ebri.org
Employee Benefit Research Institute

September 2012 • No. 376

Issue BRIEF

Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey

By Paul Fronstin, Ph.D., Employee Benefit Research Institute

This *Issue Brief* provides historical data through 2011 on the number and percentage of nonelderly individuals with and without health insurance. Based on EBRI estimates from the U.S. Census Bureau's March 2012 Current Population Survey (CPS), it reflects 2011 data, and also discusses trends in coverage for the 1994–2011 period as well as characteristics that typically indicate whether an individual is insured.

AT A GLANCE

- ***Health Coverage Rate Increased, Uninsured Down:*** The percentage of the nonelderly population (under age 65) with health insurance coverage increased to 82 percent in 2011, notable since increases in health insurance coverage have been recorded in only five years since 1994.
- ***Employment-Based Coverage Remains Dominant Source of Health Coverage, but Continues to Erode:*** Employment-based health benefits remain the most common form of health coverage in the United States, though it represents a declining share. In 2011, 58.4 percent of the nonelderly population had employment-based health benefits, down from the peak of 69.3 percent in 2000, during the 1994–2011 period.
- ***Public Program Coverage Is Expanding:*** Public program health coverage expanded as a percentage of the population in 2011, accounting for 22.5 percent of the nonelderly population. Enrollment in Medicaid and the State Children's Health Insurance Program (S-CHIP) also increased to a combined 46.9 million in 2011, covering 17.6 percent of the nonelderly population, significantly above the 10.2 percent level of 1999.
- ***Individual Coverage Stable****:* The percentage represented by individually purchased health coverage was unchanged in 2011 and has basically hovered in the 6–7 percent range since 1994.
- ***What to Expect in 2012:*** The unemployment rate in 2012 has been about 8 percent since the beginning of the year, and remains high amidst a still-sluggish economy. As a result, the nation is likely to see a corresponding erosion of employment-based health benefits when the data for 2012 are released next year. Until the economy gains enough strength to have a substantial impact on the labor market, a rebound in employment-based coverage is unlikely.

Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI). This *Issue Brief* was written with assistance from the Institute's research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

Recommended Citation: Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey," *EBRI Issue Brief,* no. 376, September 2012.

Report availability: This report is available on the Internet at www.ebri.org

Table of Contents

Figures

Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey

By Paul Fronstin, Ph.D., Employee Benefit Research Institute

Introduction

The percentage of nonelderly individuals (under age 65) in the United States with health insurance *increased* between 2010 and 2011, the first such increase since 2007. In 2011, 82 percent of individuals were covered, up from 81.5 percent in 2010 (calculated from Figure 1), in contrast to a downward trend that has occurred during most years since 1994. Nearly 219 million nonelderly individuals had insurance coverage in 2011, up from 216.9 million in 2010. However, nearly 1 in 5 (18 percent) individuals under age 65 did not have health insurance at any point in 2011, though this was down from 18.5 percent in 2010, the highest level during the 1994–2010 period. Nearly 48 million were uninsured in 2011, down from 49.1 million in 2010.

While the *number* of uninsured individuals in the United States decreased in 2011, fewer people were covered by employment-based health plans—a trend reflective of job losses from the 2007–2009 recession and continuing slow economic recovery. While employment-based health benefits remain the dominant source of health coverage in the United States, providing coverage for 155.5 million people under age 65 in 2011, the percentage of individuals under age 65 with employment-based coverage has declined every year since 2000.

However, enrollment in public programs increased and more than offset the decline in employment-based health coverage. In 2011, 59.9 million (or 22.5 percent of the nonelderly population) were covered by public programs, and an additional 18.9 million (or 7.1 percent) were covered by policies purchased directly from an insurer. Nearly 47 million nonelderly individuals participated in Medicaid (the federal-state health care program for poor and disabled) or the State Children's Health Insurance Program (S-CHIP),[1] and 9 million received their health insurance through the Tricare and CHAMPVA[2] programs and other government programs for retired military and their families.

While the population age 65 and older is not the focus of this report, when considering the *entire U.S. population,* 55.1 percent are covered through employment-based programs, 32.2 percent are covered through government programs, and 15.7 percent are uninsured (DeNavas-Walt, Proctor, and Smith, 2012).[3]

This *Issue Brief* examines the status of health insurance coverage in the United States. The data are based primarily on the March 2012 Current Population Survey (CPS) conducted by the U.S. Census Bureau, with some analysis based on other Census surveys.[4] The report focuses on the nonelderly population (under age 65) because this group can receive health insurance coverage from a number of different sources, and because Medicare (the federal health care insurance program for the elderly and disabled) covers nearly all individuals age 65 and older. As a result of this difference between estimates from EBRI and the Census Bureau, this report shows a higher percentage of uninsured in the United States.[5]

The next section of the report discusses recent trends in health insurance coverage and some of their causes. The following section discusses the determinants of having employment-based health coverage as well as other types of coverage, and then analyzes the uninsured population and the factors associated with being uninsured and is followed by a section examining policy implications. The final section presents conclusions. Data sources are discussed in more detail in the appendix.

Figure 1

Nonelderly Population With Selected Sources of Health Insurance Coverage, 1994–2011[a]

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
	(millions)																	
Total	229.9	231.9	234.1	236.2	238.6	242.6	244.8	247.5	250.8	252.7	255.1	257.4	260.0	261.4	262.8	264.7	266.0	266.4
Employment-based Coverage	148.1	149.7	151.7	156.9	160.4	165.6	169.7	167.8	167.2	164.4	164.6	164.9	165.3	165.9	163.9	157.3	156.1	155.5
Own name	76.3	76.9	78.0	78.5	80.2	80.1	82.3	81.8	80.2	78.8	81.4	82.1	82.7	83.8	82.3	78.9	77.5	77.1
Dependent coverage	71.9	72.8	73.7	78.4	80.2	85.5	87.4	86.0	87.0	85.6	83.2	82.8	82.6	82.1	81.6	78.4	78.6	78.4
Individually Purchased	17.3	16.8	16.8	17.1	16.5	17.6	17.8	18.0	18.8	18.7	19.0	19.0	18.9	18.8	18.2	18.4	18.9	18.9
Public	39.4	38.8	37.8	35.3	34.6	34.3	35.0	37.0	39.3	41.9	45.1	45.5	45.6	47.8	51.2	56.1	57.5	59.9
Medicaid	29.1	29.4	28.6	26.4	25.2	24.7	25.0	27.2	29.0	31.4	34.7	34.8	35.0	36.4	39.4	44.2	45.0	46.9
Medicare	3.7	4.1	4.6	4.7	4.8	5.0	5.5	5.5	5.8	6.1	6.4	6.4	6.5	7.1	7.7	7.3	7.9	8.4
Tricare/CHAMPVA[b]	8.7	7.5	6.9	6.6	6.9	6.5	6.6	6.6	6.8	6.9	7.2	7.7	7.1	7.5	7.8	8.3	8.7	9.0
No Health Insurance	36.5	37.3	38.3	38.9	39.4	37.3	36.3	37.7	39.4	41.5	41.3	42.6	44.7	43.4	44.2	48.3	49.1	47.9
	(percentage)																	
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-based Coverage	64.4	64.6	64.8	66.4	67.2	68.2	69.3	67.8	66.6	65.1	64.5	64.1	63.6	63.5	62.4	59.4	58.7	58.4
Own name	33.2	33.2	33.3	33.2	33.6	33.0	33.6	33.1	32.0	31.2	31.9	31.9	31.8	32.0	31.3	29.8	29.1	28.9
Dependent coverage	31.3	31.4	31.5	33.2	33.6	35.2	35.7	34.7	34.7	33.9	32.6	32.2	31.8	31.4	31.0	29.6	29.6	29.4
Individually Purchased	7.5	7.2	7.2	7.2	6.9	7.3	7.3	7.3	7.5	7.4	7.5	7.4	7.3	7.2	6.9	7.0	7.1	7.1
Public	17.1	16.7	16.2	15.0	14.5	14.1	14.3	15.0	15.6	16.6	17.7	17.7	17.5	18.3	19.5	21.2	21.6	22.5
Medicaid	12.7	12.7	12.2	11.2	10.6	10.2	10.2	11.0	11.6	12.4	13.6	13.5	13.5	13.9	15.0	16.7	16.9	3.2
Medicare	1.6	1.8	2.0	2.0	2.0	2.1	2.3	2.2	2.3	2.4	2.5	2.5	2.5	2.7	2.9	2.8	3.0	17.6
Tricare/CHAMPVA[b]	3.8	3.2	2.9	2.8	2.9	2.7	2.7	2.7	2.7	2.7	2.8	3.0	2.7	2.9	3.0	3.1	3.3	3.4
No Health Insurance	15.9	16.1	16.4	16.5	16.5	15.4	14.8	15.2	15.7	16.4	16.2	16.6	17.2	16.6	16.8	18.3	18.5	18.0

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 1995–2012 Supplements.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

[a] 1994–1998 is not directly comparable with 1999–2011 data because of a methodological change in the way individuals with coverage were counted. See Appendix Figure A4 for more details. Also, 2011 data based on 2010 Census weights.

[b] Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Trends

While the overall percentage of individuals in the United States without health insurance coverage has increased in most years since 1994, the periods before and after 1999 should be examined separately for two reasons. First, whereas prior to 1999, the United States experienced an erosion of public coverage, since 2000 the percentage of individuals with public coverage has been expanding. The decline was in large part the result of former welfare recipients entering the work force during the then-thriving economy.[6] Second, CPS data back to 1999 were recently revised because of a change in methodology, making comparisons in the *level* of coverage (as opposed to the *trend* in coverage) complicated when examining pre-1999 and 1999-present. The methodological change mostly resulted in higher estimates for people with employment-based, dependent coverage and coverage purchased directly from an insurer, reducing previously released uninsured estimates for 2009 by 1.7 million (see appendix for more detail).

The percentage of the nonelderly population covered by Medicaid declined from 12.7 percent in 1994 to 10.2 percent in 1999. Similarly, the percentage of nonelderly individuals covered by Tricare or CHAMPVA declined from 3.8 percent to 2.7 percent between 1994 and 1999 in large part due to military downsizing. During this same period, the percentage of nonelderly individuals covered by employment-based health benefits increased. In 1994, 64.4 percent of the nonelderly population had employment-based health benefits, and by 1999, 68.2 percent were covered. Overall, the decline in public coverage was greater than the expansion in employment-based health benefits during 1994–1998, and the percentage of individuals without health insurance coverage increased. During 1997–2000, the expansion in employment-based health benefits was large enough to offset the continued decline in public coverage and, as a result, between 1997 and 1998 the percentage of individuals without health insurance coverage was unchanged, though between 1998 and 1999 it declined.

These trends mask other important differences among various groups in the U.S. population. For example, the increase in employment-based health benefits between 1994 and 1997 was limited to children; during that period, the percentage of children covered by an employment-based health plan increased from 58.9 percent to 63.7 percent (Figure 2), while for adults it increased only slightly, from 66.9 percent to 67.6 percent (Figure 3). However, between 1997 and 1999, the increase in the percentage of adults with employment-based health benefits accelerated, growing from 67.6 percent to 69.5 percent (Figure 3).

Fronstin (1999) has shown why the likelihood of a child being covered by employment-based health benefits increased. The study found that the percentage of children with a working parent increased, the percentage of children in families with incomes below the poverty level decreased, and more children had a working parent employed in a large firm. The increase in employment-based coverage among children during this period (1994-1997) can, at least in part, be attributed to an increase in the number of adult women working. Figure 4 shows how the percentage of women ages 18–45 in families receiving public assistance or welfare income declined, while employment increased.

Between 1994 and 1997, the percentage of working adults with employment-based health benefits held steady at roughly 73.5 percent (Figure 5), and the percentage of workers with coverage from their own employer held steady at roughly 56 percent (Figure 6). During this period, the cost of providing health benefits to employees was in large part unchanged.

Between 1997 and 1999, the percentage of working adults with employment-based health insurance increased from 73.6 percent to 74.2 percent, and continued growing into 2001. This occurred in part because the percentage of small firms offering health benefits increased (Gabel et al., 2001), despite the rising cost of health benefits (especially among small firms) during this period (Figure 7). It was also possible that the changing composition of the labor force accounted for some of the increase in the percentage of workers covered by employment-based health benefits. For example, the percentage of workers who were self-employed declined between 1997 and 2000, as did the percentage of workers employed on a part-time basis (Figure 8).

The increase in the percentage of individuals with employment-based health benefits between 1997 and 1999 has several explanations. A strong economy and low unemployment rates caused more employers to provide health benefits in order to attract and retain workers, and also may have resulted in more workers being able to afford health

insurance. The expansion in employment-based coverage occurred despite the fact that the cost of providing health benefits to workers was increasing faster than inflation, a trend that accelerated in 1999 and 2000.

The post-2000 period has seen a significantly less stable economy. The unemployment rate increased from 4 percent in 2000 to 6 percent in 2003, fell to 4.4 percent in late 2006 and early 2007, but then started to increase, reaching 7.2 percent by the end of 2008, 10.1 percent in October 2009, averaging 9.6 percent in 2010 and 9 percent in 2011. In addition, increases in the cost of providing health benefits continued to outpace increases in worker earnings, in some years by a factor of four or five. As a result, the post-2000 period experienced an erosion of employment-based health benefits, which accelerated in 2009 as a result of growing and sustained high unemployment. The percentage of individuals with employment-based health benefits decreased from 69.3 percent in 2000 to 58.4 percent in 2011.

Expansions in the percentage of the population covered by public programs, particularly Medicaid and the S-CHIP program, to some degree offset the erosion in employment-based health benefits until 2004. Between 1999 and 2005, the percentage of nonelderly individuals with some form of public coverage increased from 14.1 percent to 17.7 percent. However, the expansion in public coverage was not large enough to fully offset the decline in employment-based health benefits. As a result, the percentage of nonelderly individuals without health insurance coverage increased from 15.4 percent in 2000 to 16.6 percent in 2005. Furthermore, between 2005 and 2006, while there was some erosion in *employment-based* coverage, *public* coverage also declined—suggesting the beginning of a new trend where the uninsured population is increasing faster than it otherwise would have if public programs had been offsetting the erosion in employment-based coverage.

The decline in the percentage and number of uninsured among the nonelderly population between 2006 and 2007 should come as no surprise. First, the percentage of employers offering health benefits was essentially unchanged between 2006 and 2007. In 2006, 61 percent of employers offered coverage while in 2007 60 percent offered it.[7] Second, premiums increased 6.1 percent while worker earnings increased 3.7 percent, that gap a record low since the mid-1990s. Third, in a more competitive labor environment, unemployment averaged 4.6 percent in 2007, down from 6 percent in 2003. When employers increasingly compete for workers and more individuals are at work, the percentage of individuals with employment-based health benefits tends to expand.

As was reported in the past, the decrease in the uninsured rate that occurred between 2006 and 2007 was not expected to continue. Unemployment subsequently increased and remained high. Fewer individuals working meant that fewer had access to health benefits in the work place. Furthermore, even among workers, an increasing number likely declined coverage even when it was available because of affordability issues, and fewer workers may have been eligible for coverage. As a result, the percentage of individuals under age 65 with employment-based health benefits fell from 62.4 percent in 2008 to 58.4 percent in 2011, and the percentage of workers with coverage through their own employer fell from 54.2 percent in 2007 to 51 percent in 2011, the lowest level during the 1994–2011 period.

Determinants of Coverage

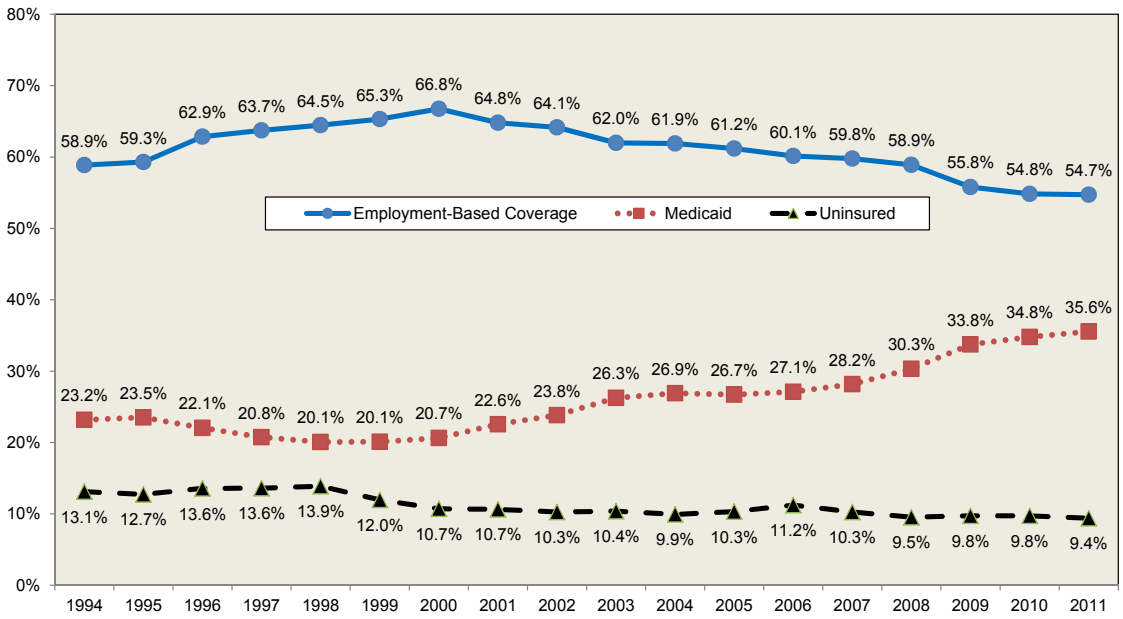
Full-time, full-year workers; public-sector workers; workers employed in manufacturing, managerial and professional workers, and individuals living in high-income families are most likely to have employment-based health benefits. Poor families are most likely to be covered by public programs, such as Medicaid or S-CHIP.

Employment status remains the most important determinant of health insurance coverage. Just over 58 percent of the nonelderly population had employment-based health benefits in 2011, either directly through their employer, union, or previous employer, or indirectly through an employed person in one's family.[8]

Large employers that provide access to group health coverage often are able to provide health benefits at lower cost than small employers, because they are subject to less adverse selection and their administrative costs and marketing costs are lower. But larger firms often also provide broader coverage and thus ultimately pay more per worker covered. Workers in large firms are more likely to be covered than those in small firms.

Figure 2

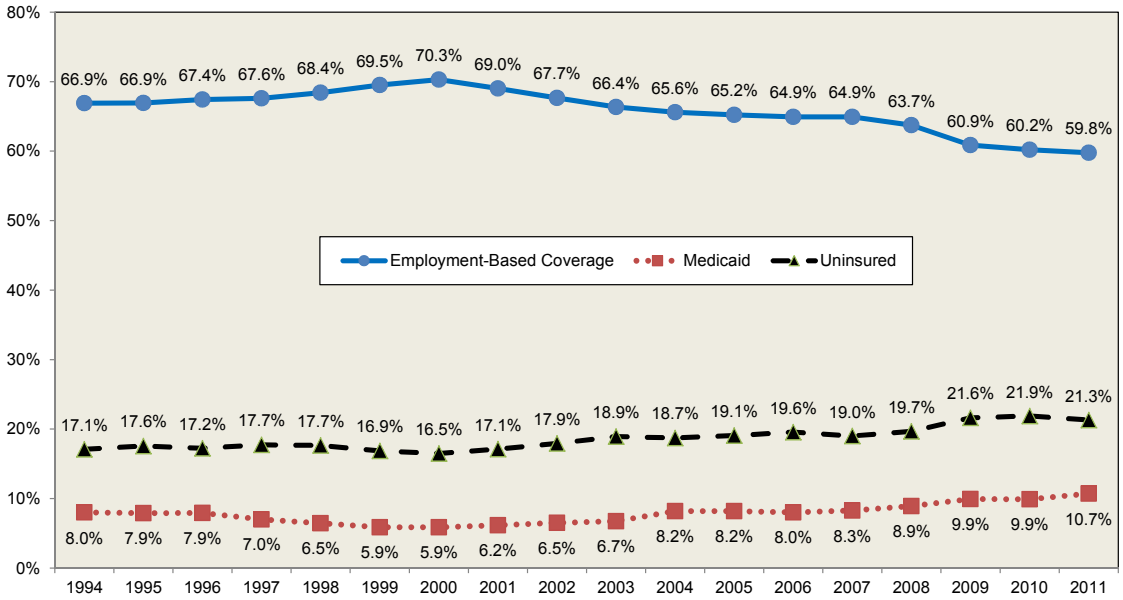
Percentage of Children Under Age 18 With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1994–2011



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2012 Supplements.
Note: 1994–1998 is not directly comparable with 1999–2011 data because of a methodological change in the way individuals with coverage were counted. See Appendix Figure A4 for more details. Also, 2011 data based on 2010 Census weights.

Figure 3

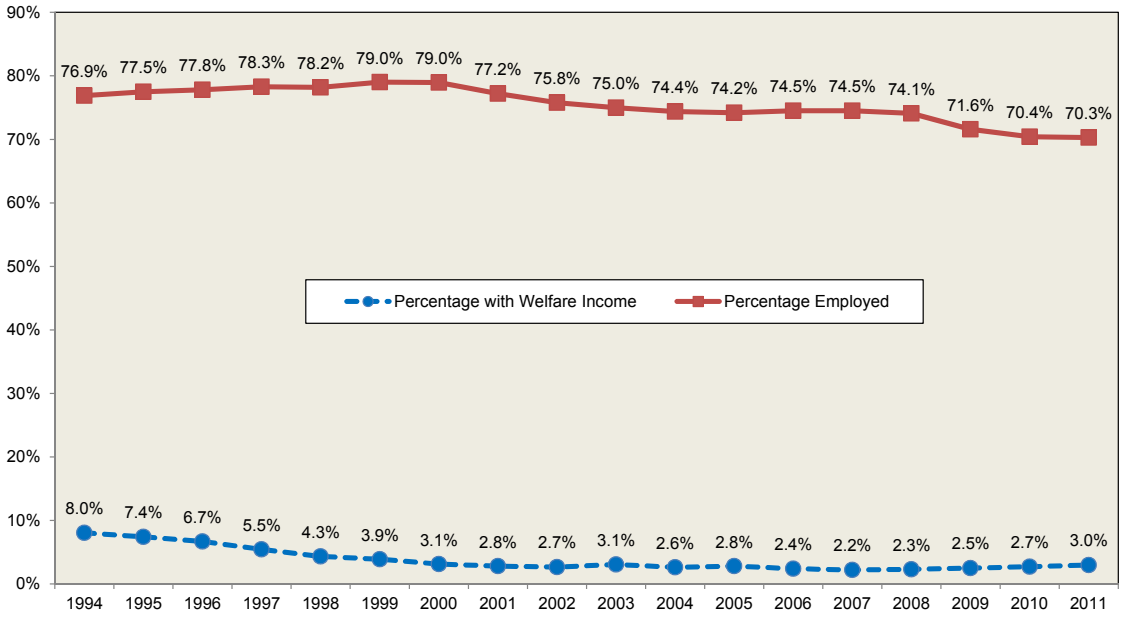
Percentage of Adults, Ages 18–64, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1994–2011



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2012 Supplements.
Note: 1994–1998 is not directly comparable with 1999–2010 data because of a methodological change in the way individuals with coverage were counted. See Appendix Figure A4 for more details. Also, 2011 data based on 2010 Census weights.

Figure 4

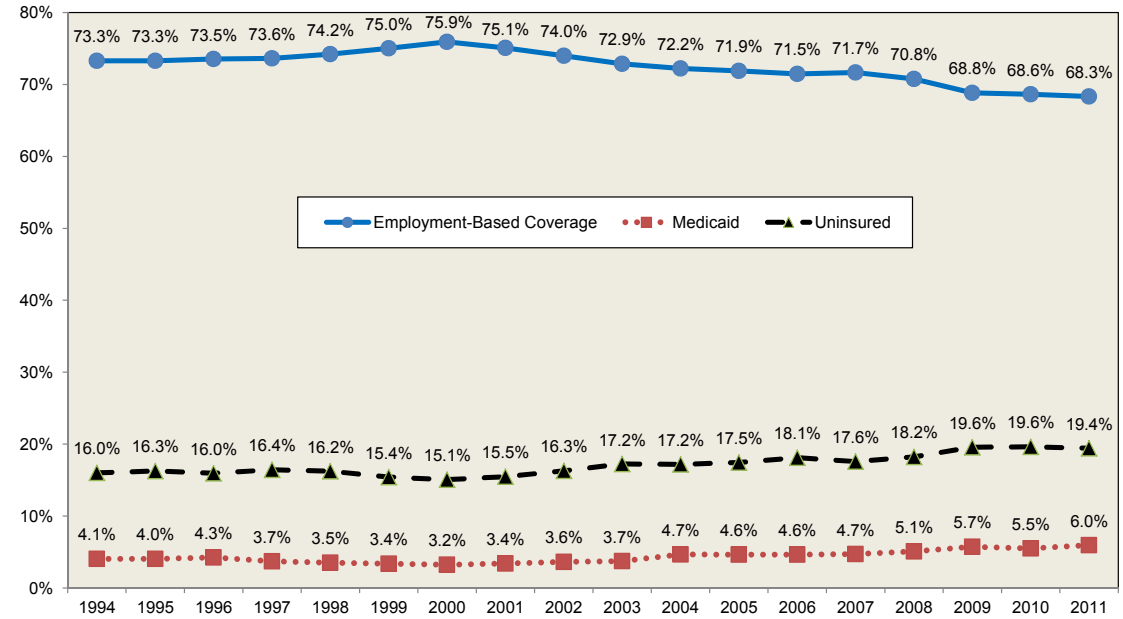
Percentage of Women Ages 18–45 Who Were in Families With Welfare Income or Who Were Employed, 1994–2011



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2012 Supplements.

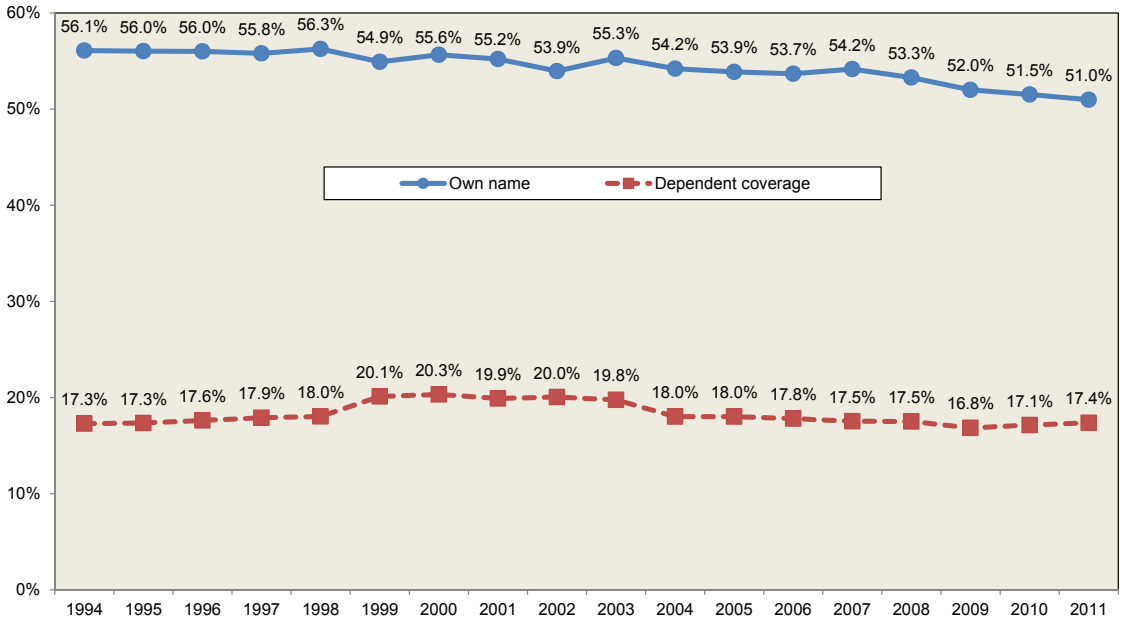
Figure 5

Percentage of Workers, Ages 18–64, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance, 1994–2011



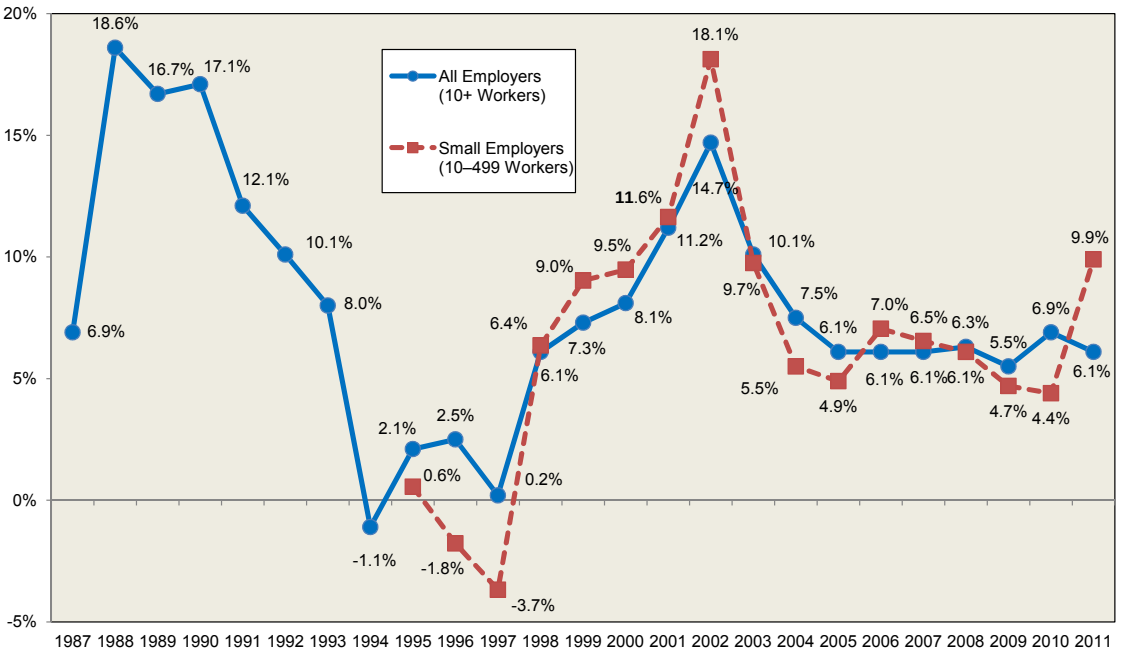
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2012 Supplements.
Note: 1994–1998 is not directly comparable with 1999–2010 data because of a methodological change in the way individuals with coverage were counted. See Appendix Figure A4 for more details. Also, 2011 data based on 2010 Census weights.

Figure 6
Percentage of Workers, Ages 18–64, With Employment-Based Health Benefits in their Own Name and as a Dependent, 1994–2011



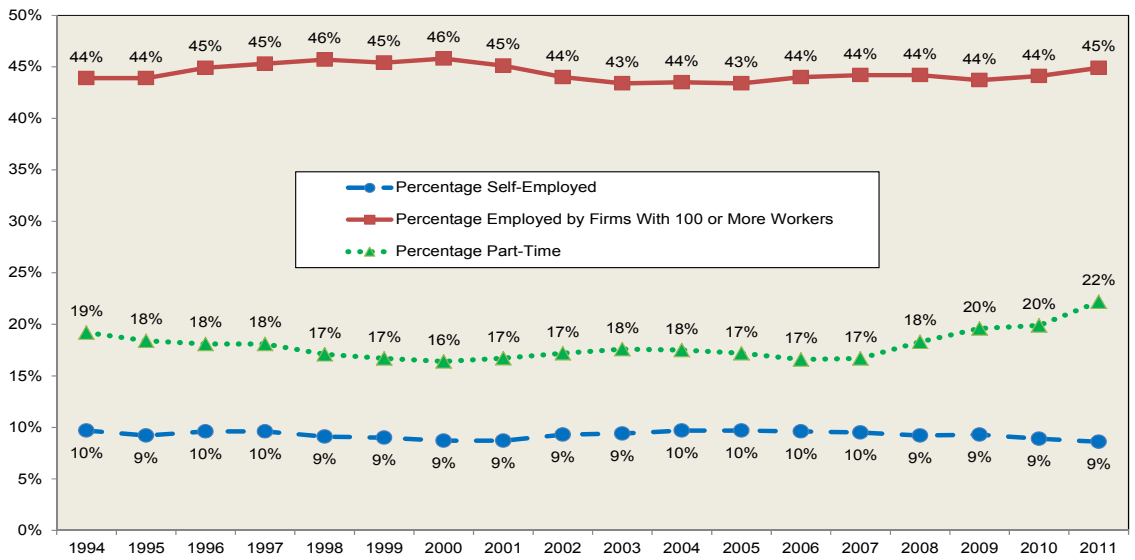
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2012 Supplements.
Note: 1994–1998 is not directly comparable with 1999–2010 data because of a methodological change in the way individuals with coverage were counted. See Appendix Figure A4 for more details. Also, 2011 data based on 2010 Census weights.

Figure 7
Premium Increases, by Firm Size, 1987–2011



Source: Mercer National Survey of Employer-Sponsored Health Plans.

Figure 8
Percentage of Workers Who Were Self-Employed, Employed in Large Firms, or Employed Part-Time, 1994–2011



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2012 Supplements.

Furthermore, the nature of employment, the individual industry, and firm size often determine the cost and extent of coverage. In 2011, workers were much more likely to have employment-based health benefits than nonworkers, who typically receive such coverage through spouses or parents (Figure 9). Over 68 percent of workers had employment-based health benefits, compared with 34.7 percent of nonworkers. In addition, 71.8 percent of individuals in families headed by full-year, full-time workers had employment-based health benefits, compared with 34.2 percent among those in families headed by part-time, part-year workers, and 18.2 percent of individuals in families headed by a nonworker (Figure 10).

Workers employed in the public sector and in manufacturing were more likely than other workers to have employment-based health benefits in their own name in 2011 (Figure 11). Just over 20 percent of self-employed workers and 23.4 percent of private-sector workers in firms with fewer than 10 employees had employment-based health benefits in their own name in 2011, compared with 62.5 percent of private-sector workers in firms with 1,000 or more employees (Figure 12). The gap by firm size shrinks when considering the fact that many workers get health coverage through someone else in their family. Overall, in 2011, about 45.6 percent of self-employed workers and private-sector workers in firms with fewer than 10 employees had some form of employment-based health benefits, compared with 77.4 percent of private-sector workers in firms with 1,000 or more employees.

Occupation also has an impact. Slightly more than 65 percent of workers in managerial and professional occupations had employment-based health benefits in their own name in 2011, compared with 30.4 percent among workers in service occupations (Figure 13). In addition, hours worked and weeks worked have a strong impact on the likelihood that a worker has employment-based health benefits. In 2011, 64.1 percent of workers employed full time and full year had employment-based health benefits from their own employer, compared with 35.9 percent among part-time, full-year employees; 20.5 percent among full-time, part-year employees; and 10.3 percent among part-time, part-year employees (Figure 14).

In general, individuals with high levels of income are more likely to be covered by employment-based health benefits. In 2011, 4.5 percent of individuals in families with annual income below $10,000 had employment-based health benefits in their own name, compared with 38 percent of those in families with annual income of $75,000 or more (Figure 15).

Whether an individual has employment-based coverage also varies by race and ethnicity. Two-thirds (66.9 percent) of whites had employment-based coverage in 2011 (Figure 16), compared with 46.7 percent of blacks and 38.8 percent of

Figure 9

Nonelderly Population With Selected Sources of Health Insurance, by Own Work Status, 2011

Own Work Status	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	266.4	155.5	77.1	78.4	18.9	59.9	46.9	47.9
Child	74.1	40.6	0.2	40.4	4.3	28.7	26.3	7.0
Family-head worker	93.7	62.4	56.1	6.3	7.3	8.8	6.1	18.8
Other worker	49.6	35.5	16.9	18.6	3.6	3.9	2.4	9.0
Nonworker	49.0	17.0	3.9	13.1	3.8	18.4	12.0	13.1
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Child	27.8	26.1	0.3	51.5	22.5	48.0	56.1	14.5
Family-head worker	35.2	40.1	72.8	8.0	38.4	14.7	13.1	39.3
Other worker	18.6	22.9	21.9	23.8	19.1	6.6	5.1	18.8
Nonworker	18.4	10.9	5.0	16.8	20.0	30.7	25.7	27.3
				(percentage within work status categories)				
Total	100.0%	58.4%	28.9%	29.4%	7.1%	22.5%	17.6%	18.0%
Child	100.0	54.7	0.3	54.5	5.7	38.8	35.5	9.4
Family-head worker	100.0	66.6	59.9	6.7	7.8	9.4	6.6	20.1
Other worker	100.0	71.6	34.0	37.6	7.3	7.9	4.8	18.2
Nonworker	100.0	34.7	7.9	26.9	7.7	37.5	24.6	26.7

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 10

Nonelderly Population With Selected Sources of Health Insurance, by Work Status of Family Head, 2011

Work Status of Family Head	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	266.4	155.5	77.1	78.4	18.9	59.9	46.9	47.9
Full time	202.6	139.4	68.2	71.2	14.6	31.4	23.8	30.3
full-year, full-time worker	186.4	133.9	65.3	68.5	13.1	26.4	19.5	25.6
full-time, part-year worker	16.2	5.6	2.9	2.7	1.5	4.9	4.3	4.7
Part time	26.9	9.3	5.0	4.3	1.9	9.2	8.2	7.7
part-time, full-year worker	18.9	6.6	3.5	3.1	1.2	6.4	5.9	5.7
part-time, part-year worker	8.1	2.8	1.5	1.2	0.7	2.8	2.3	2.0
Nonworker	36.9	6.7	3.8	2.9	2.4	19.3	15.0	10.0
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Full time	76.1	89.7	88.5	90.8	77.3	52.4	50.6	63.2
full-year, full-time worker	70.0	86.1	84.7	87.4	69.4	44.1	41.5	53.4
full-time, part-year worker	6.1	3.6	3.8	3.4	8.0	8.3	9.1	9.8
Part time	10.1	6.0	6.5	5.5	10.2	15.3	17.5	16.1
part-time, full-year worker	7.1	4.2	4.6	3.9	6.3	10.7	12.5	11.8
part-time, part-year worker	3.0	1.8	1.9	1.6	3.9	4.7	5.0	4.2
Nonworker	13.8	4.3	5.0	3.7	12.5	32.3	31.9	20.8
				(percentage within work status categories)				
Total	100.0%	58.4%	28.9%	29.4%	7.1%	22.5%	17.6%	18.0%
Full time	100.0	68.8	33.7	35.2	7.2	15.5	11.7	14.9
full-year, full-time worker	100.0	71.8	35.0	36.8	7.0	14.2	10.4	13.7
full-time, part-year worker	100.0	34.4	18.0	16.5	9.3	30.5	26.5	28.9
Part time	100.0	34.7	18.7	16.0	7.1	34.1	30.5	28.6
part-time, full-year worker	100.0	35.0	18.7	16.2	6.3	33.9	31.0	30.0
part-time, part-year worker	100.0	34.2	18.7	15.5	9.1	34.6	29.2	25.2
Nonworker	100.0	18.2	10.4	7.8	6.4	52.4	40.6	27.0

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 11

Workers Ages 18–64 With Selected Sources of Health Insurance, by Industry, 2011

Industry	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	143.3	97.9	73.0	24.9	10.9	12.7	8.5	27.9
Agriculture, forestry, fishing, mining & construction	12.1	6.4	4.5	1.9	1.2	1.0	0.8	4.0
Manufacturing	23.4	17.9	15.1	2.7	1.3	1.6	1.1	3.7
Wholesale & retail trade	45.0	30.3	21.8	8.5	3.8	3.9	2.6	8.8
Personal services	42.1	25.6	16.5	9.1	3.4	4.4	3.3	9.9
Public sector	20.7	17.8	15.0	2.7	1.2	1.8	0.8	1.5
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Agriculture, forestry, fishing, mining & construction	8.5	6.5	6.2	7.5	11.3	7.9	8.8	14.5
Manufacturing	16.3	18.2	20.7	10.9	12.2	12.5	12.6	13.2
Wholesale & retail trade	31.4	30.9	29.9	34.0	34.8	30.3	30.5	31.5
Personal services	29.4	26.2	22.6	36.5	30.9	34.8	39.0	35.4
Public sector	14.5	18.1	20.5	11.0	10.8	14.5	9.1	5.3
				(percentage within industry category)				
Total	100.0%	68.3%	51.0%	17.4%	7.6%	8.9%	6.0%	19.4%
Agriculture, forestry, fishing, mining & construction	100.0	52.5	37.1	15.3	10.1	8.3	6.2	33.3
Manufacturing	100.0	76.3	64.7	11.6	5.7	6.8	4.6	15.7
Wholesale & retail trade	100.0	67.4	48.6	18.8	8.4	8.6	5.8	19.5
Personal services	100.0	60.9	39.3	21.6	8.0	10.5	7.9	23.4
Public sector	100.0	85.6	72.4	13.2	5.7	8.9	3.7	7.2

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Hispanics. Even after controlling for poverty status, whites were, nearly across the board, more likely to have employment-based coverage than other races/ethnicities. For example, 84.1 percent of whites in families with income of at least 300 percent of poverty had employment-based coverage, compared with 78 percent among blacks and 73.7 percent among Hispanics (Figure 17).

Although public programs cover many individuals in poor families, most poor families are not covered. In 2011, 52.6 percent of the nonelderly with family incomes below the poverty line were covered by a public plan—48.7 percent by Medicaid or S-CHIP (Figure 18)—although many more low-income individuals may be eligible for Medicaid coverage.[9] Other sources of public health coverage include Medicare (which covers many disabled as well as the elderly), Tricare, CHAMPVA, and Veterans Administration (VA) health insurance, but eligibility for these programs is unrelated to the federal poverty level.

There is also some variation in the percentage of individuals with employment-based coverage and public coverage, and the percentage uninsured by self-reported health status. In 2011, individuals in excellent and very good health were more than twice as likely as those in poor health to have employment-based coverage. Nearly two-thirds (64 percent) of those in excellent or very good health had employment-based coverage, compared with 27.4 percent among those in poor health (Figure 19). In contrast, those in poor health were more likely to have public coverage.

The Uninsured

Many factors influence whether an individual has any insurance coverage. This section presents data on the characteristics of the uninsured population.

Location

The proportion of the nonelderly population with and without health insurance varies by location.[10] In 13 states, the uninsured accounted for 20 percent or more of the population during 2009–2011 (Figure 20). These states include Arkansas, Arizona, California, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, New Mexico, Oklahoma, South Carolina, and Texas.

Figure 12

Workers Ages 18–64 With Selected Sources of Health Insurance, by Firm Size, 2011

Firm Size	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	143.3	97.9	73.0	24.9	10.9	12.7	8.5	27.9
Self-Employed	12.4	5.6	2.5	3.1	2.7	1.1	0.8	3.5
Wage and Salary Workers	130.9	92.3	70.5	21.8	8.2	11.6	7.8	24.4
Public sector	20.7	17.8	15.0	2.7	1.2	1.8	0.8	1.5
Private sector	110.2	74.5	55.5	19.0	7.0	9.8	7.0	22.9
fewer than 10	16.6	7.6	3.9	3.7	1.7	1.9	1.4	6.0
10–49	19.9	11.3	7.1	4.2	1.5	1.9	1.5	5.5
50–99	9.3	6.4	4.8	1.6	0.5	0.8	0.6	1.9
100–499	15.4	11.4	9.2	2.3	0.8	1.2	0.8	2.6
500–999	6.0	4.5	3.7	0.9	0.3	0.4	0.3	0.9
1,000 or more	43.1	33.3	26.9	6.4	2.1	3.5	2.3	5.9
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Self-Employed	8.6	5.8	3.4	12.6	25.0	8.9	9.2	12.5
Wage and Salary Workers	91.4	94.2	96.6	87.4	75.0	91.1	90.8	87.5
Public sector	14.5	18.1	20.5	11.0	10.8	14.5	9.1	5.3
Private sector	76.9	76.1	76.0	76.4	64.2	76.6	81.8	82.1
fewer than 10	11.6	7.7	5.3	14.8	15.9	14.6	16.9	21.5
10–49	13.9	11.5	9.7	16.8	14.1	15.1	17.3	19.9
50–99	6.5	6.5	6.6	6.4	4.9	6.4	6.8	6.9
100–499	10.8	11.7	12.5	9.2	7.0	9.5	9.6	9.4
500–999	4.2	4.6	5.0	3.5	3.1	3.5	3.9	3.3
1,000 or more	30.0	34.0	36.9	25.8	19.2	27.4	27.3	21.2
				(percentage within firm size categories)				
Total	100.0%	68.3%	51.0%	17.4%	7.6%	8.9%	6.0%	19.4%
Self-Employed	100.0	45.6	20.3	25.3	22.1	9.2	6.3	28.2
Wage and Salary Workers	100.0	70.5	53.9	16.6	6.2	8.9	5.9	18.6
Public sector	100.0	85.6	72.4	13.2	5.7	8.9	3.7	7.2
Private sector	100.0	67.6	50.4	17.3	6.3	8.9	6.3	20.8
fewer than 10	100.0	45.5	23.4	22.1	10.4	11.2	8.7	36.0
10–49	100.0	56.8	35.7	21.0	7.7	9.7	7.4	27.9
50–99	100.0	68.7	51.6	17.0	5.8	8.8	6.3	20.7
100–499	100.0	74.3	59.4	14.8	4.9	7.9	5.3	16.9
500–999	100.0	76.1	61.4	14.7	5.8	7.5	5.5	15.2
1,000 or more	100.0	77.4	62.5	14.9	4.8	8.1	5.4	13.7

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

These states with 20 percent or higher uninsured rates are mostly in the south and south-central United States. In many of these states, a smaller proportion of the population was eligible for employment-based health benefits and/or a larger proportion was eligible for publicly funded programs than the national average. Both lower average income and higher unemployment rates may contribute to this difference. In addition, many of these states have a higher concentration of racial and ethnic groups that are less likely to be covered by health insurance.[11]

In 2009–2011, the states with less than 10 percent uninsured included Massachusetts (5.1 percent), and Hawaii (8.8 percent).

Citizenship

The proportion of the nonelderly population without health insurance varies by citizenship. In 2011, 15.2 percent of Native Americans were uninsured (Figure 21). In contrast, 23.4 percent of citizens who were naturalized were uninsured and 46 percent of individuals who were not U.S. citizens were uninsured.

Figure 13

Workers Ages 18–64 With Selected Sources of Health Insurance, by Occupation, 2011

Occupation	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	143.3	97.9	73.0	24.9	10.9	12.7	8.5	27.9
Managerial and professional specialty	51.9	42.7	33.8	8.9	4.4	2.9	1.5	4.6
Service occupations	26.5	13.3	8.1	5.2	2.1	3.8	2.9	8.3
Sales and office occupations	33.9	23.3	16.4	6.9	2.7	3.2	2.1	6.2
Farming, fishing, and forestry	1.1	0.4	0.2	0.2	0.1	0.1	0.1	0.6
Construction, extraction, and maintenance	12.4	7.2	5.6	1.6	0.8	1.0	0.7	3.9
Production, transportation, and material moving	17.4	11.2	9.0	2.1	0.9	1.7	1.3	4.4
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Managerial and professional specialty	36.2	43.6	46.2	35.9	40.5	22.8	17.0	16.4
Service occupations	18.5	13.5	11.0	20.9	19.0	29.7	33.5	29.7
Sales and office occupations	23.7	23.7	22.4	27.6	24.3	25.0	24.8	22.1
Farming, fishing, and forestry	0.8	0.4	0.3	0.8	0.9	1.0	1.4	2.1
Construction, extraction, and maintenance	8.7	7.3	7.6	6.3	7.2	8.2	8.5	13.9
Production, transportation, and material moving	12.2	11.4	12.4	8.5	8.1	13.2	14.8	15.9
				(percentage within occupation category)				
Total	100.0%	68.3%	51.0%	17.4%	7.6%	8.9%	6.0%	19.4%
Managerial and professional specialty	100.0	82.3	65.1	17.2	8.5	5.6	2.8	8.8
Service occupations	100.0	50.0	30.4	19.6	7.8	14.3	10.8	31.1
Sales and office occupations	100.0	68.6	48.3	20.2	7.8	9.4	6.2	18.2
Farming, fishing, and forestry	100.0	33.6	17.4	16.3	8.2	11.5	10.2	49.8
Construction, extraction, and maintenance	100.0	57.7	45.0	12.7	6.4	8.4	5.9	31.2
Production, transportation, and material moving	100.0	64.1	51.9	12.2	5.1	9.7	7.2	25.4

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

Employment

Just below 80 percent of the uninsured lived in families headed by workers in 2011 (calculated from Figure 10). Most people (86.2 percent) live in families headed by workers, including one-person families.

Industry

Workers employed in agriculture, forestry, fishing, mining, and construction in 2011 were disproportionately more likely to be uninsured: 33.3 percent. This compares with 15.7 percent uninsured among workers in the manufacturing sector, 19.5 percent in wholesale and retail trade, and 23.4 percent in the service sector. Uninsured workers were most likely to be employed in the wholesale and retail trade or service industry, which collectively accounted for 60.7 percent of employment (Figure 11).

Firm Size

About 61 percent of all uninsured workers were either self-employed or working in private-sector firms with fewer than 100 employees in 2011 (Figure 12). More than 28 percent of self-employed workers were uninsured, compared with 19.4 percent of all workers. Thirty-six percent of workers in private-sector firms with fewer than 10 employees were uninsured, compared with 13.7 percent of workers in private-sector firms with 1,000 or more employees.

Figure 14

Workers Ages 18–64 With Selected Sources of Health Insurance, by Hours and Weeks Worked, 2011

Hours and Weeks Worked	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	143.3	97.9	73.0	24.9	10.9	12.7	8.5	27.9
Full-time	111.6	81.7	65.0	16.7	8.1	7.8	4.8	19.0
full-time, full-year	96.7	74.0	62.0	12.0	6.7	5.8	3.4	14.9
full-time, part-year	14.9	7.7	3.1	4.6	1.4	2.0	1.5	4.1
Part-time	31.7	16.2	8.0	8.2	2.7	4.9	3.7	8.8
part-time, full-year	18.6	10.2	6.7	3.5	1.5	2.5	1.9	5.2
part-time, part-year	13.2	6.1	1.4	4.7	1.2	2.4	1.9	3.6
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Full-time	77.8	83.4	89.0	67.0	74.8	61.3	56.5	68.4
full-time, full-year	67.4	75.5	84.8	48.4	61.7	45.9	39.4	53.6
full-time, part-year	10.4	7.9	4.2	18.7	13.1	15.5	17.1	14.8
Part-time	22.2	16.6	11.0	33.0	25.2	38.7	43.5	31.6
part-time, full-year	13.0	10.4	9.1	14.0	13.9	19.8	21.7	18.6
part-time, part-year	9.2	6.2	1.9	19.0	11.3	18.9	21.9	13.0
				(percentage within hours and weeks category)				
Total	100.0%	68.3%	51.0%	17.4%	7.6%	8.9%	6.0%	19.4%
Full-time	100.0	73.2	58.3	15.0	7.3	7.0	4.3	17.1
full-time, full-year	100.0	76.5	64.1	12.5	6.9	6.0	3.5	15.4
full-time, part-year	100.0	51.7	20.5	31.2	9.6	13.2	9.8	27.6
Part-time	100.0	51.1	25.3	25.8	8.7	15.5	11.7	27.8
part-time, full-year	100.0	54.7	35.9	18.7	8.2	13.6	10.0	28.0
part-time, part-year	100.0	46.1	10.3	35.9	9.4	18.2	14.2	27.5

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 15

Nonelderly Population With Selected Sources of Health Insurance, by Family Income, 2011

Family Income	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	266.4	155.5	77.1	78.4	18.9	59.9	46.9	47.9
Under $10,000	24.6	2.7	1.1	1.6	1.3	12.3	11.4	8.1
$10,000–$19,999	23.8	4.0	2.3	1.8	1.2	11.2	9.6	7.8
$20,000–$29,999	25.6	8.0	5.1	2.9	1.5	9.2	7.9	7.8
$30,000–$39,999	25.5	11.9	7.2	4.7	1.7	7.1	5.8	6.2
$40,000–$49,999	21.9	12.5	7.2	5.3	1.6	5.0	3.8	4.5
$50,000–$74,000	45.7	32.0	16.5	15.5	3.6	7.0	4.5	6.8
$75,000 and over	99.4	84.4	37.8	46.6	8.1	8.0	4.0	6.7
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under $10,000	9.2	1.8	1.4	2.1	7.0	20.6	24.3	16.9
$10,000–$19,999	8.9	2.6	2.9	2.3	6.2	18.8	20.4	16.3
$20,000–$29,999	9.6	5.1	6.6	3.7	7.9	15.4	16.7	16.3
$30,000–$39,999	9.6	7.6	9.3	6.0	8.9	11.9	12.4	13.0
$40,000–$49,999	8.2	8.0	9.3	6.7	8.2	8.4	8.0	9.4
$50,000–$74,000	17.1	20.6	21.4	19.8	18.9	11.7	9.6	14.2
$75,000 and over	37.3	54.3	49.0	59.4	42.9	13.3	8.5	14.0
				(percentage within family income category)				
Total	100.0%	58.4%	28.9%	29.4%	7.1%	22.5%	17.6%	18.0%
Under $10,000	100.0	11.1	4.5	6.7	5.4	50.2	46.4	33.1
$10,000–$19,999	100.0	16.9	9.5	7.4	4.9	47.2	40.2	32.8
$20,000–$29,999	100.0	31.1	19.8	11.3	5.8	36.0	30.7	30.4
$30,000–$39,999	100.0	46.7	28.2	18.5	6.6	28.0	22.8	24.4
$40,000–$49,999	100.0	57.1	33.0	24.1	7.1	22.9	17.3	20.6
$50,000–$74,000	100.0	70.1	36.1	34.0	7.8	15.3	9.9	14.9
$75,000 and over	100.0	84.9	38.0	46.9	8.2	8.0	4.0	6.7

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 16

Nonelderly Population With Selected Sources of Health Insurance, by Race, 2011

Race	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	266.4	155.5	77.1	78.4	18.9	59.9	46.9	47.9
White	161.6	108.1	54.5	53.6	13.9	28.5	19.7	21.4
Black	33.5	15.6	8.5	7.2	1.5	11.3	9.4	7.0
Hispanic	49.2	19.1	8.6	10.5	1.8	15.0	13.7	15.5
Other	22.2	12.7	5.5	7.2	1.7	5.1	4.1	4.0
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
White	60.7	69.5	70.7	68.4	73.5	47.6	41.9	44.7
Black	12.6	10.0	11.0	9.1	7.8	18.9	20.0	14.7
Hispanic	18.5	12.3	11.2	13.3	9.6	25.1	29.2	32.4
Other	8.3	8.2	7.2	9.2	9.0	8.5	8.8	8.3
				(percentage within race category)				
Total	100.0%	58.4%	28.9%	29.4%	7.1%	22.5%	17.6%	18.0%
White	100.0	66.9	33.7	33.2	8.6	17.6	12.2	13.2
Black	100.0	46.7	25.3	21.4	4.4	33.8	28.1	21.0
Hispanic	100.0	38.8	17.5	21.3	3.7	30.5	27.9	31.6
Other	100.0	57.4	25.0	32.4	7.7	22.9	18.6	17.9

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Occupation

The uninsured are concentrated disproportionately in service-sector occupations or blue-collar jobs. In 2011, about 22 percent of workers were employed in blue-collar-type jobs, i.e., jobs in farming, fishing, forestry, construction, extraction, maintenance, production, transportation, and material moving, yet 32 percent of uninsured workers were in these jobs (calculated from Figure 13).

Hours of Work

Not surprisingly, part-time and part-year (usually seasonal) workers are less likely to have employment-based health benefits than full-time and full-year workers. In 2011, part-time or part-year workers accounted for 32.6 percent of the employed population, but 46.4 percent of uninsured workers (Figure 14). Over 27 percent of full-time, part-year workers were uninsured, while 27–28 percent of part-time, part-year workers and part-time, full-year workers were uninsured. About 15 percent of full-time, full-year workers were uninsured. Full-time workers employed for only part of the year were more likely to be uninsured than part-time, part-year workers because the later were more likely to be covered by Medicaid.

Income

The uninsured tend to be members of low-income families. In 2011, one-third (33.2 percent) of the uninsured were in families with annual incomes of less than $20,000 (calculated from Figure 15). About 33 percent of individuals in families with incomes less than $10,000 were uninsured, compared with 6.7 percent of those in families with annual incomes of $75,000 or more. Generally, as income increases, the percentage of the population without health insurance decreases when the percentage covered by employment-based benefits increases more than the percentage covered by publicly financed health insurance programs decreases.

Workers with low earnings are much more likely to be uninsured than those with high earnings. In 2011, one-third (31.3 percent) of workers with earnings of less than $10,000 and 37 percent of workers with earnings between $10,000 and $20,000 were uninsured, compared with 4.7 percent of workers with earnings of $70,000 or more (Figure 22). Low-income workers are employed generally in industries that are less likely to offer health benefits, and may have a weaker (or temporary) attachment to the work force and less disposable income to allocate to the purchase of health benefits.

Figure 17

Nonelderly Population With Selected Sources of Health Insurance, by Race and Family Poverty Status, 2011

Race and Family Poverty Status	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
White	161.6	108.1	54.5	53.6	13.9	28.5	19.7	21.4
0–99% of poverty	17.1	2.8	1.2	1.6	1.1	8.1	7.2	5.2
100%–149% of poverty	11.3	3.2	1.4	1.9	0.8	4.7	3.7	3.0
150%–199% of poverty	11.9	5.3	2.5	2.8	1.1	3.4	2.5	2.7
200%–299% of poverty	25.5	16.2	8.0	8.2	2.4	4.4	2.8	4.3
300% of poverty or more	95.8	80.6	41.5	39.1	8.5	7.8	3.4	6.2
Black	33.5	15.6	8.5	7.2	1.5	11.3	9.4	7.0
0–99% of poverty	9.6	1.0	0.4	0.6	0.3	5.8	5.4	2.6
100%–149% of poverty	4.0	1.2	0.5	0.7	0.1	1.8	1.4	1.2
150%–199% of poverty	3.5	1.6	0.9	0.7	0.1	1.1	0.8	0.9
200%–299% of poverty	5.9	3.6	1.8	1.7	0.3	1.4	1.0	1.1
300% of poverty or more	10.5	8.2	4.8	3.4	0.7	1.3	0.7	1.2
Hispanic	49.2	19.1	8.6	10.5	1.8	15.0	13.7	15.5
0–99% of poverty	12.7	1.2	0.4	0.8	0.3	6.9	6.7	4.7
100%–149% of poverty	7.9	1.5	0.6	0.9	0.2	3.1	2.9	3.3
150%–199% of poverty	6.6	2.3	0.9	1.4	0.3	1.9	1.7	2.5
200%–299% of poverty	9.0	4.5	2.0	2.5	0.4	1.7	1.5	2.9
300% of poverty or more	13.0	9.6	4.7	4.9	0.7	1.3	0.9	2.2
Other	22.2	12.7	5.5	7.2	1.7	5.1	4.1	4.0
0–99% of poverty	3.5	0.4	0.2	0.3	0.3	1.8	1.6	1.0
100%–149% of poverty	2.1	0.6	0.2	0.4	0.1	0.9	0.8	0.5
150%–199% of poverty	2.1	0.9	0.4	0.5	0.1	0.6	0.5	0.6
200%–299% of poverty	3.6	1.9	0.8	1.1	0.3	0.8	0.6	0.8
300% of poverty or more	10.9	8.9	4.0	4.9	0.9	1.0	0.6	1.0
				(percentage within race and poverty category)				
White	100.0%	67.5%	34.4%	33.0%	7.7%	16.3%	11.4%	14.1%
0–99% of poverty	100.0	16.5	6.8	9.6	6.5	47.3	42.1	30.6
100%–149% of poverty	100.0	28.5	12.1	16.4	7.4	41.8	33.0	26.3
150%–199% of poverty	100.0	44.3	20.7	23.5	8.9	28.7	21.3	23.1
200%–299% of poverty	100.0	63.6	31.3	32.3	9.4	17.4	11.1	16.9
300% of poverty or more	100.0	84.1	43.3	40.8	8.9	8.2	3.6	6.4
Black	100.0	46.7	25.3	21.4	4.4	33.8	28.1	21.0
0–99% of poverty	100.0	10.6	4.4	6.2	3.3	60.9	56.7	27.3
100%–149% of poverty	100.0	30.2	13.6	16.6	3.1	44.3	36.5	29.2
150%–199% of poverty	100.0	45.3	24.3	21.0	3.7	31.4	24.0	25.1
200%–299% of poverty	100.0	61.0	31.2	29.8	4.4	23.1	17.5	19.5
300% of poverty or more	100.0	78.0	45.6	32.4	6.2	12.1	6.2	11.7
Hispanic	100.0	38.8	17.5	21.3	3.7	30.5	27.9	31.6
0–99% of poverty	100.0	9.5	3.0	6.5	2.2	54.1	52.4	36.7
100%–149% of poverty	100.0	19.3	7.7	11.7	2.5	40.0	37.4	41.7
150%–199% of poverty	100.0	34.3	13.6	20.6	4.0	29.3	25.9	37.2
200%–299% of poverty	100.0	50.2	22.4	27.7	4.6	19.0	16.5	32.3
300% of poverty or more	100.0	73.7	36.3	37.4	5.1	10.2	7.1	17.1
Other	100.0	57.4	25.0	32.4	7.7	22.9	18.6	17.9
0–99% of poverty	100.0	12.2	4.5	7.7	9.0	50.0	46.1	29.1
100%–149% of poverty	100.0	28.3	11.0	17.4	7.0	44.1	39.6	25.3
150%–199% of poverty	100.0	43.4	17.3	26.1	5.5	28.4	25.1	28.1
200%–299% of poverty	100.0	54.0	22.6	31.4	7.1	22.6	16.9	22.6
300% of poverty or more	100.0	81.4	36.5	44.9	8.1	9.0	5.1	9.3

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 18

Nonelderly Population With Selected Sources of Health Insurance, by Family Income as a Percentage of Poverty, 2011

Family Poverty Status	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	266.4	155.5	77.1	78.4	18.9	59.9	46.9	47.9
0–99% of poverty	42.9	5.5	2.1	3.3	2.0	22.6	20.9	13.5
100%–149% of poverty	25.2	6.5	2.7	3.8	1.3	10.5	8.9	7.9
150%–199% of poverty	24.0	10.0	4.6	5.4	1.6	7.0	5.6	6.7
200%–299% of poverty	43.9	26.2	12.6	13.6	3.3	8.3	6.0	9.2
300% of poverty or more	130.3	107.3	55.0	52.2	10.7	11.4	5.5	10.6
				(percentage within poverty category)				
Total	100.0%	58.4%	28.9%	29.4%	7.1%	22.5%	17.6%	18.0%
0–99% of poverty	100.0	12.7	5.0	7.8	4.7	52.6	48.7	31.5
100%–149% of poverty	100.0	25.9	10.9	15.0	5.2	41.8	35.5	31.5
150%–199% of poverty	100.0	41.6	19.0	22.6	6.5	29.2	23.3	27.7
200%–299% of poverty	100.0	59.7	28.7	31.0	7.6	18.9	13.5	20.9
300% of poverty or more	100.0	82.3	42.2	40.1	8.2	8.8	4.2	8.2

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 19

Nonelderly Population With Selected Sources of Health Insurance, by Self-Reported Health Status, 2011

Self-Reported Health Status	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	266.4	155.5	77.1	78.4	18.9	59.9	46.9	47.9
Excellent	95.1	61.8	24.4	37.5	7.6	17.8	14.6	12.9
Very Good	87.2	54.6	29.3	25.3	6.2	15.8	12.8	15.5
Good	60.0	30.6	18.4	12.2	3.8	15.0	11.9	14.3
Fair	17.5	6.7	4.1	2.6	1.1	7.4	5.0	4.0
Poor	6.5	1.8	1.0	0.8	0.3	3.9	2.5	1.2
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Excellent	35.7	39.8	31.6	47.8	40.4	29.7	31.2	27.0
Very Good	32.7	35.1	37.9	32.3	32.5	26.3	27.3	32.3
Good	22.5	19.7	23.9	15.6	19.9	25.1	25.4	29.9
Fair	6.6	4.3	5.3	3.4	5.6	12.4	10.7	8.4
Poor	2.4	1.1	1.3	1.0	1.6	6.5	5.4	2.5
				(percentage within work status categories)				
Total	100.0%	58.4%	28.9%	29.4%	7.1%	22.5%	17.6%	18.0%
Excellent	100.0	65.0	25.6	39.4	8.0	18.7	15.4	13.6
Very Good	100.0	62.5	33.5	29.0	7.1	18.1	14.7	17.7
Good	100.0	51.1	30.7	20.4	6.3	25.0	19.9	23.9
Fair	100.0	38.2	23.2	15.0	6.0	42.2	28.6	22.8
Poor	100.0	27.4	15.4	11.9	4.8	59.9	38.9	18.4

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 20

Nonelderly Population With Selected Sources of Health Insurance, by Region and State, Three-Year Average 2009–2011

Region and State	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	265.7	156.3	77.8	78.5	18.7	57.8	45.4	48.5
New England	12.3	8.5	4.0	4.5	0.8	2.6	2.3	1.1
Maine	1.1	0.7	0.3	0.3	0.1	0.3	0.3	0.1
New Hampshire	1.1	0.8	0.4	0.4	0.1	0.1	0.1	0.1
Vermont	0.5	0.3	0.2	0.2	0.0	0.2	0.1	0.1
Massachusetts	5.6	4.0	1.9	2.1	0.3	1.3	1.2	0.3
Rhode Island	0.9	0.6	0.3	0.3	0.1	0.2	0.2	0.1
Connecticut	3.0	2.1	1.0	1.2	0.3	0.5	0.4	0.4
Middle Atlantic	34.8	21.8	10.7	11.1	2.4	7.5	6.5	5.2
New York	16.7	9.8	4.9	4.9	1.1	4.3	3.8	2.6
New Jersey	7.5	5.0	2.3	2.7	0.4	1.2	1.0	1.3
Pennsylvania	10.6	7.0	3.5	3.5	0.9	2.0	1.7	1.3
East North Central	39.7	24.9	11.9	12.9	2.6	8.5	7.0	6.0
Ohio	9.8	6.1	3.0	3.1	0.6	2.0	1.6	1.5
Indiana	5.5	3.5	1.7	1.8	0.3	1.3	1.0	0.8
Illinois	11.2	6.8	3.4	3.4	0.7	2.4	2.0	1.8
Michigan	8.4	5.3	2.4	2.9	0.6	1.8	1.5	1.2
Wisconsin	4.8	3.2	1.5	1.7	0.3	1.0	0.8	0.5
West North Central	17.5	11.3	5.6	5.7	1.6	3.3	2.6	2.4
Minnesota	4.5	3.1	1.5	1.6	0.4	0.8	0.7	0.5
Iowa	2.6	1.7	0.9	0.9	0.2	0.5	0.4	0.3
Missouri	5.1	3.1	1.6	1.5	0.5	1.0	0.8	0.9
North Dakota	0.6	0.4	0.2	0.2	0.1	0.1	0.1	0.1
South Dakota	0.7	0.4	0.2	0.2	0.1	0.2	0.1	0.1
Nebraska	1.6	1.0	0.5	0.5	0.2	0.3	0.2	0.2
Kansas	2.4	1.5	0.7	0.8	0.2	0.5	0.3	0.4
South Atlantic	50.7	29.2	15.0	14.3	3.5	10.9	7.4	10.3
Delaware	0.8	0.5	0.2	0.2	0.0	0.2	0.1	0.1
Maryland	5.0	3.4	1.7	1.7	0.4	0.8	0.6	0.8
District of Columbia	0.5	0.3	0.2	0.1	0.0	0.1	0.1	0.1
Virginia	6.8	4.4	2.1	2.3	0.5	1.4	0.7	1.0
West Virginia	1.5	0.9	0.5	0.5	0.0	0.4	0.3	0.3
North Carolina	8.1	4.6	2.5	2.1	0.5	1.9	1.4	1.6
South Carolina	3.9	2.2	1.1	1.1	0.2	0.9	0.6	0.9
Georgia	8.7	4.8	2.3	2.5	0.5	1.9	1.3	1.9
Florida	15.3	8.1	4.4	3.8	1.2	3.2	2.2	3.8
East South Central	15.7	8.9	4.6	4.4	1.0	4.1	3.0	2.8
Kentucky	3.7	2.2	1.1	1.1	0.2	0.9	0.7	0.6
Tennessee	5.4	3.1	1.6	1.5	0.4	1.4	1.0	0.9
Alabama	4.0	2.4	1.2	1.2	0.3	1.0	0.7	0.7
Mississippi	2.5	1.3	0.7	0.6	0.2	0.7	0.6	0.5
West South Central	32.0	16.7	8.5	8.3	1.8	7.0	5.5	8.1
Arkansas	2.4	1.3	0.7	0.6	0.1	0.7	0.5	0.5
Louisiana	3.9	2.1	1.0	1.1	0.3	1.0	0.8	0.8
Oklahoma	3.2	1.8	0.9	0.9	0.2	0.8	0.5	0.6
Texas	22.5	11.6	5.9	5.7	1.2	4.6	3.7	6.1
Mountain	19.4	11.2	5.4	5.8	1.6	4.0	3.0	3.8
Montana	0.8	0.4	0.2	0.2	0.1	0.2	0.1	0.2
Idaho	1.3	0.8	0.4	0.4	0.2	0.2	0.2	0.3
Wyoming	0.5	0.3	0.1	0.1	0.0	0.1	0.1	0.1
Colorado	4.4	2.7	1.3	1.4	0.5	0.8	0.6	0.7
New Mexico	1.7	0.8	0.4	0.4	0.1	0.5	0.4	0.4
Arizona	5.8	3.1	1.5	1.5	0.4	1.5	1.2	1.2
Utah	2.5	1.7	0.7	1.1	0.2	0.3	0.2	0.4
Nevada	2.3	1.4	0.7	0.7	0.1	0.4	0.2	0.6
Pacific	43.7	23.8	12.2	11.7	3.4	9.9	8.2	8.8
Washington	5.9	3.5	1.9	1.6	0.5	1.4	1.0	0.9
Oregon	3.3	2.0	1.0	0.9	0.3	0.6	0.5	0.6
California	32.9	17.3	8.6	8.6	2.5	7.4	6.4	7.1
Alaska	0.6	0.4	0.2	0.2	0.0	0.2	0.1	0.1
Hawaii	1.1	0.7	0.4	0.3	0.1	0.3	0.2	0.1

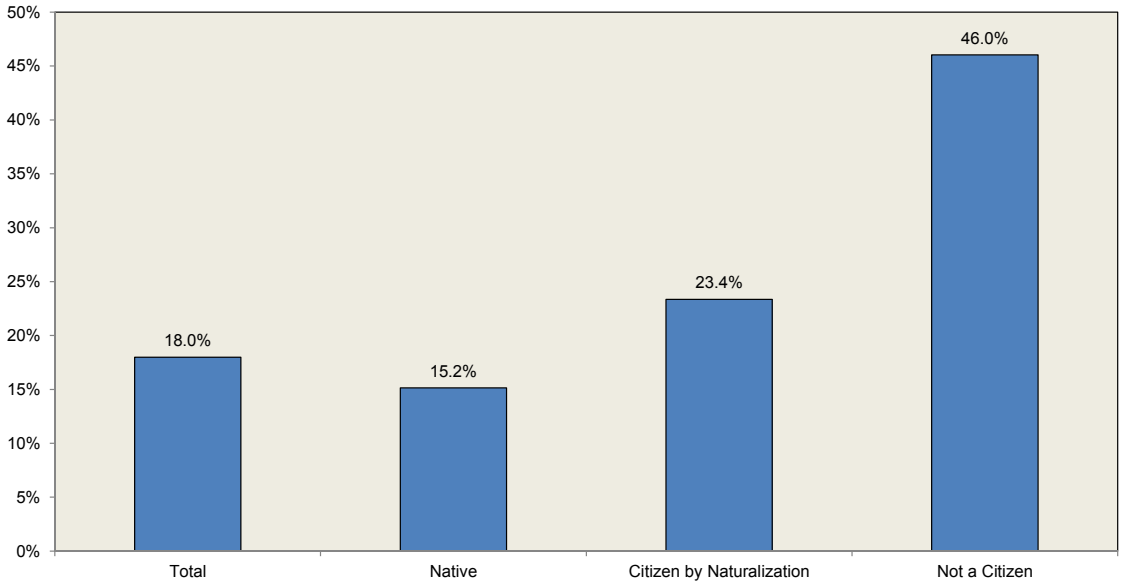
(more)

(cont'd. from previous page)

Region and State	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
					(percentage)			
Total	100.0%	58.8%	29.3%	29.5%	7.1%	21.7%	17.1%	18.2%
New England	100.0	69.1	32.7	36.4	6.9	21.3	18.5	8.8
Maine	100.0	60.9	31.4	29.5	6.2	29.6	23.3	11.6
New Hampshire	100.0	72.2	33.6	38.6	7.4	12.0	7.8	12.5
Vermont	100.0	62.4	31.5	30.9	6.9	29.2	25.1	10.5
Massachusetts	100.0	70.9	33.4	37.5	6.0	23.5	21.8	5.1
Rhode Island	100.0	63.4	30.7	32.7	6.0	23.1	19.4	13.6
Connecticut	100.0	70.6	32.5	38.1	8.8	15.9	13.1	11.6
Middle Atlantic	100.0	62.6	30.7	31.9	7.0	21.5	18.8	15.0
New York	100.0	58.6	29.5	29.1	6.4	25.6	23.0	15.5
New Jersey	100.0	66.7	30.3	36.4	5.9	15.3	12.9	17.1
Pennsylvania	100.0	66.0	32.9	33.0	8.9	19.4	16.4	12.8
East North Central	100.0	62.6	30.1	32.6	6.5	21.3	17.7	15.0
Ohio	100.0	62.4	30.7	31.6	6.4	20.3	16.4	15.7
Indiana	100.0	63.0	30.1	32.9	6.2	23.3	18.2	15.0
Illinois	100.0	60.6	30.0	30.6	6.6	21.4	18.3	16.4
Michigan	100.0	62.9	28.4	34.5	6.7	21.4	18.2	14.6
Wisconsin	100.0	67.1	31.7	35.3	6.3	20.4	17.4	11.1
West North Central	100.0	64.4	32.1	32.4	9.4	19.1	14.6	13.8
Minnesota	100.0	68.7	33.4	35.3	9.3	18.5	15.2	10.3
Iowa	100.0	66.4	33.2	33.2	9.0	18.5	15.5	12.5
Missouri	100.0	60.9	31.2	29.7	9.2	19.7	15.4	16.7
North Dakota	100.0	65.6	33.4	32.2	14.2	16.1	9.8	12.5
South Dakota	100.0	60.7	30.1	30.6	11.3	21.8	15.0	15.1
Nebraska	100.0	64.5	31.3	33.2	11.8	17.9	11.9	13.9
Kansas	100.0	62.5	30.8	31.7	7.4	20.3	13.6	15.2
South Atlantic	100.0	57.7	29.6	28.1	6.8	21.5	14.6	20.4
Delaware	100.0	65.5	32.4	33.1	5.8	22.4	17.5	13.2
Maryland	100.0	68.1	33.6	34.5	7.2	16.3	11.8	15.0
District of Columbia	100.0	56.7	39.2	17.5	8.6	27.5	25.3	12.3
Virginia	100.0	64.8	31.1	33.7	7.3	20.0	10.1	15.3
West Virginia	100.0	60.1	29.9	30.1	2.9	28.6	19.6	16.3
North Carolina	100.0	56.5	30.7	25.9	6.4	23.8	16.9	19.6
South Carolina	100.0	55.5	28.5	27.0	6.4	22.9	16.1	21.8
Georgia	100.0	55.5	26.6	28.9	6.1	22.1	15.0	21.8
Florida	100.0	52.9	28.5	24.5	7.6	21.2	14.5	24.8
East South Central	100.0	57.0	29.1	27.9	6.4	26.0	19.0	17.5
Kentucky	100.0	58.5	30.4	28.2	4.8	25.0	19.2	17.2
Tennessee	100.0	56.9	28.9	28.0	7.2	26.5	18.7	16.5
Alabama	100.0	59.5	29.5	30.0	6.9	25.0	17.2	17.1
Mississippi	100.0	50.7	27.1	23.5	6.5	28.1	21.9	20.8
West South Central	100.0	52.3	26.5	25.8	5.5	21.9	17.1	25.2
Arkansas	100.0	52.4	28.3	24.2	6.1	26.7	19.6	21.1
Louisiana	100.0	52.8	25.5	27.3	6.5	25.3	20.2	20.9
Oklahoma	100.0	57.0	28.9	28.1	5.5	23.9	16.9	20.1
Texas	100.0	51.6	26.2	25.4	5.3	20.5	16.3	27.0
Mountain	100.0	57.7	27.8	29.9	8.3	20.5	15.5	19.5
Montana	100.0	51.9	26.9	25.0	11.3	21.6	14.3	20.4
Idaho	100.0	56.5	26.8	29.6	12.1	18.4	14.6	19.4
Wyoming	100.0	61.2	30.4	30.8	7.7	17.8	12.7	19.1
Colorado	100.0	61.7	30.4	31.3	10.2	17.9	12.8	16.2
New Mexico	100.0	47.9	23.6	24.4	5.4	29.5	23.7	23.9
Arizona	100.0	53.2	26.6	26.6	7.3	25.4	20.3	20.6
Utah	100.0	68.8	27.2	41.6	7.9	13.6	9.8	15.6
Nevada	100.0	58.5	30.1	28.5	6.3	15.9	10.3	24.3
Pacific	100.0	54.5	27.8	26.7	7.8	22.7	18.7	20.2
Washington	100.0	59.9	32.5	27.4	8.2	24.1	16.6	15.5
Oregon	100.0	59.7	31.8	27.9	8.9	19.5	15.5	18.3
California	100.0	52.5	26.3	26.3	7.7	22.5	19.5	21.6
Alaska	100.0	59.0	30.6	28.4	4.5	26.5	13.8	19.5
Hawaii	100.0	68.0	36.7	31.3	6.8	27.0	18.4	8.8

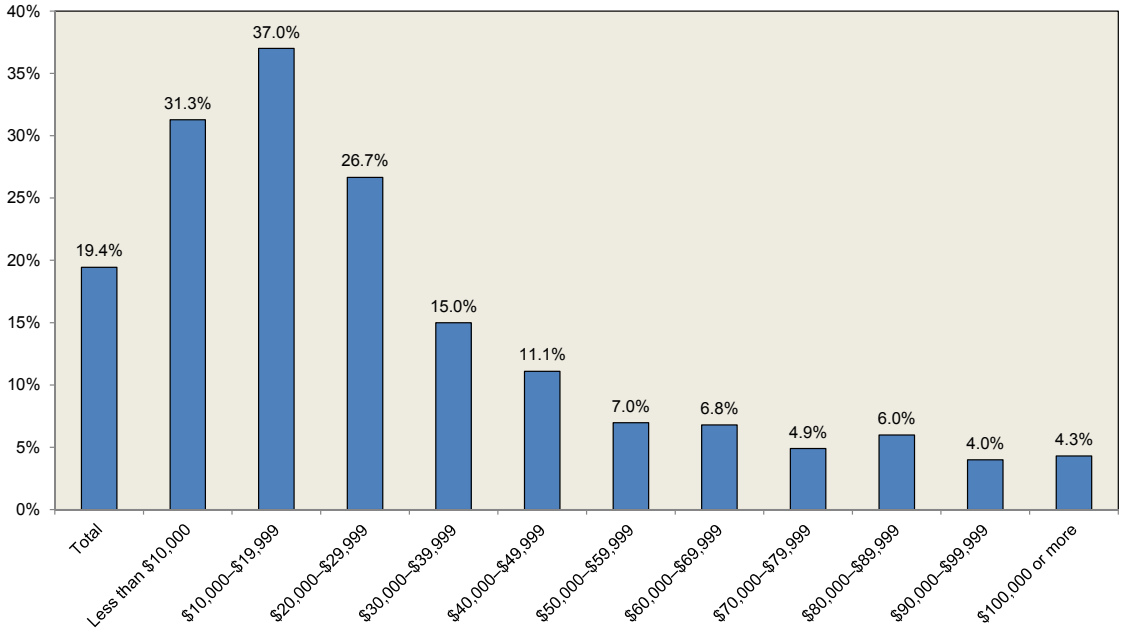
Source: Employee Benefit Research Institute estimates of the 2010–2012 Current Population Survey, March Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 21
Percentage Uninsured Among Individuals Under Age 65, by Citizenship, 2011



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2012 Supplement.

Figure 22
Percentage Uninsured Among Workers Ages 18–64, by Total Earnings, 2011



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2012 Supplement.

Race and Ethnic Origin

While 60.7 percent of the nonelderly population is white, whites comprised 44.7 percent of the uninsured. Individuals of Hispanic origin were more likely to be uninsured than other groups (31.6 percent) (Figure 16). This may be due in part to the fact that 58 percent of the Hispanic population reported income of less than 200 percent of the federal poverty level. Also, a higher proportion of Hispanics than the general population are immigrants and may work for small firms or be employed on a part-time or part-year basis. However, in 2011, even at high income levels, Hispanics generally were more likely to be uninsured than other racial groups, and were less likely to have employment-based health benefits.

Gender and Age

Men are generally more likely than women to be uninsured. One-quarter (23.1 percent) of men were uninsured in 2011, compared with 19.6 percent of women (Figure 23). This difference between men and women is observed at all age groups under age 55, especially below age 35.

Younger adults are more likely than older adults to be uninsured. Nearly 31 percent of men ages 21–24 and 26.4 percent of women ages 21–24 were uninsured in 2011. This compares with 19.1 percent of men ages 45–54 and 16.8 percent of women ages 45–54 uninsured. Young adults are often more likely to be uninsured because they are no longer covered by a family policy and may not have established themselves as permanent members of the work force, although some young adults may recently have had access to their parents' employment-based coverage because of a provision in PPACA.[12] Some young adults may also have lost access to Medicaid, which covered them through age 18. Many in this age group may think that they do not need health insurance because the likelihood of encountering a high-cost medical event is very low.[13] In addition, young workers may be ineligible for employment-based health benefits because of waiting periods imposed prior to eligibility.

Children

Nearly one in 10 children—or 7 million children—were uninsured in 2011 (Figure 24). More than 66 percent of all uninsured children were in families with income below 200 percent of the federal poverty level. Over 13 percent of children whose family head did not work were uninsured (Figure 25), though most uninsured children were in families with heads who were employed full-time and full-year (60.9 percent) (Figure 26). In families where the head worked part time or experienced some unemployment, the probability of being uninsured was higher than average (Figure 25).

Policy Implications

Uninsured individuals are a public policy concern for a number of reasons. First, individuals without health insurance are less likely to receive basic health care services. The uninsured report having fewer ambulatory visits than individuals with health insurance, and, as a result, are more likely to seek care in a more costly emergency room setting.[14] This population's overall health status may be lower, and individuals' overall productivity may be lower (Fronstin and Holtmann, 2000). Historically, providers of health care, especially hospitals but also physicians, have not been paid for care provided to uninsured individuals, and have tried to shift the cost of that care to other payers.[15]

An Institute of Medicine report provides detailed information on the cost of the uninsured to society (Institute of Medicine, 2003). According to the report, society is affected in a number of ways:

There is lost work-place productivity and lost health and longevity. There is financial risk, uncertainty, and anxiety. And there are financial stresses and instability for health care providers and institutions in communities with relatively high uninsured rates. The mortality rate is 25 percent higher among the uninsured than it is among the insured. In addition, uninsured children are at greater risk of suffering delays in development that may affect their educational achievements and prospects later in life. Overall, the report suggests that the aggregate, annualized cost of diminished health and shorter life spans of the uninsured is between $65 billion and $135 billion.

The combination of a growing economy in the 1990s and the lowest unemployment rates in more than 25 years resulted in an increase in the percentage of individuals in the United States with employment-based health benefits and a decrease in the uninsured in 1999 and 2000. However, despite the fact that the average annual unemployment rate declined from 6 percent in 2003 to only 5.1 percent in 2005 the percentage of individuals with coverage did not increase. This may mean that the labor market was not strong enough to offset the impact of the rising cost of health coverage. In 2011, the unemployment rate averaged 9 percent. Prior to the recession that started in December 2007, the last year that unemployment averaged more than 9 percent was 1983. Unemployment in 2012 has continued to average slightly above 8 percent between January and August.

As a result, the nation is likely to see continued erosion of employment-based health benefits when the data for 2012 are released in 2013. Until employment rebounds, there will be fewer individuals with access to health benefits in the work place. That will be coupled with an increasing number of workers who will likely forego coverage when it is available because of uncertainty about the economy, the future of job security, and prospects for health reform.

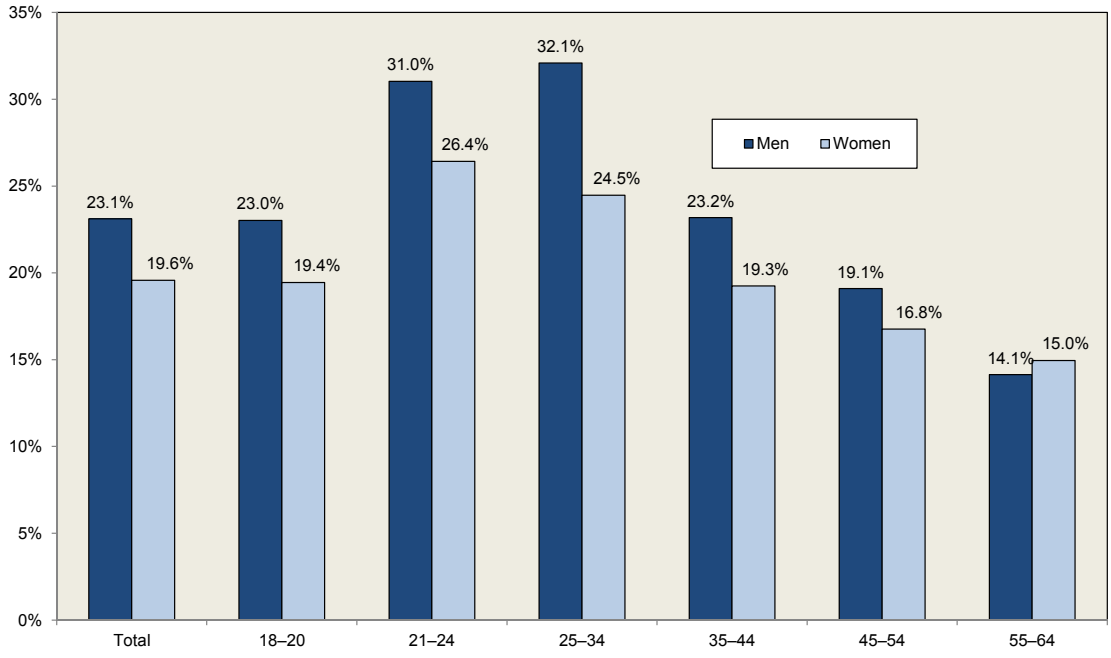
This *Issue Brief* has provided data on recent trends in health benefits, a summary of the characteristics of people with and without health insurance, and the sources of the health insurance. The data and issues discussed are important not only to policymakers but also to employers, because health insurance remains the benefit most valued by workers and their families (Fronstin, 2012). Nearly 60 percent of individuals rate employment-based health benefits as the most important benefit. Health benefits provide workers and their families with financial security against losses that can accompany unexpected serious illness or injury. Employers offer health insurance as an employee benefit for a number of reasons—to promote health and increase worker productivity as well as to provide financial security. Health benefits also are a form of compensation used to recruit and retain workers. There also may be a "business case" for health benefits, meaning employers may want to offer them if a compensation package comprised of both wages and health benefits is more profitable than one providing wages alone. However, the recent enactment and ongoing implementation of federal health reform legislation may change that equation.

Conclusion

This *Issue Brief* finds that many factors affect the likelihood of an individual having health insurance and the source of that coverage. These factors include the strength of the economy, demographics, and employment characteristics, all of which often vary by location. For example, work status and income play a dominant role in determining an individual's likelihood of having health insurance. In addition, age, gender, firm size, hours of work, occupation, and industry are all important determinants of an individual's likelihood of having coverage; however, these variables are also closely linked to employment status and income. Variations by race and ethnicity also are closely linked to employment status and income.

Research illustrates the advantages to individuals of having health insurance and the benefits to employers of offering it. In general, the availability of health insurance allows individuals to avoid unnecessary pain and suffering and improves the quality of life, and employers report that offering benefits has a positive impact on worker recruitment, retention, health status, and productivity (Fronstin and Helman, 2003; Fronstin, 2007). Employers may believe in the business case for providing health benefits today, but in the future they may rethink the value that offering coverage provides, especially if the economy does not rebound and unemployment remains high, or if employers determine that the health reform legislation passed in March 2010 changes the value proposition.

Figure 23
Percentage Uninsured Among Individuals Ages 18–64, by Gender and Age, 2011



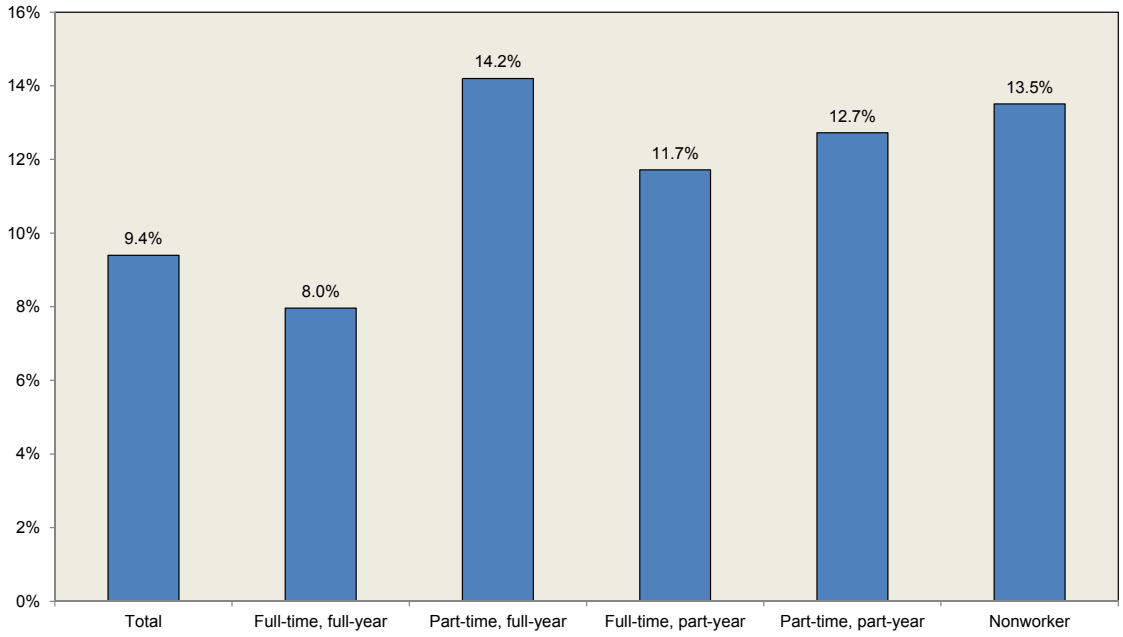
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2012 Supplement.

Figure 24
Children With Selected Sources of Health Insurance, by Poverty Level, 2011

Poverty Level	Total	Employment-Based Coverage	Individually Purchased	Public		Uninsured
				Total	Medicaid	
			(millions)			
Total	74.1	40.6	4.3	28.7	26.3	7.0
0–99% of poverty	16.5	2.2	0.5	12.4	12.2	2.3
100%–149% of poverty	8.9	2.5	0.3	5.5	5.3	1.3
150%–199% of poverty	7.6	3.4	0.4	3.5	3.3	1.0
200%–299% of poverty	12.3	7.9	0.9	3.8	3.2	1.2
300% of poverty or more	28.7	24.5	2.2	3.5	2.4	1.2
			(percentage within coverage category)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
0–99% of poverty	22.3	5.5	11.7	43.3	46.3	32.9
100%–149% of poverty	12.0	6.2	7.5	19.3	20.0	18.8
150%–199% of poverty	10.3	8.3	9.8	12.3	12.4	14.5
200%–299% of poverty	16.7	19.5	20.1	13.1	12.2	17.2
300% of poverty or more	38.7	60.5	50.9	12.1	9.2	16.6
			(percentage within poverty category)			
Total	100.0%	54.7%	5.7%	38.8%	35.5%	9.4%
0–99% of poverty	100.0	13.4	3.0	75.4	73.9	13.9
100%–149% of poverty	100.0	28.2	3.6	62.3	59.1	14.7
150%–199% of poverty	100.0	44.0	5.5	46.3	42.6	13.2
200%–299% of poverty	100.0	64.2	6.9	30.4	26.1	9.7
300% of poverty or more	100.0	85.5	7.5	12.1	8.4	4.0

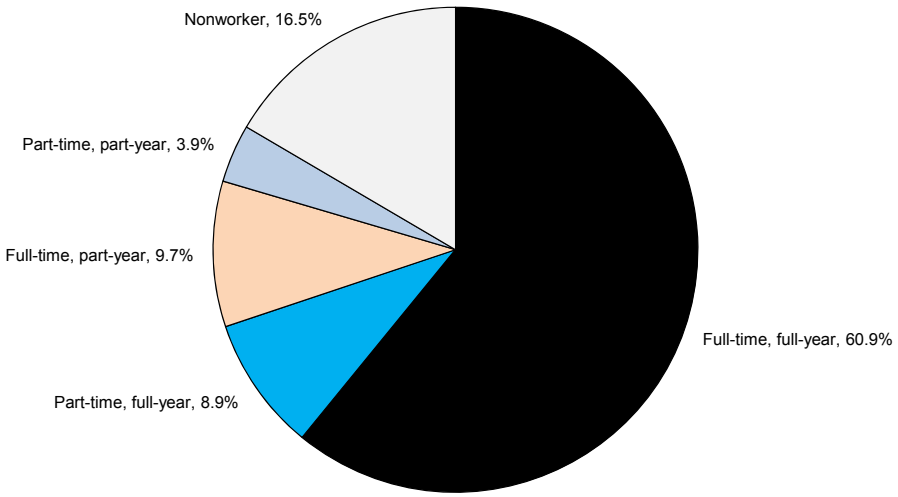
Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2012 Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Figure 25
Percentage Uninsured Among Children Under Age 18, by Work Status of the Family Head, 2011



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2012 Supplement.

Figure 26
Children Under Age 18 Without Health Insurance, by Work Status of the Family Head, 2011



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2012 Supplement.

Appendix–Current Population Survey

The data presented in this *Issue Brief* come from the March Supplement to the Current Population Survey (CPS), conducted by the Census Bureau (part of the U.S. Department of Commerce) for the Bureau of Labor Statistics (BLS, part of the U.S. Department of Labor) every month for more than 50 years. It is the primary source of data on labor force characteristics of the U.S. civilian noninstitutionalized population. It is also the official source of data on unemployment rates, poverty, and income in the United States. Approximately 57,000 households, representing 112,000 individuals, are interviewed each month.

Households are scientifically selected on the basis of geographic region of residence to collect data representative of the nation, individual states, and other specified areas. Eight panels are used to rotate the sample each month. This improves the reliability of estimates of month-to-month and year-to-year changes. A sample unit is interviewed for four consecutive months, and then is interviewed again for the same four months a year later. The unit is not interviewed during the eight months in between.

Theoretically, individuals can be followed over time. For example, approximately 50 percent of the sample interviewed in March of 2005 was re-interviewed in March 2006. But in practice, the survey does not re-interview *individuals*: Instead, the survey re-interviews the occupants of the *households* that were selected for inclusion in the sample. If the occupants of a household change over the course of the eight interviews, the new occupants in the household will take the place of the former occupants for the remaining interviews.

The first- and the fifth-month interviews are almost always conducted in person by an interviewer. More than 90 percent of the interviews conducted in months two through four and six through eight are conducted by telephone. Interviewers continue to visit households without telephones, with poor English-language skills, or that decline a telephone interview. Interviewers usually obtain responses from more than 93 percent of their eligible cases. The response rate varies by type of area and the mix of telephone vs. personal-visit interviews.

Since 1980, the supplement to the March CPS has included questions on health insurance coverage. Separate questions are asked about employment-based health insurance, health insurance purchased directly from an insurer, insurance from a source outside of the household, Medicare, Medicaid, Tricare, CHAMPVA, Indian Health Service, or other state-specific health programs for low-income uninsured individuals. These questions are asked of the household respondent, and potentially could miss nonrespondents, but the CPS also follows each question with a question about who else in the household is covered by the health plan.

Until recently, a question about being uninsured was never asked. Estimates of the uninsured were calculated as a residual; that is, people were counted as being uninsured if they did not report having any type of health insurance coverage.

The questions on health insurance refer to the previous calendar year. For example, in March 2009, interviewers asked about health insurance coverage during 2008. Assuming that respondents answered the questions correctly, the uninsured estimate should represent the number of people who were uninsured for the entire previous calendar year. One measurement issue that arises in this structure is that individuals potentially are asked to recall the type of health insurance they had 14 months prior to being interviewed. A second issue is that some individuals do not understand the question and report the type of health insurance they have as of the interview date. Third, the CPS may not be picking up all Medicaid recipients because some states do not call the program Medicaid. In fact, there is strong evidence that the CPS under-reports Medicaid coverage, based on comparisons of these data with enrollment and participation data provided by the Centers for Medicare & Medicaid Services (CMS), the federal agency primarily responsible for administering Medicaid.

Because respondents are asked to provide information about all sources of health insurance coverage during the previous calendar year, some individuals reported having health insurance coverage from more than one source. It is not possible to determine when during the calendar year an individual was covered by multiple sources of health

insurance. While these plans may have been held simultaneously, they were more likely held at different points during the year except among Medicare beneficiaries.

The CPS has undergone a number of changes over the years that affect the comparability of data in the time series. The remainder of this section discusses those changes.

In March 1988, the CPS questionnaire was substantially changed. Among the changes that were made, questions were added that inevitably picked up more people with health insurance coverage and reduced the number of uninsured in the survey (Moyer, 1989; and Swartz and Purcell, 1989). Prior to the March 1988 CPS, only employed people were asked about employment-based health insurance. Starting with the March 1988 CPS, all people age 15 and older were asked about employment-based coverage. This change resulted in the identification of coverage for people (and their families) covered by former employers through either retiree health benefits or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Another major change in March 1988 affected the health insurance coverage of children. Questions were added about coverage from sources outside the household. Imputation methods for children's coverage were also revised to collect more accurate information about coverage type and policyholders. An additional set of questions was added to get more accurate information about children on Medicaid and those covered by a plan purchased directly from an insurer. Finally, weighting, programming, and processing improvements were made to the survey (Levit et al., 1992).

In March 1995, the CPS questionnaire was revised again. The Census Bureau utilized a more detailed set of health insurance questions designed to take advantage of computer-assisted survey interviewing collection (CASIC) technology. The order of the questions was changed, and the wording in some of the questions was changed. In addition, the sampling frame was changed, potentially complicating comparability of the estimates prior to March 1995 with those starting in or after March 1995. The new questions appeared to have affected responses regarding the total number of respondents covered by employment-based health insurance coverage, individually purchased coverage, Tricare, and CHAMPVA. Questions on Medicare and Medicaid were also revised, but because estimates of Medicare and Medicaid from the CPS do not vary much from year to year even when the survey is unchanged, it is difficult to know how much of the estimates were affected by changes to the survey and how much of the estimates represent true changes. The longer-term trends in coverage are likely to be representative of the true change, because the estimates do not change much from year to year. Swartz (1997) documents these data issues in greater detail.

In March 1998, the Census Bureau made another change in the CPS by modifying its definition of the population with Medicaid coverage. Previously, an individual reporting coverage from the Indian Health Service (IHS) only was counted as part of the Medicaid population. Beginning with the March 1998 CPS, individuals covered solely by IHS are counted as uninsured. This methodological change affected roughly 300,000 individuals. If this change had not taken place, the Medicaid population would have fallen by 0.9 percentage points between 1996 and 1997, instead of by 1.1 percentage points. Overall, this was a minor change to the uninsured estimates in the CPS.

In March 2000, the Census Bureau added a question to the CPS to verify whether or not a person was uninsured. In essence, anyone who did not report any health insurance coverage during 2000 was asked an additional question about whether they were uninsured. Those who reported that they had coverage were then asked about the type of coverage. The verification questions resulted in the Census Bureau providing a "corrected" estimate for the uninsured in 1999. As shown in Figure A1, prior to the correction, 17.5 percent of the nonelderly population, representing 42.1 million individuals, was estimated to be uninsured in 1999. The verification questions resulted in a 7.4 percent decline in the number and percentage of nonelderly individuals without health insurance coverage in 1999. Most of the people who would have been counted as uninsured under the old methodology are now counted as having either employment-based health insurance or having purchased health insurance directly from an insurer. Hence, the corrected estimate for the uninsured in 1999 is 16.2 percent, or 39 million, down from 17.5 percent, or 42.1 million.[16]

The verification questions were not asked prior to the March 2000 CPS. As a result, data prior to 1999 are not directly comparable with data from 1999 and later. In order to provide roughly comparable estimates over time, the estimates

of health insurance coverage for 1994–1998 in this report have been recalculated using the one-time percentage change in the 1999 health insurance coverage estimates shown in Figure A1.

In 2001, two changes were made to the CPS. First, the sample was expanded to improve state estimates of S-CHIP enrollees. Overall, this change increased the uninsured estimate from 14 percent of the population to 14.1 percent, which accounted for an increase of nearly 200,000 uninsured people (Mills, 2002). However, the change in the uninsured percentage varied significantly from state to state, ranging from a 1.8 percentage point increase in Connecticut to a 2-percentage-point decline in Vermont. The Census Bureau also introduced Census 2000-based weights starting with the March 2002 CPS and provided new estimates for the March 2000 and March 2001 CPS that are based on the new weights. When using the Census 1990-based weights for the March 2001 CPS, 15.8 percent of the nonelderly population, or 38.4 million people, were uninsured (Figure A2). However, when using the Census 2000-based weights, 16.1 percent of the nonelderly population is estimated to be uninsured, representing 39.4 million people. The S-CHIP sample expansion combined with an Hispanic sample expansion each March results in 99,000 households interviewed for the survey, representing 211,000 individuals.

In August 2006, the Census Bureau released a revised March 2005 CPS dataset. Its 2004 data were revised to reflect a correction to the weights and the estimates based on improvements to the methodology that assigns health insurance coverage to dependents. As a result, the 2004 data published in previous EBRI reports have been updated in this report.

In March 2007, the Census Bureau announced that it had revised the March 2005 and March 2006 datasets. The Census Bureau revised its estimates after discovering a coding error that affected a small number of individuals. These individuals were coded as not having health insurance coverage when in fact they did have coverage. Based on the new Census data, the number of individuals under age 65 with health insurance increased by 1.8 million in both 2004 and 2005 (Figure A3). The reported increase in coverage was mainly due to an increase in the reported number of people with employment-based health benefits as a dependent. The 1.8 million additional people reported with health insurance coverage represents 0.7 percent additional individuals with coverage and 0.7 percent fewer individuals counted as uninsured.

In September 2011, the Census Bureau announced another revision to the CPS that affects the historical time series. Census revised calendar-year coverage estimates for 1999 to 2009 as a result of enhancements to the editing process, such as the assignment of a family health plan to all individuals in the household and the addition of a new variable.[17] As a result of the change, the number of people with employment-based coverage as a dependent increased by 1.4 million, and the likelihood of having employment-based coverage increased by 0.5 percent (Figure A4). There was a corresponding decline in the uninsured estimates.

The Census Bureau has released corrected historical data that addresses the coding error. The data in this report from 2000-2010 are based on the corrected historical data and may not match previous EBRI publications that contain data on health insurance coverage. Data from 1994-1999 have not been revised.

Finally, in September 2012, the Census Bureau adopted weights based on the 2010 Census. This change had a negligible impact on the health insurance estimates.

Figure A1

Change in the Number and Percentage of Nonelderly Individuals With Selected Sources of Health Insurance Due to Change in CPS Methodology for Counting the Uninsured, 1999

	Millions of Individuals by Coverage Type		Percentage of Individuals by Coverage Type		Change in Estimate Due to New Methodology
	Old Methodology	New Methodology	Old Methodology	New Methodology	
Total Population	240.7	240.7	100.0%	100.0%	0.0%
Employment-based coverage	158.4	160.3	65.8	66.6	1.2
Own name	80.3	81.4	33.4	33.8	1.4
Dependent coverage	78.1	78.9	32.4	32.8	1.1
Individually Purchased	15.8	16.6	6.6	6.9	5.2
Public	34.1	34.5	14.2	14.3	1.1
Medicare	4.8	4.9	2.0	2.0	0.4
Medicaid	25.0	25.3	10.4	10.5	1.3
Tricare/CHAMPVA[a]	6.5	6.6	2.7	2.7	0.5
No Health Insurance	42.1	39.0	17.5	16.2	(7.4)

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2000 Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a] Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Figure A2

Change in the Number and Percentage of Nonelderly Individuals With Selected Sources of Health Insurance Due to Introduction of Census 2000-Based Weights, 2000

	Millions of Individuals by Coverage Type		Change in Population Estimate Due to New Weights	Percentage of Individuals by Coverage Type		Change in Insurance Status Estimate Due to New Weights
	Census 1990-Based Weights	Census 2000-Based Weights		Census 1990-Based Weights	Census 2000-Based Weights	
Total Population	242.8	244.8	0.9%	100.0%	100.0%	0.0%
Employment-based coverage	163.4	164.4	0.6	67.3	67.1	-0.3
Own name	83.7	84.8	1.3	34.5	34.6	0.4
Dependent coverage	79.7	79.6	-0.2	32.8	32.5	-1.0
Individually Purchased	16.1	16.1	-0.1	6.6	6.6	-0.9
Public	34.3	34.6	0.8	14.1	14.1	-0.1
Medicare	5.3	5.3	0.7	2.2	2.2	-0.2
Medicaid	25.3	25.5	0.8	10.4	10.4	0.0
Tricare/CHAMPVA[a]	6.2	6.2	-0.8	2.6	2.5	-1.6
No Health Insurance	38.4	39.4	2.5	15.8	16.1	1.6

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2001Supplement.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a] Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Figure A3

Change in the Number and Percentage of Nonelderly Individuals With Selected Sources of Health Insurance Due to March 2007 Census Bureau Coding Error Correction, 2004 and 2005

	2004[b]	2004[c]	2004 Change	2005[b]	2005[c]	2005 Change
			(millions)			
Total	255.1	255.1	–	257.4	257.4	0.0
Employment-based coverage	159.2	161.0	1.8	159.5	161.3	1.8
Own name	81.7	81.6	-0.1	82.4	82.3	0.0
Dependent coverage	77.5	79.4	1.8	77.2	79.0	1.9
Individually Purchased	17.9	18.0	0.2	17.8	17.9	0.1
Public	45.0	45.1	0.1	45.5	45.5	0.0
Medicare	6.3	6.3	0.0	6.5	6.4	0.0
Medicaid	34.6	34.6	0.0	34.7	34.7	0.0
Tricare/CHAMPVA[a]	7.3	7.4	0.1	7.7	7.7	0.0
No Health Insurance	44.8	43.0	-1.8	46.1	44.4	-1.8
			(percentage)			
Total	100.0%	100.0%	–	100.0%	100.0%	0.0
Employment-based coverage	62.4	63.1	0.7	62.0	62.7	0.7
Own name	32.0	32.0	0.0	32.0	32.0	0.0
Dependent coverage	30.4	31.1	0.7	30.0	30.7	0.7
Individually Purchased	7.0	7.1	0.1	6.9	7.0	0.0
Public	17.6	17.7	0.0	17.7	17.7	0.0
Medicare	2.5	2.5	0.0	2.5	2.5	0.0
Medicaid	13.6	13.6	0.0	13.5	13.5	0.0
Tricare/CHAMPVA[a]	2.9	2.9	0.1	3.0	3.0	0.0
No Health Insurance	17.6	16.9	-0.7	17.9	17.2	-0.7

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2005 and 2006 Supplements.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

[a] Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members.CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

[b] Estimates based on uncorrected Census data

[c] Estimates based on corrected Census data.

Figure A4

Change in the Number and Percentage of Nonelderly Individuals With Selected Sources

	2009 Before Correction	2009 After Correction	Change	2009 Before Correction	2009 After Correction	Change
	(millions)			(percentage)		
Total	264.7	264.7	–	103.8%	103.8%	0.0
Employment-based coverage	156.1	157.3	1.2	61.2	61.7	0.5
Own name	79.1	78.9	-0.2	31.0	30.9	-0.1
Dependent coverage	77.0	78.4	1.4	30.2	30.7	0.6
Individually Purchased	16.7	18.4	1.7	6.6	7.2	0.7
Public	56.0	56.1	0.1	21.9	22.0	0.0
Medicaid	44.1	44.2	0.1	17.3	17.3	0.0
Medicare	7.3	7.3	0.0	2.9	2.9	0.0
Tricare/CHAMPVA[a]	8.3	8.3	0.0	3.2	3.2	0.0
No Health Insurance	50.0	48.3	-1.7	19.6	19.0	-0.6

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 2010 Supplement.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

[a] Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program of the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

References

Bhandari, Shailesh. "People With Health Insurance: A Comparison of Estimates from Two Surveys." U.S. Census Bureau. Working Paper No. 243, www.census.gov/sipp/workpapr/wp243.pdf (June 2004).

Cooper, Philip F., and Barbara Steinberg Schone. "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996." *Health Affairs.* Vol. 16 (November/December 1997): 142–149.

Cunningham, Peter J., and Heidi Whitmore. "How Well Do Communities Perform on Access to Care for the Uninsured?" *Research Report 1*. Washington, DC: Center for Studying Health System Change, September 1998.

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith. "Income, Poverty, and Health Insurance Coverage in the United States: 2011." *Current Population Reports.* P60-243. Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, September 2012.

Fronstin, Paul. "Access to Health Care and Satisfaction: Differences by Insurance Coverage and Insurance Type." *EBRI Notes,* no. 4 (Employee Benefit Research Institute, April 1998): 1–5.

_____. "Employment-Based Health Insurance for Children: Why Did Coverage Increase in the Mid-1990s?" *Health Affairs.* Vol. 18 (September/October 1999): 131–136.

_____. "The Working Uninsured: Who They Are, How They Have Changed, and the Consequences of Being Uninsured." *EBRI Issue Brief,* no. 224 (Employee Benefit Research Institute, August 2000a).

_____."Counting the Uninsured: A Comparison of National Surveys." *EBRI Issue Brief,* no. 225 (Employee Benefit Research Institute, September 2000b).

_____. "Employment-Based Health Benefits: Trends in Access and Coverage." *EBRI Issue Brief,* no. 284 (Employee Benefit Research Institute, August 2005).

_____. "The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?" *EBRI Issue Brief,* no. 312 (Employee Benefit Research Institute, December 2007).

_____. "The Impact of Immigration on Health Coverage in the United States, 1994–2006." *EBRI Notes,* no. 8 (Employee Benefit Research Institute, August 2008).

_____. "Views on Employment-Based Health Benefits: Findings from the 2012 Health Confidence Survey." *EBRI Notes,* no. 11 (Employee Benefit Research Institute, 2012), forthcoming.

Fronstin, Paul, and Alphonse G. Holtmann. "Productivity Gains From Employment-Based Health Insurance." In Paul Fronstin, ed., *The Economic Costs of the Uninsured: Implications for Business and Government.* Washington, DC: Employee Benefit Research Institute, 2000, pp. 25–39.

Fronstin, Paul, and Ruth Helman. "Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey." *EBRI Issue Brief,* no. 253 (Employee Benefit Research Institute, January 2003).

Gabel, Jon et al. "Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats." *Health Affairs.* Vol. 20, no. 3 (September/October 2001): 180–186.

Hoffman, Catherine, and John Holahan. "What Is the Current Population Survey Telling Us About the Number of Uninsured?" Kaiser Family Foundation Commission on Medicaid and the Uninsured Issue Paper #7384. www.kff.org/uninsured/7384.cfm (August 2005).

Institute of Medicine. *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: The National Academies Press, 2003.

Krauss, N.A., S. Machlin, and B.L. Bass. "Use of Health Care Services, 1996." *MEPS Research Findings No. 7*. AHCPR Pub. No. 99-0018. Rockville, MD: Agency for Health Care Policy and Research, March 1999.

Levit, Katharine R., Gary L. Olin, and Suzanne W. Letsch. "Americans' Health Insurance Coverage, 1980–91." *Health Care Financing Review.* Vol. 14, no. 1 (Fall 1992): 31–57.

Mills, Robert J. "Health Insurance Coverage: 2001." *Current Population Reports.* P60-220. Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, U.S. Bureau of the Census, September 2002.

Morrisey, Michael. "Hospital Cost Shifting, a Continuing Debate." *EBRI Issue Brief,* no. 180 (Employee Benefit Research Institute, December 1996).

Moyer, M. Eugene. "A Revised Look At The Number of Uninsured Americans." *Health Affairs.* Vol. 8 (Summer 1989): 102–110.

Nelson, Charles T., and Robert J. Mills. "The March CPS Health Insurance Verification Question and Its Effect on Estimates of the Uninsured." Housing and Household Economic Statistics Division, U.S. Bureau of the Census, August 2001 www.census.gov/hhes/www/hlthins/publications/verification.html (Last reviewed September 2012).

Swartz, Katherine. "Changes in the 1995 Current Population Survey and Estimates of Health Insurance Coverage." *Inquiry* (Spring 1997): 70–79.

Swartz, Katherine, and Patrick J. Purcell. "Letter: Counting Uninsured Americans." *Health Affairs.* Vol. 8 (Winter 1989): 193–196.

U.S. Congressional Budget Office. *How Many People Lack Health Insurance and For How Long?* www.cbo.gov/sites/default/files/cbofiles/ftpdocs/42xx/doc4210/05-12-uninsured.pdf (Last reviewed September 2012).

Endnotes

[1] The estimate for Medicaid also includes children enrolled in the State Children's Health Insurance Program (S-CHIP). Medicaid and S-CHIP (and Medicare) estimates are under-reported in the CPS, according to comparisons of these data with enrollment and participation data provided by the Centers for Medicare & Medicaid Services (CMS) (DeNavas-Walt, Proctor, and Lee, 2006). According to Hoffman and Holahan (2005), the CPS may be overestimating the number of uninsured individuals by between 3.6 million and 9.1 million because of the undercount in Medicaid enrollment.

[2] Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA (the Civilian Health and Medical Program for the Department of Veterans Affairs) is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

[3] These estimates sum to more than 100 percent because individuals can have multiple sources of coverage throughout the year as well as during a point in time. For instance, Medicare beneficiaries often have private coverage as a supplement to Medicare.

[4] The uninsured estimates from the March CPS are supposed to represent the percentage of individuals without health insurance coverage during an entire calendar year. However, based on comparisons with other surveys, many researchers concur that the uninsured estimate from the CPS is closer to a point-in-time estimate than to a calendar year estimate. If the CPS represents a point-in-time estimate and not a calendar year, it would mean that the data from the March 2012 CPS represent the number of uninsured during March 2012 instead of during the previous calendar year. More information about the CPS, and other surveys that collect data on the uninsured, can be found in Fronstin (2000b). See also Bhandari (2004) and U.S. Congressional Budget Office (2004).

[5] The census reports 48.6 million uninsured, or 15.7 percent of the entire United States population. Because this report examines only the population under age 65, it reports 47.9 million uninsured, or 18 percent of the *nonelderly* population.

[6] Expansion in S-CHIP during the late 1990s may have offset the decline in Medicaid coverage.

[7] See Exhibit 2.1 in www.kff.org/insurance/7672/upload/76723.pdf

[8] In this report, individuals who receive coverage directly through their employer, union, or a previous employer are categorized as having coverage in their *own name*. Individuals who receive employment-based coverage indirectly are categorized as having *dependent* coverage.

[9] It has been estimated that 95 percent of low-income children are eligible for either Medicaid or S-CHIP. See www.cbpp.org/12-6-00schip.htm (last reviewed September 2009).

[10] The region and state data in this section are not based on the most recent 2011 data, but instead based on a three-year average of 2009–2011 data. The Census Bureau recommends using three-year averages to compare estimates across states. State estimates are considerably less reliable than national estimates and fluctuate more widely year-to-year than national estimates.

[11] See Fronstin (2008).

[12] Patient Protection and Affordable Care Act of 2010.

[13] Both Fronstin (2005) and Cooper and Schone (1997) found that young workers are less likely than older workers to be covered by employment-based health benefits even when a plan is offered to them.

[14] Krauss et al. (1999) found that 55.7 percent of the uninsured had at least one ambulatory medical care visit in 1996, compared with 76.2 percent of individuals with only public insurance and 77.2 percent of individuals with any private insurance. They also found that among people with at least one visit, the uninsured had an average of 5.1 visits, compared with 8.7 visits by people with only public insurance and 6.5 visits by those with any private insurance. Another study found that among people visiting a health care provider, 17 percent of the uninsured received health care in an emergency room, compared with 9 percent of the privately insured (Cunningham and Whitmore, 1998). Furthermore, Fronstin (1998 and 2000a) found that 22 percent of the uninsured were in a family where someone had difficulty obtaining needed care, compared with 10–11 percent of the insured population, mainly because they could not afford health care.

[15] Traditionally, cost shifting occurs when a health care provider raises its prices to one set of payers because it lowered them to another set (Morrisey, 1996).

[16] See Nelson and Mills (2001) for additional information about the verification questions.

[17] See www.census.gov/hhes/www/hlthins/data/revhlth/usernote.html for more details.

ebri.org
Employee Benefit Research Institute

Where the world turns for the facts on U.S. employee benefits.

Retirement and health benefits are at the heart of workers', employers', and our nation's economic security. Founded in 1978, EBRI is the most authoritative and objective source of information on these critical, complex issues.

EBRI focuses solely on employee benefits research — no lobbying or advocacy.

EBRI stands alone in employee benefits research as an independent, nonprofit, and nonpartisan organization. It analyzes and reports research data without spin or underlying agenda. All findings, whether on financial data, options, or trends, are revealing and reliable — the reason EBRI information is the gold standard for private analysts and decision makers, government policymakers, the media, and the public.

EBRI explores the breadth of employee benefits and related issues.

EBRI studies the world of health and retirement benefits — issues such as 401(k)s, IRAs, retirement income adequacy, consumer-driven benefits, Social Security, tax treatment of both retirement and health benefits, cost management, worker and employer attitudes, policy reform proposals, and pension assets and funding. There is widespread recognition that if employee benefits data exist, EBRI knows it.

EBRI delivers a steady stream of invaluable research and analysis.

- EBRI publications include in-depth coverage of key issues and trends; summaries of research findings and policy developments; timely factsheets on hot topics; regular updates on legislative and regulatory developments; comprehensive reference resources on benefit programs and workforce issues; and major surveys of public attitudes.
- EBRI meetings present and explore issues with thought leaders from all sectors.
- EBRI regularly provides congressional testimony, and briefs policymakers, member organizations, and the media on employer benefits.
- EBRI issues press releases on newsworthy developments, and is among the most widely quoted sources on employee benefits by all media.
- EBRI directs members and other constituencies to the information they need and undertakes new research on an ongoing basis.
- EBRI maintains and analyzes the most comprehensive database of 401(k)-type programs in the world. Its computer simulation analyses on Social Security reform and retirement income adequacy are unique.

EBRI makes information freely available to all.

EBRI assumes a public service responsibility to make its findings completely accessible at www.ebri.org — so that all decisions that relate to employee benefits, whether made in Congress or board rooms or families' homes, are based on the highest quality, most dependable information. EBRI's Web site posts all research findings, publications, and news alerts. EBRI also extends its education and public service role to improving Americans' financial knowledge through its award-winning public service campaign *ChoosetoSave*® and the companion site www.choosetosave.org

EBRI is supported by organizations from all industries and sectors that appreciate the value of unbiased, reliable information on employee benefits. Visit www.ebri.org/about/join/ for more.

1100 13th Street NW · Suite 878
Washington, DC 20005
(202) 659-0670
www.ebri.org
www.choosetosave.org

ebri.org
Employee Benefit Research Institute

Issue BRIEF

EBRI Employee Benefit Research Institute Issue Brief (ISSN 0887–137X) is published monthly by the Employee Benefit Research Institute, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, at $300 per year or is included as part of a membership subscription. Periodicals postage rate paid in Washington, DC, and additional mailing offices. POSTMASTER: Send address changes to: *EBRI Issue Brief,* 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051.

Who we are

The Employee Benefit Research Institute (EBRI) was founded in 1978. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is the only private, nonprofit, nonpartisan, Washington, DC-based organization committed exclusively to public policy research and education on economic security and employee benefit issues. EBRI's membership includes a cross-section of pension funds; businesses; trade associations; labor unions; health care providers and insurers; government organizations; and service firms.

What we do

EBRI's work advances knowledge and understanding of employee benefits and their importance to the nation's economy among policymakers, the news media, and the public. It does this by conducting and publishing policy research, analysis, and special reports on employee benefits issues; holding educational briefings for EBRI members, congressional and federal agency staff, and the news media; and sponsoring public opinion surveys on employee benefit issues. **EBRI's Education and Research Fund** (EBRI-ERF) performs the charitable, educational, and scientific functions of the Institute. EBRI-ERF is a tax-exempt organization supported by contributions and grants.

Our publications

EBRI Issue Briefs is a monthly periodical with in-depth evaluation of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. ***EBRI Notes*** is a monthly periodical providing current information on a variety of employee benefit topics. EBRI ***Fundamentals of Employee Benefit Programs*** offers a straightforward, basic explanation of employee benefit programs in the private and public sectors. The ***EBRI Databook on Employee Benefits*** is a statistical reference work on employee benefit programs and work force-related issues.

Orders/ Subscriptions

Contact EBRI Publications, (202) 659-0670; fax publication orders to (202) 775-6312. Subscriptions to *EBRI Issue Briefs* are included as part of EBRI membership, or as part of a $199 annual subscription to *EBRI Notes* and *EBRI Issue Briefs*. ***Change of Address:*** EBRI, 1100 13th St. NW, Suite 878, Washington, DC, 20005-4051, (202) 659-0670; fax number, (202) 775-6312; e-mail: subscriptions@ebri.org ***Membership Information:*** Inquiries regarding EBRI membership and/or contributions to EBRI-ERF should be directed to EBRI President Dallas Salisbury at the above address, (202) 659-0670; e-mail: salisbury@ebri.org

EBRI Issue Brief is registered in the U.S. Patent and Trademark Office. ISSN: 0887–137X/90 0887–137X/90 $ .50+.50