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Inequality in the United States Healthcare System

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Inequality in the United States Healthcare System

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Although the United States (US) has been rated highly in the United Nations Human Development Index, the shining health indicators of the general population do not reflect the great disparity in the health of certain subpopulations. Absolute health indicators often make the suffering of the vulnerable, especially those living in the wealthiest nation, invisible to the world.

In this paper, I will demonstrate why the US private-public healthcare system should not be used as a model for other countries as it exacerbates the inequality in access to care and health status between the haves and the have-nots.

Part I: I will first describe the variation in health status by location, race/ethnicity, gender, and poverty level. This variation highlights the vast inequality in the health of the US population, a reflection on insufficient access to care and health insurance coverage.

Part II: I will then establish the link between health insurance and health status to provide evidence that the lack of adequate health insurance in certain subpopulations directly results in their inferior health status.

Part III: To provide background, I will briefly discuss how most Americans obtain health insurance and how the US healthcare system functions, or malfunctions.

Part IV: In this section, I will profile the uninsured by work status, poverty level, location, race/ethnicity, and gender to show who is most likely to not have coverage and who the losers are of the US healthcare system.

Part V: I will analyze how the US Healthcare system through a mostly private insurance model is exacerbating these health inequalities.

Part I: What is the current health situation in the US by location, race/ethnicity, gender and income?

Location:
There is wide variation among states. Infant deaths per 1,000 live births varies from 10.7 in Delaware to 3.8 in New Hampshire (US average 6.8). Number of deaths per 100,000 population varies from 1058.3 in the District of Columbia to 674.4 in Hawaii (US average of 868.3). The number of heart disease deaths per 100,00 population varies from 344.5 in Mississippi to 179.9 in Minnesota (US average of 260.4). *(Figures 1, 2, 3)*

Race/Ethnicity:
People of color (Latinos, African Americans, Asian/Pacific Islanders, and American Indians/Alaska Natives) make up nearly a third of the US population *(Figure 4).* American Indians/Alaska Natives, African Americans and Latinos are more likely to rate their health as fair or poor than are whites and Asians (*Figure 5)*. Infant mortality rates are higher among African Americans and American Indian/Alaska Natives than among other racial/ethnic groups, even when comparing women of similar socioeconomic conditions *(Figure 6)*. On average, Latinos, African Americans, American Indians and whites have higher mortality rates than Asian/Pacific Islanders at each stage of the lifespan *(Figure 7)*.

Women of Color:
There are some notable differences in health status between white women and women of color, particularly African Americans. Women of color are more likely to report they are in fair or poor health: 20% of African American women, 29% of Latinas, and 13% of white women assess their health status as fair or poor *(Figure 8).* 57% of African American women age 45 to 64 have been diagnosed with hypertension, twice the rate of white women (28%) of the same age. African American women (40%) are also significantly more likely to have arthritis than Latinas (33%) and white women (32%). African American (16%) and Latina (17%) women both experience higher prevalence of diabetes compared with white women (9%). These differences could be attributed to delaying care: 32% of Latinas and 32% of African American women report delaying or foregoing care in the past year, as did 25% of white women (*Figure 9).* Women report several reasons for delaying care, including cost, lack of insurance, and competing family/work responsibilities (*Figure 10)*.

Poverty Level:
Regardless of racial/ethnic group, people living in poverty report worse health than the non-poor *(Figure 11).* Although disparity in heart disease mortality rates exists between African Americans and whites, the disparity by income is larger than race. African American men with family incomes less than $10,000 have a heart disease mortality rate that is nearly three times that of their counterparts with incomes greater than $15,000 *(Figure 12).*

Part II: How does Health Insurance affect Health Status?

Access to Health Care:

There is a strong relationship between health insurance coverage and access to medical services. Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy people are. Research has repeatedly shown that the lack of insurance ultimately compromises a persons' health because they are less likely to receive preventive care, are less able to afford prescription drugs, are more likely to be hospitalized for avoidable health problems, are more likely to be diagnosed in the late-stages of disease and once diagnosed tend to receive less therapeutic care (drugs and surgical interventions). *(Figure 1, 2)*

When women are uninsured, they are more likely to postpone care and to forgo filling prescriptions than their insured counterparts and often delay or go without important preventive care such as mammograms and Pap tests. *(Figure 3)*

There is solid evidence that uninsured babies have poorer survival than the privately insured. A study published in 1989 found that, compared to privately insured newborns, the uninsured had a higher relative risk of adverse birth outcomes. Even more strikingly, a 1998 study found that uninsured babies had relative odds of dying that were 1.5 times higher than those who were privately insured. Two studies have found that Medicaid eligibility expansions have resulted in reductions in infant mortality by 5-9%. *(Figure 4, 5)*

Research has determined that middle-aged people who were continuously uninsured over a four-year period were 1.6 times more likely than the continuously insured to have a "major health decline" including death. Those with intermittent insurance coverage were 1.4 times more likely to experience a similar decline than the continuously insured. *(Figure 6)*

Having health insurance would reduce mortality rates for the uninsured by 10-15 percent; it has been estimated that the number of excess deaths among uninsured adults age 25-64 is in the range of 18,000 a year. Having health insurance increases medical care use by about 50%. A 50% increase in medical care use could be expected to reduce mortality rates by 5-15%. *(Figure 7)*

The uninsured who did not receive care when they needed it suffered as a consequence, with 47% reporting that they had incurred a painful temporary disability and 19% reporting that they had experienced a long-term disability. Better health would improve annual earnings by about 10-30% (depending on measures and specific heart condition) and would increase educational attainment. *(Figure 8)*

Financial Consequences:

The uninsured must live each day in financial as well as physical jeopardy, knowing that if they are injured or not well, they either will not be able to obtain care- or will be forced to liquidate their savings/possessions to pay for it. Those lacking coverage are more financially vulnerable to the high cost of care, are exposed to higher out-of-pocket costs compared to the insured and are often more burdened my medical bills. Half of personal individual bankruptcies are related to medical expenses; surprisingly, 80% filing had health insurance thus even with health insurance, there is inadequate coverage as there is often a ceiling on the amount of care paid for in catastrophic illness. *(Figure 9)*

Part III: How do most Americans Obtain Health Insurance?

The US healthcare system is a patchwork of private and public coverage resulting in huge gaps and no underlying safety net. *(Figure 1, Table 1)*

Employer-Sponsored 63%:

Many employers offer group health insurance policies to their employees as a benefit and also often extend coverage to their employees' families. About half of Americans insured through employer-sponsored health plans are covered by their own employer (51%) and half are covered as a worker's dependent (49%). Employer-sponsored health insurance is voluntary; businesses are not legally required to offer a health benefit, and employees can choose not to participate. Even when businesses offer health benefits, some employees are ineligible and some do not sign up because of the required employee share of the premium. Rising health insurance costs are compromising health-insurance coverage as more and more employers shift cost for their coverage and cost-sharing burdens onto their employees through high premiums, making coverage unaffordable for the lowest wage employees. Private health insurance coverage is subsidized through the federal tax system through employee tax exclusion of the health insurance premiums paid by employers; in addition, persons with unusually high healthcare expenses (exceeding 7.5% of their adjusted gross income) can deduct the costs, including premiums, on their tax returns.

Public Programs (excluding Medicare) 14%:

Medicare covers virtually all those 65 and older while state-federal programs **Medicaid** and **State Children's Health Insurance (SCHIP)** help provide coverage for millions of low-income people.

- Medicaid covers 12% of the nonelderly and it provides health coverage based on both income and categories of eligibility primarily covering three main groups of nonelderly low-income people: children, their parents, and individuals with disabilities. Medicaid also assists low-income Medicare beneficiaries by paying Medicare premiums and the costs of services not covered by Medicare. Federal law requires states to cover children under age 19 who come from poor families (with incomes less than poverty level). However, the near-poor (those with incomes between 100% and 200% of poverty) also run a high risk of being uninsured (28%) because they are not likely to be eligible for Medicaid. The threshold is higher (133% of the poverty level) for children under age 6 and pregnant women, and states have the option to expand coverage beyond these federal minimum requirements. Still, not all those who qualify for the program are enrolled, leaving 25% of poor children uninsured. SCHIP works as a complement to Medicaid by covering low-income children not eligible for Medicaid.

- However, Medicaid does not cover single adults and childless adults regardless of how poor they are. Parents of dependent children qualify for Medicaid, though income eligibility levels are set much lower than congressionally mandated standards for children. These eligibility restrictions leave over 40% of poor adults under age 65 uninsured.

Private Non-Group 5%:

Private non-group insurance premiums are based on individual health risk and are substantially more expensive than group plans purchased by employers, with cost varying by age and health status. Insurance companies in the non-group market can deny or limit coverage to persons in poor health or with chronic conditions.

Uninsured 17%:

Part IV: Who are the uninsured?

Over 43 million Americans 17% of the population under age 65 lacked health insurance coverage in 2002. *(Figure 1, Table 1)*

Work Status:

The uninsured come primarily from working families with low and moderate income, families for whom coverage is not available in the workplace or is unaffordable. National surveys consistently show that the primary reason people are uninsured is because health coverage is too expensive. In 2002, over 8 in 10 uninsured came from working families- nearly 70% from families with one or more full-time workers and 12% from families with part-time workers. Only 19% of the uninsured are from families that have no connection to the workforce. Low-wage workers are at greater risk of being uninsured, as are those employed in small businesses, and laborers and service employees. Low-income workers are less likely to be offered coverage through their own or a spouse's job or able to afford it on their own. Individually purchased insurance is not a realistic option as these plans typically charge very high premiums or offer limited benefits. *(Figure 2, 3, Table 2)*

Poverty Level:

Because of the high cost of health insurance, the poor and near-poor have the greatest risk of being uninsured. The uninsured rate among the nonelderly poor is more than twice as high as the national average (37% vs. 17%). Among the poor, only 15% have job-based coverage and Medicaid covers 41%, leaving 37% uninsured. Because the near-poor are less likely to qualify for public insurance and also have decreased access to employer-sponsored insurance, 28% of this group are uninsured. *(Figure 4, 5)*

Location:

Insurance coverage varies by state depending on the share of families with low income, the nature of the state's employment, and the inclusiveness of state Medicaid programs. A three-fold difference exists between the states with the lowest and highest uninsured rates (ranging from MN, IA, WI with 9% vs. TX 27%). *(Figure 6, Table 3)*

Race/Ethnicity:

Racial and ethnic minorities, who now make up a third of the nonelderly population, comprise a little over half of the uninsured- in part because they are more likely to be in low-income families. About 50-60% of Blacks, Hispanics, and American Indians come from families living under the 200% of the poverty level. However, low-income does not account for all of the differences in health coverage across racial and ethnic groups. Insurance disparities persist for most groups at both lower and higher income levels. *(Figure 7-10, Table 4)*

Gender:

Nearly 16 million women are uninsured; 18% of women 18 to 64 are without coverage. Most of these women cannot afford individual policies, do not qualify for Medicaid, or do not have access to employer-sponsored plans. Individually purchased insurance is used by just 6% of women as this type of coverage can be costly and often provides more limited benefits than job-based coverage. Medicaid is only available to low-income women who are also parents, pregnant, disabled, or over 65 and who also meet the program's very restrictive income eligibility criteria. Among workers, women are less likely than men to be eligible for and to participate in their employer's health plan (39% v. 53% respectively). This is in part because they are more likely to work part-time, have lower incomes, and rely more on spousal coverage (26%). *(Figure 11, 12)*

Part V: How does the US Healthcare System through a mostly private insurance model exacerbate health inequalities?

Although there are many flaws in the US Healthcare system, the two most significant problems are rapidly escalating **costs** and a growing number of Americans without any health **coverage** which fuel each other to increase the divide between the haves and the have-nots.

Costs and coverage:

Universal public 'single-payer' healthcare systems are criticized for wasteful bureaucracy and centralization. However, the US private-public healthcare system spends much more on healthcare than any other nation; in fact, annual health care spending in the US now exceeds $1.6 trillion. On a per capita basis, health care costs in the US are more than twice the median level for the 30 industrialized nations in the OECD even though the health outcomes associated with this higher spending are no better, and by some measures, worse than outcomes in nations that spend much less.

The US private-public patchwork healthcare system is to blame. Although the US healthcare system emphasizes competition, a trademark of privatization, competition occurs at the wrong level. The relevant arena to have competition is in diagnosing and treating particular diseases or conditions thus creating an atmosphere that rewards value and quality. However, in the US, competition exists among provider networks, whether they consist of hospitals or doctors or both, to assemble bargaining power so that they can strike a better deal for themselves; healthcare is treated as a commodity. However, this kind of cost-shifting or bargaining-power competition does not reward quality or create health care value. It actually does the opposite through adding massive administrative costs and complexity into the system.

Business-oriented 'market' medicine performs less well, spends more on administration and costs more per patient overall. 30% of all direct health care expenditures today are the result of poor-quality care, consisting primarily of overuse, under use, and waste. The US spends more than any other nation- nearly $300 billion a year- to administer its health care system. The complexity of the system not only incurs outrageous costs but also confuses and frustrates all parties involved: patients, payers, and providers. In addition, because it reduces the transparency of transactions and the comparability of performance and cost data, it also undermines accountability and the capacity of the health care markets to function efficiently.

These high costs are reflected in high insurance premiums, which are now rising at high, and accelerating, rates *(Figure 1)*. This increase in premiums can be attributed to health care costs driven up by expensive new drugs, many of them heavily advertised to consumers, medical advances including diagnostic tests that require costly new machines and a reaction to past restrictions in managed care health plans that sought to rein in costs. These increases are making it more difficult for businesses to continue to provide health coverage for their employees and retirees. The strength of the economy and the

growth rate of health insurance premiums are the primary factors influencing the proportion of Americans insured through employer-sponsored benefits *(Figure 2)*. Employers shift the cost of higher premiums onto their employees: in the past, employees might pay 5% of their health care costs; this has increased to 25-30% today. As a result of this, individuals and families are finding it more difficult to pay their share of the cost of employer-sponsored coverage or, for those who are not offered coverage by employers and are not eligible for public programs, to purchase health insurance themselves in the non-group market (*Figure 3)*. Group purchasing used in employer-sponsored coverage, is more efficient and more equitable than disaggregated purchasing as risk pooling occur, ie. high-cost and low-cost patients balance each other out with healthier individuals subsidizing the care of the sicker. Purchasing insurance individually results in health insurance companies reducing their costs by screening out high-risk groups or by charging extra premiums to sicker individuals through pricing according to different 'risk categories'. As costs rise, so do the number of Americans without coverage; it is projected that in 2006, the number of uninsured Americans will reach 51.2 to 53.7 million.

As seen in Part IV, those who will suffer without coverage will most likely be the poorer members of minority groups in certain areas of the country who struggle without assistance from the state. The rapid growth in health care costs has had a disproportionate effect on these vulnerable populations because of their generally lower incomes and greater need for health care services throughout their lives (especially women). Along with the skyrocketing premiums, out-of-pocket costs such as copays, coinsurance, and deductibles add to the financial burdens.

In addition, the chances of having job-based coverage offered are less for those with lower incomes, even among those who are employed full-time for the full-year. The combination of a low income and working in a small business lowers the chances of having employer-sponsored insurance substantially. Blue-collar workers constitute a large share of uninsured workers (81%) since they are less likely to be offered insurance as a benefit and when it is available to them, they are less able to afford their required share of the costs. *(Figure 4-6)*

Economic Consequences:

The escalation of health care costs is not only a health care issue; it is also a major economic problem.

- It becomes more expensive for firms to add new workers thus slowing the rate of job growth.
- For existing workers, health care costs suppress wage increases by driving up total compensation costs.
- As the number of uninsured increases, so does the cost-shift for uncompensated care built into the insurance premiums of those who purchase coverage. A third of the medical costs for the uninsured are uncompensated; in 2004, uncompensated care is estimated to be $40.7 billion which is primarily funded

(85% of total bill) by government dollars *(Figure 7)*. A vicious cycle exists: as more people lose coverage, there will be more uncompensated medical care resulting in higher costs leading to higher premiums and more people becoming uninsured.

- The high incidence of uninsurance generates losses throughout the economy, due mainly to the lower productivity of the uninsured (and generally, less health and functional) workers. The Institute of Medicine has estimated that total economic losses attributable to uninsurance amounts to between $65 billion and $130 billion per year with the annual cost of reduced productivity alone at between $87 billion and $126 billion.

References:

All information, figures, and tables are from the following sources.

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Part I:

Figure 1

THE HENRY J. KAISER FAMILY FOUNDATION

STATE HEALTH FACTS *Online*

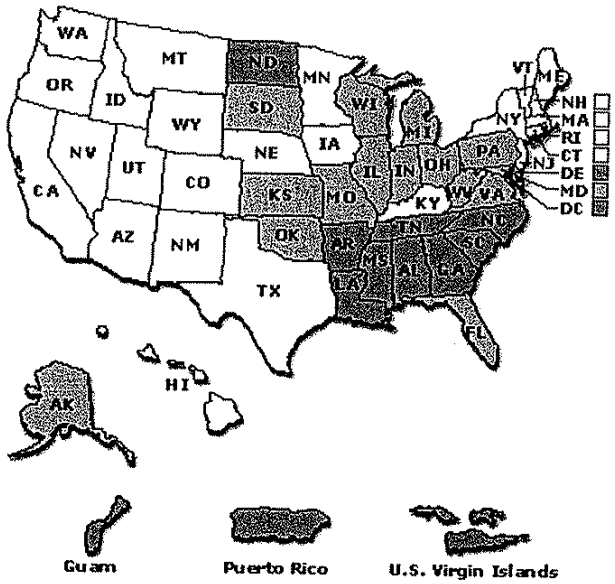
Back to web view

http://statehealthfacts.kff.org

Your source for state health data

Display by: Map (Note: table below) View by: **Rate/1,000**

Infant Deaths per 1,000 Live Births, 2001



- ☐ Less than 5.9
- ☐ 5.9 to 7
- ▨ 7.1 to 8.1
- ▩ More than 8.1
- ▩ No data available/NSD

Display by: Table

Rank by: Infant Death Rate View by: **Rate/1,000**

Infant Deaths per 1,000 Live Births, 2001

Rank		Infant Death Rate
	United States	6.8 [1]
1	Delaware	10.7
2	District of Columbia	10.6
3	Mississippi	10.5
4	Louisiana	9.8
5	Alabama	9.4
6	South Carolina	8.9
7	North Dakota	8.8
8	Tennessee	8.7
9	Georgia	8.6

10	North Carolina	8.5
11	Arkansas	8.3
12	Alaska	8.1
12	Maryland	8.1
14	Michigan	8.0
15	Illinois	7.7
15	Ohio	7.7
17	Virginia	7.6
18	Indiana	7.5
19	Kansas	7.4
19	Missouri	7.4
19	South Dakota	7.4
22	Florida	7.3
22	Oklahoma	7.3
24	Pennsylvania	7.2
24	West Virginia	7.2
26	Wisconsin	7.1
27	Arizona	6.9
28	Nebraska	6.8
28	Rhode Island	6.8
30	Montana	6.7
31	New Jersey	6.5
32	New Mexico	6.4
33	Hawaii	6.2
33	Idaho	6.2
35	Connecticut	6.1
35	Maine	6.1
37	Kentucky	5.9
37	Texas	5.9
37	Wyoming	5.9
40	Colorado	5.8
40	New York	5.8
40	Washington	5.8
43	Nevada	5.7
44	Iowa	5.6
45	Vermont	5.5
46	California	5.4
46	Oregon	5.4
48	Minnesota	5.3
49	Massachusetts	5.0
50	Utah	4.8
51	New Hampshire	3.8
	Guam	9.8
	Puerto Rico	9.3
	Virgin Islands	NSD
	Residence Unknown	NA

Notes: Infant death rates are calculated by dividing the number of infant deaths in a calendar year by the number of live births registered in the same period. Infants are defined as children under one year of age. They are presented as rates per 1,000.

Definitions: NSD: Not Sufficient Data.
NA: Data Not Available.

Sources: Arias E, Anderson RN, Hsiang-Ching K, Murphy SL, Kochanek KD. Deaths: Final Data for 2001. Division of Vital Statistics. National Vital Statistics Report, Vol 52, No. 3, Sept. 18, 2003. Hyattsville, Maryland: National Center for Health Statistics, 2003.

Raw Data: Download a tab-delimited data file for "Infant Deaths per 1,000 Live Births, 2001" or view a list of other raw data options.

Footnotes:

Figure 2

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STATE HEALTH FACTS *Online*

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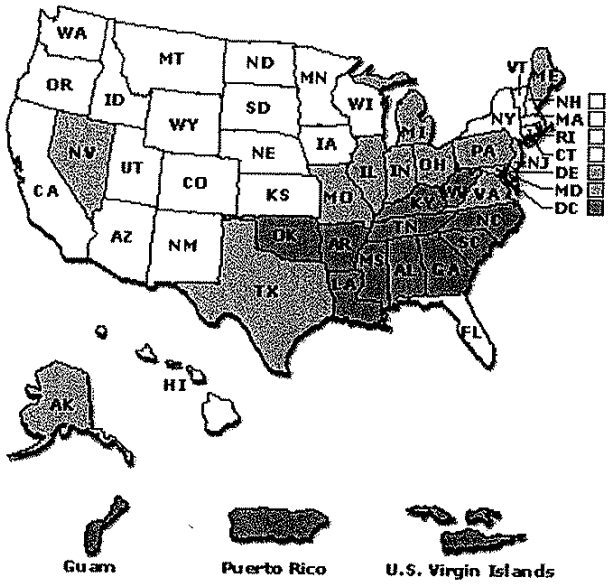
Display by: Map (Note: table below) View by: **Rate/100,000**

Number of Deaths per 100,000 Population, 2000



- ☐ Less than 808.3
- ☐ 808.3 to 852.1
- ▨ 852.2 to 929.2
- ▩ More than 929.2
- ■ No data available/NSD

Display by: Table

Rank by: Death Rate per 100,000 View by: **Rate/100,000**

Number of Deaths per 100,000 Population, 2000

Rank		Death Rate per 100,000
	United States	868.3
1	District of Columbia	1058.3
2	Mississippi	1050.9
3	West Virginia	1010.7
4	Louisiana	1005.6
5	Alabama	1003.9
6	Kentucky	998.0
7	Tennessee	996.2
8	Oklahoma	982.5
9	Georgia	979.8
10	South Carolina	979.7

11	Arkansas	976.6
12	North Carolina	951.7
13	Indiana	929.2
14	Ohio	923.0
15	Missouri	920.3
16	Nevada	918.1
17	Maryland	908.2
18	Michigan	903.8
19	Delaware	896.1
20	Pennsylvania	891.6
21	Texas	890.2
22	Virginia	889.7
23	Illinois	882.3
24	Alaska	868.5
25	Maine	859.3
26	New Jersey	852.2
27	Wyoming	851.6
28	Kansas	850.1
29	Montana	843.1
30	Oregon	830.7
31	Rhode Island	823.6
32	Vermont	821.7
33	Wisconsin	819.9
34	Massachusetts	817.6
35	New Hampshire	815.2
36	New York	813.1
37	Arizona	809.5
38	Idaho	809.0
39	New Mexico	808.3
40	Florida	806.9
41	South Dakota	805.6
42	Washington	804.3
43	Iowa	794.5
44	Nebraska	794.1
45	Connecticut	792.9
46	Colorado	791.4
47	Utah	788.2
48	California	787.2
49	North Dakota	761.8
50	Minnesota	760.4
51	Hawaii	674.4
	Guam	NA
	Puerto Rico	NA
	Virgin Islands	NA
	Residence Unknown	NA

Notes: These figures are age-adjusted to the total U.S. population in 2000.

Definitions: Causes of death include all ICD-10 codes.
NA: Data not available.

Sources: United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Office of Analysis and Epidemiology, Compressed Mortality File compiled from 1999-2000, Series 20, No. 2F 2003 on CDC WONDER On-line Database.

Raw Data: Download a tab-delimited data file for "Number of Deaths per 100,000 Population, 2000" or view a list of other raw data options.

Figure 3

THE HENRY J. KAISER FAMILY FOUNDATION

STATE HEALTH FACTS *Online*

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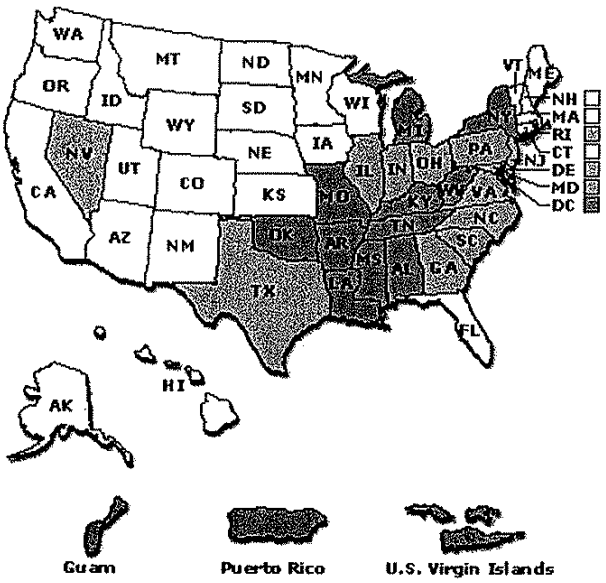
Display by: Map (Note: table below) View by: **Rate/100,000**

Number of Heart Disease Deaths per 100,000 Population, 2000



- ☐ Less than 219.2
- ☐ 219.2 to 247.9
- ▨ 248.0 to 282.0
- ■ More than 282.0
- ■ No data available/NSD

Display by: Table

Rank by: Death Rate per 100,000 View by: **Rate/100,000**

Number of Heart Disease Deaths per 100,000 Population, 2000

Rank		Death Rate per 100,000
	United States	260.4
1	Mississippi	344.5
2	Oklahoma	317.2
3	District of Columbia	314.6
4	West Virginia	307.6
5	Kentucky	306.0
6	Alabama	302.1
7	Tennessee	297.2
8	New York	296.4
9	Louisiana	292.2
10	Missouri	288.8

11	Michigan	288.6
12	Arkansas	285.5
13	Ohio	282.0
14	Georgia	279.9
15	Indiana	275.1
16	Pennsylvania	274.0
17	New Jersey	271.7
18	South Carolina	271.2
19	North Carolina	268.3
20	Texas	267.4
21	Illinois	266.2
22	Delaware	265.6
23	Maryland	265.3
24	Nevada	257.1
25	Rhode Island	251.4
26	Virginia	248.0
27	California	243.1
28	Florida	241.6
29	New Hampshire	239.8
30	Wisconsin	239.6
31	Iowa	238.8
32	South Dakota	236.8
33	Maine	236.7
34	Kansas	236.2
35	Connecticut	234.5
36	Vermont	231.1
37	Wyoming	219.7
38	Massachusetts	219.4
39	Nebraska	219.2
40	Idaho	217.2
41	Arizona	216.8
42	North Dakota	216.5
43	Alaska	213.6
44	Washington	212.2
45	Montana	207.5
46	Oregon	200.7
47	New Mexico	198.3
48	Hawaii	197.6
49	Utah	196.4
50	Colorado	187.8
51	Minnesota	179.9
	Guam	NA
	Puerto Rico	NA
	Virgin Islands	NA
	Residence Unknown	NA

Notes: These figures are age-adjusted to the total U.S. population in 2000.

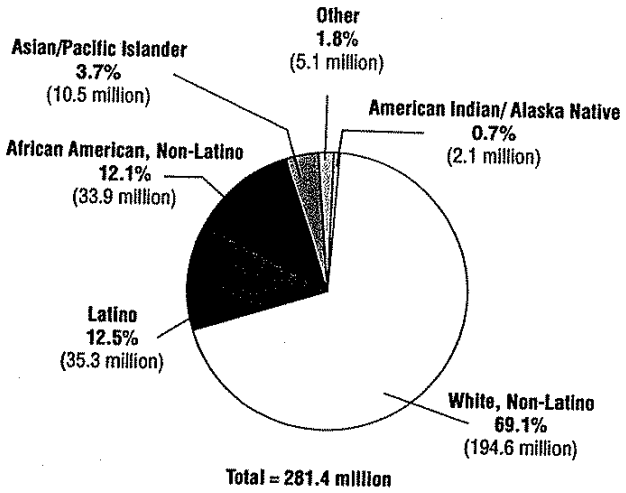
Definitions: Causes of death attributable to heart disease mortality include ICD-10 Codes I00-I09.9; I11-I13.9; I20-I51.9.
NA: Data not available.

Sources: United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Office of Analysis and Epidemiology, Compressed Mortality File compiled from 1999-2000, Series 20, No. 2F 2003 on CDC WONDER On-line Database.

Raw Data: Download a tab-delimited data file for "Number of Heart Disease Deaths per 100,000 Population, 2000" or view a list of other raw data options.

Figure 4

Percent Distribution of U.S. Population, by Race/Ethnicity, 2000

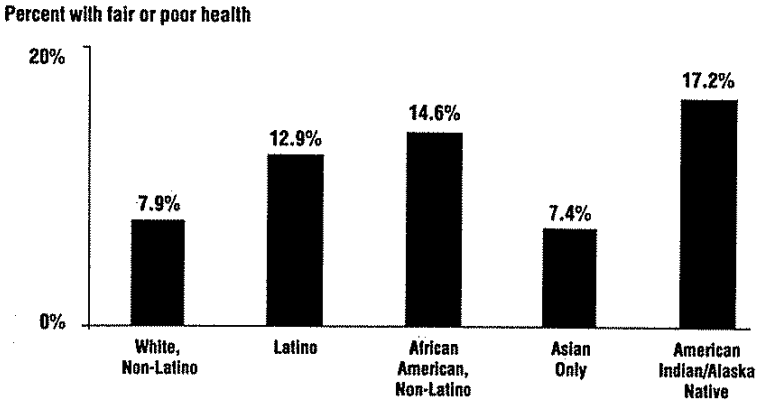


NOTE: Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marina Islands. Non-Latino individuals who reported "Some other race" or "Two or more races" are included in the "Other" category. For the purposes of this chart, Asians and Native Hawaiians or Other Pacific Islanders are combined into one category.

SOURCE: U.S. Census Bureau, Census 2000 Redistricting Data.

Figure 5

Fair or Poor Health, by Race/Ethnicity, 2000

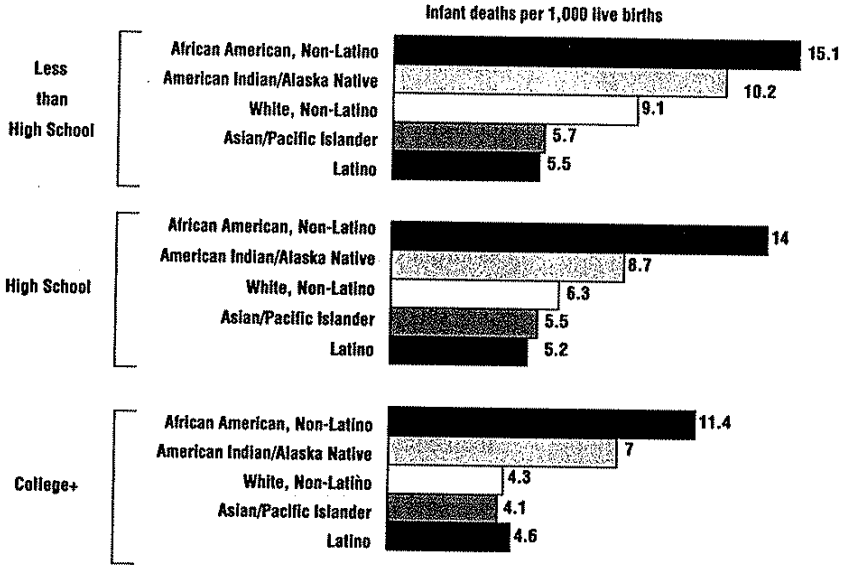


DATA: National Center for Health Statistics, National Health Interview Survey, 2000.

SOURCE: Health, United States, 2002, Table 59.

Figure 6

Infant Mortality Rates for Mothers Age 20+, by Race/Ethnicity and Education, 1998–2000

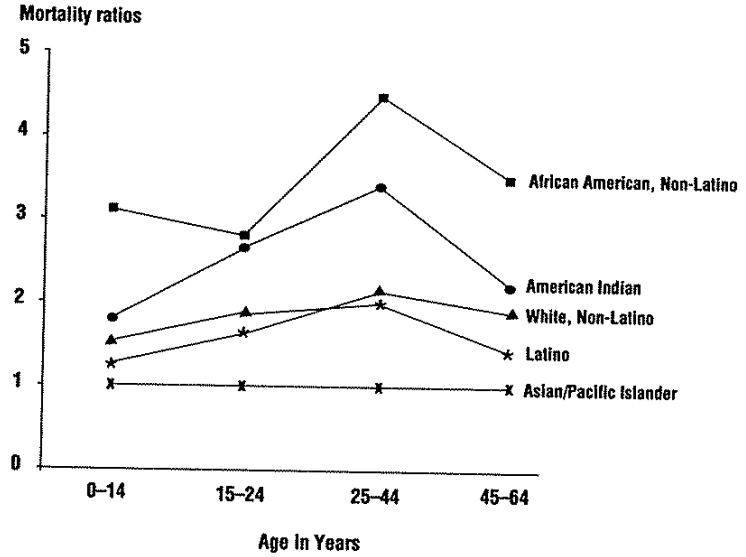


DATA: National Center for Health Statistics, National Vital Statistics System, National Linked Birth/Infant Death Data.

SOURCE: Health, United States, 2002, Table 21.

Figure 7

Mortality Ratios, by Age and Race/Ethnicity, 2000

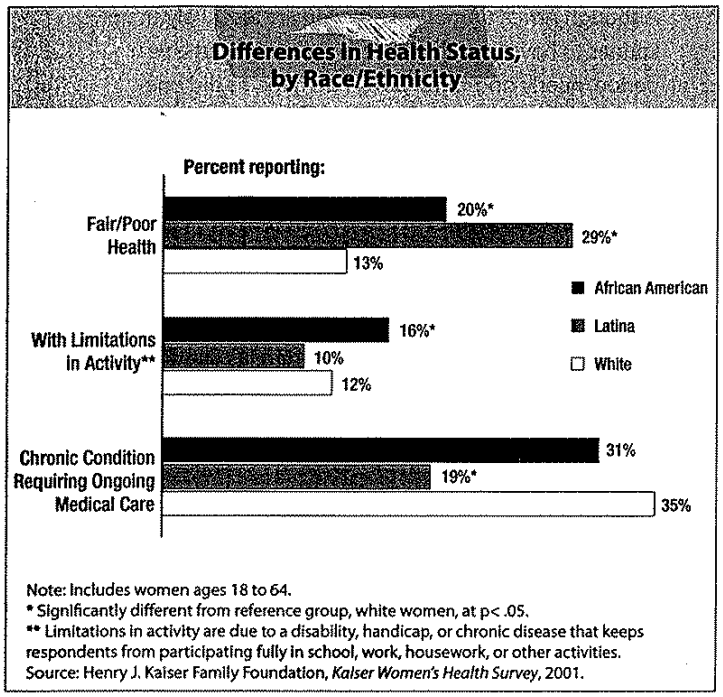


NOTE: These data compare the mortality rate of each racial/ethnic group to that of Asian/Pacific Islanders, the group with the lowest mortality rates at each age.

DATA: National Center for Health Statistics, National Vital Statistics System.

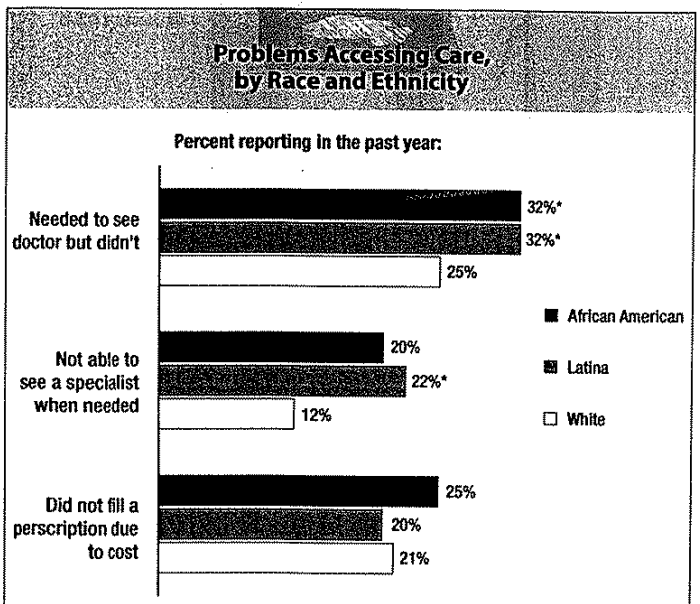
SOURCE: National Vital Statistics Report, Vol. 50, No. 15, September 16, 2002.

Figure 8



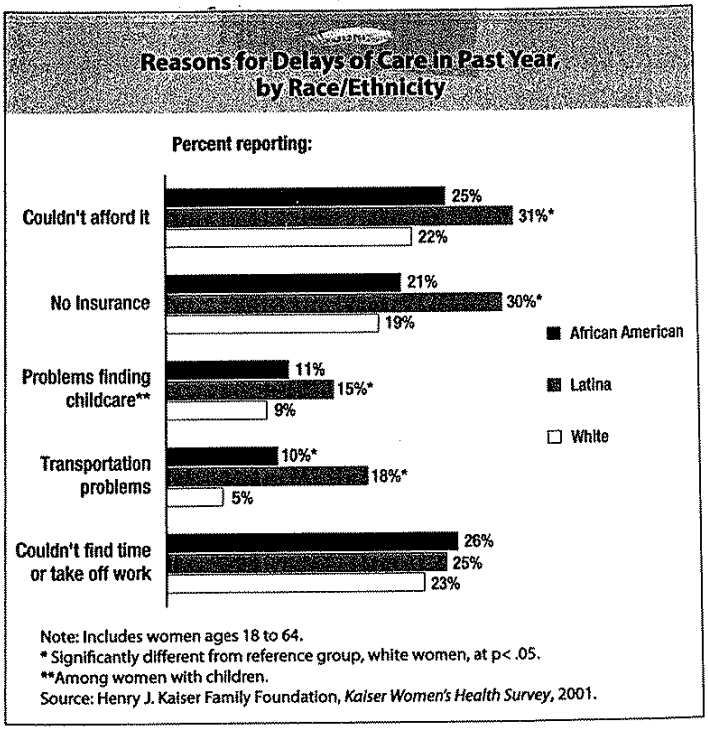
Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
** Limitations in activity are due to a disability, handicap, or chronic disease that keeps respondents from participating fully in school, work, housework, or other activities.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Figure 9



Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

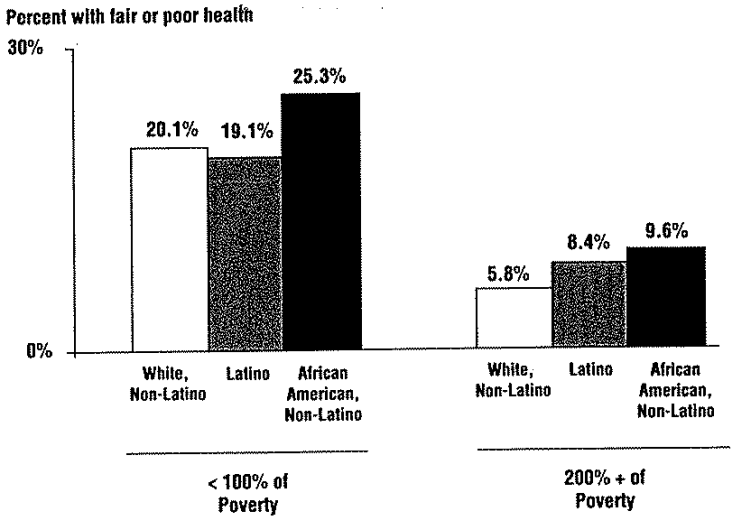
Figure 10



Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
**Among women with children.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Figure 11

Fair or Poor Health, by Race/Ethnicity and Income, 2000

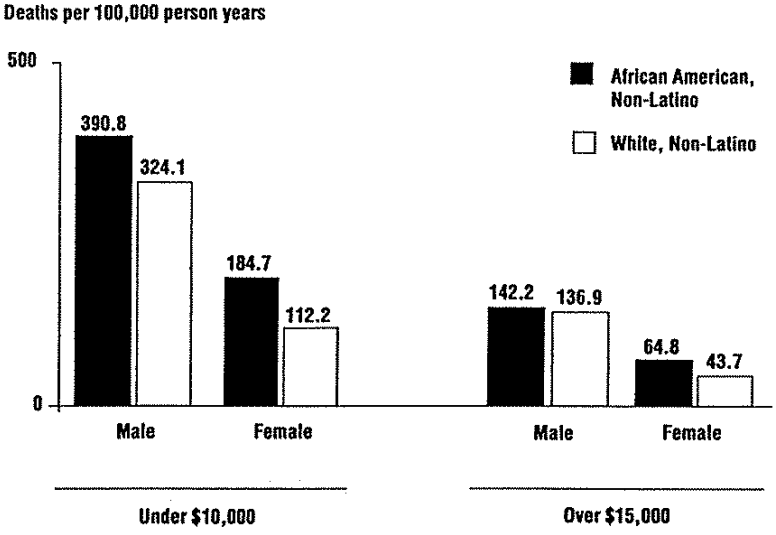


DATA: National Center for Health Statistics, National Health Interview Survey, 2000.

SOURCE: Health, United States, 2002, Table 59.

Figure 12

Heart Disease Death Rates for Adults 25–64, by Income, Race and Gender, 1979–1989



NOTE: These data are the most recently available by race and income.

SOURCE: Health, United States, 1998, *Socioeconomic Status and Health Chartbook*, Data Table for Figure 27.

Part II:

Figure 1

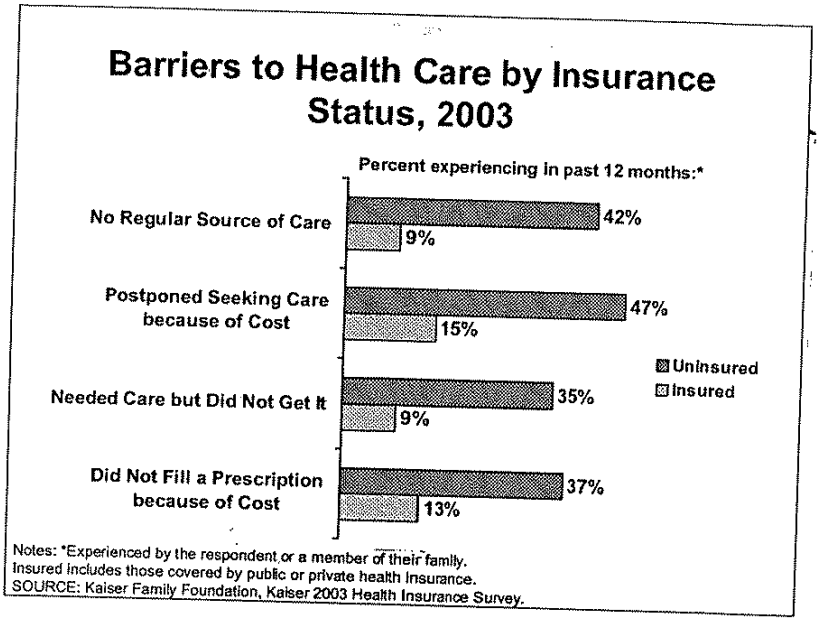


Figure 2

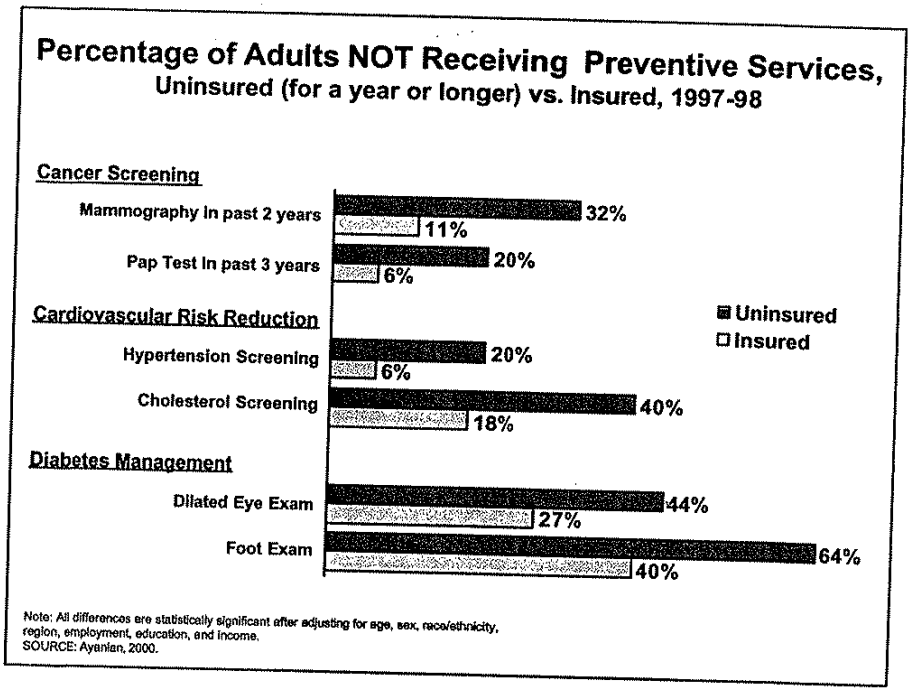


Figure 3

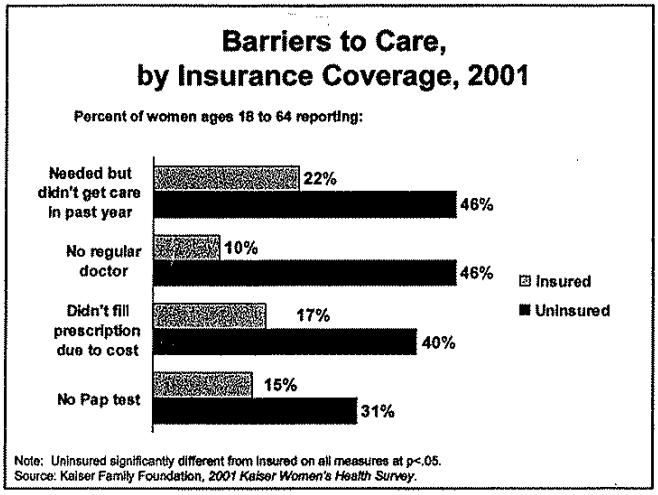
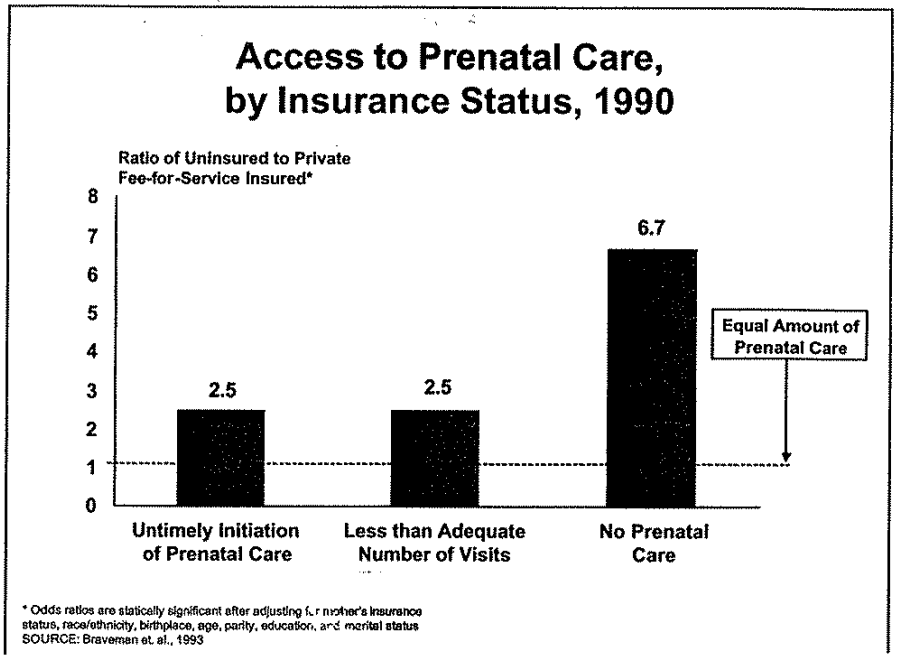


Figure 4, 5



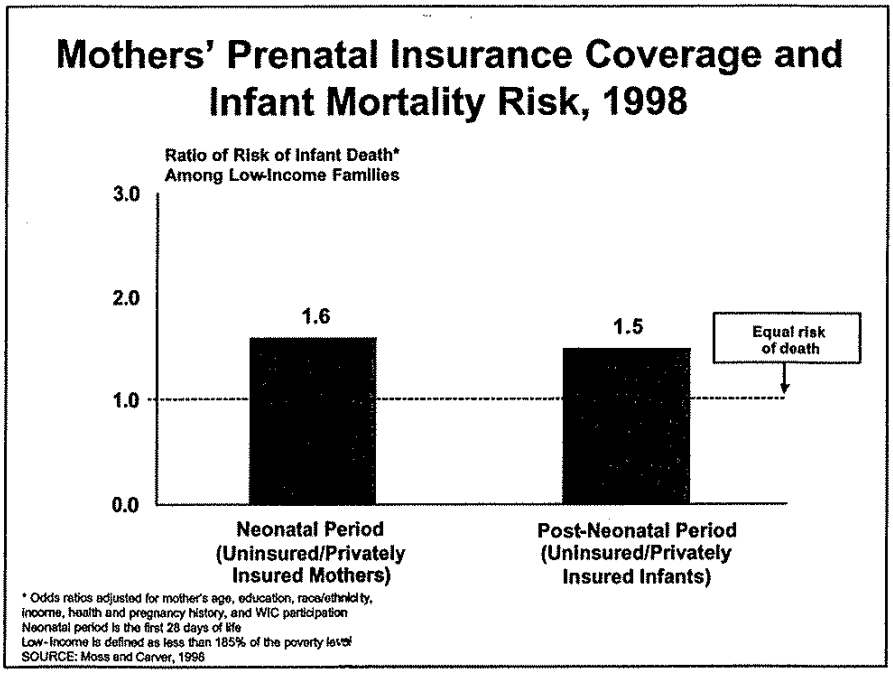


Figure 6

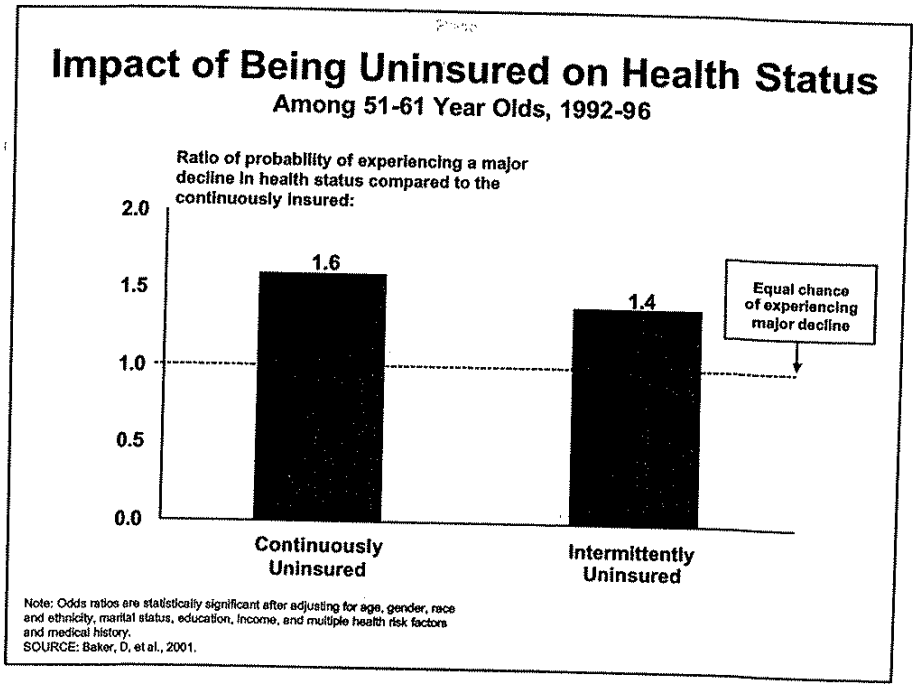


Figure 7

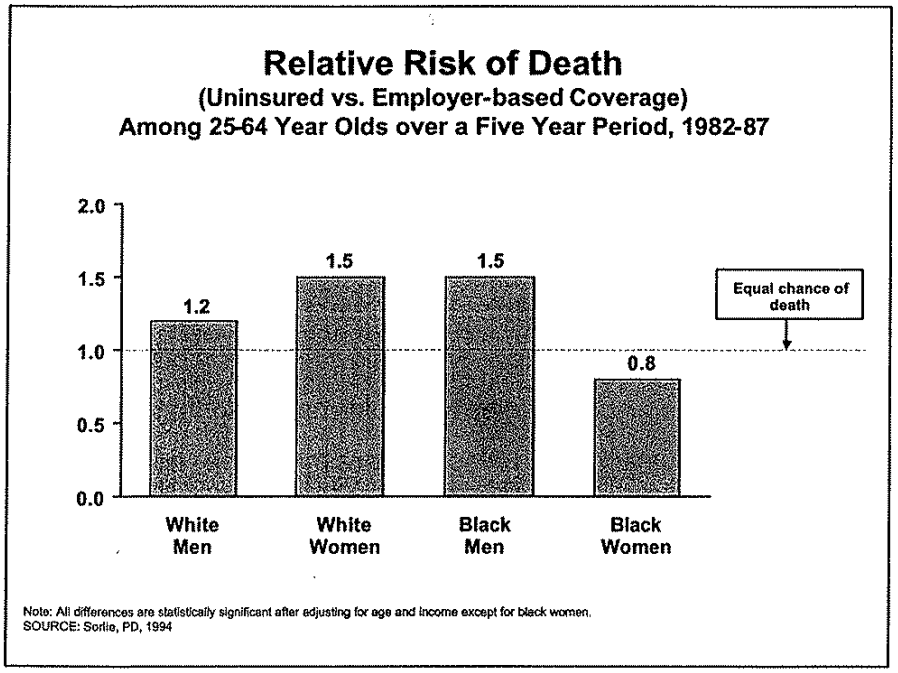


Figure 8

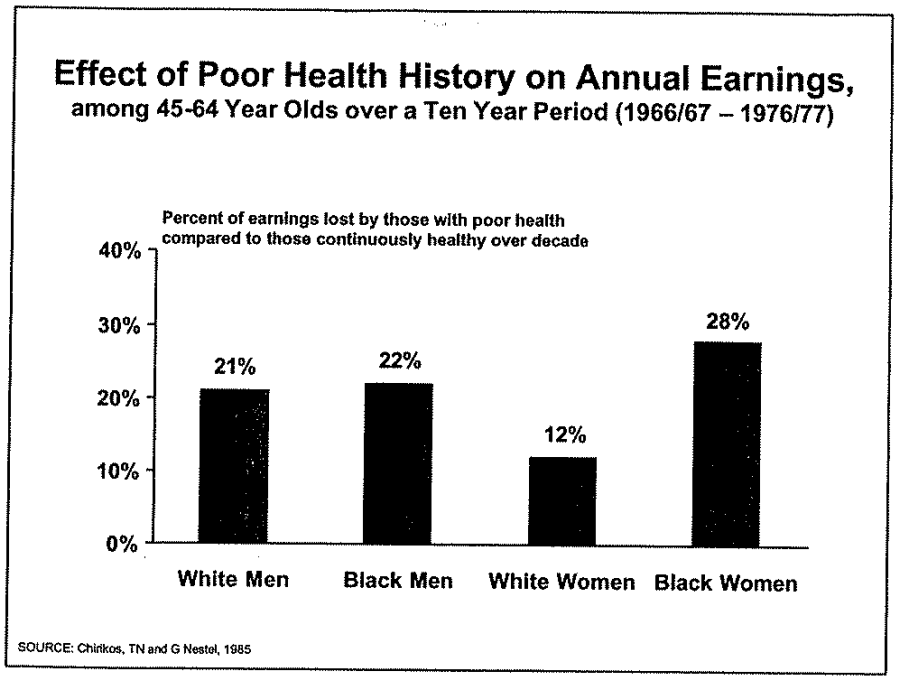
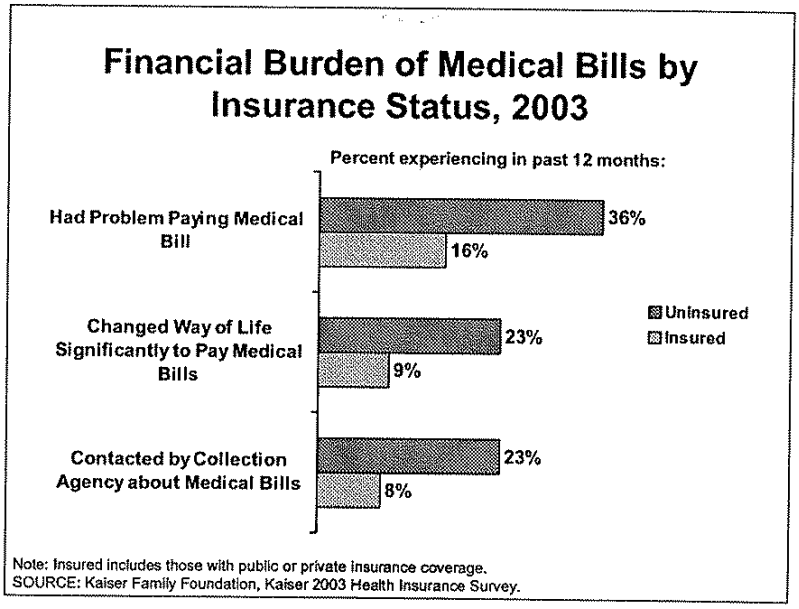


Figure 9

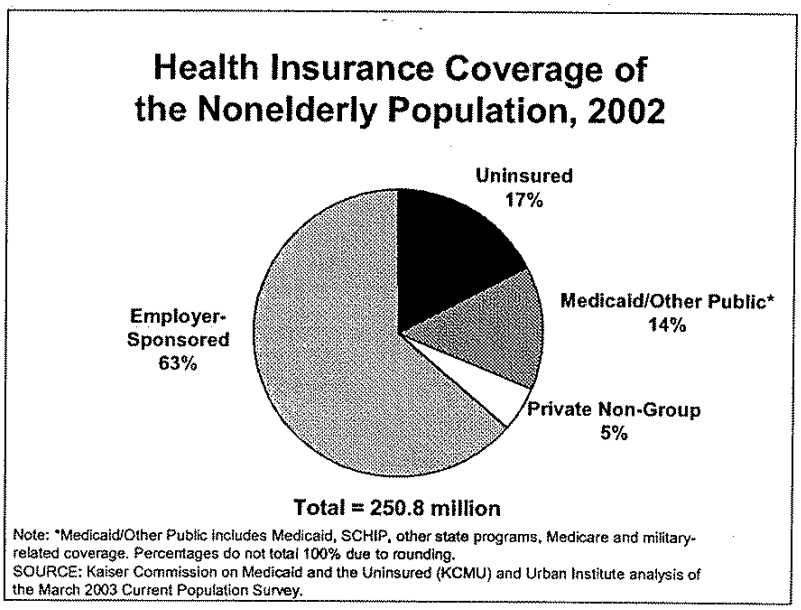


Health Insurance Coverage of Nonelderly Adults, 2002

	Nonelderly Adults (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
Total - Nonelderly Adults[j]	**173.6**	**65.3%**	**5.8%**	**6.8%**	**2.6%**	**19.6%**
Gender/Age						
Adult Males Total	**85.1**	**65.3%**	**5.4%**	**5.1%**	**2.5%**	**21.6%**
M 19-34	31.0	55.7%	6.5%	5.1%	1.1%	31.6%
M 35-54	41.0	71.2%	4.5%	5.0%	2.2%	17.1%
M 55-64	13.1	69.6%	6.0%	5.2%	7.3%	11.9%
Adult Females Total	**88.5**	**65.2%**	**6.1%**	**8.5%**	**2.6%**	**17.7%**
F 19-34	31.3	56.8%	6.9%	11.2%	1.6%	23.5%
F 35-54	42.9	71.6%	4.8%	6.7%	2.0%	14.8%
F 55-64	14.2	64.2%	8.2%	7.6%	6.2%	13.8%
Annual Family Income						
<$20,000	42.6	24.4%	8.8%	19.9%	5.2%	41.6%
$20,000 - $39,999	40.0	62.0%	5.7%	5.5%	2.6%	24.1%
$40,000 +	91.0	85.9%	4.4%	1.2%	1.3%	7.3%
Family Poverty Level[c]						
<100%	**25.5**	**16.1%**	**8.8%**	**25.9%**	**4.6%**	**44.6%**
100-199%	**27.9**	**42.4%**	**7.2%**	**11.2%**	**4.7%**	**34.6%**
...100-149%	13.9	33.7%	7.8%	14.5%	5.9%	38.1%
...150-199%	14.1	50.9%	6.6%	7.9%	3.5%	31.2%
200-399%	**50.9**	**72.4%**	**5.5%**	**3.0%**	**2.2%**	**16.9%**
400%+	**69.2**	**87.4%**	**4.3%**	**0.8%**	**1.2%**	**6.3%**
Parent Status[d]						
M Parents	29.0	75.6%	4.0%	4.3%	1.2%	14.9%
M Non-Parents	56.1	60.0%	6.2%	5.5%	3.3%	25.0%
F Parents	37.4	67.2%	4.4%	10.6%	1.6%	16.2%
F Non-Parents	51.1	63.7%	7.4%	6.9%	3.3%	18.7%
Family Work Status						
2 Full-time	49.0	85.8%	3.0%	1.3%	1.0%	9.0%
1 Full-time	93.1	68.2%	5.5%	4.3%	1.4%	20.7%
Only Part-time[f]	12.6	34.1%	14.5%	12.8%	3.5%	35.1%
Non-Workers	18.8	18.4%	8.7%	29.6%	11.9%	31.3%
Education						
Less than high school	22.5	34.8%	3.4%	17.3%	3.8%	40.6%
High school graduate	54.1	60.9%	4.8%	8.2%	3.0%	23.0%
Some college/Assoc. degree	50.6	68.9%	7.4%	5.2%	2.5%	16.0%
College grad or greater	46.4	81.1%	6.3%	1.8%	1.4%	9.4%
Race/Ethnicity						
White only (non-Hispanic)	119.4	71.6%	6.6%	5.0%	2.5%	14.2%
Black only (non-Hispanic)	20.1	53.9%	3.0%	13.6%	3.8%	25.6%
Hispanic	23.2	44.9%	3.2%	9.7%	1.7%	40.6%
Asian/S. Pacific Islander only	8.0	61.3%	8.8%	5.7%	1.6%	22.7%
Am. Indian/Aleut.Eskimo only	0.9	(45.4%)	2.7%	14.1%	4.5%	(33.3%)
Two or More Races[g]	1.9	60.3%	4.5%	11.3%	4.5%	19.5%
Citizenship						
U.S. citizen - native	147.2	68.1%	5.9%	6.8%	2.7%	16.5%
U.S. citizen - naturalized	9.7	63.3%	6.2%	6.4%	2.3%	21.8%
Non-U.S. citizen, resident for < 6 years	5.6	34.5%	5.6%	6.3%	0.7%	53.0%
Non-U.S. citizen, resident for 6+ years	11.1	44.7%	3.9%	8.0%	1.1%	42.3%
Health Status						
Excellent/Very Good	113.1	71.1%	6.5%	3.6%	1.3%	17.5%
Good	42.4	60.0%	4.9%	7.6%	2.7%	24.8%
Fair/Poor	18.1	41.4%	3.5%	24.7%	10.0%	20.4%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.

Figure 1


Health Insurance Coverage of the Nonelderly Population, 2002
Uninsured 17%
Medicaid/Other Public* 14%
Private Non-Group 5%
Employer-Sponsored 63%
Total = 250.8 million
Note: *Medicaid/Other Public includes Medicaid, SCHIP, other state programs, Medicare and military-related coverage. Percentages do not total 100% due to rounding.
SOURCE: Kaiser Commission on Medicaid and the Uninsured (KCMU) and Urban Institute analysis of the March 2003 Current Population Survey.

Part IV: Table 1

Characteristics of Uninsured Nonelderly Adults, 2002

	Nonelderly Adults (millions)	Percent of Nonelderly Adults	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total - Nonelderly Adults[j]	**173.6**	**100.0%**	**34.0**	**100.0%**	**19.6%**
Gender/Age					
Adult Males Total	**85.1**	**49.0%**	**18.4**	**54.0%**	**21.6%**
M 19-34	31.0	17.8%	9.8	28.7%	31.6%
M 35-54	41.0	23.6%	7.0	20.7%	17.1%
M 55-64	13.1	7.6%	1.6	4.6%	11.9%
Adult Females Total	**88.5**	**51.0%**	**15.6**	**46.0%**	**17.7%**
F 19-34	31.3	18.0%	7.4	21.6%	23.5%
F 35-54	42.9	24.7%	6.3	18.6%	14.8%
F 55-64	14.2	8.2%	2.0	5.8%	13.8%
Annual Family Income					
<$20,000	42.6	24.6%	17.8	52.2%	41.6%
$20,000 - $39,999	40.0	23.0%	9.7	28.4%	24.1%
$40,000 +	91.0	52.4%	6.6	19.4%	7.3%
Family Poverty Level[c]					
<100%	**25.5**	**14.7%**	**11.4**	**33.4%**	**44.6%**
100-199%	**27.9**	**16.1%**	**9.7**	**28.4%**	**34.6%**
...100-149%	13.9	8.0%	5.3	15.5%	38.1%
...150-199%	14.1	8.1%	4.4	12.9%	31.2%
200-399%	**50.9**	**29.3%**	**8.6**	**25.4%**	**16.9%**
400%+	**69.2**	**39.9%**	**4.4**	**12.8%**	**6.3%**
Parent Status[d]					
M Parents	29.0	16.7%	4.3	12.7%	14.9%
M Non-Parents	56.1	32.3%	14.0	41.3%	25.0%
F Parents	37.4	21.6%	6.1	17.9%	16.2%
F Non-Parents	51.1	29.4%	9.6	28.1%	18.7%
Family Work Status					
2 Full-time	49.0	28.2%	4.4	12.9%	9.0%
1 Full-time	93.1	53.6%	19.3	56.7%	20.7%
Only Part-time[f]	12.6	7.3%	4.4	13.0%	35.1%
Non-Workers	18.8	10.8%	5.9	17.3%	31.3%
Education					
Less than high school	22.5	13.0%	9.1	26.8%	40.6%
High school graduate	54.1	31.1%	12.4	36.5%	23.0%
Some college/Assoc. degree	50.6	29.2%	8.1	23.8%	16.0%
College grad or greater	46.4	26.7%	4.4	12.9%	9.4%
Race/Ethnicity					
White only (non-Hispanic)	119.4	68.8%	16.9	49.8%	14.2%
Black only (non-Hispanic)	20.1	11.6%	5.2	15.2%	25.6%
Hispanic	23.2	13.4%	9.4	27.7%	40.6%
Asian/S. Pacific Islander only	8.0	4.6%	1.8	5.4%	22.7%
Am. Indian/Aleut.Eskimo only	0.9	0.5%	0.3	0.9%	(33.3%)
Two or More Races[g]	1.9	1.1%	0.4	1.1%	19.5%
Citizenship					
U.S. citizen - native	147.2	84.8%	24.2	71.3%	16.5%
U.S. citizen - naturalized	9.7	5.6%	2.1	6.2%	21.8%
Non-U.S. citizen, resident for < 6 years	5.6	3.2%	3.0	8.7%	53.0%
Non-U.S. citizen, resident for 6+ years	11.1	6.4%	4.7	13.9%	42.3%
Health Status					
Excellent/Very Good	113.1	65.1%	19.8	58.2%	17.5%
Good	42.4	24.4%	10.5	30.9%	24.8%
Fair/Poor	18.1	10.4%	3.7	10.9%	20.4%

( ) = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.

Figure 1

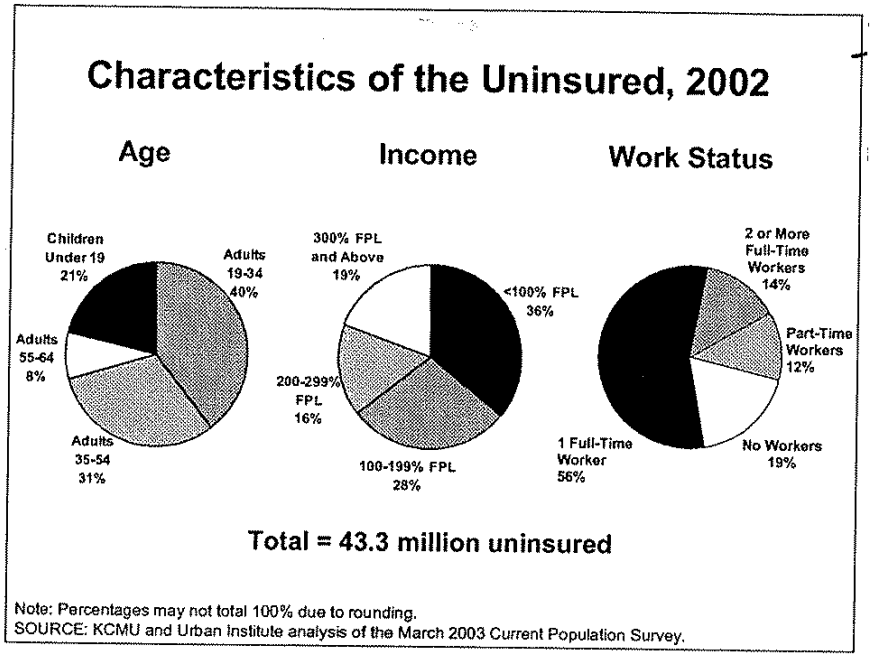


Figure 2

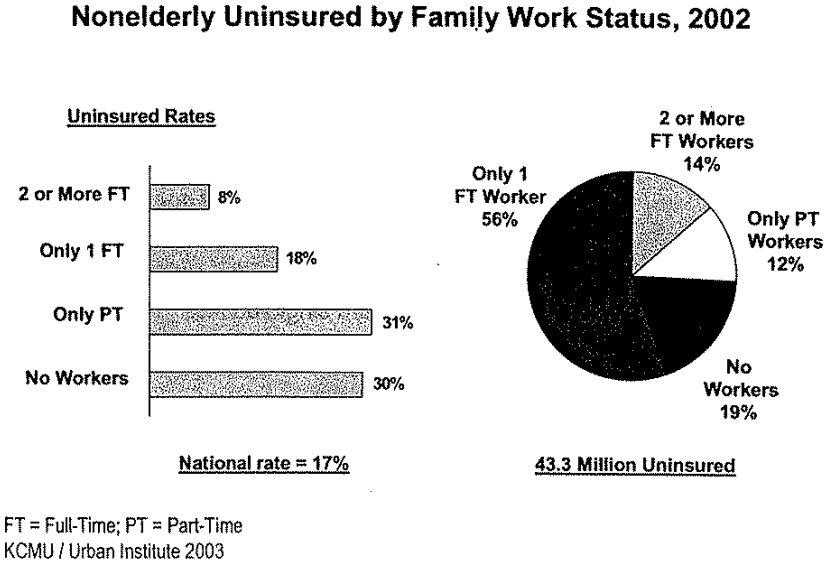
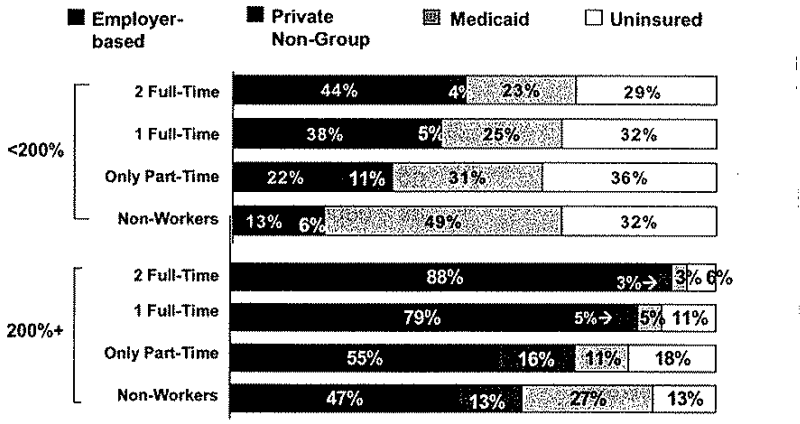


Figure 3

Health Insurance Coverage, by Family Poverty Level and Work Status, 2002



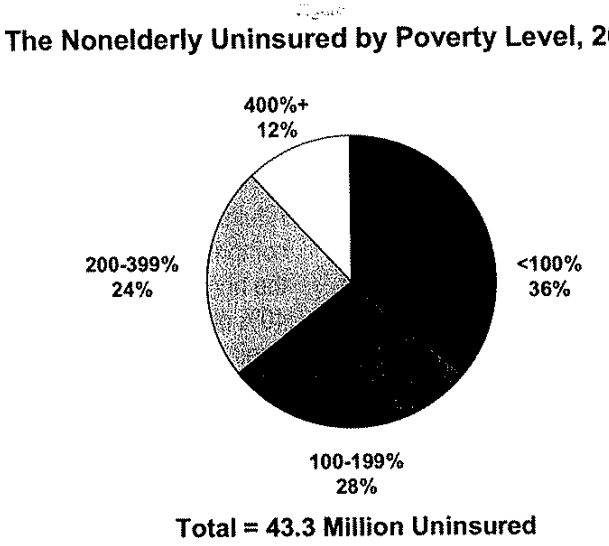
Medicaid also includes S-CHIP, other state programs, Medicare and military-related coverage. Less than 200% of poverty level = $28,696 for family of 3 in 2002.
KCMU / Urban Institute 2003

Table 2

Health Insurance Coverage of Workers, 2002

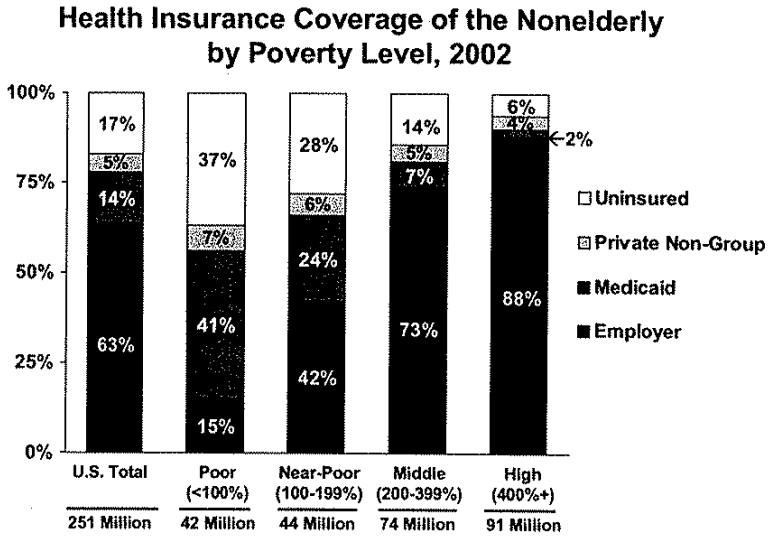
	Workers (millions)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
Total - Workers[k]	**142.1**	**71.6%**	**5.5%**	**3.7%**	**1.1%**	**18.1%**
Age						
18-34	53.0	61.6%	6.4%	5.8%	0.9%	25.1%
35-54	70.8	77.4%	4.6%	2.6%	0.9%	14.5%
55-64	18.3	78.0%	6.7%	1.7%	2.1%	11.5%
Worker's Annual Income[l]						
<$20,000	46.5	49.9%	8.0%	8.3%	1.6%	32.2%
$20,000 - $39,999	47.9	76.4%	4.5%	2.2%	1.0%	15.9%
$40,000 +	47.7	88.0%	4.2%	0.7%	0.7%	6.4%
Family Poverty Level[c]						
<100%	11.9	21.5%	10.5%	17.5%	1.6%	48.9%
100-199%	21.8	45.4%	7.5%	8.0%	1.3%	37.8%
200-399%	44.9	73.9%	5.3%	2.3%	1.2%	17.3%
400%+	63.5	88.4%	4.1%	0.6%	0.8%	6.0%
Work Status[f]						
Full-time/Full-year	97.6	78.4%	4.2%	1.8%	0.7%	14.8%
Full-time/Part-year	20.1	58.1%	5.8%	7.5%	1.7%	27.0%
Part-time/Full-year	12.5	58.4%	10.4%	5.9%	1.7%	23.7%
Part-time/Part-year	11.9	52.8%	10.9%	10.4%	2.5%	23.4%
Business Size (# Workers)						
Self-employed	13.3	50.4%	19.1%	2.9%	1.3%	26.3%
<25	28.8	54.5%	7.6%	5.3%	1.3%	31.2%
25-99	17.1	69.8%	4.0%	4.2%	1.3%	20.7%
100-499	16.8	78.0%	3.0%	3.5%	0.8%	14.6%
500-999	6.3	81.1%	3.7%	2.9%	0.6%	11.7%
1000+	39.3	80.1%	3.0%	3.5%	0.8%	12.6%
Public Sector	20.6	86.4%	2.7%	2.3%	1.3%	7.3%

Figure 4



The federal poverty level was defined as $14,348 for a family of 3 in 2002.
KCMU / Urban Institute 2003

Figure 5



Medicaid also includes S-CHIP, other state programs, Medicare and military-related coverage.
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Figure 6

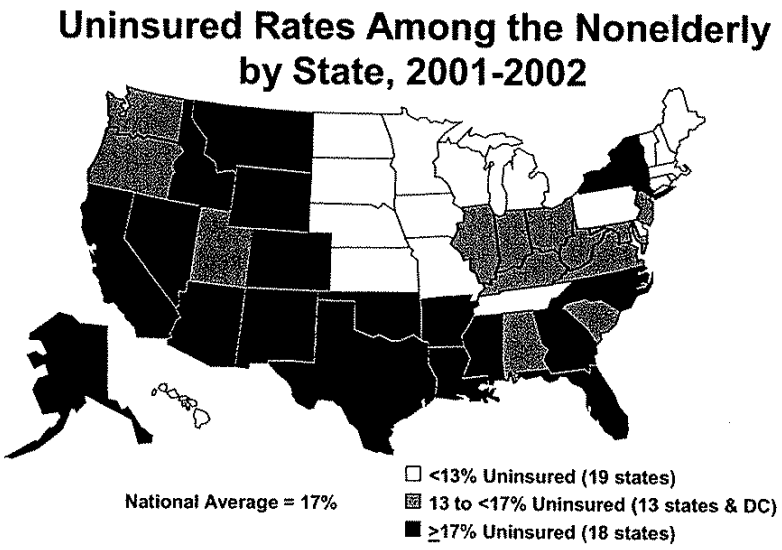
Uninsured Rates Among the Nonelderly
by State, 2001-2002
National Average = 17%
<13% Uninsured (19 states)
13 to <17% Uninsured (13 states & DC)
≥17% Uninsured (18 states)
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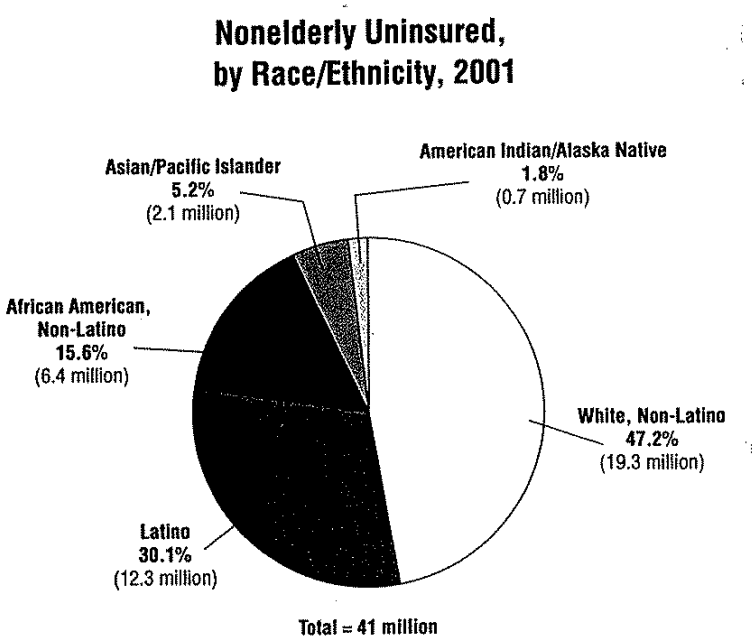
Table 3

Health Insurance Coverage of the Nonelderly by State, 2001-2002

	Nonelderly (thousands)[a]	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other[b]	
United States	**249,183**	**64.0%**	**5.2%**	**11.7%**	**2.2%**	**16.9%**
Alabama	3,822	66.3%	3.9%	12.0%	2.9%	14.9%
Alaska	579	58.5%	3.3%	14.2%	5.3%	18.7%
Arizona	4,682	58.5%	6.6%	12.2%	2.9%	19.8%
Arkansas	2,270	55.2%	5.9%	15.3%	4.7%	19.0%
California	31,370	57.4%	6.3%	13.8%	1.8%	20.8%
Colorado	3,981	66.5%	6.5%	5.9%	3.5%	17.6%
Connecticut	2,890	73.1%	4.7%	8.4%	1.7%	12.1%
Delaware	692	72.5%	4.2%	9.8%	2.5%	10.9%
District of Columbia	495	60.0%	5.5%	19.0%	1.1%	14.4%
Florida	13,642	58.8%	6.7%	11.0%	2.8%	20.7%
Georgia	7,600	64.4%	4.7%	10.3%	2.8%	17.9%
Hawaii	1,037	68.5%	4.3%	11.3%	4.6%	11.3%
Idaho	1,156	61.3%	5.2%	12.3%	2.2%	19.1%
Illinois	10,966	68.2%	4.9%	9.7%	1.6%	15.6%
Indiana	5,276	71.7%	5.1%	7.3%	1.7%	14.2%
Iowa	2,498	71.2%	8.4%	9.1%	1.5%	9.8%
Kansas	2,265	68.0%	7.1%	8.5%	3.6%	12.8%
Kentucky	3,483	64.3%	4.2%	11.9%	4.7%	14.9%
Louisiana	3,864	55.2%	5.4%	14.9%	3.2%	21.4%
Maine	1,067	64.5%	4.4%	15.6%	2.6%	12.9%
Maryland	4,759	73.5%	4.6%	6.1%	1.4%	14.4%
Massachusetts	5,548	70.5%	4.4%	13.3%	1.4%	10.4%
Michigan	8,765	70.9%	3.7%	11.5%	1.5%	12.4%
Minnesota	4,487	74.8%	6.5%	8.8%	1.1%	8.8%
Mississippi	2,476	53.6%	3.9%	21.1%	2.9%	18.6%
Missouri	4,881	68.2%	6.1%	11.7%	1.6%	12.4%
Montana	761	55.4%	11.8%	11.5%	4.3%	17.0%
Nebraska	1,478	65.7%	9.5%	10.3%	3.3%	11.2%
Nevada	1,887	67.9%	4.0%	5.9%	2.2%	20.1%
New Hampshire	1,095	77.3%	3.3%	6.5%	1.8%	11.1%
New Jersey	7,353	71.4%	3.0%	8.9%	1.2%	15.5%
New Mexico	1,574	50.4%	4.1%	18.2%	3.2%	24.0%
New York	16,609	61.4%	3.9%	15.7%	1.2%	17.8%
North Carolina	7,087	61.4%	4.2%	12.1%	4.5%	17.8%
North Dakota	534	63.6%	10.8%	9.3%	4.2%	12.1%
Ohio	9,792	71.2%	4.0%	10.1%	1.5%	13.2%
Oklahoma	2,965	58.4%	5.1%	11.9%	4.1%	20.5%
Oregon	3,096	61.6%	8.0%	13.3%	1.8%	15.4%
Pennsylvania	10,404	71.4%	5.0%	10.5%	1.3%	11.9%
Rhode Island	895	68.6%	4.9%	15.3%	1.1%	10.2%
South Carolina	3,461	63.5%	4.5%	14.3%	3.4%	14.3%
South Dakota	641	66.7%	10.0%	8.8%	2.6%	12.0%
Tennessee	5,049	60.8%	5.1%	19.4%	2.4%	12.3%
Texas	19,162	55.5%	4.9%	10.8%	1.5%	27.2%
Utah	2,110	68.7%	5.8%	9.0%	1.3%	15.2%
Vermont	539	63.7%	5.7%	17.8%	1.3%	11.5%
Virginia	6,211	69.4%	4.8%	7.0%	5.0%	13.9%
Washington	5,295	63.8%	6.1%	12.6%	2.2%	15.3%
West Virginia	1,469	58.6%	3.0%	17.7%	4.2%	16.6%
Wisconsin	4,738	72.3%	6.2%	10.1%	1.5%	9.9%
Wyoming	426	63.4%	5.5%	9.2%	2.7%	19.2%

Figure 7



SOURCE: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2001 Data Update*, 2003.

Figure 8

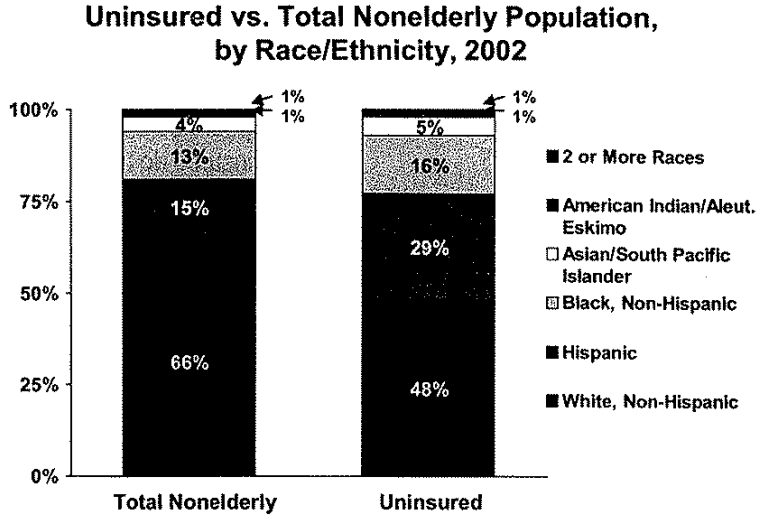


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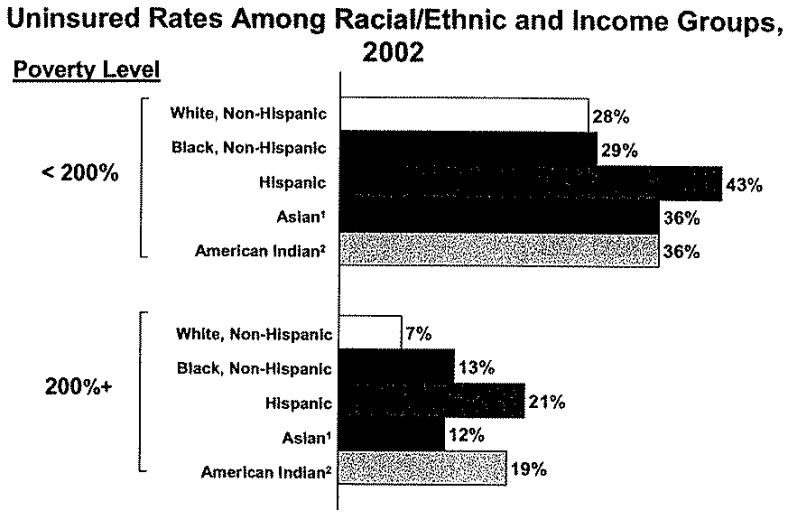
Figure 9



¹ Asian group includes Pacific Islanders. ² American Indian group includes Aleutian Eskimos. 200% of poverty level = $28,696 for family of 3 in 2002.
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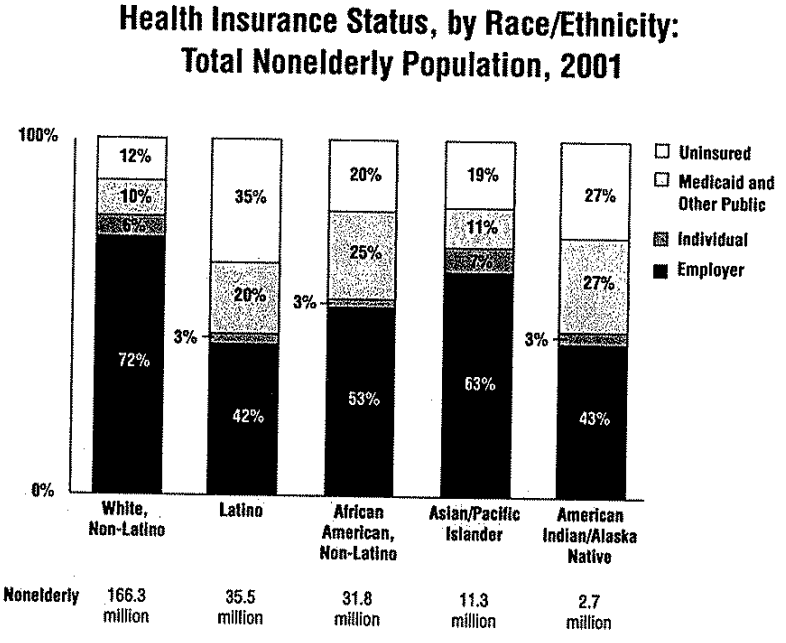
Figure 10



NOTE: "Other Public" includes Medicare and military-related coverage.
SOURCE: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2001 Data Update*, 2003.

Table 4

Nonelderly Uninsured Rates, by State, Region, and Race/Ethnicity, 2000–2001

Region/State	White, Non-Latino	African American, Non-Latino	Latino	Asian/Pacific Islander	American Indian/ Alaska Native
United States	11.4%	20.1%	34.6%	18.9%	26.8%
Northeast	**9.8%**	**20.7%**	**29.0%**	**25.3%**	**18.0%**
Connecticut	9.4%	18.1%	22.9%	10.4%	*
Maine	12.4%	*	*	30.3%	14.9%
Massachusetts	7.7%	13.8%	22.3%	12.7%	*
New Hampshire	10.0%	9.5%	20.1%	19.0%	*
New Jersey	9.3%	22.1%	31.1%	18.8%	*
New York	12.0%	23.4%	31.0%	33.0%	25.9%
Pennsylvania	8.7%	15.7%	27.2%	20.6%	*
Rhode Island	7.0%	18.8%	21.1%	7.5%	*
Vermont	10.5%	*	*	4.8%	*
South	**13.1%**	**21.0%**	**39.5%**	**19.4%**	**23.6%**
Alabama	12.2%	19.8%	49.1%	*	*
Arkansas	15.6%	21.9%	40.8%	*	*
Delaware	9.6%	11.5%	21.4%	11.2%	*
District of Columbia	5.6%	16.7%	34.9%	14.8%	*
Florida	14.6%	26.0%	35.6%	16.0%	22.2%
Georgia	13.1%	20.5%	40.0%	12.3%	*
Kentucky	14.1%	15.6%	37.0%	8.1%	*
Louisiana	17.1%	28.3%	27.1%	19.0%	*
Maryland	8.6%	15.7%	36.3%	19.4%	*
Mississippi	12.6%	23.0%	*	*	*
North Carolina	11.8%	19.8%	46.3%	17.3%	19.9%
Oklahoma	18.9%	23.7%	39.2%	35.3%	29.0%
South Carolina	11.1%	19.0%	31.8%	22.6%	*
Tennessee	10.9%	13.1%	49.2%	6.7%	*
Texas	13.7%	24.7%	41.3%	23.6%	25.6%
Virginia	9.5%	16.5%	33.7%	17.4%	*
West Virginia	15.8%	18.2%	*	*	*
Midwest	**10.0%**	**18.3%**	**29.1%**	**16.3%**	**23.1%**
Illinois	10.5%	23.2%	30.8%	19.9%	11.6%
Indiana	12.2%	19.4%	24.5%	23.3%	*
Iowa	8.7%	12.6%	23.1%	8.1%	*
Kansas	11.4%	14.5%	31.8%	18.3%	17.0%
Michigan	9.5%	15.7%	26.2%	8.8%	19.5%
Minnesota	7.3%	17.7%	38.8%	8.6%	27.4%
Missouri	10.1%	15.4%	27.1%	16.4%	*
Nebraska	9.2%	15.9%	23.0%	10.5%	31.9%
North Dakota	10.2%	*	8.4%	*	38.1%
Ohio	11.6%	16.0%	30.7%	28.1%	*
South Dakota	9.3%	36.2%	26.9%	*	38.2%
Wisconsin	7.2%	14.5%	23.1%	14.1%	20.9%
West	**12.4%**	**17.2%**	**33.5%**	**17.0%**	**32.0%**
Alaska	14.9%	16.1%	24.9%	20.6%	31.4%
Arizona	12.3%	20.9%	32.7%	13.7%	40.9%
California	12.0%	16.6%	33.6%	18.0%	25.1%
Colorado	11.0%	21.7%	35.6%	26.2%	19.4%
Hawaii	10.5%	17.7%	12.8%	10.7%	*
Idaho	14.4%	*	48.2%	4.5%	32.5%
Montana	16.0%	*	15.3%	*	42.2%
Nevada	12.4%	16.1%	35.5%	17.4%	23.1%
New Mexico	20.0%	28.2%	25.8%	*	44.5%
Oregon	11.4%	21.3%	36.9%	14.1%	17.4%
Utah	12.2%	7.3%	34.4%	21.1%	*
Washington	12.5%	15.3%	36.5%	18.4%	32.6%
Wyoming	17.0%	*	32.9%	*	22.7%

* sample size too small for reliable estimate

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2001 and 2002 CPS.

Figure 11

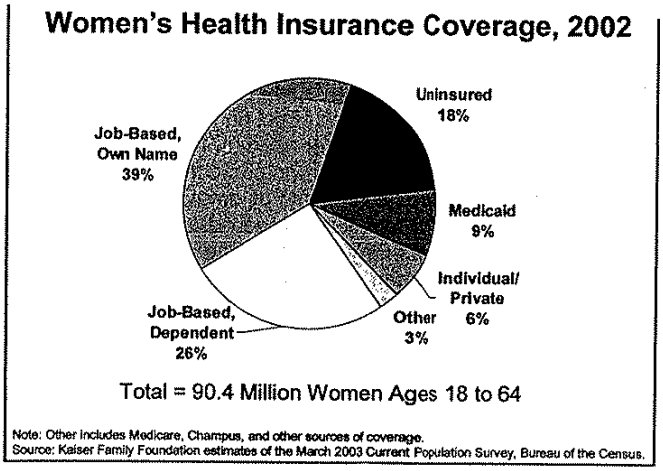
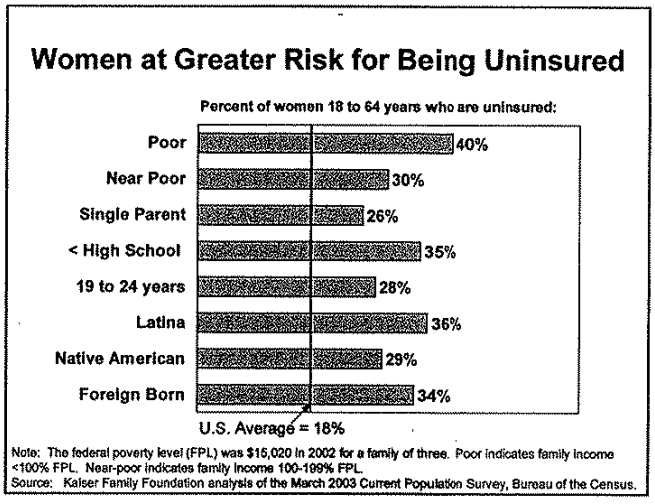


Figure 12



Part V:

Figure 1

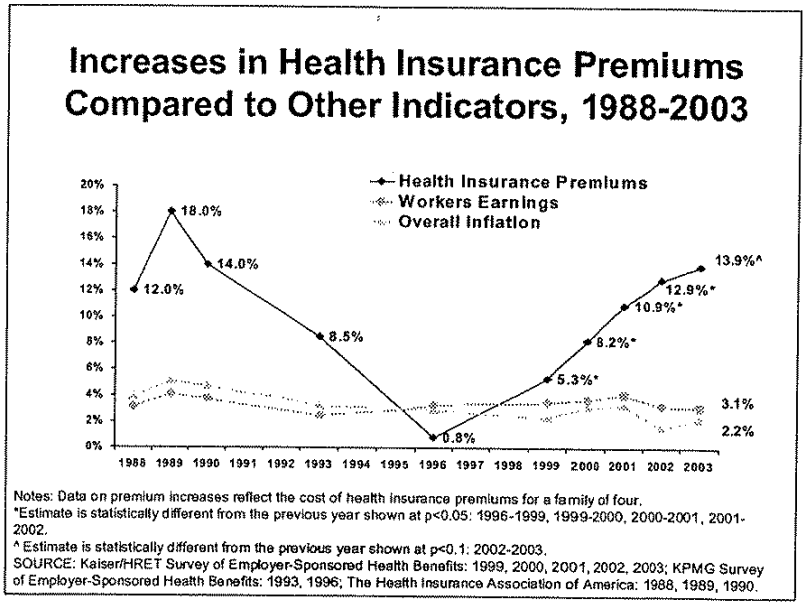


Figure 2

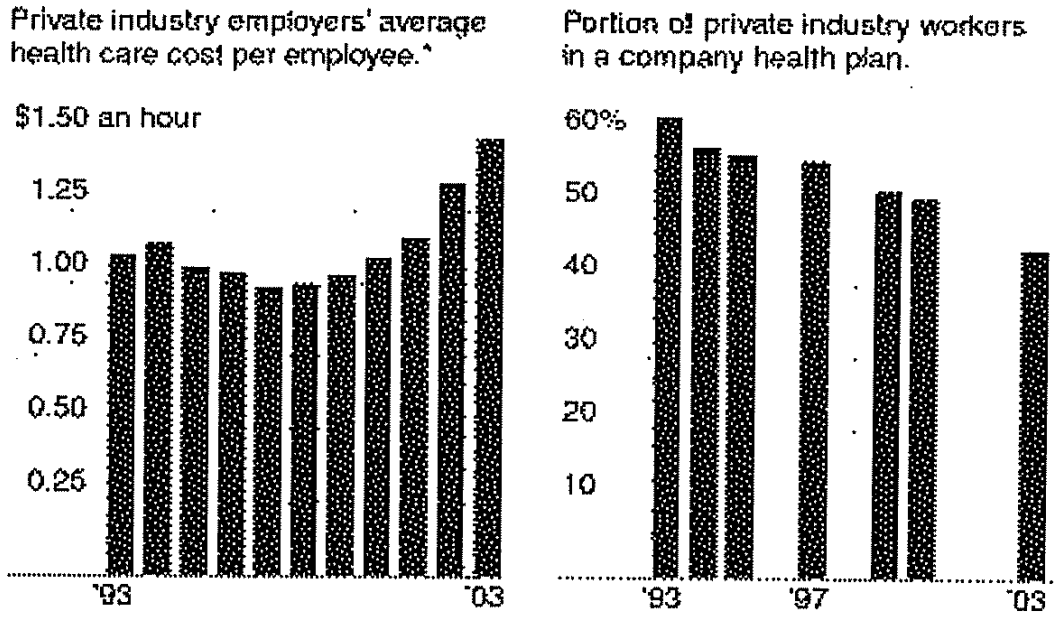
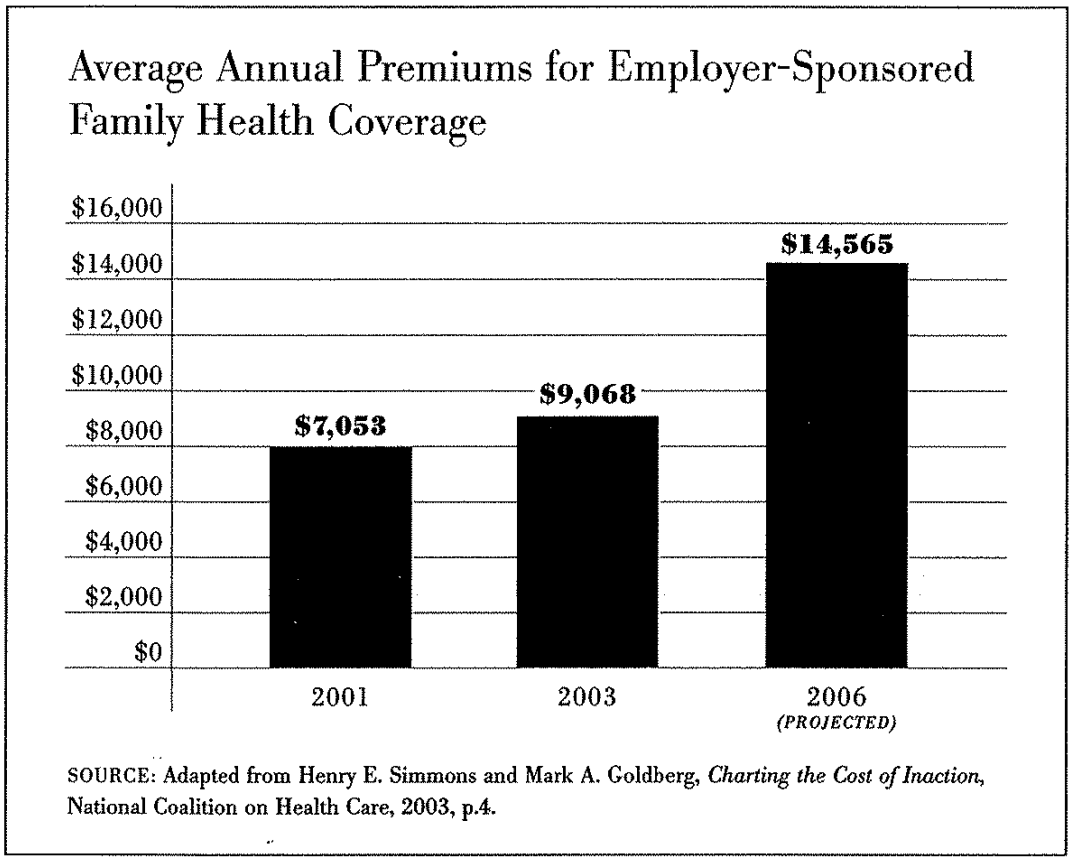


Figure 3



SOURCE: Adapted from Henry E. Simmons and Mark A. Goldberg, *Charting the Cost of Inaction*, National Coalition on Health Care, 2003, p.4.

Figure 4

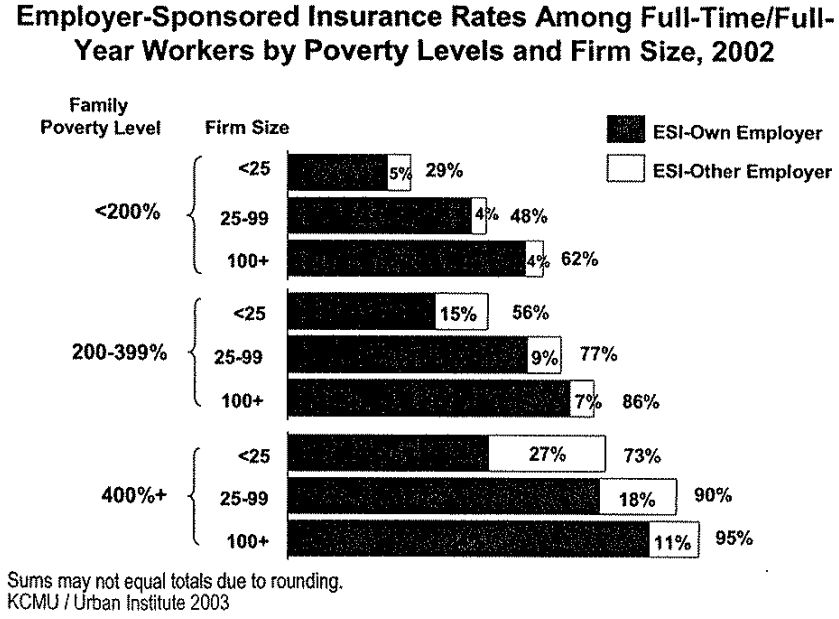


Figure 5

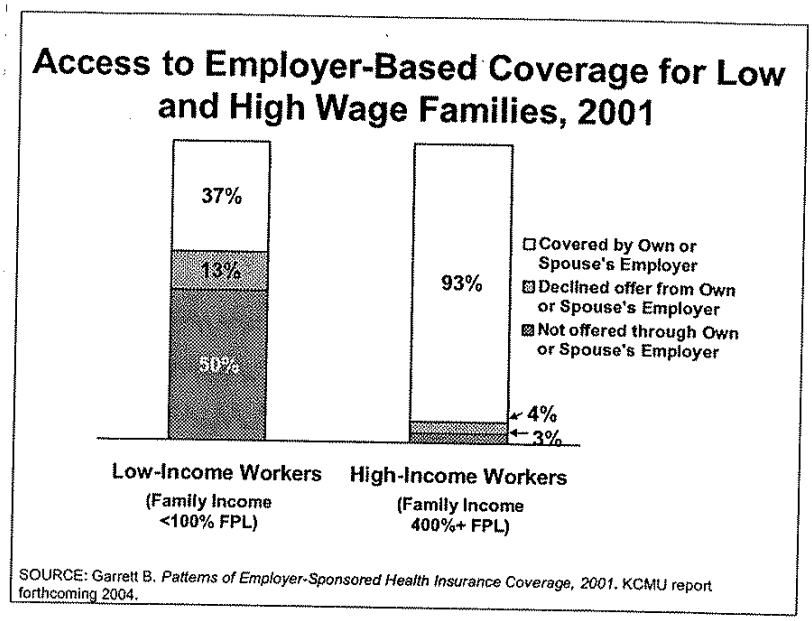
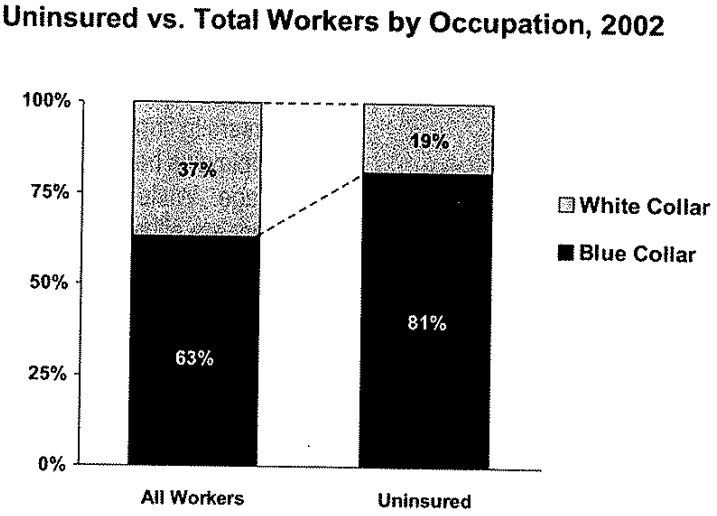


Figure 6



White collar workers include all professionals and managers; examples of blue collar workers include assemblers, clerical, technician, service, labor and sales workers.
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Figure 7