

## **A Profile of American Indians and Alaska Natives and Their Health Coverage**

Prepared by  
Cara James, Karyn Schwartz and Julia Berndt

## **Executive Summary**

Treaties and laws have established the U.S. government's unique responsibility to provide American Indians and Alaska Natives with medical care. Despite this responsibility, a relatively high proportion of American Indians and Alaska Natives lack access to health care. The Indian Health Service (IHS) was designed to fulfill the U.S. government's role in providing health care to this population, but inadequate funding has left those who depend on the IHS with only limited access to care. American Indians and Alaska Natives are particularly vulnerable to problems getting needed health care because they have a relatively high poverty rate compared to other racial and ethnic groups. They also have high rates of chronic conditions relative to other racial and ethnic populations, which makes it particularly important that they receive ongoing preventive care. This brief gives an overview of some of the demographic factors that influence the health and insurance coverage of American Indians and Alaska Natives. It then examines their health insurance coverage and access to care. The following key findings are highlighted:

### **Profile of American Indians and Alaska Natives**

American Indians and Alaska Natives have a high poverty rate and tend to have lower levels of education compared to other racial and ethnic groups. They also experience some of the worst health outcomes for preventable conditions compared to individuals of other racial and ethnic groups. Their health status is the result of numerous health determinants such as exposure to risk factors, availability and accessibility of health care, individual behaviors and social factors.

- One-third of American Indians and Alaska Natives are in families with incomes below the federal poverty line and almost one-in-five American Indian and Alaska Native adults has not graduated from high school.
- American Indian and Alaska Native adults have among the highest rates of certain health conditions, such as diabetes and obesity.

### **Insurance Coverage**

Health insurance helps individuals access the care that they need. Compared to most other racial and ethnic populations, a smaller percent of American Indians and Alaska Natives have private coverage and a greater share rely on Medicaid or other public programs. The U.S. government has signed treaties with American Indian tribes that make the U.S. responsible for the provision of medical care to American Indians and Alaska Natives. The Indian Health Service is the primary mechanism for the U.S. to fulfill that obligation and provides direct care or contracts out services for many American Indians and Alaska Natives.

- One in three nonelderly American Indians and Alaska Natives is either uninsured or depends solely on services provided through the Indian Health Service.
- Lack of funding has prevented the Indian Health Service from offering a full range of health care services.
- Medicaid and other public coverage play a key role in covering American Indians and Alaska Natives, but the program's reach among childless adults is limited due to restrictions on eligibility.

The challenges of providing affordable care to low-income populations and those with significant health needs are central to the debate over health care reform. American Indians and Alaska Natives are disproportionately represented among the low-income and face unique health care challenges. Efforts to improve the overall health of this population will require that special attention be paid to these challenges.

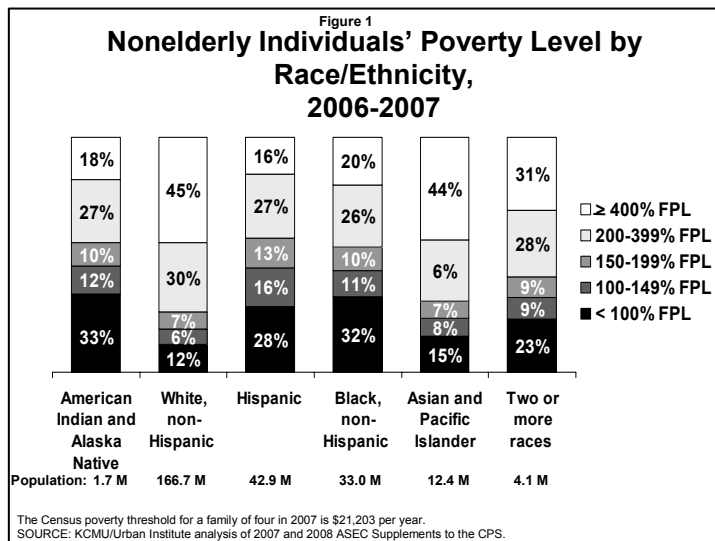
## Introduction

Although the U.S. government has an established responsibility to provide health care services to members of federally recognized Indian tribes, many American Indians and Alaska Natives lack access to health care. The government's role in financing care for American Indians and Alaska Natives is crucial because of their high rate of poverty and low rate of private coverage compared to many other racial and ethnic groups. American Indians and Alaska Natives also have high rates of many health problems, making it critical that they receive needed medical care and preventive screenings. This brief provides a profile of the American Indians and Alaska Native population as well as information on the Indian Health Service and health coverage and access to care for this population.

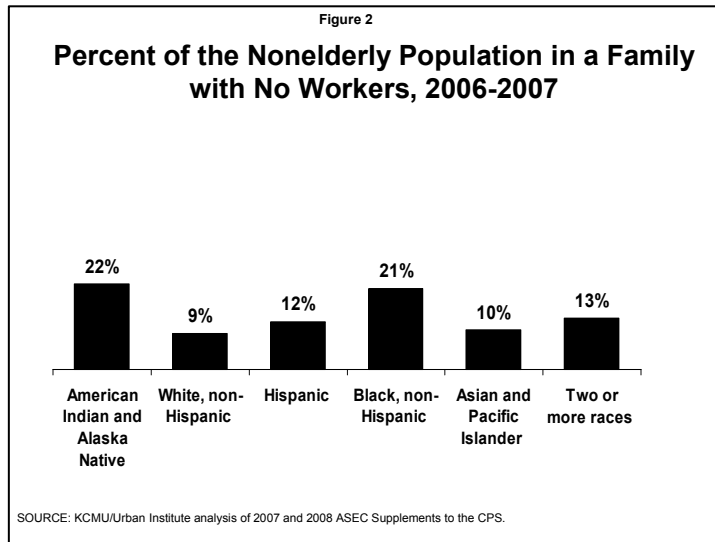
## Profile of American Indians and Alaska Natives

American Indians and Alaska Natives are an extremely diverse group of people. There are more than 560 federally recognized sovereign tribes, each with its own unique customs and beliefs. This brief focuses on American Indians and Alaska Natives who are under age 65 since virtually all of those who are age 65 and older are eligible for Medicare. About 1.7 million nonelderly American Indians and Alaska Natives live in the U.S., making them one of the smallest racial and ethnic population groups. While American Indians and Alaska Natives comprise just 1% of nonelderly U.S. population, they make up 5% or more of the population in Alaska, Montana, New Mexico, North Dakota, Oklahoma and South Dakota.<sup>1</sup> About one-third (34%) of all nonelderly American Indians and Alaska Natives live in one of those six states. Despite their diversity and geographic distribution, there are many challenges associated with health and access to care that are shared by many American Indians and Alaska Natives.

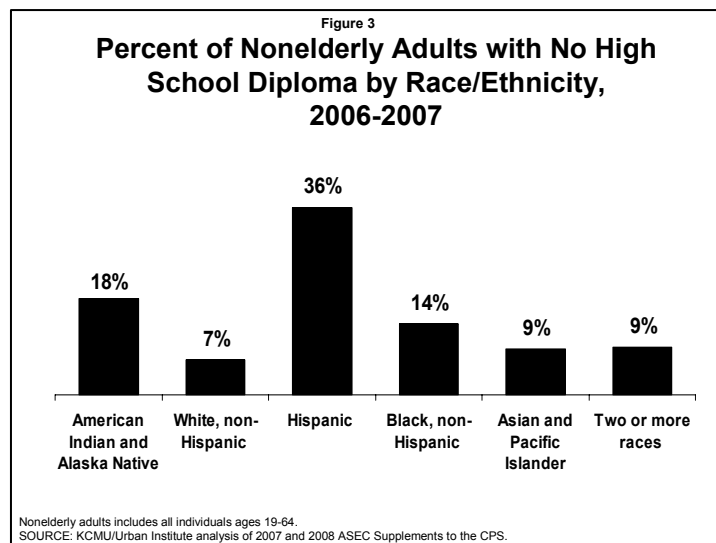
**American Indians and Alaska Natives have a high poverty rate, which may contribute both to health problems and a lack of access to health care.** One-third of nonelderly American Indians and Alaska Natives are in families with incomes below the federal poverty level (\$21,203 for a family of four in 2007). Their poverty rate is higher than any other racial or ethnic group and about twice as high as the poverty rate of the overall nonelderly population (Figure 1).<sup>2,3</sup> About half of American Indians and Alaska Natives are low-income (below 200% of the federal poverty level or \$42,406 for a family of four in 2007), compared to about one-quarter of whites. Individuals in low-income families are less likely to have access to employer-sponsored coverage and may not be able to afford their own coverage. Even with coverage, these individuals may find that their co-payments and deductibles make it difficult for them to afford needed care.



**More than one in five American Indians and Alaska Natives lives in a family with no workers.** They are more than twice as likely as whites to live in a family with no ties to the workforce (22% vs. 9%) (Figure 2).<sup>4</sup> Since American Indians and Alaska Natives live in families with fewer ties to the workforce, they have decreased access to health insurance through an employer. Of the American Indians and Alaska Natives who are working, many work in low-wage jobs. Almost half (47%) of employed American Indians and Alaska Natives adults earn less than \$25,000 a year, compared to 35% of the overall population. Workers with low-wage jobs may not be able to afford their share of the premium for employer-sponsored insurance if it is available through their workplace.



**Almost one in five American Indian and Alaska Native adults has no high school diploma.** They are more than twice as likely to have not finished high school as non-Hispanic whites (Figure 3). Hispanics are the only racial or ethnic group with a higher percentage of adults who do not have a high school degree.<sup>5</sup> Just 13% of American Indian and Alaska Native nonelderly adults have a college diploma, compared to 32% of whites (data not shown). The lower levels of education among these adults may make it more difficult for them to gain the types of higher-skilled jobs that are more likely to pay higher wages and offer benefits. Lower levels of education are also associated with increased risks of health problems and higher mortality rates.<sup>6</sup>



## Health Status

Health status is a result of numerous factors, including the presence of chronic conditions, exposure to risk factors, the availability and accessibility of health care services, individual behaviors, and social factors such as education and income. American Indians and Alaska Natives have among the highest rates of certain health conditions and consequently have among the highest mortality rates for many related conditions. The prevalence rate of diabetes among American Indians and Alaska Natives is at least twice that of all other racial and ethnic groups with the exception of blacks, and the rate of unintentional injuries among American Indian and Alaska Native individuals is higher than any other racial and ethnic group. Health issues such as these are largely preventable, and are a result of the complexities of social determinants that directly influence health status.

### **American Indians and Alaska Natives have the highest rate of many health conditions.**

About 1 in 5 (18%) American Indian and Alaska Native individuals have two or more chronic conditions (Figure 4). In addition, the prevalence of diabetes among American Indian and Alaska Native individuals (12%) is at least twice that of any other racial and ethnic group, with the exception of blacks (8%). American Indians and Alaska Natives, as well as blacks, have higher rates of obesity compared to individuals of other racial and ethnic groups. American Indians and Alaska Natives are also one of the groups with the highest reported rates of feeling anxious or depressed.

Figure 4  
**Prevalence of Health Conditions by Race/Ethnicity, 2004-2007**

	American Indian and Alaska Native	White, Non-Hispanic	Hispanic	Black, Non-Hispanic	Asian and Pacific Islander	Two or More Races
Two or more Chronic Conditions	18%	10%*	6%*	11%*	5%*	9%*
Diabetes	12%	5%*	6%*	8%*	5%*	3%*
Frequently Anxious or Depressed	23%	16%	13%*	14%*	8%*	21%
Obesity	39%	28%*	31%*	38%	12%*	20%*

\*Significantly different from American Indians and Alaska Natives (p<0.05).  
SOURCE: KCMU analysis of 2004-2007 NHIS data.

### **American Indians and Alaska Natives also have higher rates of certain behaviors that can negatively impact health.**

More than one-quarter (27%) of American Indians and Alaska Natives are current smokers, which is a higher rate than any other racial or ethnic group (Figure 5). About 1 in 5 (19%) American Indians and Alaska Natives are binge drinkers. Risky health behaviors such as these can lead to adverse health outcomes such as cancer, chronic liver disease, unintentional injuries, diabetes and heart problems, which are the top five leading causes of death for American Indians and Alaska Natives.

Figure 5  
**Prevalence of Health Behaviors by Race/Ethnicity**

	American Indian and Alaska Native	White, Non-Hispanic	Hispanic	Black, Non-Hispanic	Asian and Pacific Islander	Two or More Races
Current Smoker	27%	21%*	10%*	17%*	9%*	15%*
Binge Drinker	19%	19%	16%	13%*	8%*	20%
Inactivity	40%	31%*	50%*	47%*	37%	21%*

\*Significantly different from American Indians and Alaska Natives (p<0.05).  
The CDC defines binge drinker as men who reported consuming 5 or more alcoholic drinks on one occasion, or women who reported consuming 4 or more alcoholic drinks on one occasion in the past 30 days.  
Inactivity defined as percent of adults 18-64 reporting that they never engage in vigorous, moderate or light physical activity during leisure time for at least 10 minutes.  
SOURCE: Current Smoker & Inactivity: KCMU analysis of 2004-2007 NHIS data.  
Binge Drinker: KFF analysis of 2008 BRFSS data.

**Unintentional injury is the third leading cause of death of American Indians and Alaska Natives, and almost half (47%) of these unintentional injuries are due to motor vehicle accidents.**<sup>7</sup> Of the fatalities due to motor vehicle accidents on reservations, 56% are due to alcohol-related crashes, 15% more than the national average.<sup>8</sup> The overall mortality rate is the third highest among American Indians and Alaska Natives when compared to that of other racial and ethnic groups, and many of these deaths are from preventable conditions such as suicide, motor vehicle accidents and some cases of chronic liver disease (Figure 6). American Indians and Alaska Natives also have high mortality rates due to diabetes. Furthermore, American Indians and Alaska Natives are the only racial and ethnic population in which chronic liver disease is one of the ten leading causes of death.

Figure 6  
**Mortality Rate by Race/Ethnicity, 2005**

	American Indian and Alaska Native	White, Non-Hispanic	Hispanic	Black	Asian and Pacific Islander
Heart Disease	141.8	210.7	157.3	271.3	113.3
Cancer	123.2	187.0	122.8	222.7	110.5
Diabetes	41.5	21.5	33.6	46.9	16.6
Chronic Liver Disease	22.6	8.7	13.9	7.7	3.6
Unintentional Injuries	54.7	41.0	31.3	38.7	17.9
Motor Vehicle Accidents	24.8	15.5	14.7	14.5	7.6
Suicide	11.7	12.9	5.6	5.2	5.2

Age-adjusted death rates per 100,000 population  
SOURCE: The Centers for Disease Control and Prevention. *Health, United States, 2008*. Table 28.

## Indian Health Service

The U.S. government has unique responsibilities towards the provision of health care for American Indians and Alaska Natives that do not exist for other racial or ethnic groups. Treaties signed between the United States and American Indian tribes promise that the U.S. would provide tribes with doctors and supplies.<sup>9</sup> One key early piece of legislation was the Snyder Act of 1921, which provided explicit legislative authority for a federal health program serving American Indians and Alaska Natives.<sup>10</sup> In 1976, the United States enacted the Indian Health Care Improvement Act. That legislation includes the following language detailing the country's obligations: "Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy." The Indian Health Service (IHS), founded in 1955, is the primary mechanism for the federal government to fulfill its legal obligations to the health of Native American and Alaska Native communities. Although reauthorization for the Indian Health Care Improvement Act expired in 2000, Congress has continued to allocate funds for the IHS.<sup>11</sup>

The IHS is responsible for providing federal health services to American Indians and Alaska Natives who are members of the 564 federally recognized tribes. The IHS does not operate like traditional insurance. Those who receive care through the IHS are restricted to services provided by the clinics or hospitals on their reservation or to providers who contract with the IHS. This structure does not allow individuals who depend on the IHS to access most doctors and hospitals. The services American Indians and Alaska Natives receive through the IHS consist largely of primary care, but include some ancillary and specialty services.

The IHS has had significant difficulty adapting to the changing practice of medicine and the movement of American Indians and Alaska Natives off of reservations. The majority of IHS facilities are located on reservations, which makes accessing care a challenge for American Indians and Alaska Natives who live off of reservations. Estimates of the percentage of American Indians and Alaska Natives living on or near a reservation vary substantially. These variations are largely the result of differences in how the reservation or American Indian or Alaska Native service area are defined, but also reflect some of the difficulty associated with tracking with population. This year, the IHS estimates that more than 4 in 10 (43%) American Indians and Alaska Native live outside of a contract health service delivery area.<sup>12</sup> These health service areas encompass reservations, the counties containing them, and the counties adjoining them.<sup>13</sup>

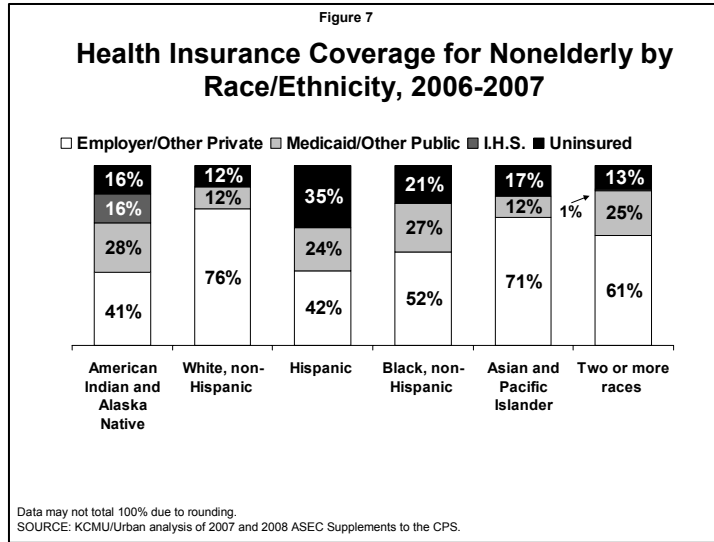
Treaties and laws have established the federal responsibility to provide for the health of American Indians and Alaska Natives through the IHS. However, the IHS is classified for budgetary purposes as a discretionary program, meaning that there is no federal guarantee that there will be adequate funding for the IHS to provide medical services. In contrast, Medicaid and Medicare are federal entitlements and all who are eligible for these programs are guaranteed access to them.

Chronic under-funding of the IHS has limited the services it can provide to American Indians and Alaska Natives, and many IHS facilities only offer primary care services. When these facilities are unable to diagnose and treat health conditions, they must purchase care elsewhere. Budgets for outside contracting of services are limited however, and a 2005 study by the General Accountability Office found that some facilities had no funding to contract for non-urgent care.<sup>14</sup> Since the IHS's budget constraints force its facilities to prioritize urgently needed care, preventive care and treatment for non-urgent conditions may not be available. For example, the same GAO study found that 11 of 13 facilities surveyed had no or limited ability to treat chronic pain and 7 of 13 facilities had no or limited ability to perform cancer screenings. When routine services are available at IHS facilities, access may be limited because demand for services often exceeds supply. Delays in receiving care can be particularly harmful for individuals with chronic conditions such as diabetes and mental health problems, both of which are relatively common among Native Americans and Alaska Natives. Although the IHS includes access to some specialty care and has established urban Indian health clinics, shortages in funding and a lack of facilities and health care professionals have left many eligible American Indians and Alaska Natives struggling to obtain timely, high-quality health care.

The IHS and government-sponsored health insurance, such as Medicaid and the Children's Health Insurance Program, play a crucial role for American Indians and Alaska Natives because they have relatively low rates of private health coverage. A higher percentage of American Indians and Alaska Natives compared to other racial and ethnic groups are low-income and live in families without a full-time worker, both of which contribute to their low rates of private coverage and high uninsured rates. While Medicaid and other public coverage provide coverage for more than one-quarter of American Indians and Alaska Natives, limits on eligibility prevent these programs from covering more individuals. American Indians and Alaska Natives without public or private coverage may only have limited access to certain services through the IHS and others are uninsured. When American Indians and Alaska Natives are covered through Medicaid or the Children's Health Insurance Program, the federal government pays for the full cost of any care they receive from IHS facilities, instead of that cost being shared by the state and federal government as is typically the case.

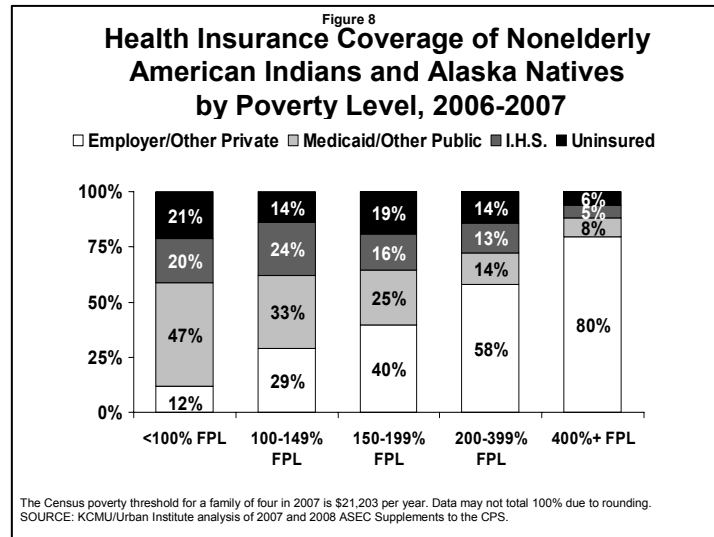
## Health Coverage and Access to Care

Among those under age 65, American Indians and Alaska Natives have the lowest rate of private health insurance coverage of any racial/ethnic group.<sup>15</sup> Just 41% of nonelderly American Indians and Alaska Natives compared to 76% of whites are covered by private insurance, making public insurance an important source of coverage for this group (Figure 7). While 28% have comprehensive public coverage through Medicaid or other public programs, 16% depend solely on the IHS. The remaining 16% of nonelderly American Indians and Alaska Natives are uninsured.

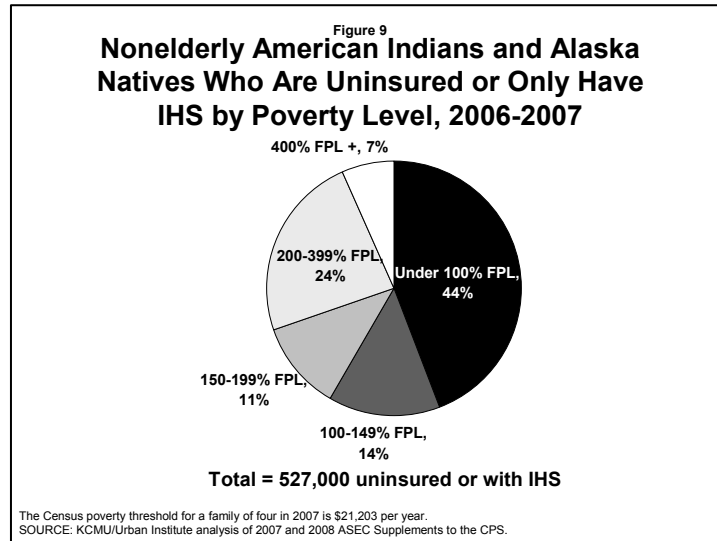


Americans age 65 and older are typically covered through Medicare. After reaching age 65, adults qualify for Medicare if they or their spouse made payroll tax contributions for at least 10 years. More than 9 in 10 (92%) American Indians and Alaska Natives are covered by Medicare, and many of those individuals also have coverage through Medicaid or private insurers (data not shown). An additional 6% of American Indians and Alaska Natives over age 65 have other health insurance and 2% are uninsured or rely solely on the IHS. The percentage of American Indians and Alaska Natives age 65 and older who are uninsured or rely solely on the IHS is slightly higher than the 1% of all U.S. citizens age 65 and older who are uninsured.

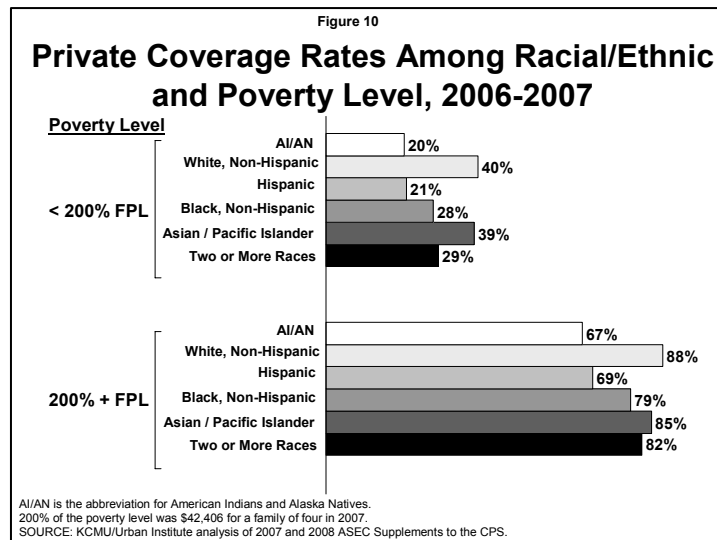
Few American Indians and Alaska Natives below poverty have private coverage, and private coverage rates are below 50% for those with family incomes up to 200% of poverty (\$42,406 for a family of four in 2007). Among American Indians and Alaska Natives in families between 150% and 200% of poverty, 35% are uninsured or depend solely on the IHS (Figure 8). Medicaid or other public coverage insures slightly less than half of American Indians and Alaska Natives in families below poverty.



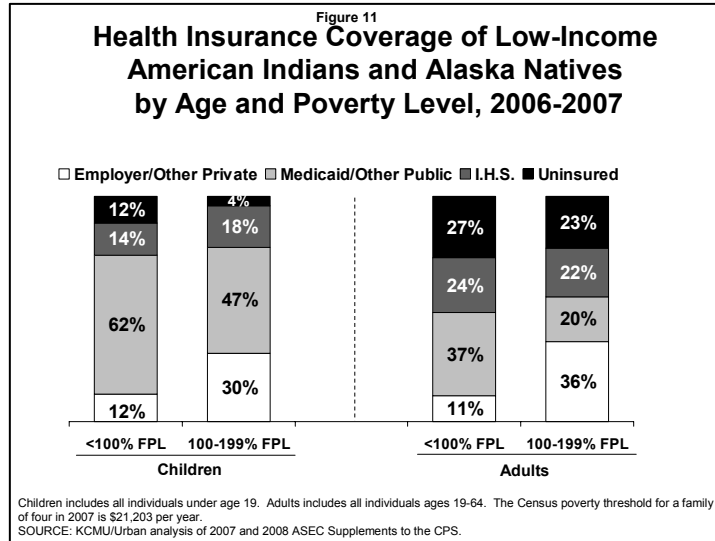
**Almost half (44%) of American Indians and Alaska Natives who are uninsured or have only IHS coverage live in families with incomes below the federal poverty level (Figure 9).** Among uninsured American Indians and Alaska Natives and those who rely solely on IHS, less than 1 in 3 has a family income above twice the poverty level (about \$42,406 a year for family of four). Due to the low-incomes of most American Indians and Alaska Natives who are uninsured or have IHS, these individuals would likely have trouble affording insurance premiums or the cost-sharing that is typically part of private coverage.



**Private coverage rates for American Indians and Alaska Natives are lower than most other racial and ethnic groups above and below 200% of poverty (about \$42,406 a year for family of four).<sup>16</sup>** Hispanics are the only population with a similarly low rate of private coverage. Just 20% of American Indians and Alaska Natives below 200% of poverty have private coverage—a rate that is half that of whites, the group most likely to have private coverage (Figure 10). Similar patterns exist among American Indians and Alaska Natives in families below poverty. While just 12% of nonelderly American Indians and Alaska Natives below poverty have private coverage, 27% of nonelderly whites in this income bracket have private coverage. Among those with higher incomes, American Indians and Alaska Natives still lag behind members of other racial and ethnic populations—88% of whites above 200% of poverty have private coverage compared to 67% of American Indians and Alaska Natives in the same category.



**Medicaid and other public coverage is crucial for low-income American Indians and Alaska Natives, due to lower rates of private coverage.** Low-income American Indian and Alaska Native adults and children have similar rates of private coverage, but the percent of adults who are uninsured or only have access to services provided through the IHS is about twice that of children (Figure 11). Children have much lower uninsured rates because they are more likely to qualify for Medicaid or the Children's Health Insurance Program (CHIP). Among all low-income American Indians and Alaska Natives (below 200% of poverty), 56% of children are covered by Medicaid or other public coverage, compared to 30% of adults.

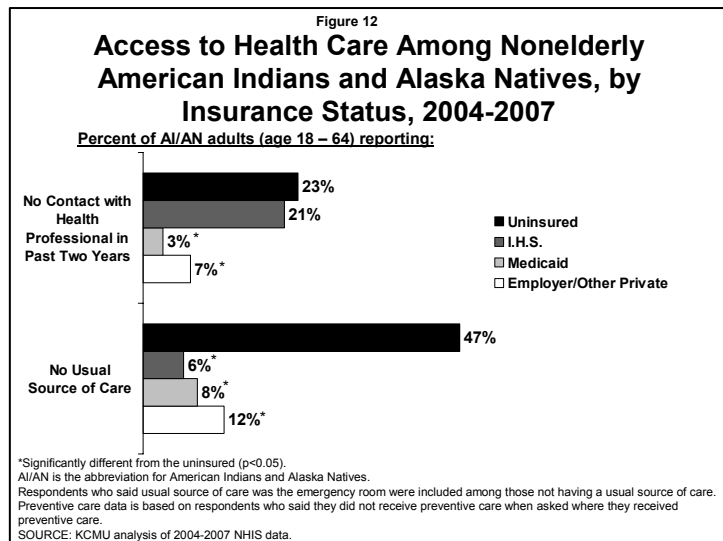


Medicaid coverage for adults is more limited than for children due to differences in eligibility rules. To be eligible for Medicaid, individuals under age 65 must fall into one of the following groups of low-income individuals: children, parents, pregnant women, or people with disabilities. In most states, adults who are not parents of dependent children are not eligible for Medicaid or other public coverage because states are not required to provide coverage for even the poorest childless adult. While each state must cover parents, states have a lot of flexibility in setting eligibility levels, and 33 states have set the eligibility cut-off for working parents below the poverty level (\$21,203 a year for a family of four in 2007).<sup>17</sup>

The majority of low-income children who are uninsured are eligible for Medicaid or CHIP.<sup>18</sup> Some families are not aware of the availability of the programs or may not believe their children are eligible. Thus, finding and enrolling more children would improve access to care and ultimately health.

**Uninsured American Indians and Alaska Natives fare worse on key access measures, compared to those with private insurance or Medicaid (Figure 12).**

Almost half (47%) of uninsured American Indians and Alaska Natives adults do not have a usual source of care, which may make it more difficult for them to receive preventive services and timely care for acute health problems. While most adults who only have access to care through the IHS do have a usual source of care, they are about as likely as the uninsured to have had no contact with a doctor or other health professional in the past two years. This is partially the result of budgetary constraints and the IHS system of rationing of care that

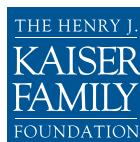


prioritizes the most urgent cases. It is also related to the shortage of providers in IHS. Since American Indians and Alaska Natives have relatively high rates of chronic conditions, going without contact with a health professional for two years may put them at increased risk of developing more serious health problems.

## **Implications**

American Indians and Alaska Natives face a range of health challenges that make it particularly important for them to have comprehensive health coverage that allows them to receive necessary care. Ensuring that American Indians and Alaska Natives receive needed care is especially challenging since more than half are low-income. Low-income individuals who do not have coverage that protects them from high out-of-pocket costs may forgo the care they need. The deductibles and cost-sharing in most private insurance plans may be difficult to afford for many American Indians and Alaska Natives since so many are low-income and have high rates of health conditions that require ongoing care. While Medicaid provides coverage with a wide scope of benefits and limited cost sharing to a majority of low-income American Indian and Alaska Native children, current eligibility rules have left many American Indian and Alaska Native adults uninsured. Expanding Medicaid's reach and ensuring that eligible but uninsured American Indians and Alaska Natives enroll would improve access to care for this population. Given the range of health and social factors that leave American Indians and Alaska Natives at increased risk for serious problems, improving their access to care could deliver significant health dividends. As policy makers continue to discuss health care reform, it is important that the debate includes ways to best improve coverage and access for American Indians and Alaska Natives.

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- <sup>1</sup> KCMU/Urban Institute analysis of 2007 and 2008 ASEC Supplements to the CPS.
- <sup>2</sup> American Indians and Alaska Natives have a significantly higher poverty rate ( $p < 0.05$ ) compared to other racial or ethnic groups with the exception of non-Hispanic blacks.
- <sup>3</sup> 18% of the overall nonelderly population is in a family with income below the federal poverty level.
- <sup>4</sup> American Indians and Alaska Natives have a significantly higher rate of having no full-time workers in the family ( $p < 0.05$ ) compared to other racial or ethnic groups with the exception of non-Hispanic blacks.
- <sup>5</sup> The percent of American Indians and Alaska Natives with no high school diploma is significantly different from all other racial/ethnic groups ( $p < 0.05$ ).
- <sup>6</sup> Lakdawalla D, Goldman D. "Understanding Health Disparities Across Education Groups." NBER, June 2001; Lleras-Muney A, "The Relationship Between Education and Adult Mortality in the US." *Review of Economic Studies*, Vol 72(1), January 2005; Monheit A. "The View from Here: Education Policy is Health Policy." *Inquiry* 44:233-37. Fall 2007.
- <sup>7</sup> The Centers for Disease Control and Prevention. *WISQARS Leading Causes of Death Reports, 1999-2006*. 2005. Accessed at: <http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html>
- <sup>8</sup> Department of Transportation. *Fatal Motor Vehicle Crashes on Indian Reservations 1975-2002*. 2004. Accessed at: [www-nrd.nhtsa.dot.gov/Pubs/809727.PDF](http://www-nrd.nhtsa.dot.gov/Pubs/809727.PDF)
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- <sup>10</sup> Shelton BL. "Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States." Kaiser Family Foundation (2004 #7021).
- <sup>11</sup> Shelton BL. "Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States, Issue Brief" Kaiser Family Foundation (2004 #7021).
- <sup>12</sup> J.G. Pappalardo. Personal communication, August 18, 2009.
- <sup>13</sup> Department of Health and Human Services, Indian Health Service. Geographic Composition of the Contract health Service Delivery Areas (CHSDA) and Service Delivery Areas (SDA) of the Indian Health Service. *Federal Register*; 72 (119): 34262-34267.
- <sup>14</sup> Government Accountability Office. *Indian Health Service: Health Care Services are not Always Available to Native Americans*. Washington, DC. GAO-05-789. 2005.
- <sup>15</sup> American Indians and Alaska Natives have a significantly lower rate of private coverage ( $p < 0.05$ ) compared to other racial or ethnic groups with the exception of Hispanics.
- <sup>16</sup> Both above and below 200% of poverty, American Indian and Alaska Native's have a significantly lower rate of private coverage ( $p < 0.05$ ) compared to other racial or ethnic groups with the exception of Hispanics.
- <sup>17</sup> Cohen Ross D and Marks C. *Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009*, Kaiser Commission on Medicaid and the Uninsured (2009 #7855).
- <sup>18</sup> Dubay L, Holahan J, and Allison Cook. "The Uninsured and The Affordability of Health Insurance Coverage: Examining subgroups of uninsured Americans uncovers certain patterns of coverage gaps, but affordability remains a key concern." *Health Affairs*, January/February 2007; 26(1): w22-w30.



**The Henry J. Kaiser Family Foundation**

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2400 Sand Hill Road  
Menlo Park, CA 94025  
650.854.9400 Fax: 650.854.4800

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