Are the Uninsured Responsible for the Increase in Emergency Department Visits in the United States?

Ellen J. Weber, MD
Jonathan A. Showstack, PhD, MPH
Kelly A. Hunt, MPP
David C. Colby, PhD
Barbara Grimes, PhD
Peter Bacchetti, PhD
Michael L. Callaham, MD

From the Division of Emergency Medicine (Weber, Callaham); Institute for Health Policy Studies (Showstack); and Department of Epidemiology and Biostatistics (Grimes, Bacchetti), School of Medicine, University of California, San Francisco, San Francisco, CA; the New York State Health Foundation, New York, NY (Hunt); and the Robert Wood Johnson Foundation, Princeton, NJ (Colby).

Study objective: The rise in emergency department (ED) use in the United States is frequently attributed to increased visits by the uninsured. We determine whether insurance status is associated with the increase in ED visits.

Methods: Using the national Community Tracking Study Household Surveys from 1996 to 1997, 1998 to 1999, 2000 to 2001, and 2003 to 2004, we determined for each period the proportion of reported adult ED visits according to insurance status, family income, usual source of care, health status, and outpatient (non-ED) visits. Trends over time were tested for statistical significance.

Results: The proportion of adult ED visits by persons without insurance was stable across the decade. Uninsured individuals accounted for 15.5% of ED visits in 1996 to 1997, 16.1% in 1998 to 1999, 15.2% in 2000 to 2001, and 14.5% of visits in 2003 to 2004 (P for trend = .43). The proportion of visits by persons whose family income was greater than 400% of the federal poverty level increased from 21.9% to 29.0% (P = .002). The proportion of visits by those whose usual source of care was a physician’s office increased from 52.4% in 1996 to 1997 to 59.0% in 2003 to 2004 (P = .002), whereas the proportion of visits by those without a usual source of care was essentially unchanged (9.7% of visits in 1996 to 1997 and 9.6% in 2003 to 2004; P = .74).

Conclusion: The rise in ED visits between 1996 and 2003 cannot be primarily attributed to the uninsured. Major contributors to increasing ED utilization appear to be disproportionate increases in use by nonpoor persons and by persons whose usual source of care is a physician’s office. [Ann Emerg Med. 2008;52:108-115.]

INTRODUCTION

Emergency department (ED) visits in the United States increased 28% between 1992 and 2005, with an annual visit rate of 35.7 visits per 100 persons in 1992 and 39.6 visits per 100 persons in 2005.1,2 The rise in ED visits is frequently attributed to the growing number of uninsured. To our knowledge, only 1 previous report examined the temporal changes in ED visits by the uninsured and found that uninsured individuals were not responsible for a disproportionate increase in visits.3 In previous work, we demonstrated that the uninsured are not disproportionately represented among ED users and have only a marginally increased likelihood of being frequent users (defined as 4 or more visits per year).4,5 Although ED visits have been increasing rapidly, the proportion of the uninsured in the population has not changed substantially; in 1995 15.4% of the population was uninsured and in 2004 15.7% was uninsured.6 Moreover, ED visits are also increasing swiftly in countries with universal health insurance.7,9 Nevertheless, scientific journals and otherwise well-informed media continue to cite the uninsured as a major source of the rise in ED visits.10-14 Therefore, we thought that additional data on this subject were needed.
The Community Tracking Study Household Survey is a population-based survey specifically designed to measure changes in insurance and health care utilization. The survey has been conducted 4 times since 1996, with the last survey completed at the beginning of 2004. We have previously demonstrated that the estimates of ED visits are similar to those of the National Hospital Ambulatory Medical Care Survey (NHAMCS).4,5 Using the survey’s data, we sought to determine whether the uninsured are accounting for an increasing proportion of ED visits and therefore are primarily responsible for the rise in ED use. The Community Tracking Study was selected for this analysis because it was specifically designed to evaluate insurance status and uses multiple questions to characterize insurance status precisely (whereas, for example, the NHAMCS relies on “expected source of payment” from the patient’s registration). Additionally, because the Community Tracking Study is population based, it allows analysis and comparisons of patient characteristics that might contribute to ED use that are not obtainable through visit-based surveys such as NHAMCS.

Goals of This Investigation
The goal of this study was to determine whether the rise in ED visits can be attributed to a disproportionate increase in visits by uninsured individuals. A secondary goal was to assess whether there has been a change over time in the characteristics of ED users with regard to family income, usual source of care, health status, and outpatient health care utilization, characteristics thought to be associated with the use of the ED.

MATERIALS AND METHODS
Study Design
The Community Tracking Study Household Survey, conducted by the Center for Studying Health System Change, is a population-based survey, designed to measure changes in health care utilization and the characteristics associated with utilization such as income, education, insurance, and health status.21 The Community Tracking Study has conducted 4 such surveys: from July 1996 through June 1997 (Round One), from July 1998 through June 1999 (Round Two), from July 2000 through June 2001 (Round Three) and from February 2003 through February 2004 (Round Four). The current study analyzes data from all 4 rounds of the Household Survey.

A family informant provided basic sociodemographic and health insurance information about the family unit. Each adult in the family (including the informant) then responded to questions about personal habits; health status; visits to physicians; EDs and hospitals in the last year; satisfaction with medical care, including satisfaction with physician choice; and unmet medical needs. Interviewers queried up to 8 members of the household. The study excluded households that could not complete the interview in either Spanish or English.

Selection of Participants
The sampling methods for the Community Tracking Study are described extensively elsewhere.21-23 Briefly, interviewers surveyed households by telephone in 60 randomly selected communities and in a national supplemental sample. (The Round Four Survey did not use a national supplemental sample.) Random-digit dialing was used to select households within these communities for interviews. Additionally, interviewers conducted field surveys to include families and individuals who do not have telephones. The base sample includes standard weights to estimate trends at the national civilian, noninstitutionalized, US population level.21 A weight is assigned to each respondent to characterize the number of people in the country he or she represents. All analyses used survey weights that account for probability of selection and nonresponse.
Primary Data Analysis

ED visits were estimated by the Community Tracking Study by weighting the individual responses to the question on number of ED visits in the previous year. All visits reported by respondents were included, whether resulting in discharge, transfer, or admission to the hospital. For each round of the survey, we determined the proportion of ED visits associated with the insurance status of individuals: no insurance, private, Medicare, Medicaid/other public, or military. To determine what other factors might be contributing to the rise in ED visits over time, we also determined the proportion of ED visits attributable to individuals with different levels of family income, those with and without a usual source of care and the type of care, individuals with poor or good health status, and individuals with different levels of outpatient utilization in each of the 4 cycles of the survey. These variables were chosen because they have been shown in previous studies to be significantly associated with the likelihood of an ED visit.4,5,27,28 Usual source of care was based on the respondent’s answer to the following question: “Is there a place that you usually go to when you are sick or need advice about your health? What kind of place is it—a physician’s office, a health maintenance organization, a hospital outpatient clinic, some other clinic or health center, an ED, or some other place?” To simplify the analysis of the data and interpretation of the results, we grouped “hospital outpatient clinic,” “some other clinic or health center” and “some other place” as a single variable because the distinctions between these have become less clear over time. Health status was determined by asking individuals, “In general, would you say your health is excellent, very good, good, fair or poor?” These responses were dichotomized into good (excellent, very good, good) or poor (fair or poor) for purposes of analysis. Outpatient health care utilization was defined as visits to an outpatient facility other than an ED and was divided into 3 tiers for analysis (0, 1 to 4, 5 or more visits annually).

Based on Round Three (2001 to 2002) data, we previously reported the likelihood of any visit to an ED and of frequent visits to an ED according to a person’s demographic, insurance, and other characteristics.4,5 For both of these questions, the response or outcome variable was dichotomous. In the current study, we use the (weighted) number of ED visits reported by each survey respondent to determine whether specific subgroups have accounted for increasing proportions of ED visits during the past decade. Therefore, trend analyses were applied to the primary outcome measure, ie, proportion of all reported visits to an ED.

Analyses were conducted with Stata, version 9.2 (StataCorp, College Station, TX), which is able to adjust for the complex survey design. We tested for linear trend over the 4 rounds in each subgroup by using a linear contrast with coefficients –3, –1, +1, and +3, calculating its estimated value and standard error from the round-specific estimates and standard errors, and applying a Z-test. Estimated changes from Round One to Round Four were calculated as the difference between those 2 rounds’ estimates, with confidence intervals (CIs) calculated from the 2 rounds’ standard errors. Results are reported as proportions with 95% CIs and P values where appropriate.

This study did not meet the definition of human subjects research at the University of California, San Francisco and thus did not require review or approval.

RESULTS

The proportion of visits by uninsured individuals was similar across the 4 study rounds (P for trend=.43) (Figure 1; also see Table E1 for all trend results, available online at http://www.annemergmed.com). Uninsured persons accounted for 15.5% (95% CI 14.0% to 16.9%) of all reported visits in 1996 to 1997 and 14.5% (95% CI 11.7% to 17.3%) of all visits in 2003 to 2004, an estimated change of –1.0% (95% CI –4.0% to 2.1%). For those with insurance, the proportion of ED visits according to insurance

Weighted response rates for the 4 surveys were 64.8%, 62.5%, 56.2%, and 56.5% for Rounds One through Four, respectively.21,24,26 Lack of response included both refusals to be interviewed and dialed telephone numbers that were not answered or were not working. Language barriers were a minor reason for nonresponse, eg, accounting for 0.3% of interview attempts in Round Three and 0.4% in Round Four.21,26

Individuals younger than 18 years were excluded from the present analysis because children were not interviewed directly and are not the primary decisionmakers about health care utilization. In addition, many of the variables of interest were not asked of children. The resulting study sample used for the current analysis consisted of 49,807 adults in Round One (1996 to 1997), 48,724 adults in Round Two (1998 to 1999), 49,603 adults in Round Three (2000 to 2001), and 39,260 adults in Round Four (2003 to 2004).

Figure 1. Percentage of visits to EDs according to insurance status, 1996 to 1997 to 2003 to 2004.
type was similar in all 4 rounds (Figure 1). Individuals in the highest income bracket accounted for an increasing portion of ED visits in each round of the survey, 21.9% in 1996 to 1997 and 29% in 2003 to 2004 ($P$ for trend $= .002$; estimated change $+7.1%$; 95% CI 2.3% to 11.9%) (Figure 2).

During the decade, there was an increasing proportion of ED visits by individuals whose usual source of care was a physician’s office, 52.4% of visits in 1996 to 1997 and 59.0% of visits in 2003 to 2004 ($P$ for trend $= .002$; estimated change $+6.6%$; 95% CI 2.4% to 10.8%) (Figure 3). The proportion of visits by individuals whose usual source of care was a hospital outpatient clinic, other clinic or health center, or some other place decreased ($P$ for trend $= .019$). The proportion of visits by those without a usual source of care appeared to be stable, there was a significant increase in the proportion of ED visits by those whose usual source of care was a private physician’s office. Together, these findings suggest that the rise in ED use is disproportionately due to nonpoor individuals who have a usual source of health care. These findings have significant implications for current policy discussions because they suggest that the provision of health insurance will not, in and of itself, address issues of ED crowding or the more general issues of access to, and appropriateness of, health care services.

**DISCUSSION**

Between 1996 and 2003, ED visits in the United States rose from 90.3 million visits annually to 113.9 million visits, an increase of 26%. Our results provide strong evidence that visits by uninsured persons during this period were not a major cause of the overall increase. The proportion of ED visits by uninsured and insured persons was essentially unchanged throughout the decade. In fact, in comparing the first and last rounds of the survey, uninsured persons were estimated to account for 1% fewer ED visits over time, with an upper confidence bound of 2.1% more visits, a number too small to account for much of the overall 26% increase in ED visits during this period. The proportion of visits by more affluent individuals increased. Although the proportion of visits by those without a usual source of care appeared to be stable, there was a significant increase in the proportion of ED visits by those whose usual source of care was a private physician’s office.

**LIMITATIONS**

Similar to other survey data, Household Survey data may be limited by recall bias and lack of response. The sampling and weighting methods of the Community Tracking Study, however, were designed to include a nationally representative sample and to account for differences in likelihood of selection and differential response rates. Children were excluded from this analysis. The study sample could underrepresent homeless persons, who might account for a disproportionate share of ED visits. However, the proportion of visits by the uninsured found in our study are similar to those of the visit-based NHAMCS for the corresponding years. Therefore, it appears to be unlikely that the findings would change substantially if the data included a larger proportion of the estimated 2.3 to 3.5 million persons who are homeless.

**Figure 2.** Percentage of visits to EDs according to family income, 1996 to 1997 to 2003 to 2004.

* $P$ for trend $= .002$. FPL, Federal poverty level, adjusted for year.

**Figure 3.** Percentage of visits to EDs according to usual source of care, 1996 to 1997 to 2003 to 2004.

*Includes hospital outpatient departments, health centers, and other places.
† $P$ for trend $= .019$.
‡ $P$ for trend $= .002$.
suggestions that the uninsured are a relatively small portion of the ED population and that they are no more likely than insured individuals to use the ED, to frequent ED users, or to use the ED unnecessarily. For example, Luo et al reviewed data from the 1997 Medical Expenditure Panel Survey and concluded there was no significant difference in the likelihood of an ED visit between children with private insurance and those with no insurance. Stingone and Claudio found that among children in New York City schools, ED use for asthma was unrelated to insurance status. Using NHAMCS data from 1997 to 2001, Simon et al demonstrated that Latino children use the ED less for injury, regardless of insurance status, and Orr et al found that black children in a pediatric primary care program used the ED with similar frequency regardless of whether they had private insurance, had Medicaid, or were self-pay. Weber et al, using the Community Tracking Study Household Tracking Survey for 2000 to 2001, found that 83% of all adult ED visitors were insured. After controlling for health status, sociodemographic status, and utilization of other health care resources, the uninsured were no more likely to have had an ED visit than those with insurance. Fryer et al used data from the 1996 Medical Expenditure Panel Survey and found that among both adults and children, the uninsured and insured were equally likely to have received health care in the ED setting. All of these studies used large numbers of patients, and most were population based, which allowed researchers to assess the likelihood of ED use, rather than simply the proportion of uninsured patients in a particular ED, to control for health status and access to outpatient care, and to avoid relying on data from a few hospitals for which outcomes are not generalizable.

Most studies have also concluded the uninsured are no more likely than insured individuals to use the ED for minor illness, often considered an “inappropriate” use of the ED, or to be frequent users of the ED. In regard to “chronic” ED users, Zuckerman and Shen, using the 1997 and 1999 National Survey of America’s Families, found that the uninsured and privately insured had the same risk of being frequent users. Hunt et al, using the 2000 to 2001 Community Tracking Study, demonstrated that 83% of all frequent (≥4 visits) ED users had insurance, approximately the same proportion as in the general population. Ruger et al found that the proportion of uninsured individuals was the same among less and more frequent users (up to 19 visits annually) at their ED; the proportion of self-pay patients increased among those with greater than or equal to 20 visits, but this group represented less than 1% of all ED visits.

Given the weight of the evidence to the contrary, why is there a perception that the poor and uninsured are overwhelming EDs? First, there are a number of hospitals, usually county hospitals, that do bear a large burden of uninsured patients. Additionally, it is easy to lose sight of the total influence of uninsured patients on ED volume when confronted with statistics (in even a few studies) that suggest the uninsured have a higher rate of use. For example, a Centers for Disease Control and Prevention report that combined results of the 2005 NHAMCS and National Ambulatory Medical Care Survey provider-based surveys found that the rate of ED utilization by the uninsured was twice that of the privately insured. However, the study also demonstrated that the proportion of visits by the uninsured was approximately the same as the proportion of uninsured in the population and that most ED visits were by the insured. Cunningham concluded that proposed cuts in Medicaid and State Children’s Health Insurance Programs funding would result in more uninsured ED visits, but the change in the overall ED volume would be small.

It is also possible that repeated efforts by emergency physicians to dramatize the importance of the “safety net” role of EDs for the poor, especially in hospitals that bear a large uninsured burden, have led the public to conclude that most ED patients nationwide do not have insurance and use the ED instead of other forms of care (and that the insured do not need this “safety net”). Attempts by the emergency medicine profession to obtain reimbursement for uncompensated care from governmental sources may also be construed as demonstrating that ED financial problems result from a huge influx of uninsured, and publicity has emphasized this interpretation. Crowded EDs and financial difficulties are separate issues. EDs are underfunded for a number of reasons, and certainly an important aspect of the problem is that 15% of their visitors are not insured. But EDs also have poor public and third-party payer reimbursement, inequities in the value of their services compared with other specialties, boarding of inpatients requiring additional staff without additional reimbursement, and a growing burden of documentation without provision for additional resources.

There are many factors contributing to the rise in ED visits, including population increases, the aging of our population, the increased numbers of time-sensitive interventions requiring state-of-the-art hospital care, larger numbers of patients with complex medical problems requiring evaluation in a setting in which sophisticated testing and consultation are available, and complications from medical and surgical treatments.

Another reason for increased ED use may be difficulty obtaining timely appointments from one’s usual source of care, or physician referrals to EDs because of their diagnostic and treatment capabilities. A study of insured Californians found 4 key factors driving visits to the ED: (1) lack of access to routine and immediate medical care; (2) lack of advice about handling acute conditions and lack of knowledge about available same- and next-day appointments; (3) lack of alternatives to the ED; and (4) positive attitudes towards the ED, including an impression of high quality of care and easy access to diagnostic technology and specialty consultation. Patients with chronic illness were disproportionately represented among insured ED users, and 55% of this group reported it to be “extremely or somewhat difficult, or impossible” to speak to...
Attributing ED crowding to the uninsured is problematic for several reasons. Perhaps most important, it furthers the impression that the problems in EDs are both caused by and affect a small proportion of disenfranchised individuals. This impression allows lawmakers to ignore the crowding crisis—because ED users are unlikely to vote—and persuades insured citizens to (mistakenly) believe they are unlikely to need an ED and therefore unlikely to be subjected to ambulance diversion, long waits, or a lower quality of care that may result from ED crowding. Hospital administrators may be reluctant to invest substantial resources and the political will necessary for resolving crowding and on-call issues if they believe there will be no additional compensation. Often, too, the fact that a person is uninsured implies they are using the ED for primary care and minor complaints (ie, “unnecessary visits”), so why improve ED use when their access? In short, attributing the increase in visits to the uninsured oversimplifies a complex problem and thereby subverts meaningful debate on how best to develop innovative and appropriate solutions to the problem of ED crowding.

In conclusion, during a period when ED visits increased 26%, the proportion of ED visits by uninsured individuals remained essentially unchanged, whereas the proportion of visits by nonpoor individuals and those with a primary physician increased. Thus, the uninsured are not primarily responsible for the increase in ED utilization. Instead, the increase in ED use may be attributable to lack of ready access to primary care and other structural problems in the health care system.

Supervising editor: Donald M. Yealy, MD

Dr. Callaham has recused himself from the editorial review of this article.

Author contributions: EJW, JAS, KAH, DCC, and MLC conceived the study, determined the theoretical model, and interpreted the results. EJW, JAS, and KAH designed the analyses. JAS, KAH, BG, and PB provided statistical consultation. KAH and BG programmed the data. EJW drafted the article, with contributions from all authors. All authors contributed substantially to revisions of the draft article. EJW takes responsibility for the paper as a whole.

Funding and support: By Annals policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article, that might create any potential conflict of interest. See the Manuscript Submission Agreement in this issue for examples of specific conflicts covered by this statement. Statistical analysis was supported by an intramural grant from UCSF’s Academic Senate.

REFERENCES


DIAGNOSIS:
Press-through package mis-swallowing. The press-through package measured about 1.8×1.5 cm, containing a tablet lodged in the esophagus, and was removed in an uncomplicated fashion endoscopically. The patient was doing well at outpatient follow-up.

The press-through package, which consists of a polyvinylchloride/aluminium blister-wrapped pack, is commonly used to protect freeze-dried tablets from moisture exposure. Accidental ingestion of a press-through package has been seen increasingly in cases of gastrointestinal tract foreign body in the emergency department. The press-through package is usually prepared for use by cutting single-tablet allotments from the blister packs. Small press-through package pieces are square, often with sharp corners. They can become lodged in the gastrointestinal tract and pose a risk for bowel perforation when inadvertently swallowed. Intestinal or esophageal perforation by blister-wrapped tablet has previously been reported.1-3 Press-through package ingestion is frequently seen in older patients, among the mentally impaired, or in patients with visual impairment.2,3 Obstructive ileus caused by a press-through package is a rare occurrence.4 A case series from the Japanese literature reported 28 cases of perforation of the small intestine by a blister-wrapped tablet in the press-through package. Most of these patients with perforation were elderly (mean age 77 years).5

The press-through package material is often difficult to detect on plain radiograph directly because of its radiolucency. However, air trapped in the press-through package makes the drug tablet visible on the plain radiograph.

REFERENCES
### Table E1. Proportion of visits to EDs according to population characteristic.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>15.5 (14.0–16.9)</td>
<td>16.1 (14.2–18.1)</td>
<td>15.2 (13.3–17.1)</td>
<td>14.5 (11.7–17.3)</td>
<td>.425</td>
</tr>
<tr>
<td>Medicare</td>
<td>24.9 (23.1–26.8)</td>
<td>24.1 (22.3–26.0)</td>
<td>24.0 (22.0–25.9)</td>
<td>23.9 (20.7–27.1)</td>
<td>.566</td>
</tr>
<tr>
<td>Medicaid/other public</td>
<td>12.5 (11.1–13.9)</td>
<td>11.0 (9.5–12.6)</td>
<td>11.7 (9.8–13.7)</td>
<td>13.9 (11.7–16.1)</td>
<td>.236</td>
</tr>
<tr>
<td>Private</td>
<td>44.8 (42.9–46.8)</td>
<td>46.6 (44.4–48.9)</td>
<td>47.7 (45.5–49.9)</td>
<td>44.4 (40.0–48.9)</td>
<td>.978</td>
</tr>
<tr>
<td>Military</td>
<td>2.3 (1.3–3.2)</td>
<td>2.0 (1.4–2.6)</td>
<td>1.4 (1.0–1.8)</td>
<td>3.3 (2.0–4.6)</td>
<td>.303</td>
</tr>
<tr>
<td><strong>Family income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;100% FPL</td>
<td>25.2 (23.2–27.1)</td>
<td>23.1 (20.7–25.6)</td>
<td>21.2 (18.3–24.0)</td>
<td>23.1 (18.8–27.3)</td>
<td>.256</td>
</tr>
<tr>
<td>100–199% FPL</td>
<td>24.6 (22.6–26.5)</td>
<td>21.9 (20.5–23.4)</td>
<td>21.5 (19.7–23.3)</td>
<td>22.3 (19.1–25.5)</td>
<td>.211</td>
</tr>
<tr>
<td>200–399% FPL</td>
<td>28.3 (26.5–30.2)</td>
<td>29.7 (28.1–31.3)</td>
<td>30.4 (28.6–32.2)</td>
<td>25.6 (22.5–28.8)</td>
<td>.178</td>
</tr>
<tr>
<td>≥400%</td>
<td>21.9 (20.4–23.5)</td>
<td>25.2 (23.2–27.3)</td>
<td>26.9 (24.8–28.9)</td>
<td>29.0 (24.3–33.7)</td>
<td>.002</td>
</tr>
<tr>
<td><strong>Usual source of care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician's office*</td>
<td>52.4 (50.2–54.6)</td>
<td>53.9 (51.9–55.9)</td>
<td>54.7 (51.8–57.6)</td>
<td>59.0 (55.2–62.7)</td>
<td>.002</td>
</tr>
<tr>
<td>Health maintenance organization</td>
<td>3.7 (3.0–4.3)</td>
<td>3.2 (2.6–3.8)</td>
<td>2.6 (2.1–3.2)</td>
<td>2.8 (1.9–3.6)</td>
<td>.059</td>
</tr>
<tr>
<td>Hospital OP/health center/other place†</td>
<td>26.1 (23.6–28.6)</td>
<td>25.0 (22.8–27.2)</td>
<td>25.0 (22.7–27.3)</td>
<td>21.4 (18.5–24.4)</td>
<td>.019</td>
</tr>
<tr>
<td>ED</td>
<td>7.7 (6.1–9.4)</td>
<td>6.4 (5.5–7.4)</td>
<td>7.1 (5.7–8.4)</td>
<td>6.9 (5.0–8.9)</td>
<td>.634</td>
</tr>
<tr>
<td>No usual source of care</td>
<td>9.7 (8.7–10.7)</td>
<td>11.1 (9.9–12.3)</td>
<td>10.3 (9.2–11.3)</td>
<td>9.6 (8.0–11.3)</td>
<td>.735</td>
</tr>
<tr>
<td><strong>Health status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good, very good, etc</td>
<td>64.4 (62.1–66.7)</td>
<td>65.8 (63.6–68.0)</td>
<td>64.6 (62.5–66.7)</td>
<td>62.1 (57.9–66.4)</td>
<td>.265</td>
</tr>
<tr>
<td>Fair/poor</td>
<td>35.6 (33.3–37.9)</td>
<td>34.2 (32.0–36.4)</td>
<td>35.4 (33.3–37.5)</td>
<td>37.9 (33.6–42.1)</td>
<td>.265</td>
</tr>
<tr>
<td><strong>No. of outpatient visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>12.6 (11.5–13.8)</td>
<td>11.6 (10.6–12.6)</td>
<td>12.0 (10.8–13.3)</td>
<td>11.2 (9.7–12.8)</td>
<td>.201</td>
</tr>
<tr>
<td>1–4</td>
<td>38.2 (36.5–39.9)</td>
<td>39.5 (37.9–41.1)</td>
<td>37.7 (36.0–39.5)</td>
<td>36.3 (33.4–39.3)</td>
<td>.147</td>
</tr>
<tr>
<td>≥5</td>
<td>49.1 (47.4–50.9)</td>
<td>48.9 (47.0–50.8)</td>
<td>50.2 (48.4–52.1)</td>
<td>52.4 (48.8–56.1)</td>
<td>.065</td>
</tr>
</tbody>
</table>

*P for trend = .002.
†P for trend = .019.