Health Insurance for Arizona Adults

Findings from the Arizona Health Survey 2008

SLHI
A Catalyst for Community Health

AZ HEALTH SURVEY

Authors

Jill Rissi, Ph.D.
Michele Walsh, Ph.D.
John Daws, Ph.D.
Mei-Kuang Chen, M.S.
Patricia Herman, N.D., Ph.D.
Frederic Malter, M.A.
Lee Sechrest, Ph.D.

Acknowledgements

St. Luke's Health Initiatives is grateful for the contributions of authorship and statistical analysis provided by the Evaluation, Research and Development Unit (ERDU) at the University of Arizona. Michele Walsh, Associate Director, was the project leader for ERDU. Data analysis was led by John Daws, Senior Research Specialist, with support from Mei-Kuang Chen, Patricia Herman and Frederic Malter.

SLHI also appreciates the insight and guidance provided by Lee Sechrest at ERDU, Kevin Driesen, Ph.D., at AHCCCS, and Roger Hughes at SLHI.

SLHI | 2929 N Central Ave, Suite 1550, Phoenix Arizona 85012 | 602.385.6500 ph | 602.385.6510 fx

WELCOME TO THE

ARIZONA HEALTH SURVEY

St. Luke's Health Initiatives (SLHI), an Arizona public foundation, invests a significant portion of its resources in the development of health care and community health research, policy analysis and public education. Central to this is the collection and dissemination of reliable, timely and credible information from a variety of sources to inform health decisions and practices.

Toward that end, the Arizona Health Survey 2008 (AHS 2008), one of the most extensive health surveys ever undertaken in the state, was developed through collaboration and community input from nonprofit organizations, university-based researchers, government agencies, healthcare providers, community health advocacy organizations and social service agencies. In addition to major support from SLHI, data collection for AHS 2008 was supported by the Virginia G. Piper Charitable Trust, the Arizona Community Foundation and Valley of the Sun United Way.

To realize a shared vision of value-based health care and community health in Arizona will require that we understand health system trends, their policy implications, and their impact on the health of Arizonans. This report is the first in a series of reports that seek to describe and understand a range of health issues at a high level of detail and relevance. In future reports, AHS data will be used similarly to inform public policy and community health/health care program planning decisions at the local, regional and state levels. This effort will require close collaboration between public, private and nonprofit organizations – and individuals and communities – that are committed to improving health. In that spirit, we hope that you find this report useful and invite you to join us in this important and worthy goal.

To find out more about SLHI, please visit our website at www.slhi.org. To find out more about the Arizona Health Survey and to view reports and analyses in the coming months, visit the AHS website: www.arizonahealthsurvey.org.

Jill Rissi, Ph.D.
Director, Arizona Health Survey
Associate Director, Research & Policy, SLHI

SLHI
A Catalyst for Community Health

www.slhi.org

AZ HEALTH SURVEY
INQUIRY · INFORMATION · INSIGHT

www.arizonahealthsurvey.org

EXECUTIVE SUMMARY

There are many factors that influence the health status of individuals and communities. Among these is access to health care. In turn, a key determinant of access to care is health insurance. Numerous studies have demonstrated that lack of insurance is associated with decreased access to care and with poorer health status.

This report examines health insurance coverage for working-age adults in Arizona. It is based on data from the Arizona Health Survey 2008 (AHS 2008) , which provides a comprehensive picture of health and health care at a level not previously available in Arizona. Given the depth and detail of the AHS 2008, this report represents just the tip of the iceberg – a snapshot of health insurance coverage among Arizona adults. Future reports will explore further the characteristics and conditions, causes and consequences, which define health in Arizona.

Health Insurance Coverage among Adults in Arizona

In Arizona, one in five adults lacked health insurance coverage for at least some portion of 2008. For working age adults between 18 and 64, this number increases to 25 percent, or 950,500.

- Employment-based coverage remains the predominant source of health insurance for working-age adults, covering over half (56%) of those between 18-64 years of age.
- Public insurance programs such as the Arizona Health Care Cost Containment System (AHCCCS), Arizona Long-Term Care System (ALTCS) and the KidsCare Parents program also figure prominently, covering 16 percent of working-age adults.
- Individual insurance purchased privately accounts for just five percent of adult coverage, similar to the five percent of persons under age 65 who are covered by Medicare.
- Combined, these sources of coverage still leave 17 percent of Arizona's working-age adults uninsured.

Coverage Varies with Demographics

Adults over age 65 have near-universal coverage through Medicare. For those under 65, age, income and a host of other demographic characteristics are associated with significant differences in coverage rates.

Age: The proportion of adults with coverage, particularly employer-based coverage, increases with age. Among young adults between the ages of 18 and 29, fewer than half are covered through an employer, and 23 percent are uninsured.

Income: Coverage rates for those at the lowest end of the income scale ($0 to $10K) are reasonably comparable to median-income households ($40K), while near-poor households ($10K to $20K) are much more likely to lack coverage.

- Nearly 40% of households with an annual income between $10,000 and $20,000, and 28% of households making between $20,000 and $40,000 lack coverage. Often making too much to qualify for AHCCCS, these households lack the resources to purchase coverage through an employer or the private market.
- More than 90 percent of those with household incomes over $60,000 have health coverage, with 74 percent provided through an employer plan.

Gender: Women are more likely to have coverage than men. While 14 percent of women lack coverage, 21 percent of men are uninsured. AHCCCS covers substantially more women (21%) than men (11%).

Ethnicity: Over a third (34%) of Arizonans of Hispanic origin lack health insurance, compared to just 11 percent of non-Hispanics. Disparities in coverage reflect differences in access to employer-based coverage, and are also related to income, education, employment sector and English-language proficiency.

Employment: Employer-based insurance, received either directly or through a spouse or parent, accounts for 56 percent of coverage for adults under age 65. Employment status and employer size contribute significantly to the likelihood of coverage.

- Of those not currently working, 96 percent of retired and 99 percent of disabled adults have coverage. Among those who are looking for work, 32 percent are uninsured; and among persons not currently employed for other reasons, 25 percent are uninsured.
- Fewer than half of those employed in firms with less than 50 employees have employer-based coverage, and almost a third of them are uninsured. Among employees in firms with more than 50 employees, just 10 percent lack coverage.

Geographic Variations in Coverage: Local area estimates of coverage within Maricopa County show substantial differences in relative proportions of the adult population covered by employer-based insurance, by AHCCCS, or who are uninsured. Variations in coverage patterns among local geographic areas do not display a readily discernible pattern, highlighting the need to work with these communities, and engage in additional analysis of the data, in order to explain the underlying dynamics.

Coverage and Access to Care: The common belief that uninsured persons are more likely to use an emergency department (ED) for standard care is not supported by the AHS 2008 data. Only one percent of the uninsured report using the ED for standard care, the same percentage as those who are employer-insured. However, four percent of those on AHCCCS report the ED as their standard source for care.

Having health insurance is also a key factor in whether a person has a usual source of care. Those without health insurance are much more likely to report having no usual source of care (62%) than are those with any form of coverage.

Coverage, Health Status and Quality of Life: The reporting patterns associated with self-reported health status and quality-of-life and coverage were similar. Those with employer-based or directly-purchased insurance are more likely to report their health and quality of life as "very good" or "excellent," compared to those who are uninsured, or have Medicare or AHCCCS coverage. The relation between health insurance status and health for those covered by Medicare and AHCCCS is a complicated one, because non-elderly Medicare and AHCCCS enrollees tend to be poorer and/or disabled because of eligibility criteria. Teasing out the health effects due to health care access barriers and those due to these other, related issues is challenging.

Coverage, Medical Debt and Access to Care: Adults who do not have health insurance coverage are more likely to delay or forego needed medical care because of cost. About 10% of people with insurance reported delaying needed medical care in the past year, compared to almost one third of those without insurance. For people who also have existing medical debt, these numbers increase substantially. Among the insured with medical debt, about 30 percent are likely to delay seeking needed medical care, and there is about a 39 percent chance that uninsured persons who also have medical debt will delay or forego needed care.

Summing Up: Recommendations for expanding coverage for non-elderly adults in Arizona must take into account *why* this population lacks coverage. A large proportion of Arizonans have coverage through an employer, either directly or through a spouse or parent. Public insurance programs – such as Medicare, which covers nearly all adults over age 65, and AHCCCS, which covers the very poor – also help to ensure access to care for the adult population. For the working poor and the unemployed, the options are few.

Over three quarters of uninsured adults in Arizona are working at least part-time. Public policies that improve the conditions of employment for these persons, or that facilitate an employer's ability to offer coverage and an employee's ability to participate in a job-based plan, would all help to ensure that Arizona's working families have health insurance. However, if Arizona is to realize its full potential, it must also look for opportunities to leverage existing public insurance programs in order to address the situational factors that often preclude employer-based coverage.

The consequences of coverage – a healthy, productive workforce and high quality-of-life – go hand in hand. As a means of informing and engaging communities, policy makers and service providers, AHS can provide insight into issues of health and health care, and the community context in which they exist. The efficient allocation of resources, whether public or private, is an ongoing concern, and it is critical that we use our resources wisely in order to recognize the long-term potential of our people and our state.

INTRODUCTION

We all share an interest in understanding and facilitating optimum population health through health promotion, program planning and policy formulation. While not the sole determinant, a key dimension of health is access to the healthcare system. In turn, access to health care can be enhanced in different ways, most notably through the availability of health insurance coverage, usually thought of as healthcare policies that are purchased by employers or individuals. Functionally similar coverage may be provided by Federal or state government programs such as Medicare and Medicaid, known in Arizona as *AHCCCS* (Arizona Health Care Cost Containment System). Still other persons may be covered by health and medical services agencies such as the Department of Veterans Affairs and Indian Health Service.

Numerous studies have demonstrated that the lack of healthcare coverage has a negative impact on overall access to care, continuity of care, and use of preventive services. Poorer access to health care, generally defined as not having a regular doctor, not having seen a doctor for a particular condition, or having delayed obtaining care, is related to poorer health status and increased mortality.[1, 2, 3, 4]

According to the U.S. Census Bureau, only five states (Texas, New Mexico, Florida, Oklahoma and Nevada) have greater proportions of residents without coverage than does Arizona. A National Health Interview Survey (NHIS) report ranked Arizona in the top five (of the 25 largest states) in terms of the proportion of residents reporting that they did not get the medical care they needed and delayed seeking medical care because of cost in 2007. In addition, Arizona ranked seventh in residents reporting that they did not get needed prescription drugs because of cost.[5]

This report examines health insurance coverage in Arizona based on data from AHS 2008. It provides a comprehensive picture at a level of detail and precision never before available to describe and understand health insurance, and uninsurance, in Arizona. In particular, we focus on sources, determinants and effects of coverage – or lack thereof – among Arizona adults. Because older Arizonans have near-universal coverage, the report focuses on adults under age 65, with a specific focus on coverage patterns among the working population. Because they are estimates, most population numbers are rounded to the nearest thousand. Throughout the report, estimates are based on weighted responses given at the time of the interview unless otherwise noted.

The following pages provide a detailed accounting of health insurance coverage for adults in Arizona – who has it, who doesn't and where they get it. It also provides a glimpse into what that means in terms of their health and economic well-being. Future reports will focus on children and the characteristics, causes and consequences of coverage for Arizona's youngest citizens, as well as other health issues facing the state.

The report begins with an overview of sources of health insurance coverage for working-age adults. Section 2 provides a more detailed examination of demographic characteristics of people who have coverage, and how coverage rates differ in relation to those characteristics. Section 3 compares overall rates of coverage within Maricopa County, including geographic differences between employer-based, AHCCCS and Medicare coverage. Section 4 considers the consequences of coverage on having a usual source of care, delaying or forgoing care, health status and medical debt. The final section considers the policy implications of the findings and offers recommendations about how we might move forward with efforts to ensure that all Arizonans have access to affordable coverage and high-quality care.

SECTION ONE

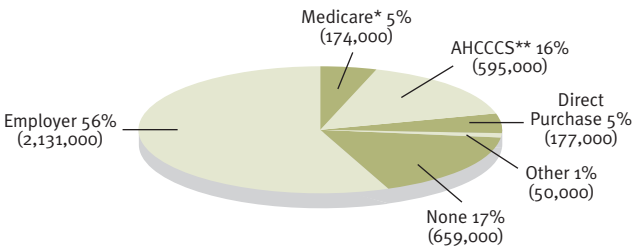
AN OVERVIEW OF HEALTHCARE COVERAGE

Estimates of insurance coverage in Arizona have varied widely, depending on the time frame and method used to make the estimate. Based on data from AHS 2008, 86 percent of all Arizona adults, about four million, have health insurance coverage. The estimated number that lack coverage is almost 670,000. Because Medicare provides nearly universal coverage for elderly and permanently disabled persons, the vast majority of uninsured adults – almost 660,000 – are between the ages of 18 and 64, when they are either starting careers or in the prime of their working years. Coverage for working-age adults helps to ensure that they remain healthy and productive, able to fully realize their potential, meet family obligations and contribute to broader society in a meaningful way. To gain a better understanding of the challenges they face, and the implications for public policy, this report focuses on coverage of working-age adults.

Stability of Coverage

One out of four adults under age 65 report that they were without coverage for at least some portion of the year. To get a better understanding of coverage patterns, adults under 65 with health insurance were asked whether there had been any time in the past year when they did not have coverage. Overall, 76 percent had coverage all year, seven percent had no coverage during some months of the past year but were covered at the time of the survey, and 17 percent were not covered at the time of the survey. (The survey did not ask respondents without coverage whether they had had coverage at any time during the previous year.)

EXHIBIT 1 Adult Health Insurance Coverage
Age 18-64 | Arizona, 2008



* Includes persons who have both Medicare and employer coverage.

** Includes persons who have employer or Medicare coverage in addition to AHCCCS.

Source: Arizona Health Survey 2008.

Sources of Coverage

Generally, healthcare coverage is defined as having at least one of the following:

- employer-provided coverage
- Medicare
- AHCCCS
- directly purchased insurance
- some other coverage (such as military healthcare)

Employment-based coverage remains the predominant source of health insurance for working-age adults. Over half (56%) of adults under age 65 have health coverage through an employer. This may include coverage from the respondent's own employer, or from the employer of their spouse or someone else.

Public programs such as AHCCCS, KidsCare (Arizona's program for near-poor children eligible for coverage through the federal State Children's Health Insurance Program), and the Arizona Long-Term Care System (ALTCS, the long-term care component of Arizona's Medicaid program) are also significant sources of coverage, accounting for 16 percent of adult coverage. Medicare, which provides coverage for permanently disabled nonelderly adults, covers five percent of those between ages 18-64.

Combined with the five percent of adults covered by privately purchased insurance and one percent with some other form of coverage, 3.1 million nonelderly adults have some form of coverage.

SECTION TWO

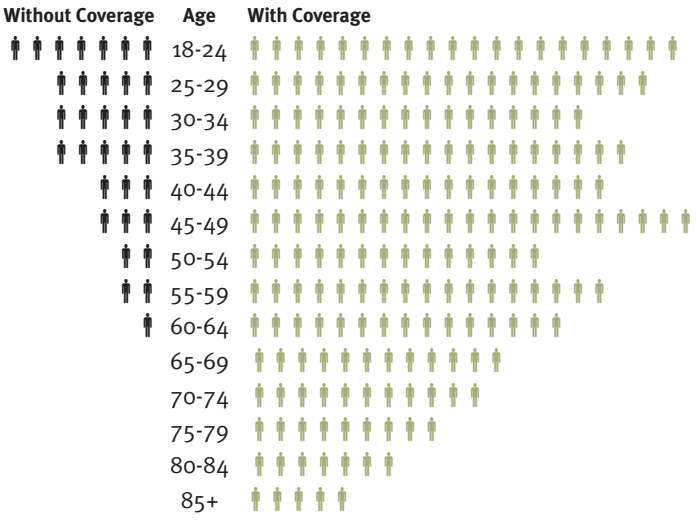
DIFFERENCES IN COVERAGE AMONG ADULTS

Adults over 65 are almost universally covered because they are entitled to Medicare. However, among working-age adults, 83 percent have health insurance, and 17 percent remain uncovered. Looking more closely at AHS data, a more nuanced picture emerges, revealing important differences in rates of coverage based on age, income, gender, education, household composition and ethnicity. Insurance coverage is also driven to a large extent by employment, in particular whether or not insurance coverage is offered by an employer. Although some of these effects are related, each is addressed separately here to provide a richer understanding of its individual relationship to coverage.

Coverage by Age

The percentage of the population covered by health insurance increases with age. The graphic below shows the Arizona population by age, and shows the proportion in each group who are covered by insurance. Virtually all Arizonans over age 65 have coverage, and nearly 90 percent of those between ages 45 and 64 are covered. Only 75 percent of adults under the age of 30 have coverage.

EXHIBIT 2 Health Coverage by Age Group
Adults Age 18+ | Arizona, 2008



One ▮ represents about 20,000 Arizonans.
Source: Arizona Health Survey 2008.

Not surprisingly, the proportion of the population having employer coverage increases with age up to age 65. Fewer than half of younger adults (18 to 29) have employer coverage, but nearly 70 percent of adults between 45 and 64 have it. This may reflect the fact that the ability to obtain coverage is closely related to income, and young adults just entering the workforce may be less likely to be offered or to be able to afford insurance.

Income: The Gap in the Middle

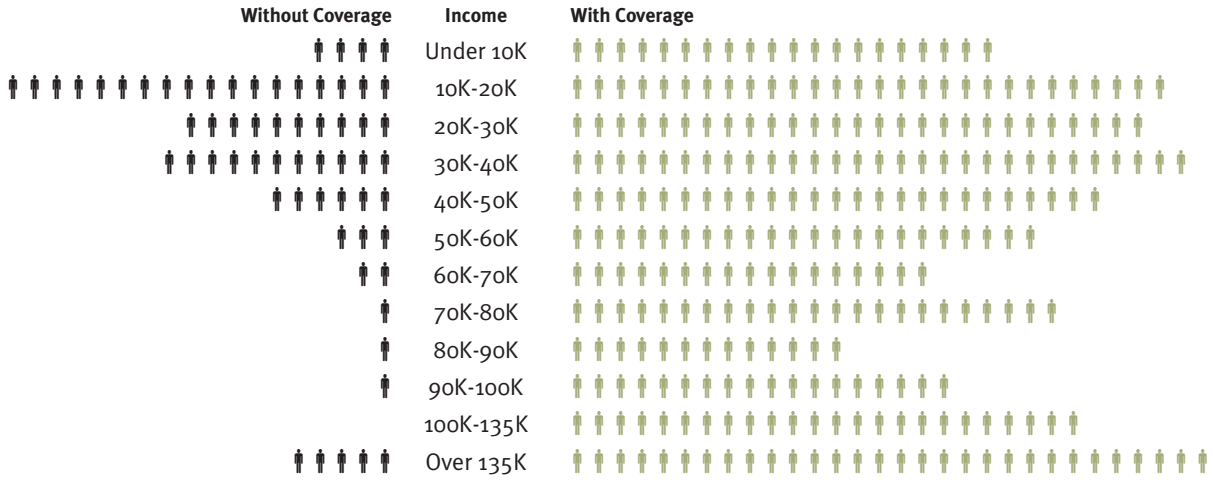
The income group least likely to have health coverage is the $10,000 to $20,000 bracket. This bracket represents adults who make too much to qualify for AHCCCS, but too little to purchase coverage either through an employer or through the private market. The result – nearly 40 percent of those whose annual household income falls in this range have no coverage.

Adults with household incomes less than $10,000 have levels of coverage that are reasonably comparable to those in households in which the annual income is greater than $40,000. About 18 percent of low-income adults under $10,000 lack coverage. Based on current eligibility guidelines, nearly all of these persons would be eligible for AHCCCS, but only 60 percent actually have AHCCCS coverage.

For those with household incomes greater than $20,000, the proportion having health coverage increases as income increases. More than 90 percent of those with household incomes over $60,000 have health coverage. However, health coverage is not universal, even for those with the highest levels of income. Approximately eight percent of persons with incomes over $135,000 report having no health coverage. Presumably, individuals in this income bracket pay for needed healthcare services directly, and/or could afford to purchase private coverage in the individual market, although pre-existing conditions may preclude that option.

In addition to its influence on rates of coverage, income is also a key determinant of the source of coverage for most adults. Employer-based coverage increases as income levels rise, as does the direct purchase of insurance, especially at the highest levels. Among persons with household income under $20,000, fewer than 20 percent have employer-based coverage. At the other end of the scale, over 80 percent of adults with an annual household income of $60,000 or more have

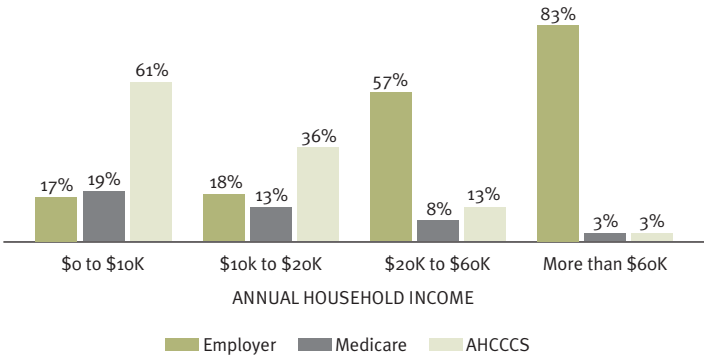
EXHIBIT 3 **Health Coverage by Income Level** | Adults Age 18-64 | Arizona, 2008



One ♟ represents about 10,000 Arizonans.

Source: Arizona Health Survey 2008.

EXHIBIT 4 **Source of Health Coverage by Income**
Adults Age 18-64 | Arizona, 2008



Source: Arizona Health Survey 2008.

employer-based coverage. Nearly 10 percent of adults with an average annual income of $90,000 or more purchase coverage directly.

AHCCCS coverage decreases with income. Over 60 percent of adults reporting annual income under $10,000 per year are covered by AHCCCS. Because eligibility for public insurance through the AHCCCS program is based on both household income and composition, some adults in families with higher income levels may also qualify for coverage. For example, among households with income above $30,000 per year, approximately five percent have AHCCCS coverage.

Coverage by Gender, Education and Marital Status

Overall, with a rate of coverage of 86%, women are more likely to have health insurance than their male counterparts, where only 79% are covered. The difference is primarily due to significantly higher rates of AHCCCS coverage among women (21%), relative to just 11% for men. This gender gap may be attributable to differential rates of AHCCCS coverage for young women (age 18-29), where pregnancy-related eligibility may contribute to a higher rate of coverage. Rates of employer-based coverage and coverage purchased directly are almost exactly the same for both men and women, where coverage may be provided by their own employer or through a spouse. About three-fifths of both sexes have employer-provided coverage.

EXHIBIT 5 Demographic Characteristics by Source of Health Coverage | Adults Age 18-64 | Arizona, 2008

	ESTIMATED NUMBER OF PERSONS	PERSONS WITHOUT HEALTH COVERAGE	TYPE OF HEALTH COVERAGE				
			Employer-provided	Medicare	AHCCCS	Direct Purchase	Other
POPULATION 18 TO 64	100% 3,802,000	17% 659,000	59% 2,242,000	8% 297,000	16% 595,000	5% 177,000	1% 50,000
Female	100% 1,884,000	14% 260,000	59% 1,109,000	8% 145,000	21% 391,000	5% 98,000	1% 19,000
Male	100% 1,902,000	21% 400,000	60% 1,133,000	8% 152,000	11% 204,000	4% 79,000	2% 30,000
Did not graduate high school	100% 649,000	35% 226,000	32% 207,000	7% 48,000	30% 198,000	0% 3,000	2% 10,000
Graduated high school	100% 1,016,000	21% 212,000	51% 516,000	11% 113,000	22% 226,000	4% 38,000	1% 9,000
Attended college or tech school	100% 716,000	16% 112,000	61% 440,000	9% 68,000	12% 85,000	5% 38,000	1% 9,000
Graduated college or tech school	100% 1,386,000	7% 100,000	77% 1,074,000	5% 65,000	6% 83,000	7% 98,000	2% 22,000
Married	100% 2,103,000	13% 274,000	69% 1,447,000	5% 115,000	9% 194,000	5% 114,000	1% 23,000
Widowed	100% 73,000	11% 8,000	56% 41,000	11% 8,000	26% 19,000	3% 2,000	0% 0
Divorced	100% 334,000	18% 61,000	55% 185,000	14% 47,000	18% 61,000	4% 13,000	1% 2,000
Separated	100% 96,000	20% 20,000	36% 35,000	30% 29,000	30% 29,000	2% 2,000	1% 1,000
Never married	100% 794,000	24% 194,000	46% 368,000	10% 83,000	24% 191,000	4% 31,000	2% 17,000
Living with partner	100% 380,000	27% 102,000	43% 163,000	4% 14,000	26% 100,000	4% 13,000	2% 6,000

*Because respondents may have more than one source of coverage, totals for demographic sub-groups may be more than 100%.

Source: Arizona Health Survey 2008.

Parallel to the impact of income, educational level is strongly associated with health coverage such that persons with more education are more likely to have health insurance coverage than persons with fewer years of education. For persons with less than a high school education, coverage is split almost equally between employer-based coverage (32%), AHCCCS (30%), and no insurance (35%). In contrast, for college graduates employer-based coverage rates increase to 77 percent, and the percentage with AHCCCS or no coverage at all decrease to six percent and seven percent, respectively.

Health coverage also varies by marital status. About 87 percent of those who are married have coverage. Among those married, 69 percent have employer-based coverage, in part because some married persons have coverage provided by their spouse's employer. Those who have been widowed are also likely to be covered (89%), but more often are covered by Medicare (11% versus 5% for those currently married), or by AHCCCS (26% versus 9% for married persons).

The lowest rates of job-based coverage are reported among those who are separated (36%), have never been married (46%), or are currently living with a partner (43%). Among individuals who have never been married, 24 percent are uninsured and 24 percent are covered by AHCCCS. Similarly, 27 percent of persons living with a partner are uninsured, and 26 percent are covered through the AHCCCS program.

Despite the relative prevalence of employer-based coverage for most households, there can be variation in the extent of coverage within a single household. For adults who live with a spouse or child(ren) (or both), 82 percent have health coverage for the whole family, 10 percent have coverage for some but not all family members, and 8 percent have no health coverage for any family member. About one-third of adults live in a household that includes neither a spouse nor children, although they may live with parents or unrelated persons. The health-coverage rate for these persons is 79 percent.

EXHIBIT 6 Hispanic Ethnicity and English Proficiency by Source of Health Coverage | Adults Age 18-64 | Arizona, 2008

	ESTIMATED NUMBER OF PERSONS	PERSONS WITHOUT HEALTH COVERAGE	TYPE OF HEALTH COVERAGE				
			Employer-provided	Medicare	AHCCCS	Direct Purchase	Other
POPULATION 18 TO 64	100% 3,802,000	17% 659,000	59% 2,242,000	8% 297,000	16% 595,000	5% 177,000	1% 50,000
Hispanic origin	100% 1,064,000	34% 357,000	42% 446,000	8% 81,000	20% 211,000	1% 16,000	1% 16,000
Not Hispanic origin	100% 2,710,000	11% 400,000	66% 1,793,000	8% 216,000	14% 384,000	6% 160,000	1% 34,000
English is first language	100% 2,972,000	12% 295,000	65% 1,936,000	7% 223,000	15% 438,000	5% 158,000	1% 37,000
Speaks English very well	100% 142,000	20% 29,000	65% 92,000	7% 10,000	9% 13,000	4% 6,000	0% 1,000
Speaks English well	100% 249,000	27% 67,000	45% 112,000	14% 36,000	20% 50,000	4% 9,000	2% 4,000
Speaks English not well	100% 274,000	51% 39,000	27% 74,000	3% 7,000	20% 54,000	1% 3,000	3% 8,000
Speaks English not at all	100% 164,000	46% 76,000	22% 36,000	17% 28,000	26% 43,000	0% 0	0% 0

Source: Arizona Health Survey 2008.

Coverage Variations by Hispanic Origin and Language

Disparities in health insurance coverage among racial and ethnic minorities reflect differences in income, education, employment sector and English-language proficiency. Arizonans of Hispanic origin (34%) are more likely than non-Hispanic persons (11%) to lack health insurance, primarily due to differences in access to employment-based coverage. Persons who identify as Latino or Hispanic have lower rates of employer coverage (42%) in comparison to non-Hispanic persons (66%). A portion of the overall coverage disparity is reduced by higher rates of AHCCCS coverage among Hispanics (20%), relative to the 14 percent of non-Hispanics covered by AHCCCS. Because they represent only a small percentage of the Arizona population, estimates of sources of insurance coverage for African Americans, Native Americans and Asian Americans are based on a very low number of respondents. Thus, these estimates are not reliable and are not reported here.

Self-reported proficiency in English is strongly related to rates of both employer-based health coverage, and coverage in general. Sixty-five percent of those who are native-English speakers or who speak English very well have employment-related coverage. Rates of employer coverage decrease as English proficiency decreases. Only a quarter of those who do not speak English, or do not speak it well, have employer-based coverage. Overall, those who speak English well (73%) or very well (80%) have health coverage rates that are still somewhat lower than native English speakers (88%). About one half of those with the lowest English proficiency are uninsured. Limited English proficiency puts non-native speakers at a disadvantage in the labor market by restricting their ability to compete for jobs that may offer health insurance, further contributing to lower household income and constraining other economic opportunities.

Employment-Based Health Coverage

Employer-based coverage is the predominant source of health insurance for Arizonans. Almost 60% of all working age adults (18-64) are covered by employer-based coverage, including both coverage through their own employer, or through that of a spouse or parent. Overall, 82 percent of adults, age 18-64, who are working have health coverage. Not surprisingly, there are significant differences in rates of coverage for non-working adults, which are related to disability and retirement status. Also of interest are the substantial differences in rates of coverage for working adults, which are related to firm size, defined as the number of employees.

Coverage Variation Among Those Not Currently Employed

Of those not currently working, retired and disabled adults are almost universally covered (96% and 99%, respectively). Among "retirees" (note that these are "early retirement" adults, not yet 65 years old.), 61 percent have employer-based health coverage, which could be a direct

retirement benefit or be coverage obtained through a spouse's employer. Seventeen percent of retirees under age 65 are covered by Medicare, while 11 percent of retired persons purchase health insurance directly, which is about twice the rate of individual coverage found among the general population.

Disabled persons often have more than one source of coverage. While they are less likely to have employer coverage, just 21 percent do, more than half (54%) of them have Medicare and more than half (53%) have AHCCCS. This reflects the situation for many disabled persons who have "dual eligibility" and are covered by both Medicare and AHCCCS for different types of services.

Persons who are currently looking for work have the lowest rate of health coverage at just 68 percent. Nearly half of this group (45%) is covered through AHCCCS, possibly reflecting changes in social welfare benefits which are designed to encourage job training and employment skills. Adults who are not working but are not retired, disabled or looking for work, have a somewhat higher coverage rate (75%) than persons who are looking for work. This heterogeneous group includes both homemakers and unemployed persons who are not looking for work. Within this group, 38 percent have employer-based coverage, presumably through a spouse or parent, and 27 percent are covered by AHCCCS.

Coverage Variation and Employer Size

Overall, 67 percent of adults under age 65 who report working at least part-time receive coverage through an employer, either their own, or through the employer of a spouse. Young adults who are students may also be covered through a parent's employer-based coverage. Many factors influence job-based coverage, including industry sector, hours worked, eligibility restrictions, offer rates, cost of coverage and firm size. Future analyses will examine the phenomenon of employer-based health insurance coverage in greater depth, but for now we focus on the relationship between firm size and employee coverage.

EXHIBIT 7 Employment Status and Sources of Coverage | Adults Age 18-64 | Arizona, 2008

	ESTIMATED NUMBER OF PERSONS	PERSONS WITHOUT HEALTH COVERAGE	TYPE OF HEALTH COVERAGE				
			Employer-provided	Medicare	AHCCCS	Direct Purchase	Other
POPULATION 18 TO 64	100% 3,802,000	17% 659,000	59% 2,242,000	8% 297,000	16% 595,000	5% 177,000	1% 50,000
Not currently employed	**100% 953,000**	**17% 160,000**	**35% 338,000**	**20% 194,000**	**33% 310,000**	**5% 50,000**	**2% 22,000**
Retired	100% 161,000	4% 7,000	61% 98,000	17% 27,000	8% 13,000	11% 18,000	5% 7,000
Disabled	100% 227,000	1% 2,000	21% 48,000	54% 122,000	53% 120,000	1% 3,000	4% 9,000
Looking for work	100% 129,000	32% 41,000	21% 27,000	8% 10,000	45% 58,000	1% 1,000	1% 1,000
Not working	100% 436,000	25% 111,000	38% 165,000	8% 35,000	27% 119,000	6% 28,000	1% 4,000
Currently employed	**100% 2,845,000**	**18% 499,000**	**67% 1,901,000**	**4% 103,000**	**10% 285,000**	**4% 127,000**	**1% 28,000**
1 to 9	100% 571,000	29% 166,000	40% 226,000	4% 25,000	16% 90,000	13% 73,000	3% 15,000
10 to 50	100% 419,000	31% 132,000	52% 219,000	2% 9,000	11% 44,000	5% 22,000	1% 4,000
51 to 99	100% 98,000	10% 10,000	66% 65,000	7% 6,000	17% 17,000	2% 2,000	1% 1,000
100 to 999	100% 408,000	11% 45,000	72% 94,000	7% 29,000	12% 51,000	2% 6,000	1% 2,000
1,000+	100% 1,225,000	9% 109,000	86% 1,053,000	1% 17,000	5% 60,000	1% 16,000	0% 4,000

Source: Arizona Health Survey 2008.

The size of the firm for which someone works is strongly associated with health coverage. Among the 2,845,000 workers in Arizona, 67 percent have employer-based coverage, 10 percent are covered by AHCCCS and 18 percent are uninsured. For persons employed by the smallest firms (between one and nine employees), employer-based coverage is just 40 percent, 16 percent are covered by AHCCCS, and 29 percent are uninsured. Employees at the smallest firms are also the group most likely to purchase health insurance directly (13%).

In contrast, among workers at the largest firms (over 1,000 employees), 86 percent have employer-based coverage, five percent are covered by AHCCCS and just nine percent are uninsured. The situation at mid-sized firms (51-99 employees) is somewhat mixed, with 66 percent of employees covered through the employer's plan, 17 percent on AHCCCS, seven percent covered by Medicare and ten percent uninsured. In general, persons working in larger firms are more likely to have employer-provided coverage and less likely to be uninsured than persons working for smaller firms.

Determinants of Coverage: What Matters?

So, what variables best explain health coverage for Arizona residents 18 to 64 years of age?

A number of variables could be argued to contribute to whether someone has health coverage or not. Many of these are individually associated with coverage status, including income, proficiency in English, age, sex, education, marital status, Hispanic ethnicity, and eligibility for employer coverage. Because some of these variables are known to be strongly related to each other (such as education level and income), it would be good to know whether they all contribute to explaining coverage status when taken as a whole, and if so, to what relative extent.

To explore this question, logistic-regression models were developed to find the best combination of these variables for explaining health coverage status. In a nutshell, the best model used a combination of income, English proficiency, age, sex, marital status, and eligibility for employer-based coverage.

Three-quarters of the explanatory power of the model came from whether the person was eligible for employer-provided coverage. Almost all persons who are eligible for employer coverage do have coverage of some kind. Although Hispanic origin and education are strongly related to coverage status, they do not make additional contributions to explaining coverage status, beyond what the other six variables do.

Given the central importance of employer-based coverage in the current healthcare system, it is not surprising this model suggests that improving eligibility rates for job-based insurance might be one way to expand adult health coverage. In fact, a number of reform proposals have focused on efforts to help small businesses and their employees by addressing the obstacles they face in the insurance market. However, the model also suggests that efforts that focus solely on small businesses through the private sector will not be enough to resolve this problem. To address these, and other issues, policy makers will need to consider who, what, when, where, how and why insurance coverage, access to care and health are impacted by public policy decisions.

SECTION THREE

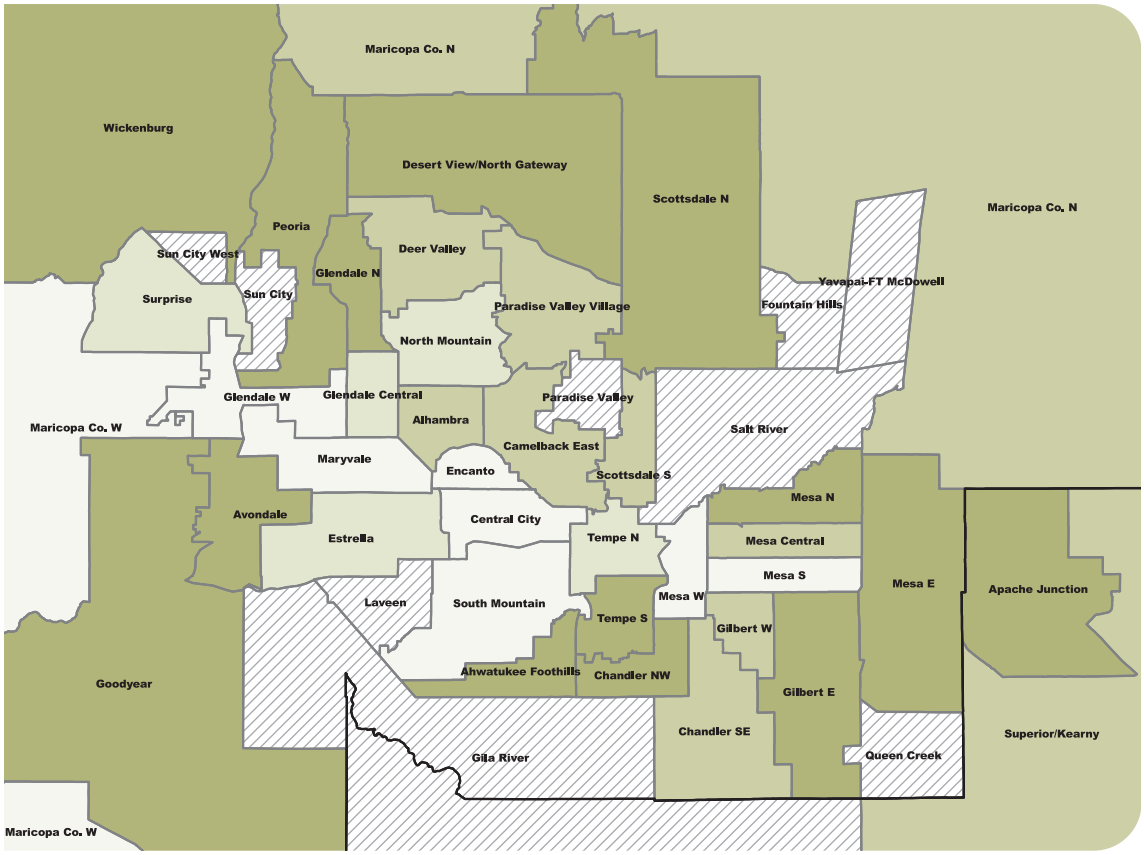
GEOGRAPHIC VARIATIONS IN HEALTH COVERAGE

The following series of maps present a picture of overall health insurance coverage within Maricopa County, followed by a more detailed analysis of AHCCCS and employer-based coverage. The areas depicted reflect Community Health Analysis Areas (CHAAs), which are geographic boundaries created by the Arizona Department of Health Services to aid in local level health planning and evaluation. They include 126 distinct areas throughout the state, 117 of which are included in the AHS 2008 sample. Developing reliable local area estimates requires a reasonably robust sample. Although slightly over 2,000 adults age 18 to 64 were sampled within Maricopa County, local area estimates are only available for areas with a reasonably large population and/or high-density. Understanding health and health care issues is important in all areas; however, low population density, limited availability of land-line telephones, caller screening and cell-phone-only households present a challenge for phone surveys, resulting in small sample sizes in some areas. Because small samples among 18-64 year old adults limited the reliability of coverage estimates in the Salt River, Yavapai/Ft. McDowell, Gila River, Paradise Valley, Fountain Hills, Sun Cities, Laveen and Queen Creek communities, local estimates for these areas are not presented.

EXHIBIT 8

Percent of Adults Under 65 with Any Type of Health Coverage

Maricopa County, 2008



PERCENT WITH HEALTH COVERAGE

- 90% or More
- 80% - 89%
- 70% - 79%
- Less than 70%
- Fewer than 15 Respondents

Source: Arizona Health Survey 2008.

Overall Coverage

Exhibit 8 shows the percent of working-age adults in each CHAA who have health coverage of any kind. The highest overall rates of coverage are found in the outlying suburbs of Goodyear, Ahwatukee Foothills, North Glendale, North Scottsdale, Peoria and Desert View/ North Gateway.

The lowest overall rates of coverage are found in Central City and West Mesa (60%), along with Maryvale and Encanto (both 63%), and South Mesa, West Glendale and Western Maricopa County (all 66%). The proportion of the working-age adult population that lacks coverage is over 25 percent in twelve of the CHAAs.

Comparisons among Exhibits 8, 9 and 10 indicate that overall coverage *rates* are comprised of a diverse combination of coverage *sources*. For example, while Central City and West Mesa have similarly low rates of coverage overall, in West Mesa 46 percent of the population has employer-based coverage and just 10 percent are covered by AHCCCS, while in Central City, AHCCCS accounts for 24 percent of those with coverage and job-based insurance covers just 37 percent. Medicare coverage of nonelderly adults (map not shown) also contributed substantially to overall coverage in Paradise Valley Village (19%), Northwest Chandler (18%) and Avondale (16%), but did not display a consistent pattern relative to other sources of coverage in these areas.

Even between contiguous geographic areas there are substantial differences. North, Central and East Mesa have relatively high rates of overall coverage (91%, 89% and 92%, respectively), while West and South Mesa are among the lowest (60% and 66%, respectively). Employer-based coverage rates explain some, but not all, of the difference. In North, Central and East Mesa, working-age adults with job-based coverage account for 72, 71 and 73 percent of those populations, respectively. The rates fall to less than half (46%) in West Mesa and just 34 percent in South Mesa. AHCCCS contributes substantially to the overall coverage rate in South (19%), East (16%) and Central (14%) Mesa, but accounts for just 10 percent in both North and West Mesa.

Employer-based Coverage

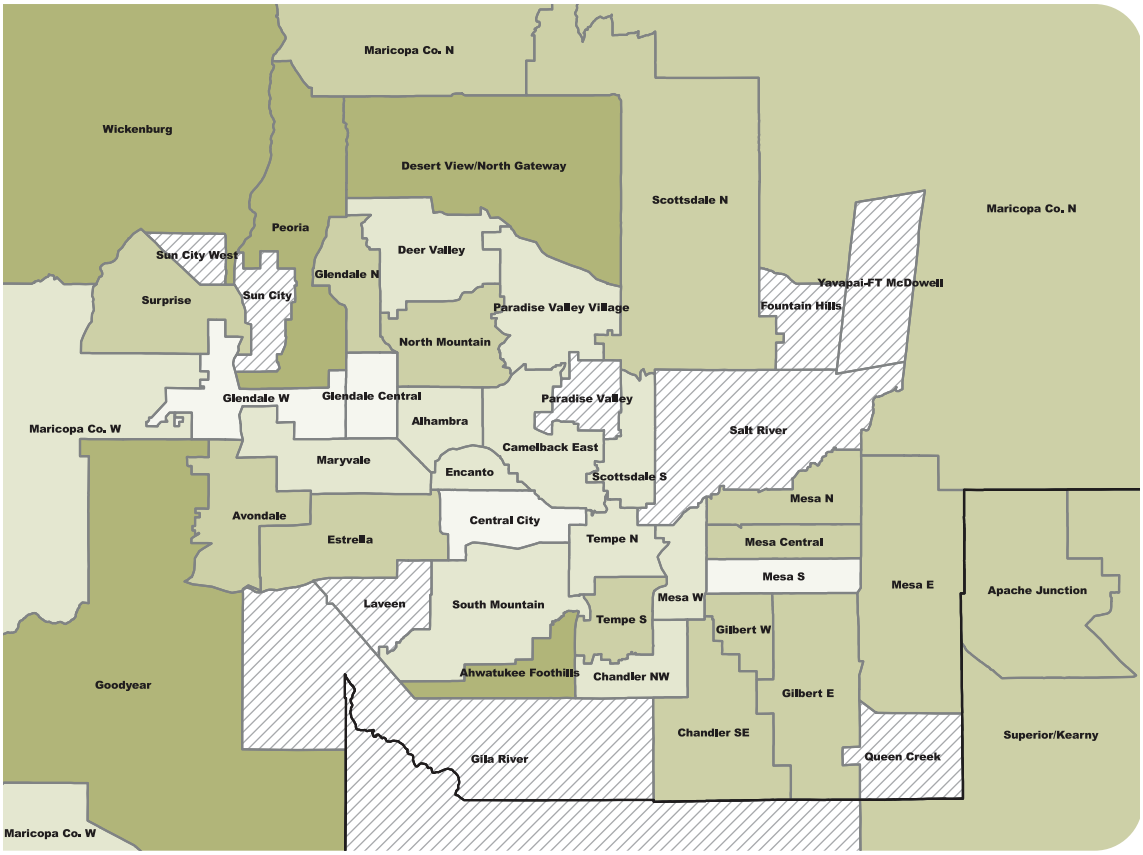
The percent of residents covered by employer-provided plans ranges from a high of 93 percent in the Ahwatukee Foothills to a low of 34 percent in South Mesa. Central City (37%), West Glendale (38%) and Central Glendale (39%) also have low rates of employer-based coverage.

Because employer-based insurance is the most common type of health coverage, Exhibits 8 and 9 show overlapping rates in many, but not all areas. For example, the overall rate of coverage in Northern Maricopa County (81%) is only slightly higher than its rate of employer-provided

EXHIBIT 9

Employer-based Coverage of Adults Under 65

Maricopa County, 2008



PERCENT WITH EMPLOYER HEALTH COVERAGE

- 80% or More
- 60% - 79%
- 40% - 59%
- Less than 40%
- Fewer than 15 Respondents

Source: Arizona Health Survey 2008.

coverage (71%), and in the Ahwatukee Foothills, employer-based coverage (93%) accounts for almost all of the 99 percent of covered adults between 18 and 64 years of age. In comparison, both Northwest Chandler (92%) and East Gilbert (93%) have relatively high overall coverage, but employer-based coverage is relatively low in both areas (58% and 69%, respectively).

AHCCCS Coverage

In this report, "AHCCCS" coverage includes those persons covered by a patchwork of public insurance programs. Over the past eight years, Arizona has implemented two programs to expand coverage for low-income residents: a ballot initiative to increase AHCCCS eligibility to 100% of Federal Poverty Level (FPL) for childless adults, and the KidsCare program which expanded coverage for low-income children. In the years that followed, enrollment increased as these two safety-net programs were implemented, eventually leveling off at just over one million members. Overall, children account for approximately 56 percent of total enrollment. Here we focus on adult coverage which accounts for approximately 44 percent of total enrollment, including about 16 percent of members who are blind or disabled.

Based on data from the AHS 2008, the percent of adult residents covered by AHCCCS ranges from a high of 30 percent in West Glendale, and four other areas where it accounts for over 20 percent of coverage (South Mountain, Central Glendale, Avondale and Central City), to seven areas where enrollment in AHCCCS accounts for three percent or less of the nonelderly adult population (Ahwatukee Foothills, Northern Maricopa County, Surprise, Desert View/North Gateway, Peoria and North Scottsdale).

A comparison of the maps in Exhibits 8 and 10 shows that some communities with low overall coverage rates have higher rates of AHCCCS coverage. For example, overall coverage in Glendale West (65%) and Central City (69%) is relatively low and AHCCCS coverage rates are relatively high (30% and 24%, respectively). However, others such as Encanto and Mesa West exhibit a different pattern in which both have low rates of overall coverage (63% and 60%, respectively) as well as relatively low AHCCCS coverage rates (12% and 10%, respectively). Alternatively, Apache Junction and Avondale have both high rates of overall coverage (93% and 91%, respectively), and high AHCCCS rates (19% and 23%, respectively).

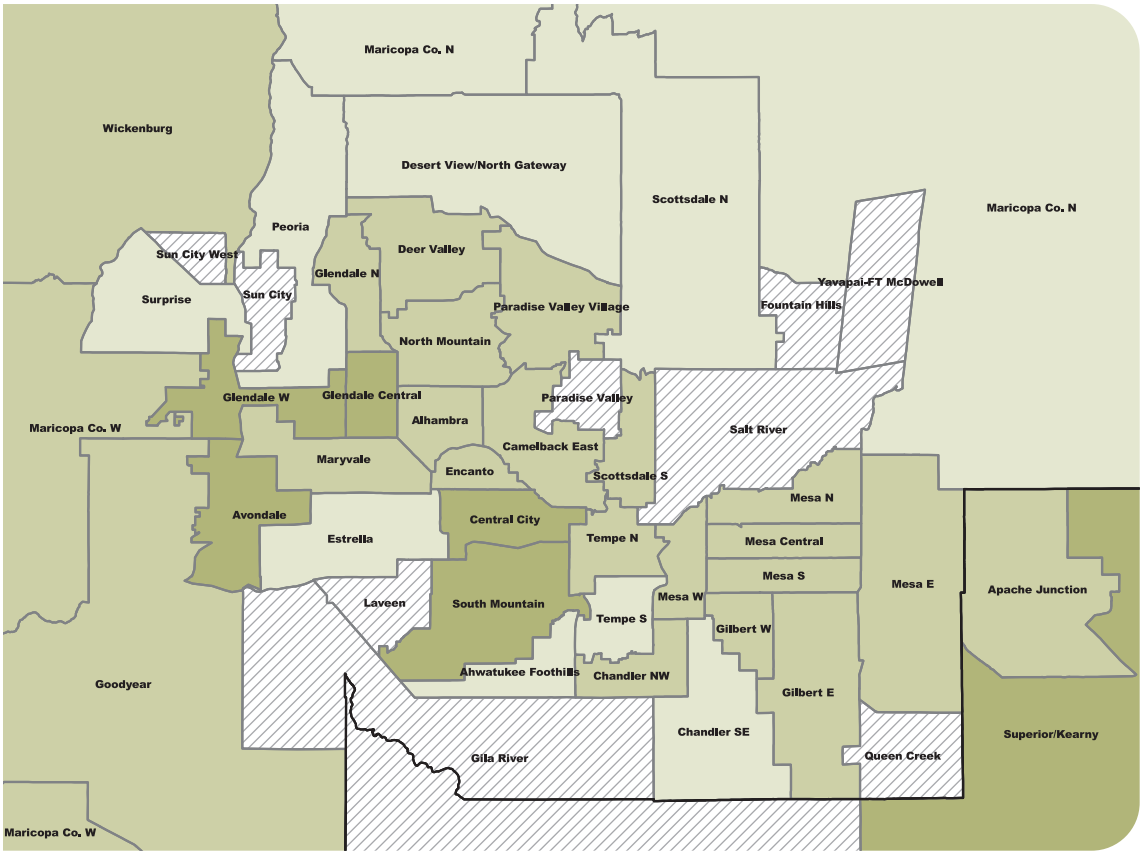
Comparing Patterns of Coverage

Overall, coverage for working-age adults is driven primarily by employer-based coverage and AHCCCS coverage, and would be expected to follow age, employment and income-based area demographics within a local area. However, comparing relative rates of AHCCCS, job-based coverage and the percentage who are uninsured, it appears that while this is the case for some areas, in others the mix is less straightforward. Variations in sources of coverage between and among local geographic areas do not display a discernible pattern, highlighting the need to work with these communities, and to engage in additional analysis of the data, in order to explain the underlying dynamics.

EXHIBIT 10

AHCCCS Coverage of Adults Under 65

Maricopa County, 2008



Source: Arizona Health Survey 2008.

SECTION FOUR

THE CONSEQUENCES OF COVERAGE

Health Status, Health Care and Health Coverage

Insurance status is closely tied to access to care. In fact, it is often used as a surrogate measure, or marker of access to care. A strong relationship has also been demonstrated between health status and insurance coverage, although this relationship is more complex as some sources of coverage may themselves be predicated on health status.

Needless to say, health outcomes are dependent upon a complex array of factors including lifestyle, attitudes, and social and environmental determinants. To get a sense of how coverage mediates access to the healthcare system, in this section we present a basic "black-and-white" picture of how having a usual source of care, self-reported health status and quality of life vary with coverage.

Coverage and Usual Source of Care

The belief that uninsured persons are more likely than the insured to use an emergency room for standard care is not supported by the AHS data. In fact, only 1 percent of the uninsured report emergency rooms as their usual source of care. This is comparable to the 1 percent of those with employer-provided insurance who report using emergency rooms as their usual source. The rates are higher for those who have publicly-provided coverage: two percent for those with Medicare, and four percent for those with AHCCCS.

On the other hand, those without health insurance are much more likely to report having no usual source of care (62%) than are those with any form of coverage. As discussed earlier, this lack of access to care has been shown to have an impact on health outcomes.

Among those with coverage, those with employer-provided coverage and those who purchase insurance directly are more likely to report having a doctor's office as their usual source of care, which may indicate better continuity of care, another factor linked to reduced health care costs and better health outcomes.

EXHIBIT 11 Usual Source of Care by Source of Coverage | Adults Age 18-64 | Arizona, 2008

	PERSONS WITHOUT HEALTH COVERAGE	TYPE OF HEALTH COVERAGE				
		Employer-provided	Medicare	AHCCCS	Direct Purchase	Other
POPULATION 18 TO 64	100% 659,000	100% 2,242,000	100% 297,000	100% 595,000	100% 177,000	100% 50,000
Doctor's office	16% 106,000	62% 1,389,000	47% 139,000	36% 215,000	59% 104,000	30% 15,000
Clinic or health center	18% 119,000	14% 311,000	27% 79,000	33% 197,000	13% 23,000	60% 30,000
Emergency room	1% 8,000	1% 33,000	2% 7,000	4% 24,000	1% 2,000	0% 0
Some other place	3% 20,000	2% 45,000	6% 17,000	2% 14,000	7% 12,000	0% 0
No usual place	62% 407,000	21% 463,000	18% 54,000	24% 141,000	20% 35,000	8% 4,000

Source: Arizona Health Survey 2008.

EXHIBIT 12 Self-Reported Health Status and Quality-of-Life by Source of Coverage | Adults Age 18-64 | Arizona, 2008

	PERSONS WITHOUT HEALTH COVERAGE	TYPE OF HEALTH COVERAGE				
		Employer-provided	Medicare	AHCCCS	Direct Purchase	Other
POPULATION 18 TO 64	100% 659,000	100% 2,242,000	100% 297,000	100% 595,000	100% 177,000	100% 50,000
General health rating						
Excellent/very good	39% 260,000	55% 1,244,000	18% 53,000	31% 185,000	74% 131,000	48% 24,000
Good	37% 242,000	32% 717,000	35% 104,000	39% 233,000	20% 35,000	26% 13,000
Fair or poor	24% 157,000	13% 281,000	47% 140,000	30% 177,000	6% 11,000	26% 13,000
Quality of life						
Excellent/very good	43% 285,000	66% 1,475,000	38% 113,000	38% 228,000	72% 127,000	60% 30,000
Good	35% 232,000	26% 579,000	27% 81,000	39% 231,000	20% 35,000	22% 11,000
Fair or poor	22% 142,000	8% 185,000	35% 103,000	23% 137,000	6% 10,000	18% 9,000

Source: Arizona Health Survey 2008.

Coverage, Health Status and Quality of Life

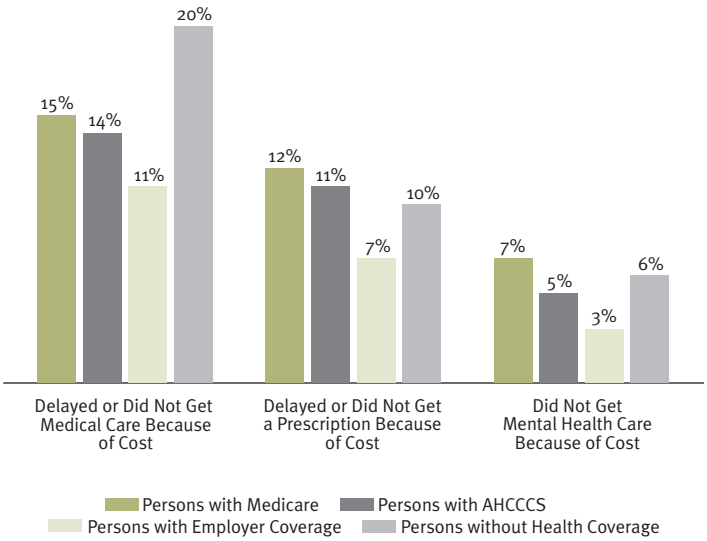
Having certain types of health coverage is positively associated with self-reported general health status and quality of life. Over half of those with employer-provided coverage, and three quarters of those who directly purchase their insurance, report being in "excellent" or "very good" health. In contrast, fewer than four in ten of those who are not insured report this high level of health. However, those with publicly-funded coverage are the least likely to report "excellent" health: fewer than a third of those on AHCCCS and fewer than one in five on Medicare. In fact, nearly half of those on Medicare report their health as "fair" or "poor." This likely reflects the fact that, in the population of those aged 18-64, those on Medicare are those who have disabilities.

Quality-of-life rating demonstrated a similar pattern. Although over two-thirds of those with employer or direct purchase insurance reported "excellent" or "very good" quality of life, fewer than half of the uninsured, and even fewer of the Medicare and AHCCCS-covered report their quality of life this way. Although fewer than ten percent of those with employer or direct purchase insurance reported having "fair" or "poor" quality of life, about a quarter of the uninsured and those on AHCCCS reported this low level, as did a third of those on Medicare.

Coverage, Medical Debt and Access to Care

Numerous studies have shown that persons who lack insurance coverage are more likely to delay or avoid seeking care, often citing cost as the primary reason. The degree to which cost is a barrier to care for those with and without insurance in Arizona is not well understood. To address this question, we examined the frequency with which AHS respondents reported delaying needed care, and how care-seeking behaviors were influenced by insurance coverage. First we looked at the

EXHIBIT 13 Delayed or Did Not Receive Care Because of Cost by Source of Coverage
Adults 18-64 | Arizona, 2008



Source: Arizona Health Survey 2008.

EXHIBIT 14 Medical Debt by Coverage Status
Adults Age 18-64 | Arizona, 2008

	ESTIMATED NUMBER OF PERSONS	PERSONS WITHOUT HEALTH COVERAGE	PERSONS WITH HEALTH COVERAGE
POPULATION 18 TO 64	3,802,000	100% 659,000	100% 3,142,000
No problems with medical debt	2,694,000	64% 421,000	72% 2,273,000
Report one or more problems with medical debt	1,108,000	36% 238,000	28% 869,000
Problems paying for medical bills during the past year	748,000	28% 182,000	18% 566,000
Currently paying off any medical bills	730,000	19% 128,000	19% 602,000
Financial hardship*	686,000	23% 155,000	17% 532,000
Report all three problems with medical debt	287,000	9% 58,000	7% 229,000

* Financial hardship is defined as one or more of the following: having large medical debts, being unable to pay for necessities, taking on credit card debt or a loan, using up savings, declaring bankruptcy.

Source: Arizona Health Survey 2008.

EXHIBIT 15 Medical Debt, Coverage Status and Delay of Care
Adults Age 18-64 | Arizona, 2008

	ESTIMATED NUMBER OF TOTAL	DELAYED OR DID NOT GET CARE	DID NOT DELAY CARE
POPULATION 18 TO 64	100% 3,775,648	13% 492,581	87% 3,283,068
No problems with medical debt			
With health coverage	100% 2,261,170	5% 102,128	95% 2,159,042
Without health coverage	100% 420,358	10% 41,239	90% 379,119
One or more problems with medical debt			
With health coverage	100% 855,731	30% 257,272	70% 598,459
Without health coverage	100% 238,389	39% 91,942	61% 146,447

Source: Arizona Health Survey 2008.

type of coverage, if any, within sub-populations who reported delaying care. Then we looked at persons who shared the same type of insurance coverage to explore how coverage impacts care-seeking behavior.

Coverage and Delayed Access to Care

As might be expected, those without health insurance are more likely to report delaying or not obtaining medical care, prescriptions, or mental-health care because of cost than are those who have employer-provided coverage. However, those with Medicare and with AHCCCS also report delaying and not obtaining care and medications because of cost. This may reflect an inability to handle even minimal co-pays, or could be, for example, that doctors have recommended prescriptions not on the formularies.

Coverage and Medical Debt

While the problem of medical debt among the uninsured is not surprising, in recent years, national studies have drawn attention to the increasing share of premium costs for health insurance coverage that are being passed on to individuals along with higher deductibles and co-payments at the point of service. These latter costs may be responsible for increasing the burden of medical debt, even for those with insurance. To explore the issue of medical debt in Arizona, we looked at the extent of medical debt among those with and without health coverage, as well as the degree to which coverage and debt combined to impact access to care.

People who lack coverage have a significantly greater burden of medical debt. Thirty-six percent report having one or more problems related to medical debt, including being unable to pay for necessities, taking on credit card debt or a loan, using up savings and declaring bankruptcy. However, as premiums, deductibles and co-payment amounts have increased, people with health insurance are also experiencing problems paying for health care. Among persons who are insured, 28 percent report having problems with medical debt.

Many persons with coverage report one or more of the following: having problems paying for medical bills during the past year (18%); currently paying off medical bills (19%); or, financial hardship caused by medical bills (17%). Although those without coverage are more likely to experience medical debt in general, the proportion of those currently paying off medical bills is the same for those with and without health coverage.

Coverage, Medical Debt and Access to Care

Compared to persons who have health coverage, persons without coverage are more likely to delay or not get care because of cost. Persons who are currently paying off medical bills also are more likely to delay or not get care. Persons with current medical debt and no health coverage are eight times more likely (39% compared to 5%) to delay or not get care, compared to persons without medical debts and with health coverage.

To assess the degree to which coverage, medical debt or other factors influence delays of care, we developed a logistic-regression model that controlled for factors such as age, sex, income, education, and marital status. The model not only confirmed these results, but showed an even higher likelihood of delay for those without health coverage when accounting for these other factors.

SECTION FIVE

WHAT TO MAKE OF ALL THIS

The Arizona Health Survey 2008 results provide ample evidence of the importance of health insurance and the role of public policy in ensuring coverage for all Arizonans. For older citizens, Medicare provides almost universal coverage, as nearly all persons over the age of 65 are eligible for and enrolled in Medicare. In addition to their Medicare coverage, some persons over 65 have employer-provided health coverage. Although most issues about medical coverage for elderly persons are not a major concern with respect to state-level health policy, others, such as long-term care, are.

The survey indicates that a large proportion of Arizona residents have health coverage through employment, either their own or someone else's. Tracking other sources of employer-based coverage, the slight gains seen in the early part of the decade have largely been erased, and employer-based coverage continues a slow, but steady, decline. While the AHS 2008 estimates for the extent of such coverage differ slightly from estimates provided by other sources, the differences are small and do not alter policy implications. The number of persons who are covered by directly purchased health insurance does serve to mitigate the impact of low levels of employer-based coverage, particularly among very small firms with high-wage employees. However, the impact of the individual health insurance market on overall coverage rates is relatively limited.

The abrupt downward trend in the economy that occurred in the months following data collection for the AHS 2008 creates an uncertain future – and a substantial fiscal strain – for individuals, employers and the state. As employer-based insurance is eroding, enrollment in public programs like Medicaid is expanding. The current state of the economy is likely to exacerbate this trend.

Given that the central mechanism for healthcare coverage in Arizona and the United States – employer-provided coverage – is not likely to change soon, it is important that policy initiatives consider ways to support that mechanism, at least until there is a viable alternative on the political and economic horizon. If more employers cease to offer healthcare benefits because of cost, the effects could be dire. Determining how to contain health care costs must be given high priority, but we also must continue to encourage and support employers in providing healthcare benefits.

Of equal importance is the critical role played by public insurance programs, most notably AHCCCS, KidsCare and Medicare. The coverage provided in Arizona through a combination of public insurance programs and private, employer-based coverage is substantial, and should not be allowed to erode while the state continues to explore ways to expand coverage for the uninsured.

Even in difficult economic times, Arizona has many policy options to address issues of access, coverage and cost. It should be possible, we think, to devise public policies that alleviate the problems stemming from the uninsured. To inform such policies, we need a better understanding of just what kinds of persons do not have coverage and the circumstances that exacerbate the situation.

The model used in this report shows that understanding healthcare coverage is relatively straightforward: it stems from employment or public programs. Understanding lack of coverage, however is less transparent.

The reasons why different people do not have healthcare coverage are various. Some cannot afford it, some do not think they need it, some may choose to provide their own coverage, some may not even be fully aware of provisions for health coverage, and still other people may not be eligible for some forms of coverage because they are not citizens. The fact that it is difficult to specify the reasons why people do not have coverage does not, however, mean that they cannot be clustered according to characteristics that are useful in defining them, locating them, and formulating policy options that might help them.

To illustrate some of the possibilities, we identify two important groups of the uninsured whose circumstances would presumably dictate different policy choices.

The Face of the Uninsured: The Working Poor

One group of the uninsured consists of those classified as the "working poor." These are people who are employed in jobs that choose not to offer health insurance, may not pay wages high enough for employees to pay their portion of premiums where it is offered or allow them to purchase other insurance directly, and where employers likely cannot afford to pay the premiums themselves. While some of these persons may be self-employed, it is likely that most work for small-scale businesses. The group is apparently heterogeneous, for they cannot easily be identified by such characteristics as age and education. For example, retail sales employees, who are numerous among the uninsured, may be both young and old, well-educated or not.

About three out of four uninsured Arizonans work. Many can be defined as "working poor," consisting of persons who are employed and whose income falls below 133% of the Federal Poverty Level. Among persons with insurance, 9% fall into the category of working poor, compared to the uninsured, among which 23% fall into this category. The definition of working poor matters when it comes to affordability of health insurance. Given that insurance obtained by direct purchase is likely to cost about $12,000 per year for a family, even families at two or three times the poverty level would have difficulty paying for privately acquired health coverage.

The uninsured working poor (about 9% of the total population) are predominantly male and Hispanic. More than half of them were born in Mexico and speak Spanish as their first and preferred language. Most of them are young, less than 40 years of age. For the most part, further descriptors of the uninsured working poor, e.g., educational level, almost certainly have more to do with why they are poor than with why they are uninsured.

The obvious policy implication for this group of uninsured working poor is to improve their conditions of employment. Interventions might help some of the working poor to move up to better positions that would be more likely to provide health benefits or pay sufficiently well to make at least some insurance coverage possible. As it stands, 28% of the uninsured working poor are eligible for employer-based insurance, but have not taken it up.

It is important to note that the uninsured working poor tend, much more than insured workers in Arizona, to work for small employers. One policy option might be to move toward subsidizing purchase of health insurance by small employers to make it more likely that they can offer health benefits, and that they and their employees can afford them. Alternatively, allowing more small employers to join Healthcare Group or buy into AHCCCS would help the working poor. Another option might be to increase in the ceiling for AHCCCS benefits, a step that several states have taken in recent years with their own Medicaid programs.

The Face of the Uninsured: The Unemployed

The second sizable group of uninsured persons are unemployed persons, often Hispanic, and more likely than the working poor to be female. In other respects, they closely resemble the working poor. Notably, however, 63% of these unemployed persons should be eligible for AHCCCS (based solely on income), but they are not enrolled. In fact, the proportion of AHCCCS-eligible persons is even larger among the younger (18-29) unemployed. It is possible that at least some of these individuals may not be citizens and, therefore, are ineligible for state or federal healthcare coverage. On the other hand, some of these persons may be unaware of AHCCCS or of their potential eligibility to enroll.

In any event, policies directed toward helping such persons begin with the basic proposition that it is in the interests of the broader society to assist the poorest of the poor, persons who live outside of what are considered the ordinary boundaries of mainstream society. This is true not only for overriding principles of fairness and compassion toward others, but for more instrumental reasons of economic and social efficiency and effectiveness.

Clearly the first policy imperative to assist the unemployed and uninsured is to help them move toward employment. That may not be easily achieved to the extent that persons in this group may have little education and a limited knowledge of English. On the other hand, many of the unemployed have recently held employment of some sort and, presumably, could resume work if opportunities were available. At the very least, the unemployed and uninsured need to be made aware of and directed toward charitable and safety-net providers. It will only make things worse if they are allowed to decline in health and capabilities because of lack of any health coverage at all.

Where To From Here?

Working-age adults are the backbone of society. Yet, all too often, it is this group that is the least likely to have the insurance coverage that allows them to remain healthy – and productive – members of that society. Arizona faces a difficult challenge in addressing the complex factors that impede coverage, access to care, health and productivity of its adult workforce. This challenge is particularly acute in an era of budget deficits that may discourage any effort to address expansion of private and public healthcare coverage, and could even precipitate reductions in existing programs. Taking a long-term view, the costs associated with lack of health insurance far exceed the costs of finding the means to ensure that all Arizonans have coverage that provides meaningful access to high-quality health care.

Beyond presenting a picture of health insurance coverage in Arizona, this report is intended to stimulate public dialogue on the strengths and resources we can all bring to bear to address this problem. Bridging the coverage gap in Arizona may require expansion of employer-based coverage, public programs, individual plans or any and all of these. Regardless of the policies and means chosen, any effort will require informed and thoughtful dialogue among policy makers, healthcare providers and the public.

The Arizona Health Survey can provide insight into the complex relationships, underlying causes and potential consequences of a host of health-related issues. But it cannot tell us what to do, or why. To realize our potential as individuals and as a state, we must commit ourselves to using the best evidence available, and to an honest, open public discussion that leverages the rich heritage and diversity of our state.

We invite you to join us in that conversation.

ABOUT THE ARIZONA HEALTH SURVEY

About the Arizona Health Survey

The Arizona Health Survey 2008 is an extensive effort to collect data on a range of indicators, including health status and conditions, health-related behaviors, health insurance coverage, and access to healthcare services. In addition, AHS 2008 includes information about informal sources of care, resilience, and broader social and environmental determinants of health. Together, these indicators paint a more complete picture of health status, access, behaviors, and the social and environmental factors that affect health outcomes and population health. Most importantly, the data is both timely and relevant.

EXHIBIT 16 AHS 2008 Adult Respondent Demographics
Age 18+ | Weighted and Unweighted

	AHS RESPONDENTS		US CENSUS ESTIMATES FOR JULY 2007
	UNWEIGHTED	WEIGHTED	
TOTAL	100% 4,196	100% 4,695,593	100% 4,668,889
18 to 29 years old	7% 289	22% 1,024,334	23% 1,072,509
30 to 39 years old	12% 509	19% 869,801	19% 871,968
40 to 49 years old	16% 664	19% 873,322	18% 859,521
50 to 64 years old	29% 1,208	22% 1,034,077	22% 1,044,500
65 or older	36% 1,522	19% 891,824	18% 820,391
Female	63% 2,631	51% 2,375,893	50% 2,349,550
Male	37% 1,564	49% 2,319,406	50% 2,319,339
Maricopa County	75% 3,139	59% 2,782,545	60% 2,721,798
Other Counties	25% 1,057	41% 1,913,048	40% 1,783,110
Hispanic origin	14% 575	25% 1,153,342	25% 1,118,525
Not Hispanic origin	86% 3,621	75% 3,542,251	75% 3,386,383

NOTE: Census estimates by age and gender are for all adults, 18 and older. Census estimates for Maricopa residents and Hispanic origin are for persons 20 and older.

Source: Arizona Health Survey 2008.

As a population-based survey, AHS provides the information that policy makers need to monitor the performance of the healthcare system and to develop programs to respond to critical issues of cost growth, uneven quality and disparities in access to coverage and care. To capture the rich diversity of Arizona's Hispanic population, the questionnaires were translated and interviews were conducted in both English and Spanish.

AHS 2008 was developed with broad input from the community through a series of meetings that highlighted the critical need for better information. Health and social service providers, public health officials and community advocates all noted the need for state and local level data as they sought cost-effective solutions to address population health problems. These meetings also highlighted the expertise and interest of a cadre of highly-qualified and committed researchers, epidemiologists, statisticians and policy analysts capable of designing, analyzing and interpreting the data to provide useful information for both policy and system planning.

In addition to community input, items in the AHS 2008 questionnaire are drawn from several other surveys, including:

- California Health Interview Survey (CHIS)
- National Survey of Children's Health (NSCH)
- Medical Expenditure Panel Survey-Household Component (MEPS-HC)
- National Health Interview Survey (NHIS)

The survey was conducted by Westat, a national corporation with extensive experience in survey research, between March and June 2008 using random-digit dialing and a computer assisted telephone interview (CATI) protocol.

The survey included almost 4,200 households. By design, three-quarters of the sample was drawn from Maricopa County, and one-quarter was drawn from the rest of the state. Within each household, one adult was randomly selected for interview (the "sample adult"). In Maricopa County households with children, one adolescent age 12–17 (the "sample adolescent") was also interviewed, and information for one child under age 12 (the "sample child") was obtained by interviewing the adult who is most knowledgeable about the child.

Those not living in a private residence (for example, homeless persons and persons living in facilities such as military barracks, prisons, college dormitories or other institutions) were excluded from the sample by design. Strictly speaking, the results of the survey should not be generalized to such persons.

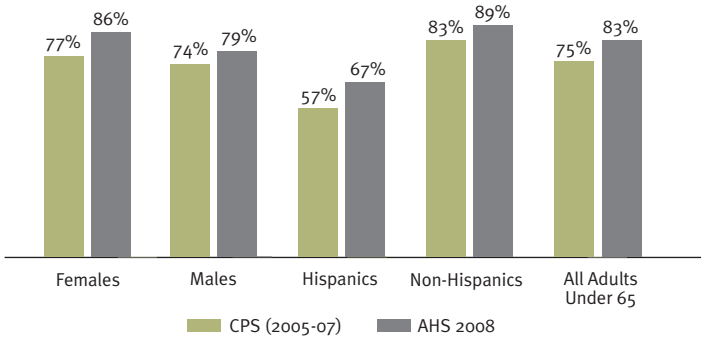
Because not all residents of the state had an equal chance of being selected and interviewed (for example, persons without land-line telephones at home), Westat created a weighting system to correct for sampling biases such that the survey matches the adult resident population of the state. Weighting characteristics included: sex, age, race and ethnicity, education, home ownership, and Maricopa County residence.

Coverage Estimates: Arizona Health Survey and Current Population Survey

Most estimates of health insurance coverage are based on the Current Population Survey (CPS), a national phone survey of households conducted by the U.S. Census Bureau. In October 2008, the Census Bureau reported that in 2005 about 21% of Arizona residents lacked insurance.[6] In a pattern similar to virtually all state-level surveys, estimates of uninsurance based on AHS 2008 data are lower than estimates based on CPS data. This is because the Arizona Health Survey differs from CPS in several important ways. These include the timeframe for which health insurance coverage is measured, the breadth of questions, sampling techniques and the number of Arizonans sampled. For example, CPS defines a person as being covered if they had coverage any time during the previous calendar year, even if they were not covered at the time of the survey, which tends to increase coverage estimates. However, CPS samples are not based on random-digit dialing and may place more weight on lower-income households, which are less likely to have health coverage, thus tending to decrease coverage estimates.[7]

An excellent summary of CPS health insurance coverage estimates is included in the recent AHCCCS state planning grant report.[8] Of particular importance, that report notes that the CPS does not include information about the health status of the uninsured, and little information about Hispanics with and without coverage. These are strengths of the AHS. A comparison of CPS average estimates and AHS 2008 estimates of adult (age 18-64) coverage is presented below.

EXHIBIT 17 Adult Health Insurance Coverage in Arizona
Age 18 to 64 | CPS Average 2005-07 and AHS 2008



Source: Arizona Health Survey 2008.

1 Ayanian JZ, Weissman JS, Schneider EC, Ginsburg JA, Zaslavsky AM. Unmet Health Needs of Uninsured Adults in the United States. *JAMA*. 2000;284:2061-2069.

2 Hadley, J. *Sicker and Poorer: The Consequences of Being Uninsured*. 2002. Washington, DC, Kaiser Family Foundation.

3 Institute of Medicine. *Coverage Matters: Insurance and Health Care*. Washington, DC: National Academy Press; 2001.

4 Brown ME, Bindman AB, Lurie N. Monitoring the Consequences of Uninsurance: A Review of Methodologies. *Medical Care Research and Review*. 1998;55:177.

5 National Center for Health Statistics. *Health, United States, 2007*. Washington, DC: US Government Printing Office P60-235. 2007. Hyattsville, MD, US Government Printing Office.

6 Census Bureau report.

7 State Health Access Data Assistance Center. *State Health Insurance Coverage Estimates: A Fresh Look at Why State-Survey Estimates Differ from CPS*. 12. 2007. University of Minnesota, Minneapolis, MN. Issue Brief.

8 Arizona Health Care Cost Containment System Administration. *Arizona State Planning Grant: Final report to the Secretary of Health and Human Services*. March, 2007.

AZ HEALTH SURVEY

Introducing one of the most extensive health surveys ever undertaken in the state.

St. Luke's Health Initiatives

2929 N Central Ave, Suite 1550, Phoenix Arizona 85012

NONPROFIT
U.S. Postage
P A I D
Phoenix, Arizona
Permit No. 4288