a high of 8700 net in-migration in 2004. It fell during the recession years of the early 1990s and today accounts for more than half of all population growth. From these data, it is clear that Delaware's population growth is partially influenced by local labor market conditions, particularly in New Castle County. Delaware's economy has consistently produced unemployment rates below those for the nation and region and has continued to generate new jobs sufficient to attract net in-migration. The characteristics of those jobs, in particular their health benefits, can and probably have affected coverage rates in Delaware.

Household Composition

The size and structure of the households, within which individuals live, has much to do with the probability of having health care coverage. Each of the variables addressed in this section, to include household size, marital status, and relationship to head of household, give a slightly different slant on the problem. Figure 3-3 contains information about the percentage of uninsured in relation to household size within Delaware and the region. The most disadvantaged group is the single person household. The percentage of uninsured is well above the proportions for most of the other categories. Single person households also fare somewhat better in Delaware than in the region. Those individuals are somewhat disadvantaged since there is no second worker in the household to share the risk of losing coverage. They are also more likely to be a younger person at the low-end of the life cycle of earnings and are more likely to work in a job

that does not provide health insurance coverage. Of course, the rate is reduced somewhat by older persons living alone who are covered by Medicare.

Figure 3-3
Percent of Persons without Health Insurance
by Household Size and Area



Household Size by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

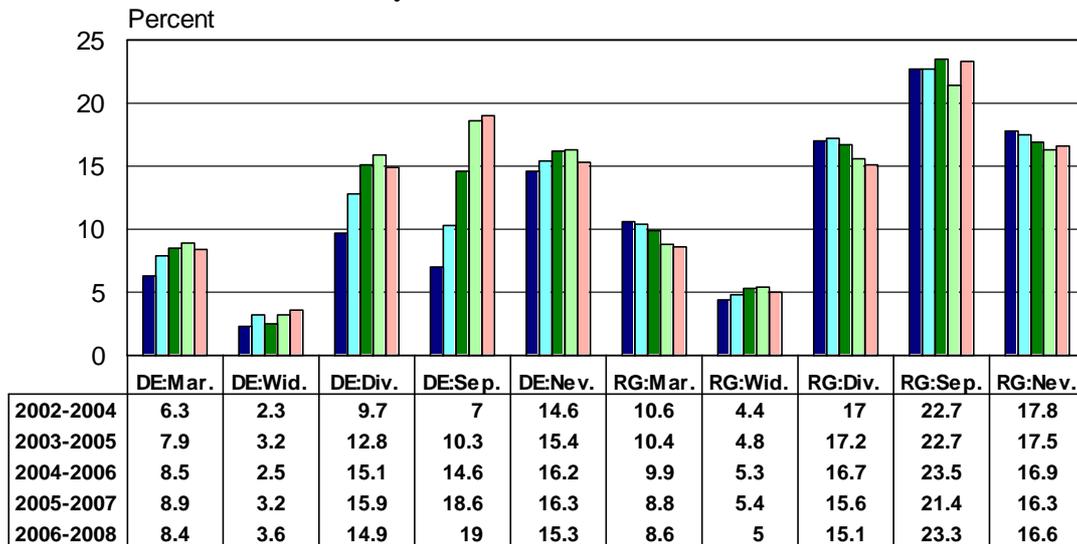
Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Two and four person households were least likely to report lacking health coverage. The two-person household has a high probability of being a married couple with two incomes. The four-person household is also likely to have two working adults within it. The three-person household is a mixed picture since it also includes a single parent with two minor children, thus the risk of being without coverage rises. Overall the relationship between household size and the lack of health insurance coverage in Delaware (DE) tracks well with that of the region (RG).

Marital status is closely linked to household size and composition. This relationship can be easily seen in Figure 3-4. For instance, the lowest rates observed over the period, usually around 3%, are reported by the widowed. This is expected since the largest majority of this group is qualified for Medicare. Thus, age may have more to do with their higher insurance rate than marital status. Married people have the next lowest rate, 8.9%. Married couples, with or without children, usually have two chances to obtain coverage. That may not be true if one spouse is not in the labor force or only works part-time. Still, the probabilities of having health insurance

increases and household members are more likely to be protected against the loss of coverage during times when one or the other is unemployed.

Figure 3-4
Percent of Persons without Health Insurance
by Marital Status and Area



Marital Status by Area

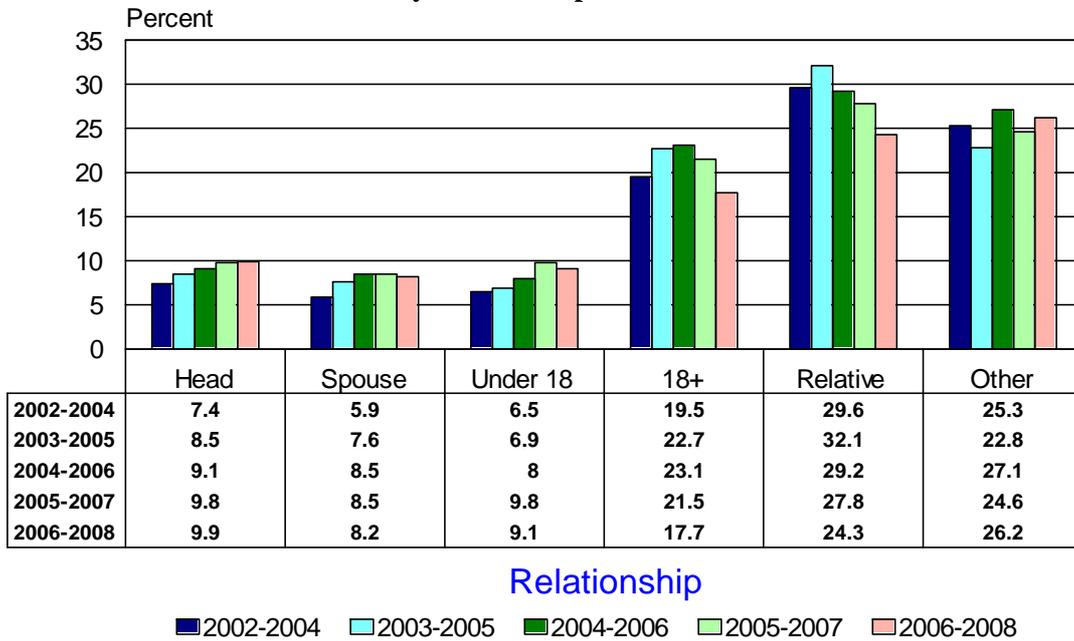
■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Younger adults heavily populate the “never married” category and, as will be explained later, are less likely to have coverage. For this reason, their risk of being uninsured is nearly twice that of a married person.

The last two groups, which are usually one-adult households, are interesting for different reasons. First, the “separated” group in Delaware (DE) is small and volatile. This group is typically a transitional one and the person will probably move on to the divorced category. The separated person’s lack of coverage is now higher than that of the divorced person. Presumably this convergence is related to legal arrangements made to retain coverage until a final disposition of the marriage is reached. Once the person is divorced, the probability of having coverage will depend in large part on the person’s labor force status. It should be kept in mind that a significant number of people in this category are making major transitions and may suffer significant income losses. Interestingly, Delawareans in this category are significantly better off than their regional (RG) counterparts.

Figure 3-5
Percent of Persons without Health Insurance in Delaware
by Relationship to Head



Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

The final demographic variable in this series is relationship to the head of household. Figure 3-5 depicts its association with the risk of being without health insurance. There are, once again, two distinct groupings. First, there are the spouses and minor children whose risk levels are around 9%. (This group of children excludes many who are not the children of the head of household but are living in the house.) The head group also includes all of those single person households whose risks were also elevated. This is the reason why the spouse group has less risk of being without health insurance. Minor children are dependent on the adult(s) health insurance coverage and there may be either one or two adults in the household. Thus, the risk will always be higher than that for the spouse group where there must be two married adults in the household.

The second major grouping includes adult offspring who are living at their parent’s home, relatives or non-related persons. The risk level for all three groups is almost three times that of the first group. With the exception of full-time students who still might be covered by their parent’s insurance, all will require health insurance through some other means. The fact that they are adults living in a household, where they are not the head or spouse in the household,

suggests that they are less likely to be active labor force participants. In addition, there are children in these groups as well.

Taken together these demographic variables point in the same direction. Does the person have multiple opportunities to obtain health insurance coverage? For instance, households that contain two married adults have a lower risk not only for themselves, but also for any minor children. Unfortunately, demographic trends do not favor this model. First, from 1990 to 2007 the number of single person households rose from 23% of all households to 26% and is continuing to grow. Second, non-family households rose from 28% in 1990 to 32% in 2000. The number of married couple households with or without children has fallen from 57% in 1990 to 50% in 2007. Finally, the percentage of children under the age of 18 living with only one parent has risen to 34% in 2007. None of these trends favors reducing the risk of being without health insurance coverage, and it is unlikely that those trends will be easily reversed.

Age Structure

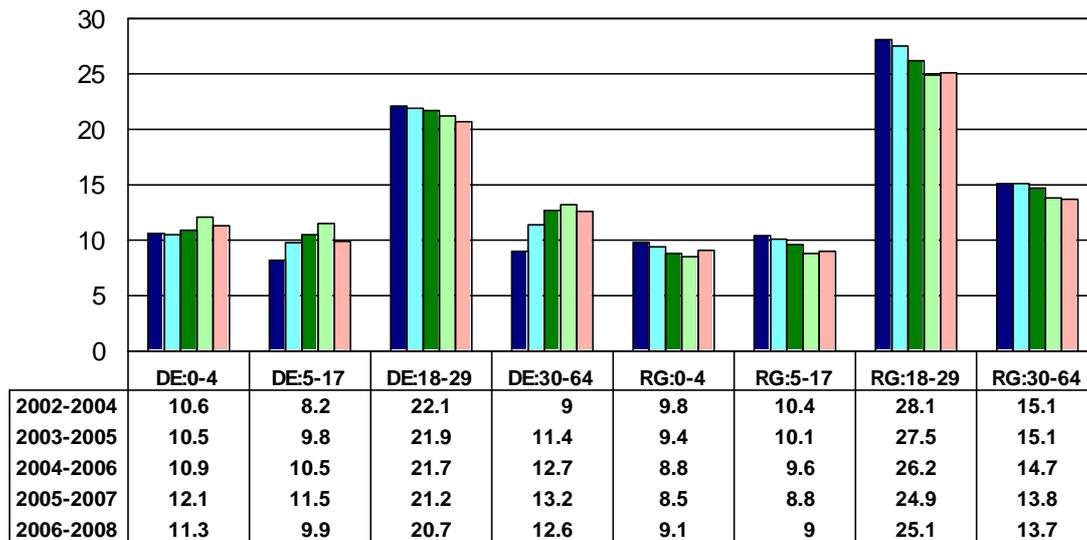
By and large, age appears to be a factor that influences the probability a person has health coverage. The most obvious example is the relationship between age and one's eligibility to qualify for Medicare, i.e. the person is 65 years old or older. Thus, the question for that age group must focus on the extent of coverage and not on its existence.

Because almost all persons 65 years and older have access to health coverage, only the percentage of persons without health insurance coverage for the other age groups is found in Figure 3-6. In both Delaware and the region, dependent children, those under the age of 18, have the lowest risk of being uninsured. Only about 11.5% of them are estimated to lack health coverage. Their uninsured rate is somewhat higher than it was in Figure 3-5, which imposed the additional requirement that they also live in and were related to the head of household. Thus, it should be remembered that the following graph contains information for all children, regardless of their living arrangement. Only recently has the CHIP program affected these measurements.

For a variety of reasons, persons aged 18-29 were most likely to report being uninsured. In both the state and the region, the risk of not having health coverage for this group is more than 20%. There is really no improvement in the time series presented here. This group suffers from a multitude of disadvantages. First, they are more likely to be unmarried. Second, they are more likely to hold lower paying jobs which provide no health benefits. Third, because their income

levels are generally lower, it is often difficult for them to purchase private insurance. Fourth, since they are generally healthy, it may seem reasonable not to expend the additional resources needed to purchase health coverage. As this group ages into the next group, aged 30-64, the risk begins to fall as those disadvantages recede. The recent trend is however not encouraging.

Figure 3-6
Percent of Persons without Health Insurance
by Age Group and Area



Age Group by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

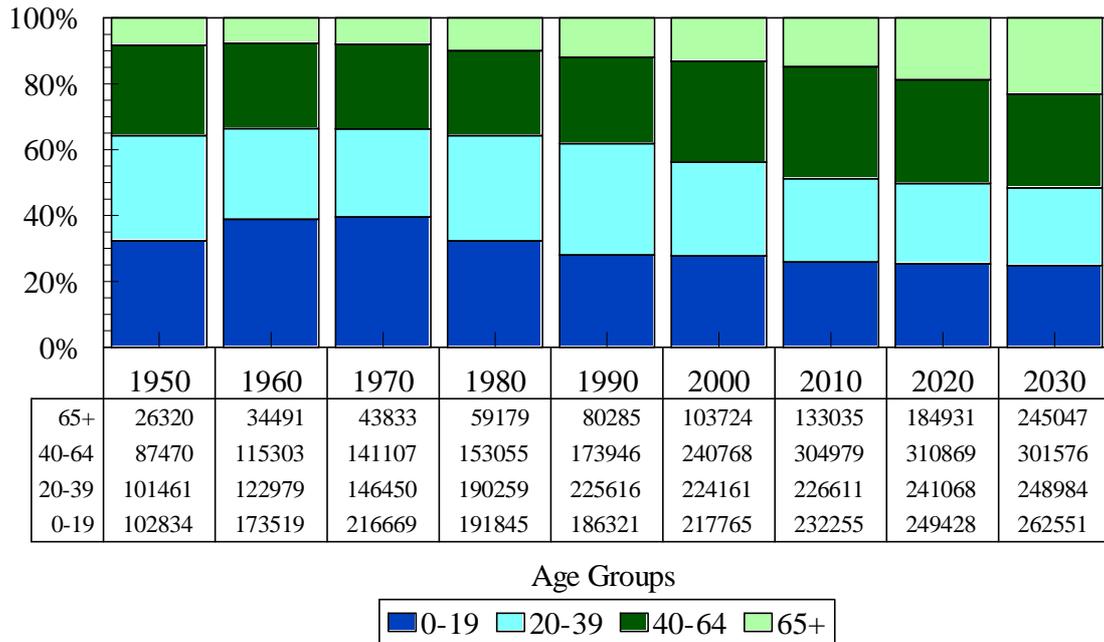
Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Given these very predictable differences, the way the age distribution changes over time will have a definite impact on the overall level of health insurance coverage in Delaware (DE). This progression is found in Figure 3-7. In 2000, the largest age group is 40-64 and contains about 30% of the population. This group contains the boomers and will continue to be the largest population cohort through the next 30 years.

There are several observations to be made about Figure 3-7. First, the proportion of the population ages 0-19 and 20-39 decreases steadily over the coming decades. The falling proportions in these groups are part of the reason Delaware’s health coverage rates have been stable. The overall risk of being uninsured should fall as the population in the two oldest groups increases. As the “baby boomers” age (and they represent a significant part of the age

distribution), their overall risk level should decrease. The real issue, therefore, will be economic conditions in the state and in the nation as this huge group reaches what would normally be their peak earning years.

**Figure 3-7
Age Structure in Delaware
1950-2030**



Source: Center for Applied Demography & Survey Research, University of Delaware Delaware Population Consortium, October 2007

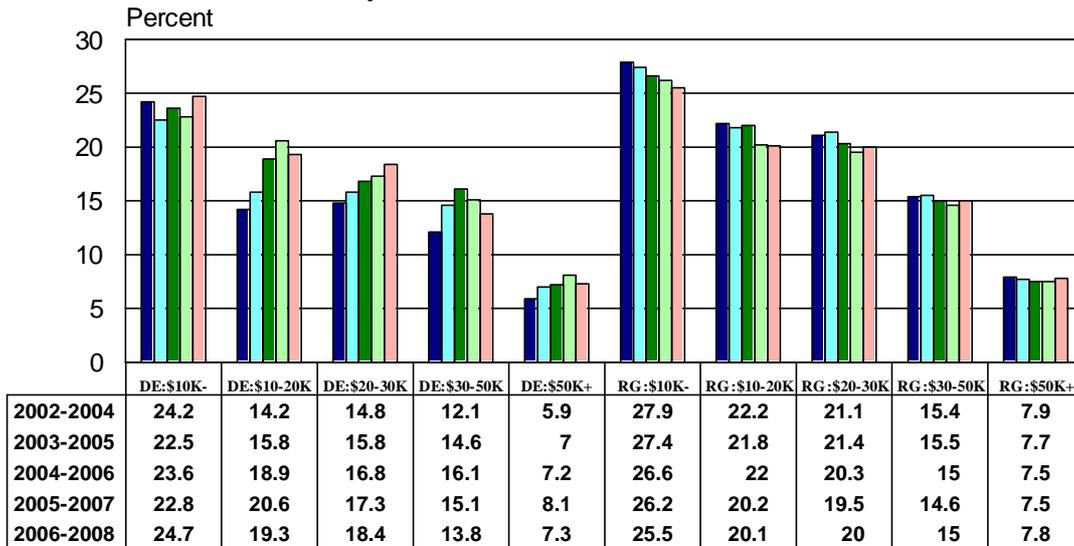
Will they be the victims of another round of downsizing? Will they become frustrated with the lack of advancement since there are so many competing for the same jobs? Will they turn to self-employment as a means of increasing their standard of living? All of these are unknown at this point but are likely to have an effect either positive or negative on health insurance coverage. This aging population will also put pressure on health care costs and will probably alter the behavior of employers.

Income and Poverty

Economic wellbeing has two different effects on the probability of having health insurance coverage. At the low end of the income spectrum, there are programs such as Medicaid available as part of the social safety net. Individuals at the high end of the income spectrum have the assets and income that allow them to be unconcerned about insuring their health. They can

afford to take the risk. The biggest problem arises among those that do not qualify for a government program, cannot afford insurance, and certainly cannot pay the medical bills if their luck runs out. Figure 3-8 provides data with respect to annual income and lack of health insurance.

Figure 3-8
Percent of Persons without Health Insurance
by Household Income and Area



Income Level by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

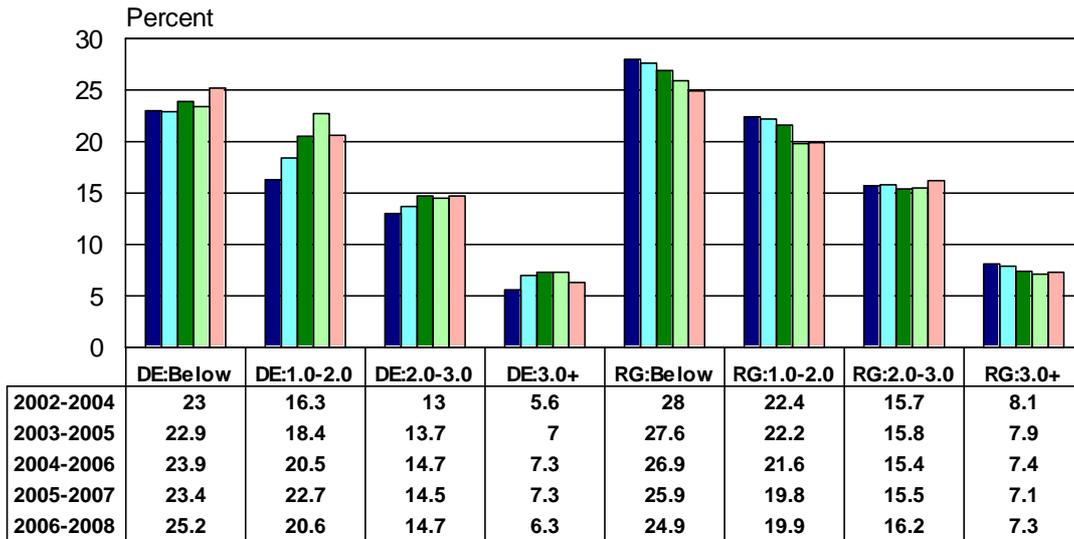
Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Persons whose annual income is under \$20,000 per year have a risk of just over one in five of being without health insurance coverage. In the lowest income category, Delaware (DE) averages better than the region (RG) as a whole. As income increases, the percentage of persons without coverage falls. At the \$50,000 and over level, about 8% or one in 12 is without health insurance, but some of those may have sufficient assets to warrant self-insurance. This strong relationship undoubtedly represents the fact that health insurance as a percentage of total compensation falls as income rises and thus holders of those jobs are likely to be given those benefits.

Poverty is a function of two variables, household income and household size. It is poverty status that tends to be used to define who is eligible for government health insurance programs. In Figure 3-9 data are found relating poverty to the lack of health insurance coverage. There seems to be very little difference between those below poverty and the near poverty group,

which is between 1.0 and 1.5(not shown) of the poverty level. The Medicaid program serves to keep the rate somewhat lower for those below poverty than it would be in the absence of the program. Some people in the second group also qualify for Medicaid, but the proportion is smaller than in the below poverty group. The trend for the lowest group is in the right direction.

Figure 3-9
Percent of Persons without Health Insurance
by Poverty Level and Area



Poverty Level by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Overall, the percentage of persons without health insurance falls as the distance from the below poverty group increases. The lowest level of risk appears to be experienced by households with incomes above \$47,000, the median household income in Delaware (DE). Finally, the rates in Delaware are roughly comparable to those in the region (RG). However, there does seem to be a steady increase in the proportion of persons without health insurance in the poverty group in Delaware, while the regional proportion has decreased slightly for that group. Increased Medicaid coverage in Delaware is probably the reason. It should also be noted that many people who are eligible for Medicaid in the lowest poverty group do not apply until a problem occurs. This will be addressed later in this report.

Table 3-1
Persons by Poverty Status, Age Group,
and Health Insurance Coverage
(3-year average 2006-2008)

Poverty	0-18 All	0-18 No HI	19+	19+ No HI
Not Measured	2236	740	0	0
under 0.50	12855	2372	20998	6838
0.50 to 0.74	6522	1211	12206	2992
0.75 to 0.99	8172	1679	18413	4719
1.00 to 1.24	8815	1217	17719	4389
1.25 to 1.49	10895	2129	24094	5596
1.50 to 1.74	11549	1626	24965	4209
1.75 to 1.99	11805	2493	25667	6008
2.00 to 2.49	21380	2521	54053	8723
2.50 to 2.99	19656	1684	59130	9743
3.00 to 3.49	18140	1052	52274	6002
3.50 to 3.99	14633	1795	49339	4876
4.00 to 4.49	9771	920	35042	2133
4.50 to 4.99	11117	484	37421	2469
5.00 & over	48426	973	208892	9679
Totals	215973	22896	640215	78377

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2006-2008

In Table 3-1, the distribution of persons by poverty, age, and health insurance status is shown. A three-year moving average is used to reduce the sampling variability. These data have particular meaning for those charged with providing healthcare to those 18 years and younger in Delaware. The table shows that an estimated 22,896 are without health insurance. Of those, only 5,262 are officially classified as being under the poverty line, and over 41% are above 2.00 times the poverty line. The very first line in the table shows those without insurance for which poverty measures are not provided, e.g. foster children. In Delaware, these children would have separate Medicaid eligibility.

Another measure of economic wellbeing is the accumulation of assets. One such measure of that accumulation is home ownership. Those results are found in Figure 3-10. The graph shows that for renters, the percentage of those without coverage is about twice the rate for those who own or are buying their principal place of residence. That pattern is confirmed by the results for the region, which are quite comparable to those reported for Delaware. Certainly, this finding is not unexpected given that renters tend to be younger and have lower incomes, both

Figure 3-10
Percent of Persons without Health Insurance
by Home Ownership and Area

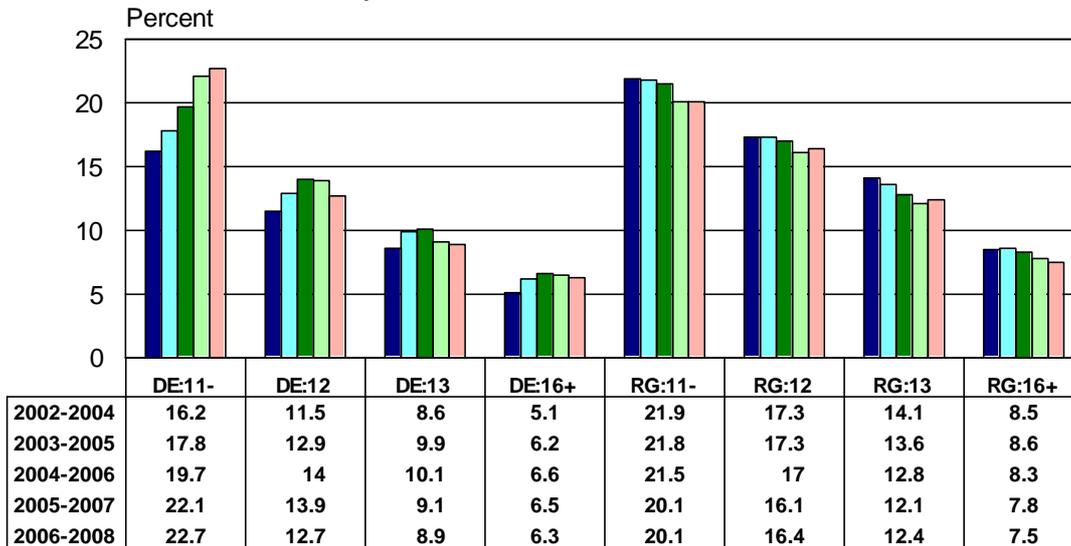


Home Ownership by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Figure 3-11
Percent of Persons without Health Insurance
by Years of Education and Area



Years of Education by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

factors that are correlated with higher risk. They are also less likely to have the assets to continue their insurance privately if there is an interruption in coverage.

The final figure in this section, Figure 3-11 relates the educational level of the respondents and their health insurance status. Education could have two significant effects on health insurance coverage. First, it is possible that more educated people are better able to understand the advantages and disadvantages of health coverage and therefore, make better decisions. More likely, however, education is having an indirect effect with higher education being correlated with higher incomes and better jobs/benefits.

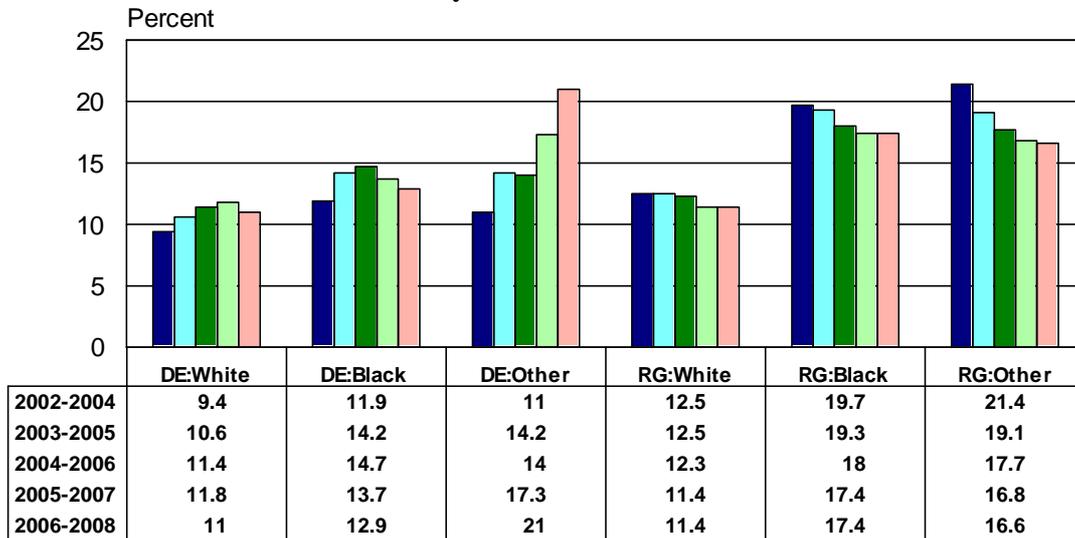
Coverage rates increase significantly as educational level increases. Predictably, those without a high school diploma are the most at risk of being without health insurance. It appears that the most disadvantaged group fares about the same in Delaware (DE) as in the region (RG). The uninsured rate falls 10% for a high school diploma, another 4% for post high school education and finally another 3% for those completing college.

Race and Hispanic Origin

Health insurance coverage or lack thereof within sub-groups of the general population is shown in Figure 3-12 to illustrate the impact of all the underlying contributing variables which determine who has health insurance coverage and who does not. Most of the research in this area suggests that there are significant differences, but do not report any divergence in cultural or risk-taking characteristics that would explain those differences. Thus, the differences are the result of other variables, which themselves differ within segments of the population.

There are significant differences between the three racial groups. Those respondents who classify themselves as black have nearly a 17% higher risk of being without health insurance coverage as those that report being white. African Americans experience significantly lower rates of being uninsured in Delaware (DE) than in the region (RG) and the historical trend has been decreasing for African-Americans. The “other” category includes primarily Native Americans, Asians, those of mixed race, and those who do not find any of the categories listed to be appropriate.

Figure 3-12
Percent of Persons without Health Insurance
by Race and Area

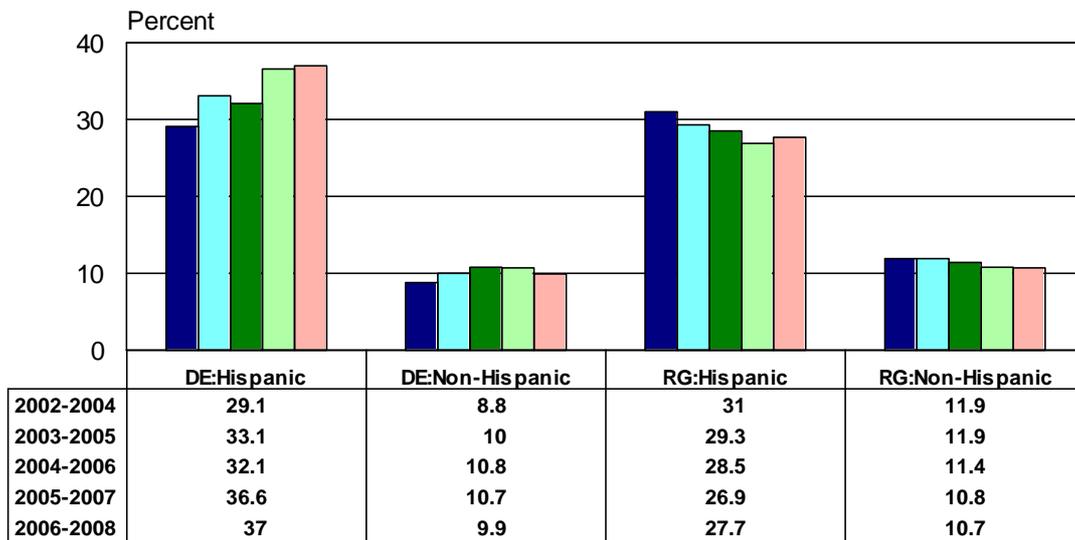


Race by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

Figure 3-13
Percent of Persons without Health Insurance
by Hispanic Origin and Area



Hispanic Origin by Area

■ 2002-2004 ■ 2003-2005 ■ 2004-2006 ■ 2005-2007 ■ 2006-2008

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2002-2008

The results for Hispanic respondents are shown in Figure 3-13. The percentages within Delaware (DE) are quite volatile because of the small sample size, but on average during the period, more than 37% of those respondents who classify themselves as being of Hispanic origin were without health insurance coverage. This rate is more than triple that for non-Hispanics. In 2008, more than 22% of all the uninsured are estimated to be Hispanic. The regional (RG) results are similar to those found in Delaware.

Observations

Those lacking health care coverage in Delaware are a diverse group. This is summarized by the list below. The numbers in the table are the percentages of the uninsured that have the characteristic listed in the first column. The second column references all of the uninsured. Each of the following columns pertains to a different poverty level starting with those who are under the poverty line. All of the estimates are based on the three-year average from 2006 to 2008. The percentages of the poverty level and the approximate income levels of an average household size of 2.6 head the table.

**Table 4-1
Who are the 101,000 Uninsured
by Poverty Level?**

Category	All	0-100% (\$16,160)	100-200% (\$24,240)	200-300% (\$40,400)	300-400% (\$56,560)	400% and over (\$64,640 up)
Working Adults 19+	53.0	34.5	50.8	54.6	62.1	69.5
Male	53.8	42.8	51.7	53.8	61.4	65.0
White	69.1	70.5	71.6	67.6	68.1	66.1
Hispanic	22.3	33.1	30.9	20.0	13.9	5.1
Homeowner	58.4	45.1	45.4	65.6	70.2	76.8
Live alone	20.7	36.7	19.8	14.4	13.3	16.9
Income > \$50k	33.7	0.0	4.5	36.4	66.2	92.9
Self-employed	8.0	5.5	5.3	6.1	9.1	17.8
Non-citizens	20.9	28.1	26.1	18.2	17.4	9.6
Age 0-18	22.6	29.2	27.0	18.5	20.7	14.3
Age 19-34	36.0	35.4	38.2	37.4	30.9	35.4
Age 35-49	24.6	19.9	23.0	26.2	27.7	28.1
Age 50-64	15.6	14.2	11.3	16.7	18.9	19.9
Total Uninsured	101274	20552	27668	22670	13726	16658

Source: Center for Applied Demography & Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 2006-2008

This list illustrates both the complexity of the task of covering the uninsured and the need to use targeted strategies. Since 22.6% of the uninsured are children, efforts to increase the coverage of Medicaid, and the SCHIP program are likely to be effective. There are, however, still an estimated 9,429 children who may never qualify under Medicaid or SCHIP because their parents are above the income limits and yet may still experience periodic unemployment (see Table 4-3). The effectiveness of the program in covering children will depend significantly on the actions taken by the parent(s) of those children. As shown in Table 4-1, 14.3% of those in the 400% + of the poverty level are without health insurance.

Since 53% of the uninsured are working full-time, legislative initiatives that encourage employer offered health coverage may have some effect. It's not clear at this point in time if any plan can help the low wage earner or part-time employee, since the cost of the insurance might represent a huge increase in labor costs. The working poor, in particular those in the 1.0-1.5 category of poverty, are of particular concern. Many of those adults who are working and uninsured are also self-employed.

Age makes a difference. In contrast with those under 18 whose insurance status improves as poverty declines, the 19-34 age group represents just more than a third of uninsured in all of the poverty classes. In comparison, they are currently 20.5% of Delaware's population. Fortunately the expected amount of health care needed is certainly the least. The cost of traditional health insurance almost certainly outweighs the expected benefits. The same cannot be said for those in the 50-64 age group whose probability of requiring hospitalization rises rapidly with age. This pre-Medicare group is probably the one that deserves the most attention.

Table 4-2
Percent of Persons who Changed Insurance Status
between Years One and Two

		Year Two	
		Uninsured	Insured
Year One	Uninsured	4.7%	6.4%
	Insured	5.9%	82.9%

Source: Center for Applied Demography & Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 2004-2008

Dealing with the uninsured is not an easy task because people are continually joining and leaving the ranks of the uninsured (see Table 4-2). This table was developed by matching the same people between two adjacent years, i.e. 2005-2006, 2006-2007, and 2007-2008. The insurance status for each matched individual was examined to produce this table. The table

shows that 82.9% of those matched will have health insurance in both years, and 4.7% will not have health insurance in either year. This means that there is considerable movement in and out of the ranks of the uninsured. It also suggests that a major program that affects everyone to solve the long-term problem of less than 5% of the population should be undertaken with great care.

The final table in the report, Table 4-3, shows the number of uninsured persons by three key characteristics, namely age, poverty status, and employment status. Following the estimates are the existing programs (Medicaid and SCHIP) and potential programs that could possibly alleviate this problem. The total number of the current uninsured that could be assisted and the proportion of the uninsured accounted for are found at the bottom of the table. Currently, nearly 28% of the uninsured are eligible for an existing program but were not enrolled at the time of the survey. Clearly there are people who do not enroll in programs until the need arises, and there will always be processing time when they do enroll.

Approximately 25% of the uninsured are working full-time and are earning wages above 200% of the poverty level. They may either not have access to employer sponsored health insurance or are unwilling to pay their share. This is a group that may best be addressed through employers with or without government assistance. In addition, about 11% of the uninsured are working full-time but clearly do not earn wages sufficient to pay the employee share, and are unlikely to have access to employer sponsored health insurance. Clearly government would have to play a larger role to solve this problem, perhaps with some employer assistance.

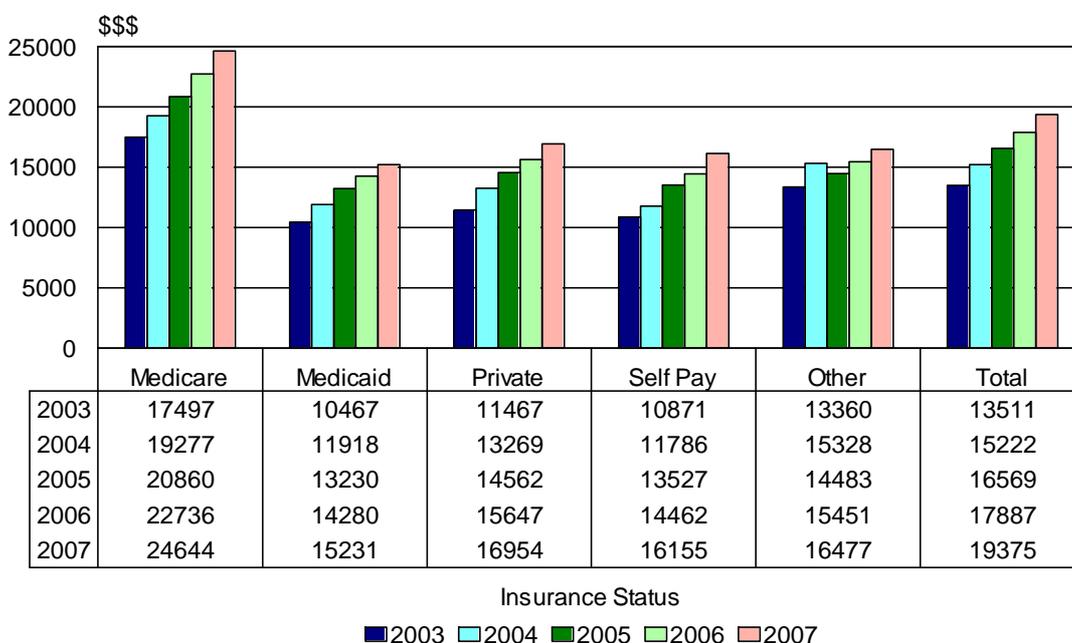
The final group in the table comprises 37% of the uninsured. These are both children and adults who are above the poverty line but who currently do not have full-time employment. In the absence of full-time employment, the average individual has little or no chance to obtain employer-sponsored health insurance. These are the most difficult cases to deal with from a public policy perspective and more than 4,800 of those are in the particularly vulnerable 50-64 age group.

Table 4-3
The Uninsured by Age, Poverty Status, and Employment Status

Characteristics	Estimate	Medicaid	SCHIP	Employers	Emp&Govt	Govt
0-14:Foster Child	740	X				
0-18: 0-100% Poverty	5263	X				
0-18: 100-200% Poverty	7465		X			
0-18: 200% + Poverty	9429					X
19-34: 0-100% Poverty, not FT	4551	X				
19-34: 0-100% Poverty, FT	2729	X				
19-34: 100-200% Poverty, not FT	4782					X
19-34: 100-200% Poverty, FT	5780				X	
19-34: 200%+ Poverty, not FT	8462					X
19-34: 200%+ Poverty, FT	10146			X		
35-49: 0-100% Poverty, not FT	2528	X				
35-49: 0-100% Poverty, FT	1561	X				
35-49: 100-200% Poverty, not FT	2694					X
35-49: 100-200% Poverty, FT	3672				X	
35-49: 200%+ Poverty, not FT	4936					X
35-49: 200%+ Poverty, FT	9478			X		
50-64: 0-100% Poverty, not FT	2439	X				
50-64: 0-100% Poverty, FT	486	X				
50-64: 100-200% Poverty, not FT	1724					X
50-64: 100-200% Poverty, FT	1399				X	
50-64: 200%+ Poverty, not FT	4813					X
50-64: 200%+ Poverty, FT	4904			X		
Total	99981	20298	7465	24528	10851	36839
Percent of Total	100.0%	20.3%	7.5%	24.5%	10.9%	36.8%
65+ uninsured	1291					
All uninsured	101272					

Source: Center for Applied Demography & Survey Research, University of Delaware
 US Bureau of Census, Current Population Survey, March 2006-2008

Figure 4-1
Average Hospital Charges
by Source of Payment



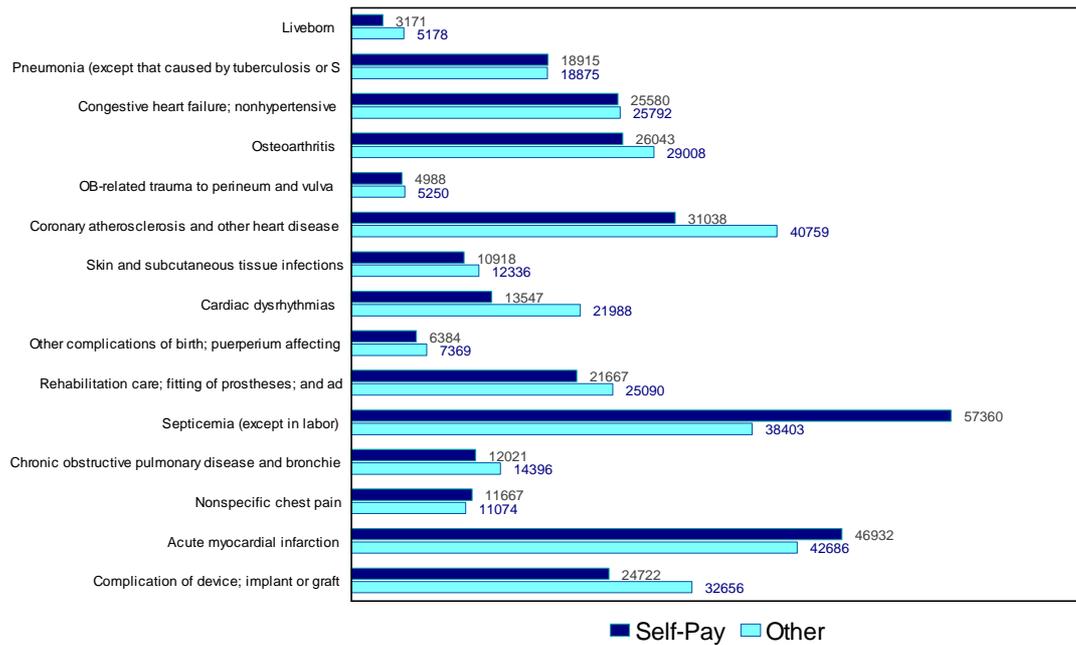
Source: Center for Applied Demography & Survey Research, University of Delaware
 Delaware Health Statistics Center, Hospital Discharge Data System 2003-2007

There are several misperceptions about the uninsured that need to be addressed. One of these is that the uninsured cost more because they are sicker when they present themselves for health care. The logic behind this is that the lack of insurance has caused them to delay seeking care. In Figure 1-7 earlier, there was evidence that suggested that the uninsured adults characterized their own health less positively than the insured population. While the differences were not large, they were present. In order to find more concrete evidence of this claim, the Delaware hospital discharge data from 2003-2007 was analyzed and is displayed in Figure 4-1.

The figure contains the average charges for all discharges by the primary payer. Thus, for example, the average charge for patients using Medicare in 2007 was \$24,644. It was the highest since those patients are the oldest and the most likely to need extensive health care services. The “Self Pay” category is the uninsured. The best comparison group is “Private” since it excludes the poorest and the oldest patients. The average charges for the uninsured were lower by roughly \$800. (The “Other” group includes military and other unclassifiable discharges which represent less than one percent of the discharges.)

A slightly different view is shown in Figure 4-2. This figure compares average charges by the source of payment and primary diagnosis. The costs in the “Self Pay” category are lower than for other types of payments in all but four of fifteen diagnoses.

Figure 4-2
Comparison of Hospital Charges
by Source of Payment and Principal Diagnosis



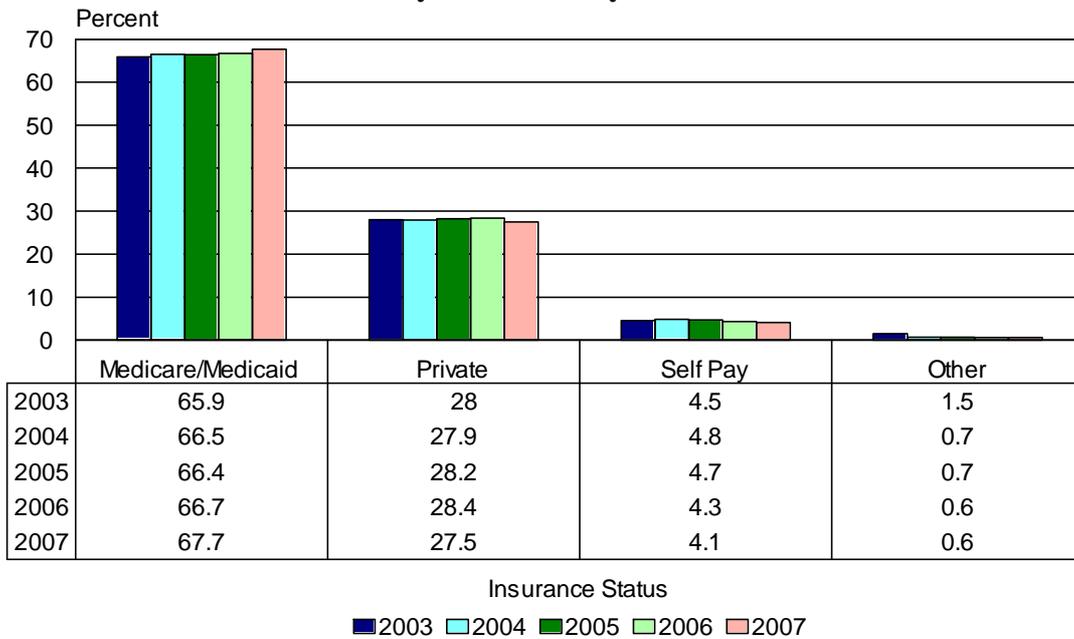
Source: Center for Applied Demography & Survey Research, University of Delaware
 Delaware Health Statistics Center, Hospital Discharge Data System 2007

While there are undoubtedly competing explanations for these results, the simplest is that the lack of health insurance is not necessarily leading to sicker people. This is completely consistent with the earlier findings that more than half of the uninsured have had a physical in the last 12 months and about half of the uninsured currently have a primary care physician. If this is coupled with the fact that 19% of the insured population hasn’t had a physical in the last 12 months and 7% of the insured don’t currently have a primary care physician, having health insurance alone is not a panacea.

Another commonly held view is that the uninsured use the emergency room far more often than those that are insured. Survey data supports this contention. It is difficult to find concrete data for the uninsured in the emergency department since Delaware does not collect out-patient data. However hospital discharge data does provide some insight

into this issue. The percentage of in-patients which originated in the emergency department by source of payment from 2003-2007 is found in Figure 4-3.

Figure 4-3
Percent In-patients Admitted from the Emergency Department
by Source of Payment



Source: Center for Applied Demography & Survey Research, University of Delaware
 Delaware Health Statistics Center, Hospital Discharge Data System 2003-2007

The percentage of in-patients that were admitted from the emergency department and were “self pay” has decreased slightly over the five year period from 4.5% to 4.1%. That provides some idea of the impact of the uninsured on emergency care. Of course that excludes the impact of uninsured out-patients on the ED. Considering that there were 344,000 out-patient visits to emergency departments in Delaware and 107,000 admissions, it might be reasonable to estimate the number of emergency out-patient visits of uninsured as 9,000 or 2.62% which includes the 2,553 admitted to the hospital through the ED. Another way of looking at this issue is to examine the percentage of hospital admissions excluding Medicare patients and compare that to the “self pay” population. In 2008, the uninsured averaged 101,000 and the population 0-64 averaged 744,000 yielding 14.4%. On the other hand, the “self pay” account for roughly 8.2% of the hospital admissions (less Medicare) through the ED. In other words, the uninsured are less likely to use the ED than the insured. The most likely reason is that the uninsured are younger and the costs of that visit are known to be high.

It is also believed that the uninsured receive their health care for free. Nothing could be further from the truth. The uninsured are truly “self pay” which means they get the opportunity to pay list price for services they receive. In the insured’s typical health care encounter, the provider sends their “charges” to the 3rd party payer and the insurance company decides how much they will pay the provider less any co-pay from the individual. On average, the insurance company will pay about a third of the provider’s charges. If the provider is under contract with the insurance company then they must accept the lower payment. At this point the claim is considered adjudicated.

If you are uninsured, the provider is permitted to send you the full bill. Granted some may use a sliding scale and reduce the bill according to your income. Others may allow you to budget your payments over time. There is no 3rd party payer to act as an adjudicator as to the appropriateness of the bill or the care rendered. The bill will be treated as any other and it may end up with a collection agency. In the worse cases people will declare bankruptcy. In a recent study in Health Affairs (5 February 2008) by Melnick and Fonkych, the uninsured were estimated to pay a larger share of the bill (29%) than either Medicaid (Medi-Cal) (23%) and Medicare (27%). Third-party payers were highest with 38%. In any event, health care is not free to the uninsured. In fact, the cost-shift reduction, if any, since the contribution to cost shift pales in contrast to Medicaid and Medicare is likely to be small. Both of those programs are larger than the uninsured and have far greater health care needs.

While the uninsured appear to be paying similar amounts as the insured, the uninsured are exposed to far higher bills that may lead to lowered credit ratings and even bankruptcy. One approach that may have some merit is to provide a centralized administrative service whereby the claims on the uninsured could be adjudicated by a third party. The objective would be to make sure that the uninsured paid the market price and not the list price for health care services.

The final topic is the question of access to health care for the uninsured and by extension, to all of those with health insurance. Health insurance alone does not guarantee access. Many of those sitting in the typical ED in the evening probably heard a message on their primary care providers answering machine that told them to call back during regular business hours or in the case of an emergency, go to the emergency room. Others will have called during normal business hours and were told that the doctor was not available, or that the next open appointment was in two weeks. If immediate care was needed, they were instructed to go to the emergency room. These situations are repeated many times on a daily basis.

Several factors are influencing this situation. The population is aging and with age the number, frequency, and intensity of health care problems grows. The state also is experiencing increasing numbers of in-migrants who must find their way to a new primary care physician. The primary care physician population is aging and newly minted physicians are finding opportunities as hospitalists in greater numbers slowing the growth in private practice primary care. Third, the cost of health care continues to rise largely due to more and better technologies and techniques. Fourth, the productivity gains that usually accompany new advances are not widespread in the health care field.

The federally qualified health centers (FQHC) and the medical aid units operated largely by the hospitals have tried to address some of the access issues and with some success. Both of these options are in population dense settings or located near or at hospitals. The primary care physicians are far more spatially distributed and are not major players in these approaches. However, these operations have characteristics that would improve access. In particular, there are generally Saturday and evening hours. There are sliding scales for the uninsured. In some instances appointments are not required.

There are many ways to address the issues of access, physician recruitment and retention, and increased productivity. A proactive approach might include a public-private partnership to develop several linked health care centers in key areas. The partners would be primary care physicians in private practice in the region. It would not replace their current practices. The objective would be to handle overflow patients in the individual practices, in particular during evening and weekend hours, but also for walk-in patients. This would enable aging physicians in general to keep their practices open during vacations, illnesses, or just generally reducing hours. These physicians would treat the health care center as a second practice site. The health care center could also be used as a place to attract new primary care physicians who are reluctant or unable to set up a new site; in effect an incubator for new practices. The health care center would make maximum use of advance practice nurses and physician assistants who could connect with member primary care physicians over the Web. The potential for networked electronic medical records systems avoiding the high cost for small practices and centralized medical case management with aggressive follow-up could lead to the gains in productivity that have been lacking.

Another promising solution proposed is to encourage or require applicants for an urgent care center to co-locate with a primary care practice.

In summary, the number of uninsured is a problem but there are many other issues that in the long run are even more important. The increasing lack of access, exacerbated by an aging population, increasing need for health care, and an impending shortage of primary care physicians, will ultimately prove more important.

APPENDIX A

Health Insurance Coverage 2007

US Bureau of Census

2008 March Current Population Survey

APPENDIX C. ESTIMATES OF HEALTH INSURANCE COVERAGE

Quality of Health Insurance Coverage Estimates

National surveys and health insurance coverage. Health insurance coverage is likely to be underreported on the Current Population Survey (CPS). While underreporting affects most, if not all, surveys, underreporting of health insurance coverage in the Annual Social and Economic Supplement (ASEC) appears to be a larger problem than in other national surveys that ask about insurance. Some reasons for the disparity may include the fact that income, not health insurance, is the main focus of the ASEC questionnaire. In addition, the ASEC collects health insurance information by asking in February through April about the previous year's coverage. Asking annual retrospective questions appears to cause few problems when collecting income data (possibly because the interview period is close to when people pay their taxes), but it may be less than ideal when asking about health insurance coverage. Compared with other national surveys, the CPS estimate of the number of people without health insurance more closely approximates the number of people who are uninsured at a specific point in time during the year than the number of people uninsured for the entire year. For a comparison of health insurance coverage rates from the major federal surveys, see *How Many People Lack Insurance and for How Long?* (Congressional Budget Office, May 2003).

Reporting of coverage through major federal health insurance programs.

The CPS ASEC data underreport Medicare and Medicaid coverage compared with enrollment and participation data from the Centers for Medicare and Medicaid Services

(CMS).³⁹ Because the CPS is largely a labor force survey, interviewers receive less training on health insurance concepts than labor concepts. Additionally, many people may not be aware that a health insurance program covers them or their children if they have not used covered services recently. CMS data, on the other hand, represent the actual number of people who have enrolled or participated in these programs.

The State Health Access Data Assistance Center (SHADAC) of the University of Minnesota has worked with the U.S. Census Bureau, CMS, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) on a research project to evaluate why CPS ASEC estimates of the number of people with Medicaid are lower than counts of the number of people enrolled in the program from CMS. Reports from Phases 1 and 2 of the research project are available from the Census Bureau's Web site at <www.census.gov/did/www/shadac/shadac.html>.

During Phase 2, files from the Medicaid Statistical Information System (MSIS) were linked with the CPS ASEC files and individual records compared. A key finding indicating survey response error in the CPS ASEC was that 16.9 percent of people with an MSIS record indicating Medicaid coverage reported in the CPS ASEC that they were uninsured.⁴⁰ The report found that those with longer and more recent Medicaid

enrollment were more likely to report coverage. Respondents for enrolled children were more apt to report coverage for those children than for adults enrolled. Families with lower incomes tended to report coverage more frequently. Individuals who received Medicaid services during the reporting cycle tended to report coverage more often than individuals who had not received services. Reporting differences were also apparent from state to state.

Last year, SHADAC released an imputation adjustment for the 2007 public-use CPS ASEC microdata that are available to the public through the Minnesota Population Center's IPUMS-CPS Web site to help researchers interested in partially adjusting the CPS ASEC data.⁴¹ This is an experimental imputation, and it is being produced for interested parties to use in their research. The Census Bureau has not evaluated the methodology, and users should be aware that this is not an official data product.

There are several ongoing projects aimed at improving the quality of health coverage data from the CPS ASEC. This research includes: 1) cognitive research to improve the wording of the CPS ASEC health coverage questions; 2) editing and imputation research, including additional research on the use of models that attempt to account for Medicaid underreporting; and 3) expanding the number of studies that match administrative Medicaid data to current survey data to include other surveys, such as the National Health Interview Survey (NHIS) and the American Community Survey (ACS). Through this research, it will be possible to compare and contrast CPS ASEC

³⁹ CMS is the federal agency primarily responsible for administering the Medicare and Medicaid programs at the national level.

⁴⁰ For consistency purposes across the MSIS and the CPS, SHADAC removed all MSIS enrollees who received only partial coverage, those who had died before the CPS reporting cycle, and all duplicate person records. Also, all State Children's Health Insurance Program (SCHIP) enrollees were removed from the MSIS count.

⁴¹ The IPUMS-CPS Web site is available at <cps.ipums.org/cps/>.

underreporting rates with other surveys, which will, in turn, allow Census Bureau analysts to better understand the nature and impact of CPS ASEC health coverage underreporting.

Changes in Medicaid coverage estimates from one year to the next should be viewed with caution. Because many people who are covered by Medicaid do not report that coverage, the Census Bureau assigns coverage to those who are generally regarded as “categorically eligible”

(those who received some other benefits, usually public assistance payments, that make them eligible for Medicaid). Since the number of people receiving public assistance has been dropping, the relationship between Medicaid coverage and public assistance has changed, causing the imputation process to introduce a downward bias in the most recent Medicaid estimates.

After consulting with health insurance experts, the Census Bureau modified

the definition of the population without health insurance in the supplement to the March 1998 CPS, which collected data about coverage in 1997. Previously, people with no coverage other than access to the Indian Health Service were counted as part of the insured population. Subsequently, the Census Bureau has counted these people as uninsured. The effect of this change on the overall estimates of health insurance coverage was negligible.

Table C-1.
Health Insurance Coverage: 1987 to 2007

(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apsd/techdoc/cps/cpsmar08.pdf)

Year	Total people	Covered by private and/or government health insurance								Not covered
		Total	Private health insurance			Government health insurance				
			Total	Employment-based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹	
Number										
2007	299,106	253,449	201,991	177,446	26,673	83,031	39,554	41,375	10,955	45,657
2006	296,824	249,829	201,690	177,152	27,066	80,270	38,281	40,343	10,547	46,995
2005 ²	293,834	249,020	201,167	176,924	27,055	80,213	38,104	40,177	11,166	44,815
2004 ²	291,166	247,669	200,924	176,247	27,551	79,486	37,955	39,703	10,789	43,498
2003	288,280	244,876	199,871	175,844	26,783	76,755	35,647	39,456	9,979	43,404
2002	285,933	243,914	200,891	177,095	26,846	73,624	33,246	38,448	10,063	42,019
2001	282,082	242,322	201,695	178,261	26,309	71,295	31,601	38,043	9,552	39,760
2000 ³	279,517	241,091	202,794	179,436	26,799	69,037	29,533	37,740	9,099	38,426
1999 ⁴	276,804	238,037	200,721	176,838	27,731	67,683	28,506	36,923	8,648	38,767
1999	274,087	233,073	196,536	171,692	27,298	66,176	27,890	36,066	8,530	41,014
1998	271,743	228,800	192,507	170,105	26,165	66,087	27,854	35,887	8,747	42,943
1997 ⁵	269,094	226,735	189,955	166,419	27,431	66,685	28,956	35,590	8,527	42,359
1996 ⁶	266,792	225,699	188,224	164,096	28,419	69,000	31,451	35,227	8,712	41,093
1995	264,314	223,733	185,881	161,453	30,188	69,776	31,877	34,655	9,375	40,582
1994 ⁷	262,105	222,387	184,318	159,634	31,349	70,163	31,645	33,901	11,165	39,718
1993 ⁸	259,753	220,040	182,351	148,318	(NA)	68,554	31,749	33,097	9,560	39,713
1992 ⁹	256,830	218,189	181,466	148,796	(NA)	66,244	29,416	33,230	9,510	38,641
1991	251,447	216,003	181,375	150,077	(NA)	63,882	26,880	32,907	9,820	35,445
1990	248,886	214,167	182,135	150,215	(NA)	60,965	24,261	32,260	9,922	34,719
1989	246,191	212,807	183,610	151,644	(NA)	57,382	21,185	31,495	9,870	33,385
1988	243,685	211,005	182,019	150,940	(NA)	56,850	20,728	30,925	10,105	32,680
1987 ¹⁰	241,187	210,161	182,160	149,739	(NA)	56,282	20,211	30,458	10,542	31,026
Percent										
2007	100.0	84.7	67.5	59.3	8.9	27.8	13.2	13.8	3.7	15.3
2006	100.0	84.2	67.9	59.7	9.1	27.0	12.9	13.6	3.6	15.8
2005 ²	100.0	84.7	68.5	60.2	9.2	27.3	13.0	13.7	3.8	15.3
2004 ²	100.0	85.1	69.0	60.5	9.5	27.3	13.0	13.6	3.7	14.9
2003	100.0	84.9	69.3	61.0	9.3	26.6	12.4	13.7	3.5	15.1
2002	100.0	85.3	70.3	61.9	9.4	25.7	11.6	13.4	3.5	14.7
2001	100.0	85.9	71.5	63.2	9.3	25.3	11.2	13.5	3.4	14.1
2000 ³	100.0	86.3	72.6	64.2	9.6	24.7	10.6	13.5	3.3	13.7
1999 ⁴	100.0	86.0	72.5	63.9	10.0	24.5	10.3	13.3	3.1	14.0
1999	100.0	85.0	71.7	62.6	9.9	24.1	10.2	13.2	3.1	15.0
1998	100.0	84.2	70.8	62.6	9.6	24.3	10.3	13.2	3.2	15.8
1997 ⁵	100.0	84.3	70.6	61.8	10.2	24.8	10.8	13.2	3.2	15.7
1996 ⁶	100.0	84.6	70.6	61.5	10.7	25.9	11.8	13.2	3.3	15.4
1995	100.0	84.6	70.3	61.1	11.4	26.4	12.1	13.1	3.5	15.4
1994 ⁷	100.0	84.8	70.3	60.9	12.0	26.8	12.1	12.9	4.3	15.2
1993 ⁸	100.0	84.7	70.2	57.1	(NA)	26.4	12.2	12.7	3.7	15.3
1992 ⁹	100.0	85.0	70.7	57.9	(NA)	25.8	11.5	12.9	3.7	15.0
1991	100.0	85.9	72.1	59.7	(NA)	25.4	10.7	13.1	3.9	14.1
1990	100.0	86.1	73.2	60.4	(NA)	24.5	9.7	13.0	4.0	13.9
1989	100.0	86.4	74.6	61.6	(NA)	23.3	8.6	12.8	4.0	13.6
1988	100.0	86.6	74.7	61.9	(NA)	23.3	8.5	12.7	4.1	13.4
1987 ¹⁰	100.0	87.1	75.5	62.1	(NA)	23.3	8.4	12.6	4.4	12.9

(NA) Not available. Respondents were not asked detailed health insurance questions about direct-purchase coverage before the 1995 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC).

¹ Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Health and Medical Program of the Department of Veterans Affairs and care provided by the Department of Veterans Affairs and the military.

² The 2004 and 2005 data were revised in March 2007. See www.census.gov/hhes/www/hlthins/usernote/schedule.html.

³ Implementation of a 28,000 household sample expansion.

⁴ Estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.

⁵ Beginning with the 1998 CPS ASEC, people with no coverage other than access to Indian Health Service are no longer considered covered by health insurance; instead, they are considered to be uninsured. The effect of this change on the overall estimates of health insurance coverage is negligible; however, the decrease in the number of people covered by Medicaid may be partially due to this change.

⁶ The data for 1996 through 2003 were constructed for consistency with the revision to the 2004 and 2005 estimates. As a result, they do not match the previously published estimates. To see the original series, see Table C-1 in *Income, Poverty, and Health Insurance Coverage in the United States: 2005* at www.census.gov/prod/2006pubs/p60-231.pdf.

⁷ Health insurance questions were redesigned. Increases in estimates of employment-based and military health care coverage may be partially due to questionnaire changes. Overall coverage estimates were not affected.

⁸ Data collection method changed from paper and pencil to computer-assisted interviewing.

⁹ Implementation of 1990 census population controls.

¹⁰ Implementation of a new CPS ASEC processing system.

Source: U.S. Census Bureau, Current Population Survey, 1988 to 2008 Annual Social and Economic Supplements.

Table C-2.
Health Insurance Coverage by Race and Hispanic Origin: 1999 to 2007

(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apso/techdoc/cps/cpsmar08.pdf)

Race, Hispanic origin, and year	Total people	Covered by private and/or government health insurance							Not covered	
		Private health insurance			Government health insurance					
		Total	Employment based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹		
ALL RACES										
Number										
2007	299,106	253,449	201,991	177,446	26,673	83,031	39,554	41,375	10,955	45,657
2006	296,824	249,829	201,690	177,152	27,066	80,270	38,281	40,343	10,547	46,995
2005 ²	293,834	249,020	201,167	176,924	27,055	80,213	38,104	40,177	11,166	44,815
2004 ²	291,166	247,669	200,924	176,247	27,551	79,486	37,955	39,703	10,789	43,498
2003	288,280	244,876	199,871	175,844	26,783	76,755	35,647	39,456	9,979	43,404
2002	285,933	243,914	200,891	177,095	26,846	73,624	33,246	38,448	10,063	42,019
2001	282,082	242,322	201,695	178,261	26,309	71,295	31,601	38,043	9,552	39,760
2000 ³	279,517	241,091	202,794	179,436	26,799	69,037	29,533	37,740	9,099	38,426
1999	276,804	238,037	200,721	176,838	27,731	67,683	28,506	36,923	8,648	38,767
Percent										
2007	100.0	84.7	67.5	59.3	8.9	27.8	13.2	13.8	3.7	15.3
2006	100.0	84.2	67.9	59.7	9.1	27.0	12.9	13.6	3.6	15.8
2005 ²	100.0	84.7	68.5	60.2	9.2	27.3	13.0	13.7	3.8	15.3
2004 ²	100.0	85.1	69.0	60.5	9.5	27.3	13.0	13.6	3.7	14.9
2003	100.0	84.9	69.3	61.0	9.3	26.6	12.4	13.7	3.5	15.1
2002	100.0	85.3	70.3	61.9	9.4	25.7	11.6	13.4	3.5	14.7
2001	100.0	85.9	71.5	63.2	9.3	25.3	11.2	13.5	3.4	14.1
2000 ³	100.0	86.3	72.6	64.2	9.6	24.7	10.6	13.5	3.3	13.7
1999	100.0	86.0	72.5	63.9	10.0	24.5	10.3	13.3	3.1	14.0
WHITE ALONE⁴										
Number										
2007	239,399	205,099	167,905	146,398	23,433	64,390	27,172	35,117	8,852	34,300
2006	237,892	202,405	167,640	146,285	23,530	62,613	26,507	34,416	8,621	35,486
2005 ²	235,903	201,957	167,430	146,365	23,452	62,138	25,968	34,326	9,020	33,946
2004 ²	234,116	201,095	167,475	145,890	23,997	61,572	25,888	34,061	8,623	33,022
2003	232,254	199,537	167,503	146,300	23,483	59,495	23,959	33,765	8,105	32,717
2002	230,809	199,392	168,745	147,706	23,686	57,072	22,171	33,135	8,065	31,417
Percent										
2007	100.0	85.7	70.1	61.2	9.8	26.9	11.4	14.7	3.7	14.3
2006	100.0	85.1	70.5	61.5	9.9	26.3	11.1	14.5	3.6	14.9
2005 ²	100.0	85.6	71.0	62.0	9.9	26.3	11.0	14.6	3.8	14.4
2004 ²	100.0	85.9	71.5	62.3	10.2	26.3	11.1	14.5	3.7	14.1
2003	100.0	85.9	72.1	63.0	10.1	25.6	10.3	14.5	3.5	14.1
2002	100.0	86.4	73.1	64.0	10.3	24.7	9.6	14.4	3.5	13.6
WHITE⁵										
Number										
2001	230,071	200,073	170,710	149,788	23,333	56,200	21,535	33,006	7,788	29,998
2000 ³	228,208	199,280	171,543	150,708	23,722	54,287	19,889	32,695	7,158	28,928
1999	225,794	197,137	170,289	149,024	24,458	53,175	18,977	32,144	6,902	28,657
Percent										
2001	100.0	87.0	74.2	65.1	10.1	24.4	9.4	14.3	3.4	13.0
2000 ³	100.0	87.3	75.2	66.0	10.4	23.8	8.7	14.3	3.1	12.7
1999	100.0	87.3	75.4	66.0	10.8	23.6	8.4	14.2	3.1	12.7

See footnotes at end of table.

Table C-2.

Health Insurance Coverage by Race and Hispanic Origin: 1999 to 2007—Con.(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apsd/techdoc/cps/cpsmar08.pdf)

Race, Hispanic origin, and year	Total people	Covered by private and/or government health insurance								Not covered
		Private health insurance				Government health insurance				
		Total	Employment based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹		
WHITE ALONE, NOT HISPANIC										
Number										
2007	196,768	176,220	149,122	129,138	21,717	52,512	17,786	32,436	8,131	20,548
2006	196,252	175,091	149,592	129,618	22,068	51,445	17,731	31,860	7,869	21,162
2005 ²	195,893	174,984	149,613	130,075	21,724	51,189	17,396	31,717	8,276	20,909
2004 ²	195,347	174,793	149,882	129,766	22,346	51,002	17,462	31,624	8,005	20,554
2003	194,877	174,409	150,563	130,614	22,090	49,743	16,247	31,458	7,563	20,468
2002	194,421	174,747	151,812	132,101	22,291	47,736	14,984	30,718	7,465	19,674
Percent										
2007	100.0	89.6	75.8	65.6	11.0	26.7	9.0	16.5	4.1	10.4
2006	100.0	89.2	76.2	66.0	11.2	26.2	9.0	16.2	4.0	10.8
2005 ²	100.0	89.3	76.4	66.4	11.1	26.1	8.9	16.2	4.2	10.7
2004 ²	100.0	89.5	76.7	66.4	11.4	26.1	8.9	16.2	4.1	10.5
2003	100.0	89.5	77.3	67.0	11.3	25.5	8.3	16.1	3.9	10.5
2002	100.0	89.9	78.1	67.9	11.5	24.6	7.7	15.8	3.8	10.1
WHITE, NOT HISPANIC										
Number										
2001	194,822	176,488	154,218	134,586	22,009	47,661	15,035	30,811	7,144	18,333
2000 ³	193,931	176,279	155,152	135,472	22,476	46,297	13,788	30,642	6,564	17,652
1999	192,858	175,045	154,407	134,436	23,110	45,540	13,157	30,256	6,326	17,813
Percent										
2001	100.0	90.6	79.2	69.1	11.3	24.5	7.7	15.8	3.7	9.4
2000 ³	100.0	90.9	80.0	69.9	11.6	23.9	7.1	15.8	3.4	9.1
1999	100.0	90.8	80.1	69.7	12.0	23.6	6.8	15.7	3.3	9.2
BLACK ALONE OR IN COMBINATION										
Number										
2007	39,683	32,059	21,226	19,498	1,771	13,985	9,606	4,398	1,445	7,624
2006	39,083	31,162	20,966	19,257	1,835	13,121	9,086	4,127	1,289	7,921
2005 ²	38,729	31,491	20,935	19,146	2,009	13,864	9,730	4,184	1,438	7,239
2004 ²	38,179	31,077	20,800	19,144	1,909	13,623	9,562	3,996	1,492	7,103
2003	37,651	30,543	20,376	18,885	1,773	13,195	9,292	4,080	1,283	7,108
2002	37,350	30,093	20,440	19,038	1,638	12,624	8,744	3,851	1,342	7,257
Percent										
2007	100.0	80.8	53.5	49.1	4.5	35.2	24.2	11.1	3.6	19.2
2006	100.0	79.7	53.6	49.3	4.7	33.6	23.2	10.6	3.3	20.3
2005 ²	100.0	81.3	54.1	49.4	5.2	35.8	25.1	10.8	3.7	18.7
2004 ²	100.0	81.4	54.5	50.1	5.0	35.7	25.0	10.5	3.9	18.6
2003	100.0	81.1	54.1	50.2	4.7	35.0	24.7	10.8	3.4	18.9
2002	100.0	80.6	54.7	51.0	4.4	33.8	23.4	10.3	3.6	19.4
BLACK ALONE⁶										
Number										
2007	37,775	30,403	20,169	18,525	1,691	13,234	8,986	4,303	1,358	7,372
2006	37,369	29,717	20,034	18,401	1,766	12,454	8,531	4,059	1,216	7,652
2005 ²	36,965	29,959	19,950	18,263	1,918	13,168	9,154	4,108	1,357	7,006
2004 ²	36,548	29,684	19,899	18,352	1,803	12,995	9,048	3,921	1,415	6,864
2003	36,121	29,234	19,552	18,135	1,701	12,585	8,797	3,989	1,225	6,887
2002	35,806	28,744	19,544	18,193	1,589	12,058	8,289	3,776	1,268	7,062
Percent										
2007	100.0	80.5	53.4	49.0	4.5	35.0	23.8	11.4	3.6	19.5
2006	100.0	79.5	53.6	49.2	4.7	33.3	22.8	10.9	3.3	20.5
2005 ²	100.0	81.0	54.0	49.4	5.2	35.6	24.8	11.1	3.7	19.0
2004 ²	100.0	81.2	54.4	50.2	4.9	35.6	24.8	10.7	3.9	18.8
2003	100.0	80.9	54.1	50.2	4.7	34.8	24.4	11.0	3.4	19.1
2002	100.0	80.3	54.6	50.8	4.4	33.7	23.1	10.5	3.5	19.7

See footnotes at end of table.

Table C-2.

Health Insurance Coverage by Race and Hispanic Origin: 1999 to 2007—Con.(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/aprd/techdoc/cps/cpsmar08.pdf)

Race, Hispanic origin, and year	Total people	Covered by private and/or government health insurance								Not covered
		Total	Private health insurance			Government health insurance				
			Total	Employment based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹	
BLACK⁵										
Number										
2001	36,023	29,359	20,569	19,177	1,713	11,616	7,994	3,783	1,192	6,664
2000 ³	35,597	29,065	20,652	19,075	1,910	11,579	7,735	3,871	1,372	6,532
1999	35,893	28,918	20,638	19,039	2,118	11,361	7,652	3,615	1,216	6,975
Percent										
2001	100.0	81.5	57.1	53.2	4.8	32.2	22.2	10.5	3.3	18.5
2000 ³	100.0	81.7	58.0	53.6	5.4	32.5	21.7	10.9	3.9	18.3
1999	100.0	80.6	57.5	53.0	5.9	31.7	21.3	10.1	3.4	19.4
ASIAN ALONE OR IN COMBINATION										
Number										
2007	14,444	12,122	9,995	8,951	1,216	2,888	1,659	1,238	379	2,321
2006	14,348	12,188	10,222	9,033	1,387	2,859	1,616	1,227	404	2,160
2005 ²	13,758	11,472	9,886	8,788	1,272	2,558	1,341	1,133	461	2,286
2004 ²	13,307	11,276	9,611	8,428	1,342	2,599	1,389	1,110	440	2,031
2003	12,905	10,577	8,908	7,891	1,181	2,478	1,385	1,096	355	2,329
2002	12,504	10,332	8,728	7,652	1,208	2,341	1,322	1,008	347	2,172
Percent										
2007	100.0	83.9	69.2	62.0	8.4	20.0	11.5	8.6	2.6	16.1
2006	100.0	84.9	71.2	63.0	9.7	19.9	11.3	8.6	2.8	15.1
2005 ²	100.0	83.4	71.9	63.9	9.2	18.6	9.7	8.2	3.3	16.6
2004 ²	100.0	84.7	72.2	63.3	10.1	19.5	10.4	8.3	3.3	15.3
2003	100.0	82.0	69.0	61.1	9.2	19.2	10.7	8.5	2.7	18.0
2002	100.0	82.6	69.8	61.2	9.7	18.7	10.6	8.1	2.8	17.4
ASIAN ALONE⁷										
Number										
2007	13,268	11,034	9,067	8,107	1,127	2,649	1,528	1,195	296	2,234
2006	13,194	11,149	9,339	8,201	1,323	2,636	1,480	1,187	335	2,045
2005 ²	12,599	10,438	9,006	7,968	1,206	2,301	1,211	1,103	353	2,161
2004 ²	12,241	10,341	8,805	7,711	1,250	2,398	1,280	1,081	366	1,900
2003	11,869	9,698	8,210	7,263	1,111	2,244	1,229	1,067	295	2,171
2002	11,558	9,499	8,024	7,004	1,151	2,132	1,202	988	270	2,060
Percent										
2007	100.0	83.2	68.3	61.1	8.5	20.0	11.5	9.0	2.2	16.8
2006	100.0	84.5	70.8	62.2	10.0	20.0	11.2	9.0	2.5	15.5
2005 ²	100.0	82.8	71.5	63.2	9.6	18.3	9.6	8.8	2.8	17.2
2004 ²	100.0	84.5	71.9	63.0	10.2	19.6	10.5	8.8	3.0	15.5
2003	100.0	81.7	69.2	61.2	9.4	18.9	10.4	9.0	2.5	18.3
2002	100.0	82.2	69.4	60.6	10.0	18.4	10.4	8.5	2.3	17.8
ASIAN AND PACIFIC ISLANDER⁵										
Number										
2001	12,500	10,291	8,716	7,748	1,099	2,312	1,257	949	414	2,208
2000 ³	12,693	10,473	8,993	8,178	1,005	2,249	1,288	886	443	2,220
1999	11,964	9,769	8,299	7,426	982	2,204	1,179	897	450	2,196
Percent										
2001	100.0	82.3	69.7	62.0	8.8	18.5	10.1	7.6	3.3	17.7
2000 ³	100.0	82.5	70.9	64.4	7.9	17.7	10.1	7.0	3.5	17.5
1999	100.0	81.6	69.4	62.1	8.2	18.4	9.9	7.5	3.8	18.4

See footnotes at end of table.

Table C-2.

Health Insurance Coverage by Race and Hispanic Origin: 1999 to 2007—Con.

(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apsd/techdoc/cps/cpsmar08.pdf)

Race, Hispanic origin, and year	Total people	Covered by private and/or government health insurance								Not covered
		Private health insurance				Government health insurance				
		Total	Employment based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹		
HISPANIC (any race)										
Number										
2007	46,026	31,256	20,194	18,551	1,804	13,031	10,348	2,887	801	14,770
2006	44,854	29,558	19,434	17,934	1,587	12,207	9,646	2,757	813	15,296
2005 ²	43,168	29,214	19,252	17,597	1,856	11,958	9,357	2,771	869	13,954
2004 ²	41,840	28,527	19,090	17,499	1,788	11,530	9,205	2,614	697	13,313
2003	40,425	27,355	18,372	16,970	1,559	10,716	8,505	2,462	639	13,070
2002	39,384	26,815	18,324	16,921	1,481	10,280	7,946	2,535	724	12,569
2001	37,438	25,146	17,460	16,096	1,401	9,227	7,074	2,295	704	12,292
2000 ³	36,093	24,340	17,264	16,031	1,354	8,566	6,552	2,141	682	11,753
1999	34,773	23,445	16,786	15,419	1,414	8,168	6,253	1,979	626	11,328
Percent										
2007	100.0	67.9	43.9	40.3	3.9	28.3	22.5	6.3	1.7	32.1
2006	100.0	65.9	43.3	40.0	3.5	27.2	21.5	6.1	1.8	34.1
2005 ²	100.0	67.7	44.6	40.8	4.3	27.7	21.7	6.4	2.0	32.3
2004 ²	100.0	68.2	45.6	41.8	4.3	27.6	22.0	6.2	1.7	31.8
2003	100.0	67.7	45.4	42.0	3.9	26.5	21.0	6.1	1.6	32.3
2002	100.0	68.1	46.5	43.0	3.8	26.1	20.2	6.4	1.8	31.9
2001	100.0	67.2	46.6	43.0	3.7	24.6	18.9	6.1	1.9	32.8
2000 ³	100.0	67.4	47.8	44.4	3.8	23.7	18.2	5.9	1.9	32.6
1999	100.0	67.4	48.3	44.3	4.1	23.5	18.0	5.7	1.8	32.6

¹ Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Health and Medical Program of the Department of Veterans Affairs and care provided by the Department of Veterans Affairs and the military.

² The 2004 and 2005 data were revised in March 2007. See <www.census.gov/hhes/www/hlthins/usernote/schedule.html>.

³ Implementation of a 28,000 household sample expansion.

⁴ The 2003 CPS asked respondents to choose one or more races. White alone refers to people who reported White and did not report any other race category. The use of this single-race population does not imply that it is the preferred method of presenting or analyzing data. The Census Bureau uses a variety of approaches. Information on people who reported more than one race, such as White **and** American Indian and Alaska Native or Asian **and** Black or African American, is available from Census 2000 through American FactFinder. About 2.6 percent of people reported more than one race in Census 2000.

⁵ The 2001 CPS and earlier years asked respondents to report only one race. The reference groups for these years are White, White not Hispanic, Black, and Asian and Pacific Islander.

⁶ Black alone refers to people who reported Black or African American and did not report any other race.

⁷ Asian alone refers to people who reported Asian and did not report any other race.

Note: All years reflect the implementation of the verification question. The data for 1999 through 2003 were revised using an approximation method for consistency with the revision to the 2004 and 2005 estimates. To see the original series, see Table C-1 in *Income, Poverty, and Health Insurance Coverage in the United States: 2005* at <www.census.gov/prod/2006pubs/p60-231.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2000 to 2008 Annual Social and Economic Supplements.

Table C-3.
Health Insurance Coverage by Age: 1999 to 2007

(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/aprd/techdoc/cps/cpsmar08.pdf)

Age	Total people	Covered by private and/or government health insurance								Not covered
		Total	Private health insurance			Government health insurance				
			Total	Employment based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹	
ALL AGES										
Number										
2007	299,106	253,449	201,991	177,446	26,673	83,031	39,554	41,375	10,955	45,657
2006	296,824	249,829	201,690	177,152	27,066	80,270	38,281	40,343	10,547	46,995
2005 ²	293,834	249,020	201,167	176,924	27,055	80,213	38,104	40,177	11,166	44,815
2004 ²	291,166	247,669	200,924	176,247	27,551	79,486	37,955	39,703	10,789	43,498
2003	288,280	244,876	199,871	175,844	26,783	76,755	35,647	39,456	9,979	43,404
2002	285,933	243,914	200,891	177,095	26,846	73,624	33,246	38,448	10,063	42,019
2001	282,082	242,322	201,695	178,261	26,309	71,295	31,601	38,043	9,552	39,760
2000 ³	279,517	241,091	202,794	179,436	26,799	69,037	29,533	37,740	9,099	38,426
1999 ⁴	276,804	238,037	200,721	176,838	27,731	67,683	28,506	36,923	8,648	38,767
Percent										
2007	100.0	84.7	67.5	59.3	8.9	27.8	13.2	13.8	3.7	15.3
2006	100.0	84.2	67.9	59.7	9.1	27.0	12.9	13.6	3.6	15.8
2005 ²	100.0	84.7	68.5	60.2	9.2	27.3	13.0	13.7	3.8	15.3
2004 ²	100.0	85.1	69.0	60.5	9.5	27.3	13.0	13.6	3.7	14.9
2003	100.0	84.9	69.3	61.0	9.3	26.6	12.4	13.7	3.5	15.1
2002	100.0	85.3	70.3	61.9	9.4	25.7	11.6	13.4	3.5	14.7
2001	100.0	85.9	71.5	63.2	9.3	25.3	11.2	13.5	3.4	14.1
2000 ³	100.0	86.3	72.6	64.2	9.6	24.7	10.6	13.5	3.3	13.7
1999 ⁴	100.0	86.0	72.5	63.9	10.0	24.5	10.3	13.3	3.1	14.0
UNDER 18 YEARS										
Number										
2007	74,403	66,254	47,750	44,252	3,930	23,041	20,899	518	2,101	8,149
2006	74,101	65,440	47,906	44,257	3,890	22,109	20,067	411	2,058	8,661
2005 ²	73,985	65,935	48,686	45,039	4,035	21,934	19,723	538	2,264	8,050
2004 ²	73,791	66,070	49,017	45,274	4,271	22,023	19,917	503	2,090	7,721
2003	73,580	65,466	48,784	45,297	3,918	21,389	19,392	483	2,021	8,114
2002	73,312	65,082	49,807	46,510	3,876	19,662	17,526	524	2,148	8,229
2001	72,628	64,401	49,978	46,762	3,647	18,822	16,502	423	2,381	8,227
2000 ³	72,314	63,929	50,755	47,679	3,604	17,658	15,090	518	2,563	8,385
1999 ⁴	72,281	63,248	50,588	47,102	4,087	16,793	14,697	364	2,076	9,033
Percent										
2007	100.0	89.0	64.2	59.5	5.3	31.0	28.1	0.7	2.8	11.0
2006	100.0	88.3	64.6	59.7	5.3	29.8	27.1	0.6	2.8	11.7
2005 ²	100.0	89.1	65.8	60.9	5.5	29.6	26.7	0.7	3.1	10.9
2004 ²	100.0	89.5	66.4	61.4	5.8	29.8	27.0	0.7	2.8	10.5
2003	100.0	89.0	66.3	61.6	5.3	29.1	26.4	0.7	2.7	11.0
2002	100.0	88.8	67.9	63.4	5.3	26.8	23.9	0.7	2.9	11.2
2001	100.0	88.7	68.8	64.4	5.0	25.9	22.7	0.6	3.3	11.3
2000 ³	100.0	88.4	70.2	65.9	5.0	24.4	20.9	0.7	3.5	11.6
1999 ⁴	100.0	87.5	70.0	65.2	5.7	23.2	20.3	0.5	2.9	12.5

See footnotes at end of table.

Table C-3.
Health Insurance Coverage by Age: 1999 to 2007—Con.

(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apsd/techdoc/cps/cpsmar08.pdf)

Age	Total people	Covered by private and/or government health insurance								Not covered
		Total	Private health insurance			Government health insurance				
			Total	Employment based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹	
18 TO 24 YEARS										
Number										
2007	28,398	20,407	17,074	13,747	1,635	4,428	3,563	180	823	7,991
2006	28,405	20,081	17,030	13,768	1,736	4,006	3,252	154	721	8,323
2005 ²	27,965	19,765	16,733	13,526	1,580	4,199	3,289	186	872	8,201
2004 ²	28,008	19,762	16,765	13,354	1,604	4,106	3,291	208	807	8,247
2003	27,824	19,703	16,834	13,720	1,637	3,929	3,016	176	902	8,121
2002	27,438	19,575	16,834	13,691	1,582	3,738	2,909	183	779	7,863
2001	27,312	19,910	17,292	14,039	1,653	3,642	2,831	180	742	7,402
2000 ³	26,815	19,612	17,295	14,351	1,554	3,361	2,508	207	805	7,203
1999 ⁴	26,326	19,245	16,817	13,836	1,591	3,485	2,684	152	787	7,081
Percent										
2007	100.0	71.9	60.1	48.4	5.8	15.6	12.5	0.6	2.9	28.1
2006	100.0	70.7	60.0	48.5	6.1	14.1	11.4	0.5	2.5	29.3
2005 ²	100.0	70.7	59.8	48.4	5.6	15.0	11.8	0.7	3.1	29.3
2004 ²	100.0	70.6	59.9	47.7	5.7	14.7	11.8	0.7	2.9	29.4
2003	100.0	70.8	60.5	49.3	5.9	14.1	10.8	0.6	3.2	29.2
2002	100.0	71.3	61.4	49.9	5.8	13.6	10.6	0.7	2.8	28.7
2001	100.0	72.9	63.3	51.4	6.1	13.3	10.4	0.7	2.7	27.1
2000 ³	100.0	73.1	64.5	53.5	5.8	12.5	9.4	0.8	3.0	26.9
1999 ⁴	100.0	73.1	63.9	52.6	6.0	13.2	10.2	0.6	3.0	26.9
25 TO 34 YEARS										
Number										
2007	40,146	29,817	26,430	24,505	2,347	4,539	3,237	501	1,047	10,329
2006	39,868	29,154	25,814	24,009	2,160	4,460	3,374	472	890	10,713
2005 ²	39,480	29,320	25,751	23,927	2,259	4,751	3,449	541	1,058	10,161
2004 ²	39,310	29,544	26,176	24,381	2,329	4,678	3,482	479	1,015	9,766
2003	39,201	29,055	25,812	24,136	2,085	4,210	3,073	538	898	10,146
2002	39,243	29,685	26,715	25,022	2,105	3,944	2,801	455	922	9,558
2001	38,670	29,826	27,124	25,521	2,087	3,653	2,587	489	817	8,844
2000 ³	38,865	30,547	27,951	26,388	2,056	3,551	2,480	403	922	8,318
1999 ⁴	39,031	30,532	27,962	26,369	2,148	3,578	2,458	332	974	8,499
Percent										
2007	100.0	74.3	65.8	61.0	5.8	11.3	8.1	1.2	2.6	25.7
2006	100.0	73.1	64.7	60.2	5.4	11.2	8.5	1.2	2.2	26.9
2005 ²	100.0	74.3	65.2	60.6	5.7	12.0	8.7	1.4	2.7	25.7
2004 ²	100.0	75.2	66.6	62.0	5.9	11.9	8.9	1.2	2.6	24.8
2003	100.0	74.1	65.8	61.6	5.3	10.7	7.8	1.4	2.3	25.9
2002	100.0	75.6	68.1	63.8	5.4	10.1	7.1	1.2	2.3	24.4
2001	100.0	77.1	70.1	66.0	5.4	9.4	6.7	1.3	2.1	22.9
2000 ³	100.0	78.6	71.9	67.9	5.3	9.1	6.4	1.0	2.4	21.4
1999 ⁴	100.0	78.2	71.6	67.6	5.5	9.2	6.3	0.8	2.5	21.8

See footnotes at end of table.

Table C-3.
Health Insurance Coverage by Age: 1999 to 2007—Con.

(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apspd/techdoc/cps/cpsmar08.pdf)

Age	Total people	Covered by private and/or government health insurance								Not covered
		Total	Private health insurance			Government health insurance				
			Total	Employment based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹	
35 TO 44 YEARS										
Number										
2007	42,132	34,415	31,067	29,009	2,687	4,546	3,027	924	1,016	7,717
2006	42,762	34,744	31,531	29,463	2,788	4,409	2,977	806	1,015	8,018
2005 ²	43,121	35,220	31,903	29,747	2,808	4,628	3,087	885	1,099	7,901
2004 ²	43,351	35,446	32,061	29,944	2,833	4,747	3,192	901	1,153	7,904
2003	43,573	35,796	32,654	30,497	2,806	4,420	2,860	940	1,111	7,777
2002	44,074	36,464	33,424	31,362	2,826	4,240	2,728	881	1,121	7,610
2001	44,284	37,272	34,449	32,522	2,655	4,003	2,532	860	1,066	7,012
2000 ³	44,566	37,820	35,186	33,135	2,747	3,920	2,390	780	1,206	6,746
1999 ⁴	44,474	37,894	35,074	32,776	3,170	4,028	2,390	825	1,257	6,580
Percent										
2007	100.0	81.7	73.7	68.9	6.4	10.8	7.2	2.2	2.4	18.3
2006	100.0	81.2	73.7	68.9	6.5	10.3	7.0	1.9	2.4	18.8
2005 ²	100.0	81.7	74.0	69.0	6.5	10.7	7.2	2.1	2.5	18.3
2004 ²	100.0	81.8	74.0	69.1	6.5	11.0	7.4	2.1	2.7	18.2
2003	100.0	82.2	74.9	70.0	6.4	10.1	6.6	2.2	2.6	17.8
2002	100.0	82.7	75.8	71.2	6.4	9.6	6.2	2.0	2.5	17.3
2001	100.0	84.2	77.8	73.4	6.0	9.0	5.7	1.9	2.4	15.8
2000 ³	100.0	84.9	79.0	74.4	6.2	8.8	5.4	1.8	2.7	15.1
1999 ⁴	100.0	85.2	78.9	73.7	7.1	9.1	5.4	1.9	2.8	14.8
45 TO 54 YEARS										
Number										
2007	43,935	37,161	33,350	30,805	3,292	5,363	3,103	1,795	1,285	6,774
2006	43,461	36,819	33,250	30,868	3,297	5,182	2,885	1,739	1,337	6,642
2005 ²	42,797	36,570	33,114	30,651	3,396	4,956	2,837	1,591	1,355	6,227
2004 ²	41,961	36,074	32,776	30,370	3,324	4,898	2,656	1,550	1,426	5,886
2003	41,068	35,443	32,368	30,053	3,255	4,569	2,359	1,569	1,369	5,625
2002	40,234	34,913	32,011	29,884	3,124	4,345	2,227	1,382	1,351	5,321
2001	39,545	34,595	31,909	29,718	3,135	3,990	2,071	1,331	1,170	4,950
2000 ³	38,720	34,227	31,659	29,578	3,103	3,964	1,996	1,384	1,169	4,492
1999 ⁴	37,334	32,927	30,548	28,448	3,226	3,682	1,769	1,162	1,244	4,407
Percent										
2007	100.0	84.6	75.9	70.1	7.5	12.2	7.1	4.1	2.9	15.4
2006	100.0	84.7	76.5	71.0	7.6	11.9	6.6	4.0	3.1	15.3
2005 ²	100.0	85.5	77.4	71.6	7.9	11.6	6.6	3.7	3.2	14.5
2004 ²	100.0	86.0	78.1	72.4	7.9	11.7	6.3	3.7	3.4	14.0
2003	100.0	86.3	78.8	73.2	7.9	11.1	5.7	3.8	3.3	13.7
2002	100.0	86.8	79.6	74.3	7.8	10.8	5.5	3.4	3.4	13.2
2001	100.0	87.5	80.7	75.2	7.9	10.1	5.2	3.4	3.0	12.5
2000 ³	100.0	88.4	81.8	76.4	8.0	10.2	5.2	3.6	3.0	11.6
1999 ⁴	100.0	88.2	81.8	76.2	8.6	9.9	4.7	3.1	3.3	11.8

See footnotes at end of table.

Table C-3.
Health Insurance Coverage by Age: 1999 to 2007—Con.

(Numbers in thousands. People as of March of the following year. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apstd/techdoc/cps/cpsmar08.pdf)

Age	Total people	Covered by private and/or government health insurance								Not covered
		Total	Private health insurance			Government health insurance				
			Total	Employment based	Direct purchase	Total	Medicaid	Medicare	Military health care ¹	
55 TO 64 YEARS										
Number										
2007	33,302	29,291	25,114	22,569	3,237	6,651	2,462	3,179	2,079	4,011
2006	32,191	28,096	24,255	21,701	3,276	6,122	2,362	2,956	1,845	4,095
2005 ²	30,981	27,154	23,543	21,092	3,194	5,886	2,325	2,708	1,908	3,826
2004 ²	29,536	26,016	22,640	20,254	3,180	5,478	2,085	2,644	1,795	3,519
2003	28,375	25,039	21,963	19,692	3,051	4,893	1,757	2,494	1,471	3,335
2002	27,399	24,219	21,170	18,844	3,123	4,882	1,773	2,392	1,482	3,180
2001	25,874	22,820	19,959	17,862	2,832	4,567	1,807	2,301	1,220	3,054
2000 ³	24,672	21,641	18,977	16,792	2,990	4,185	1,731	2,159	1,024	3,031
1999 ⁴	23,981	21,082	18,678	16,518	3,008	4,033	1,551	2,084	1,053	2,899
Percent										
2007	100.0	88.0	75.4	67.8	9.7	20.0	7.4	9.5	6.2	12.0
2006	100.0	87.3	75.3	67.4	10.2	19.0	7.3	9.2	5.7	12.7
2005 ²	100.0	87.6	76.0	68.1	10.3	19.0	7.5	8.7	6.2	12.4
2004 ²	100.0	88.1	76.7	68.6	10.8	18.5	7.1	9.0	6.1	11.9
2003	100.0	88.2	77.4	69.4	10.8	17.2	6.2	8.8	5.2	11.8
2002	100.0	88.4	77.3	68.8	11.4	17.8	6.5	8.7	5.4	11.6
2001	100.0	88.2	77.1	69.0	10.9	17.7	7.0	8.9	4.7	11.8
2000 ³	100.0	87.7	76.9	68.1	12.1	17.0	7.0	8.8	4.2	12.3
1999 ⁴	100.0	87.9	77.9	68.9	12.5	16.8	6.5	8.7	4.4	12.1
65 YEARS AND OLDER										
Number										
2007	36,790	36,103	21,206	12,558	9,546	34,464	3,263	34,278	2,604	686
2006	36,035	35,494	21,904	13,086	9,918	33,982	3,364	33,806	2,682	541
2005 ²	35,505	35,056	21,437	12,942	9,783	33,859	3,394	33,727	2,611	449
2004 ²	35,209	34,755	21,488	12,670	10,010	33,555	3,332	33,419	2,504	454
2003	34,659	34,373	21,457	12,448	10,032	33,345	3,190	33,257	2,206	286
2002	34,234	33,976	20,929	11,782	10,210	32,813	3,283	32,631	2,259	258
2001	33,769	33,498	20,984	11,837	10,299	32,618	3,270	32,458	2,156	272
2000 ³	33,566	33,314	20,971	11,512	10,746	32,398	3,339	32,289	1,410	251
1999 ⁴	33,377	33,109	21,054	11,789	10,501	32,083	2,956	32,004	1,257	268
Percent										
2007	100.0	98.1	57.6	34.1	25.9	93.7	8.9	93.2	7.1	1.9
2006	100.0	98.5	60.8	36.3	27.5	94.3	9.3	93.8	7.4	1.5
2005 ²	100.0	98.7	60.4	36.5	27.6	95.4	9.6	95.0	7.4	1.3
2004 ²	100.0	98.7	61.0	36.0	28.4	95.3	9.5	94.9	7.1	1.3
2003	100.0	99.2	61.9	35.9	28.9	96.2	9.2	96.0	6.4	0.8
2002	100.0	99.2	61.1	34.4	29.8	95.8	9.6	95.3	6.6	0.8
2001	100.0	99.2	62.1	35.1	30.5	96.6	9.7	96.1	6.4	0.8
2000 ³	100.0	99.3	62.5	34.3	32.0	96.5	9.9	96.2	4.2	0.7
1999 ⁴	100.0	99.2	63.1	35.3	31.5	96.1	8.9	95.9	3.8	0.8

¹ Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Health and Medical Program of the Department of Veterans Affairs and care provided by the Department of Veterans Affairs and the military.

² The 2004 and 2005 data were revised in March 2007. See www.census.gov/hhes/www/hlthins/usernote/schedule.html.

³ Implementation of a 28,000 household sample expansion.

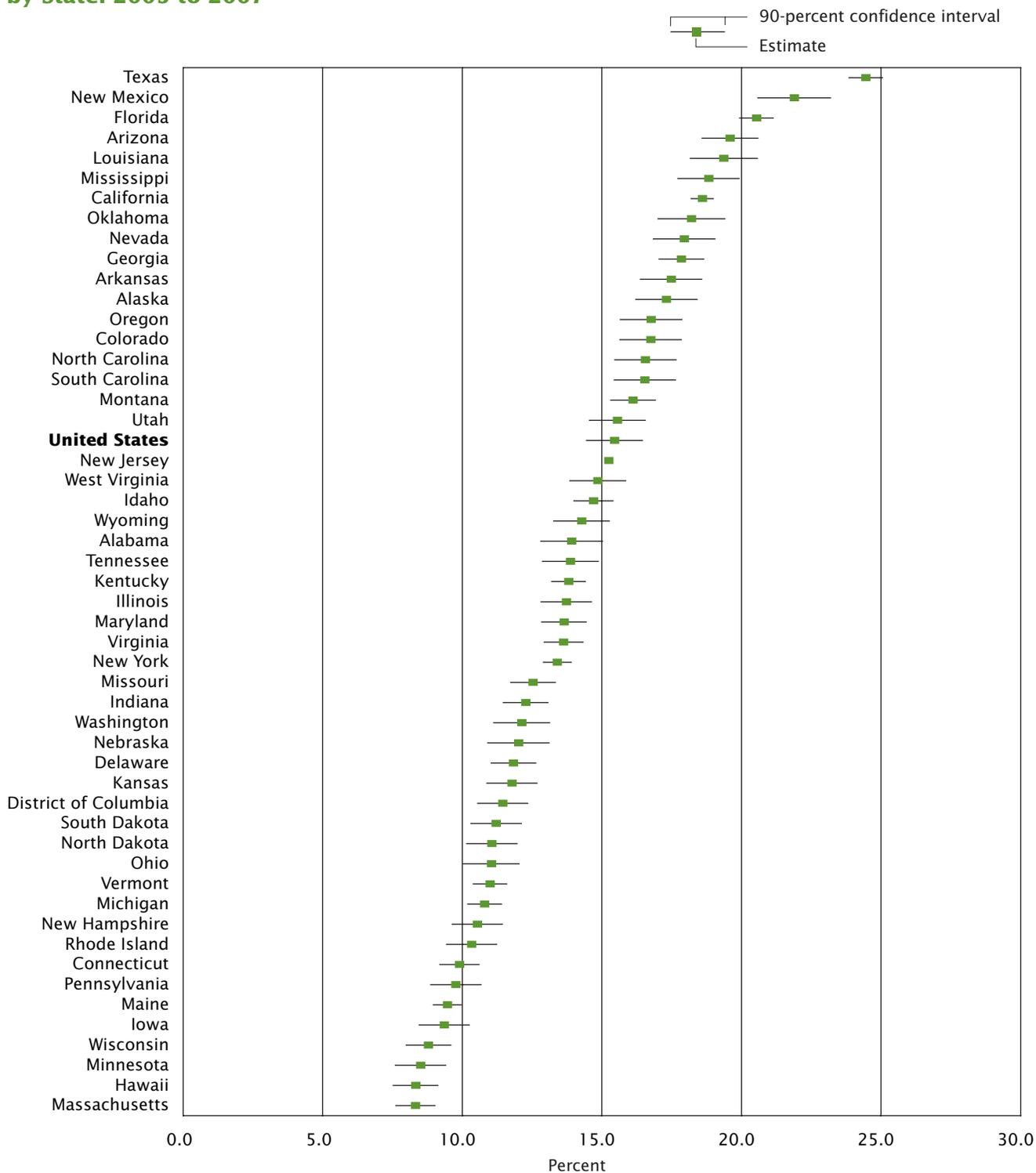
⁴ Estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.

Note: All years reflect the implementation of the verification question. The data for 1999 through 2003 were revised using an approximation method for consistency with the revision to the 2004 and 2005 estimates. To see the original series, see Table C-1 in *Income, Poverty, and Health Insurance Coverage in the United States: 2005* at www.census.gov/prod/2006pubs/p60-231.pdf.

Source: U.S. Census Bureau, Current Population Survey, 2000 to 2008 Annual Social and Economic Supplements.

APPENDIX D.
COMPARISON OF STATE HEALTH INSURANCE COVERAGE ESTIMATES

Figure D-1.
**Three-Year-Average Percentage of People Without Health Insurance Coverage
 by State: 2005 to 2007**



Source: U.S. Census Bureau, Current Population Survey, 2006 to 2008 Annual Social and Economic Supplements.

