

Variations in Affordability of Health Care by Non-Metropolitan/Metropolitan and Race/Ethnicity Status across Eight Geographically Dispersed States**Whitney E. Zahnd, PhD; Radhika Ranganathan, MPhil, MSPH; Elizabeth L. Crouch, PhD; Peiyin Hung, PhD; Jan M. Eberth, PhD; Gabriel Benavidez, MPH**

- Non-Hispanic White and non-Hispanic Black adults ages 18-64 living in non-metropolitan areas had lower health insurance rates compared to their metropolitan counterparts.
- Among non-metropolitan individuals, insurance coverage varied across racial/ethnic groups with Hispanic adults having the lowest health insurance rates.
- Non-Hispanic Black individuals reported higher levels of not seeing a doctor due to cost (18.3% metropolitan and 22.5% non-metropolitan) compared to their white counterparts (13.3% and 13.7%, respectively).
- Non-metropolitan individuals ages 18-64 were more likely to report forgoing medication due to cost (11.3%) than metropolitan individuals (9.4%).
- A larger proportion of non-metropolitan individuals reported having medical bills they were paying off over time (24.0%) than those living in metropolitan (20.8%).

INTRODUCTION

Access to and quality of healthcare services are key elements of the social determinants of health that facilitate mental and physical well-being.¹ Studies consistently show that rural residents—accounting for more than 59 million Americans—have less access to healthcare services than their urban counterparts in terms of availability (e.g., provider-population ratios) and accessibility (e.g., distance to care) as described by Penchansky’s and Thomas’s “5 As of Access”.² Rural areas have fewer primary care providers and specialists (e.g., obstetrics, cancer care) per population compared to their urban counterparts.³⁻⁵ Further, studies also show that rural populations live further from hospital-based care and specialists than urban.^{6,7} Rural-urban disparities in access to care are exacerbated by race/ethnicity as rural minoritized populations, such as Black and American Indian/Alaska Natives, often have less access than their white rural peers.⁷

A comprehensive understanding of access to care inequities requires the investigation of not only availability and accessibility but also affordability. Affordability is often characterized as having health insurance coverage. Yet, affordability includes other aspects such as cost barriers to seeking care in the short-term and amassing medical debt in the long term both of which are less studied. Rural populations consistently report having higher rates of uninsurance.⁸ Additionally, studies show that rural patients may be more likely to forgo care compared to their urban counterparts or experience long-term financial impacts (e.g., debt).^{9,10} Though earlier studies examined racial/ethnic differences in some elements of affordability within rural communities few of these elements of

affordability have been examined at the intersection of rurality and race/ethnicity.¹¹ Therefore, our objective was to examine rural-urban (i.e., non-metropolitan/metropolitan) differences in affordability inclusive of insurance coverage and cost barriers. Our examination included forgoing medical care or medication and medical debt using survey data from the health care access optional module from the Behavioral Risk Factor Surveillance System (BRFSS) survey. BRFSS is a population-based survey assessing health behaviors among non-institutionalized adults. Eight states, including at least one state from each U.S. Census Region, administered this module in 2018. Further, we also explored affordability specifically among those ages 18-64 who would not be age eligible for Medicare. More information on this methodology is in the appendix.

FINDINGS

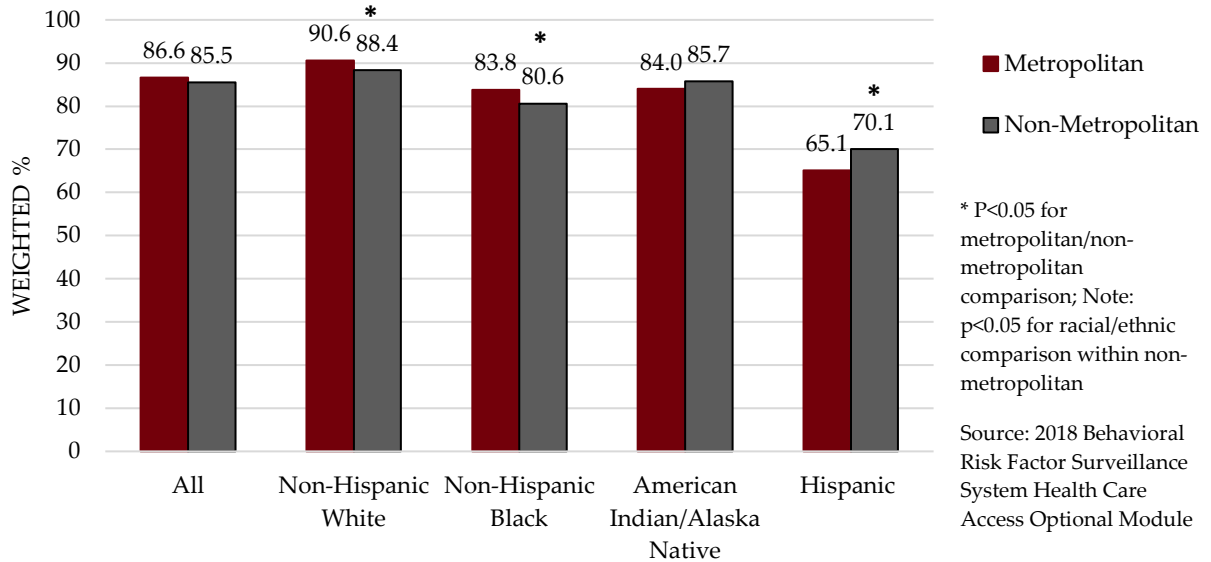
Survey Respondents Characteristics

One in four (25.2%) respondents 18 and older lived in non-metropolitan areas (**Appendix Table 1**). There were differences in racial/ethnic composition among respondents. 16.5% of non-metropolitan respondents were non-Hispanic Black compared to 21.0% of metropolitan respondents. 7.7% of non-metropolitan respondents were Hispanic compared to 9.1% of metropolitan respondents ($p < 0.001$ for both comparisons). Non-metropolitan respondents were older on average than their metropolitan counterparts (24.3% nonmetropolitan respondents were 65 or older compared to 19.5% of metropolitan respondents) ($p < 0.001$). Marital status, language used to complete the survey, educational attainment, and employment status also varied between metropolitan and non-metropolitan individuals ($p < 0.001$ for all). A higher proportion of non-metropolitan respondents were divorced (12.8% vs. 11.1%) or widowed (8.8% vs. 6.4%) compared to metropolitan. Although most respondents completed the survey in English, 3.4% of metropolitan vs. 2.5% of non-metropolitan respondents completed the survey in Spanish. More than a quarter (27.7%) of metropolitan respondents had at least a college or technical school degree compared to 17.3% of non-metropolitan respondents. Non-metropolitan/metropolitan differences in employment status included higher proportions of non-metropolitan retirees (20.8% vs. 17.4%) and those who were unable to work (12.5% vs. 8.7%) compared to metropolitan.

Insurance Coverage

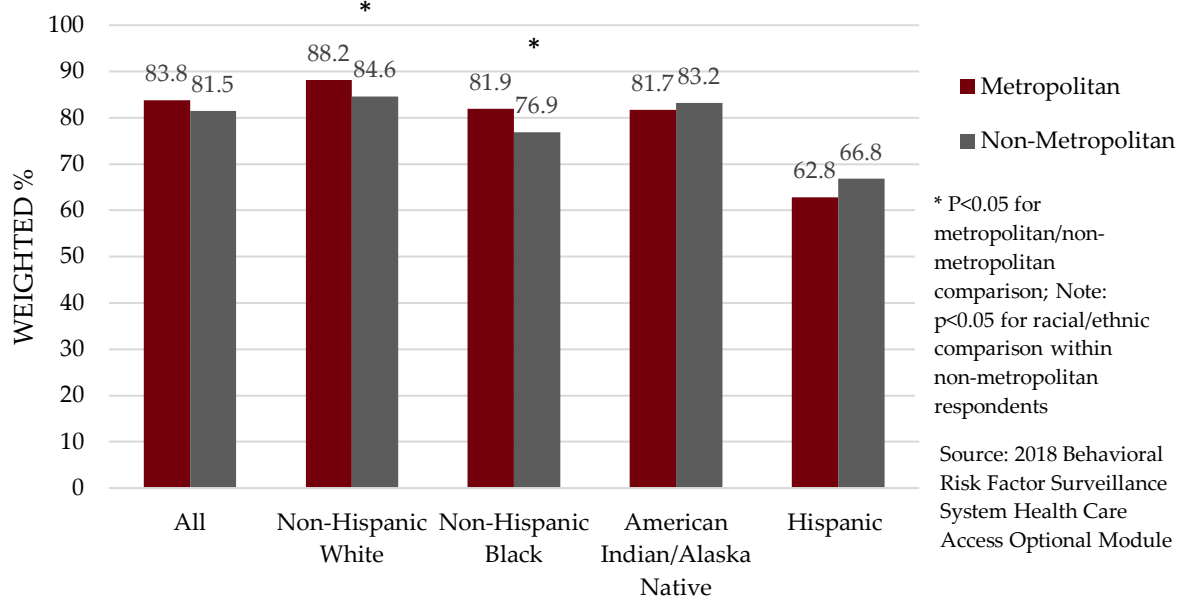
There were no statistically significant differences in having any kind of health care coverage between non-metropolitan (85.5%) and metropolitan (86.6%) respondents (**Figure 1**). Stratified by race/ethnicity, a lower percentage of non-Hispanic white (88.4% vs. 90.6%; $p < 0.05$) and non-Hispanic Black (80.6% vs. 83.3%) non-metropolitan respondents had coverage compared to those living in metropolitan areas. A higher proportion of non-metropolitan Hispanic respondents had coverage compared to their metropolitan counterparts (70.1% vs. 65.1%; $p < 0.05$), though they had the lowest percentage of respondents with coverage of any racial/ethnic group among non-metropolitan individuals. There was no significant difference in coverage among non-metropolitan and metropolitan American Indian/Alaska Native respondents.

Figure 1: Any Kind of Health Care Coverage

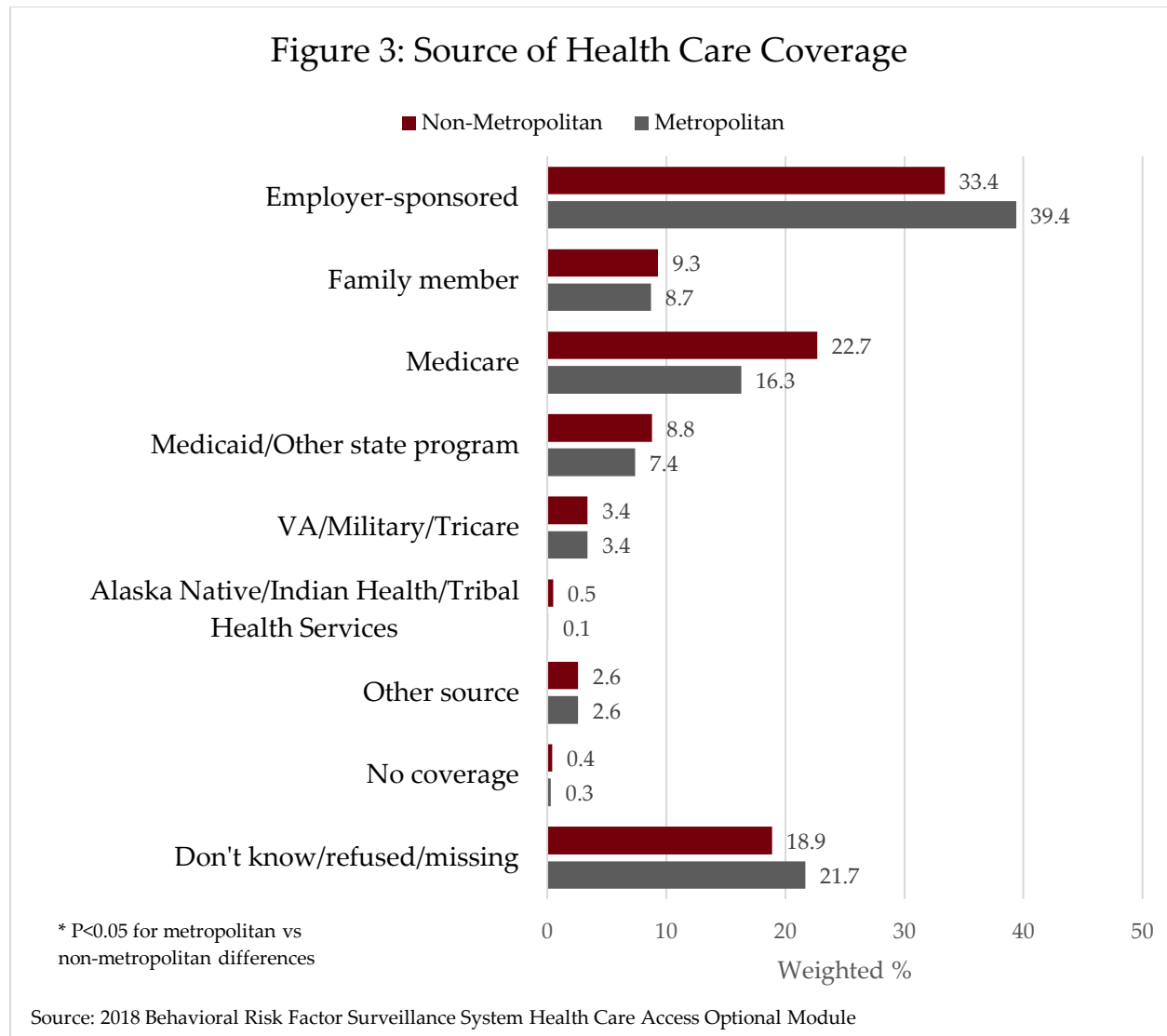


Among those between the ages of 18 and 64, there was also no statistically significant difference in having any kind of health care coverage between non-metropolitan (81.5%) and metropolitan (83.8%) respondents (**Figure 2; p<0.05**). A higher percentage of metropolitan white respondents ages 18-64 had coverage compared to non-metropolitan (88.2% vs. 84.6%, p<0.05). A higher percentage of metropolitan Black respondents had coverage compared to their non-metropolitan counterparts (81.9% vs. 76.9%, p<0.05). Among non-metropolitan respondents, Hispanic respondents had the lowest percentage with coverage (66.8%; p<0.05).

Figure 2: Any Kind of Health Care Coverage, Ages 18-64



Among those reporting health care coverage, we also identified metropolitan/non-metropolitan differences in the source of coverage with a higher percentage of non-Metropolitan respondents on Medicare compared to metropolitan (22.7% vs. 16.3%) and a higher percentage of metropolitan (39.4%) respondents on employee-sponsored insurance compared to non-metropolitan (33.4%) (Figure 3; $p < 0.05$).

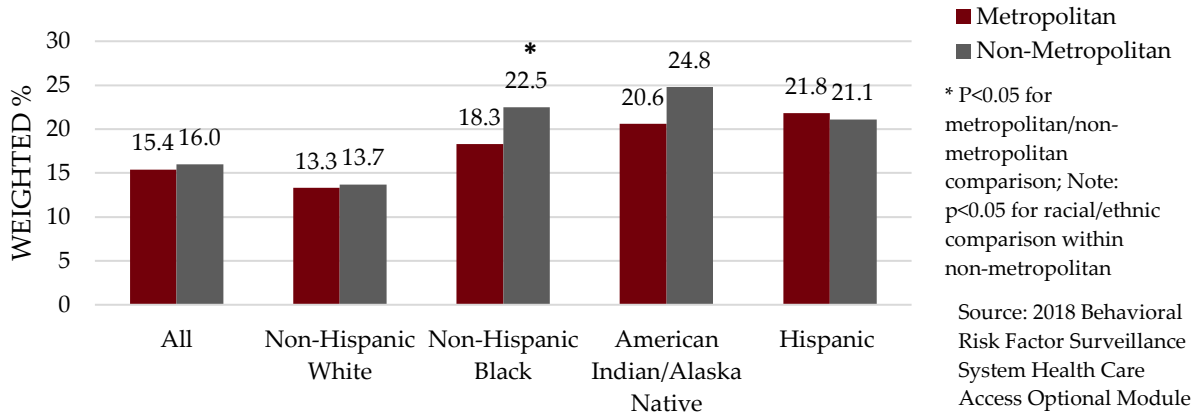


Cost Barriers

Forgoing Care Due to Costs

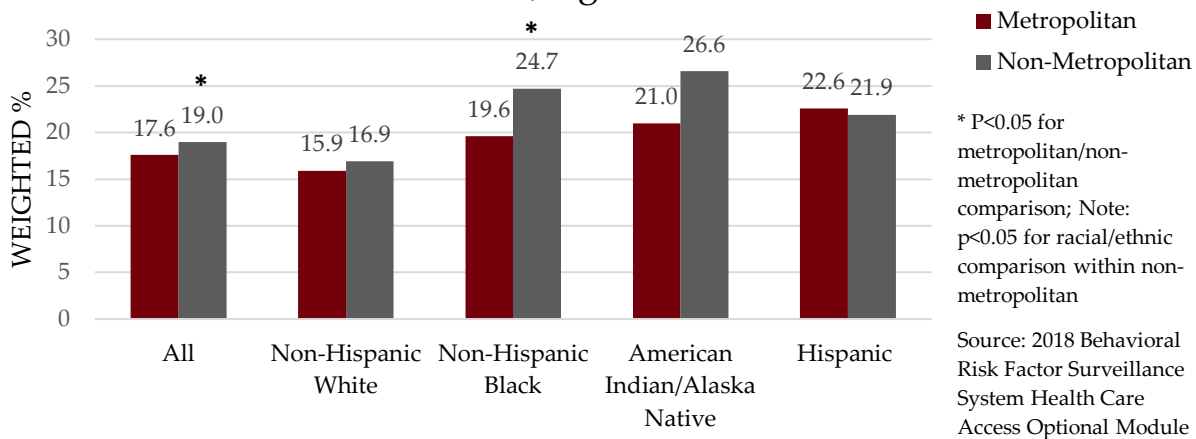
There were no statistically significant differences in reporting the inability to see a doctor due to cost among non-metropolitan (16.0%) and metropolitan (15.4%) respondents (Figure 4). A higher percentage of non-metropolitan Black respondents (22.5%) reported not being able to see a doctor due to cost compared to their metropolitan (18.3%) counterparts ($p < 0.05$). There were racial/ethnic differences in reporting not seeing a doctor due to cost among non-metropolitan respondents with the highest percentage occurring among American Indian/Alaska Native respondents (24.8%).

Figure 4: Reported Not Being Able to See a Doctor Due to Cost



Similarly, there were no non-metropolitan (19.0%)/metropolitan (17.6%) differences in reporting the inability to see a doctor due to cost among those between the ages of 18 to 64 (Figure 5). Within racial/ethnic groups, non-Hispanic Black respondents were the only group reporting non-metropolitan/metropolitan differences in reporting the inability to see a doctor due to cost (24.7% vs. 19.6%, p<0.05). Within non-metropolitan respondents, there were significant differences in reporting the inability to see a doctor due to cost ranging from 16.9% among non-Hispanic white respondents to 26.6% of American Indian/Alaska Native respondents between the ages of 18 and 64.

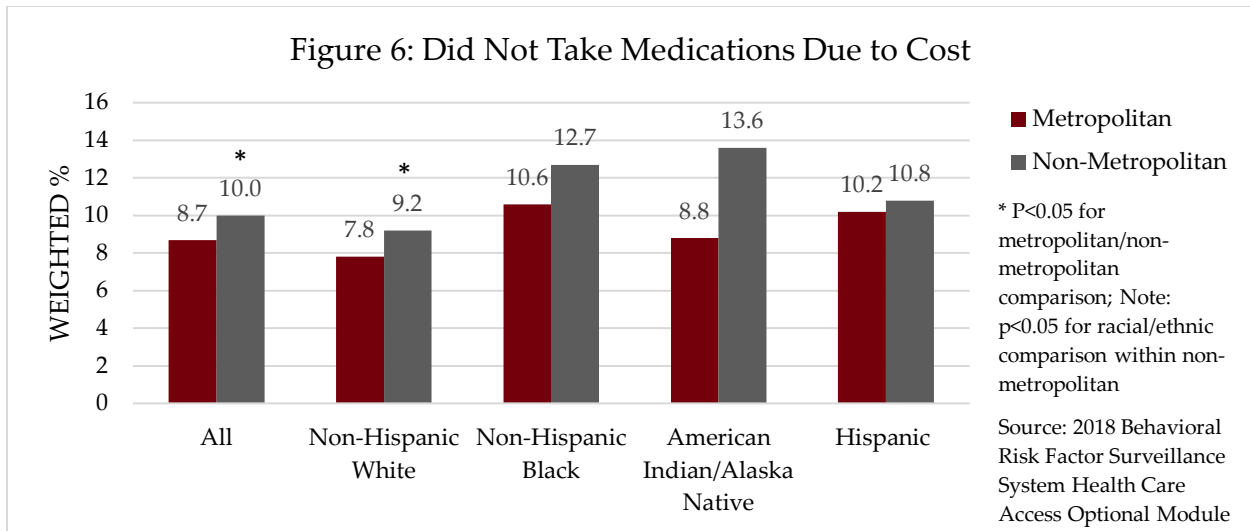
Figure 5: Reported Not Being Able to See a Doctor Due to Cost, Ages 18-64



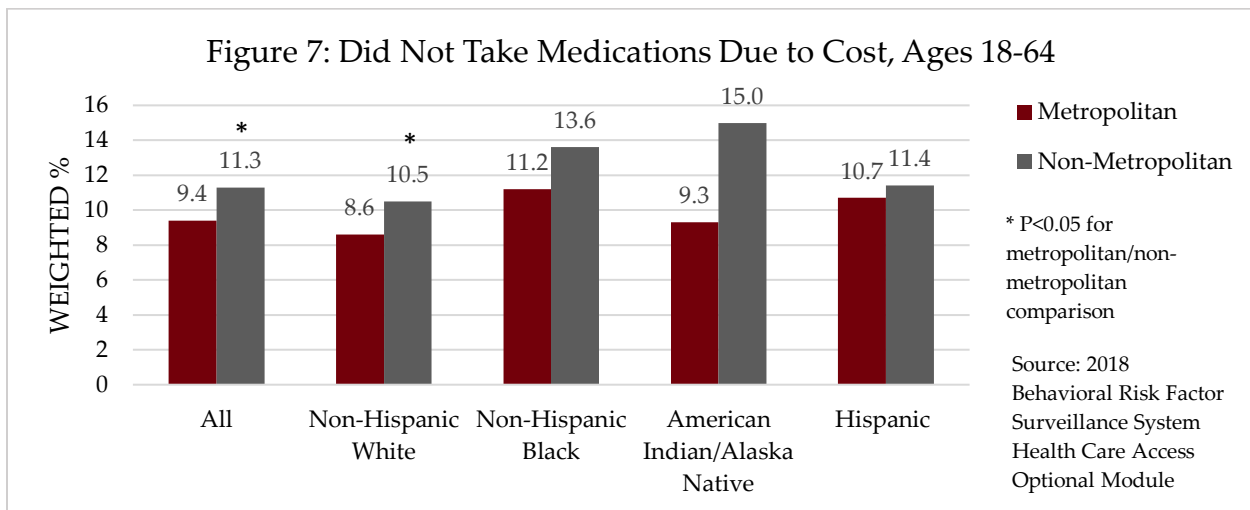
Forgoing Medications Due to Costs

There was no statistically significant difference among non-metropolitan (10.0%) and metropolitan (8.7%) respondents reporting that they did not take medications due to cost (Figure 6). The only racial/ethnic group reporting a statistically significant difference among non-metropolitan and metropolitan respondents were non-Hispanic white respondents (9.2% vs. 7.8,

respectively, $p < 0.05$). There was a statistically significant difference among non-metropolitan respondents across racial/ethnic groups ranging from 9.2% of non-Hispanic white respondents to 13.6% of American Indian/Alaska Native respondents.



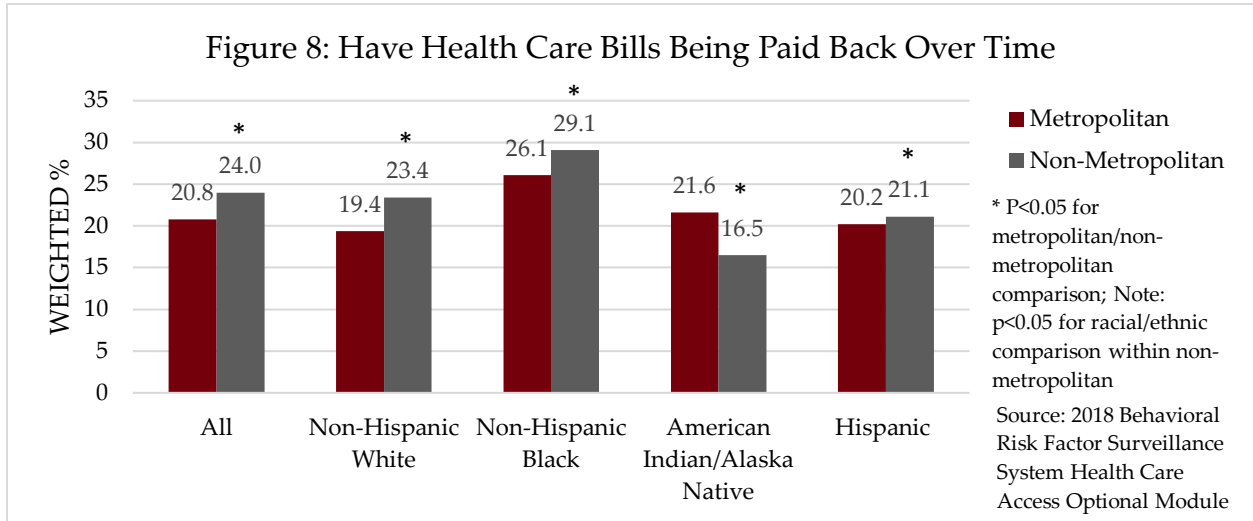
For respondents between the ages of 18 and 64, there was a statistically significant difference in the percentage of non-metropolitan (11.3%) and metropolitan (9.4%) respondents who did not take medications due to costs (**Figure 7**). Among racial/ethnic groups, a higher percentage (10.5%) of non-Hispanic white respondents in non-metropolitan areas forewent prescription drugs due to costs compared to metropolitan (8.6%, $p < 0.05$). There were no non-metropolitan/metropolitan differences among other racial/ethnic groups, nor was there a statistically significant difference among non-metropolitan racial/ethnic groups.



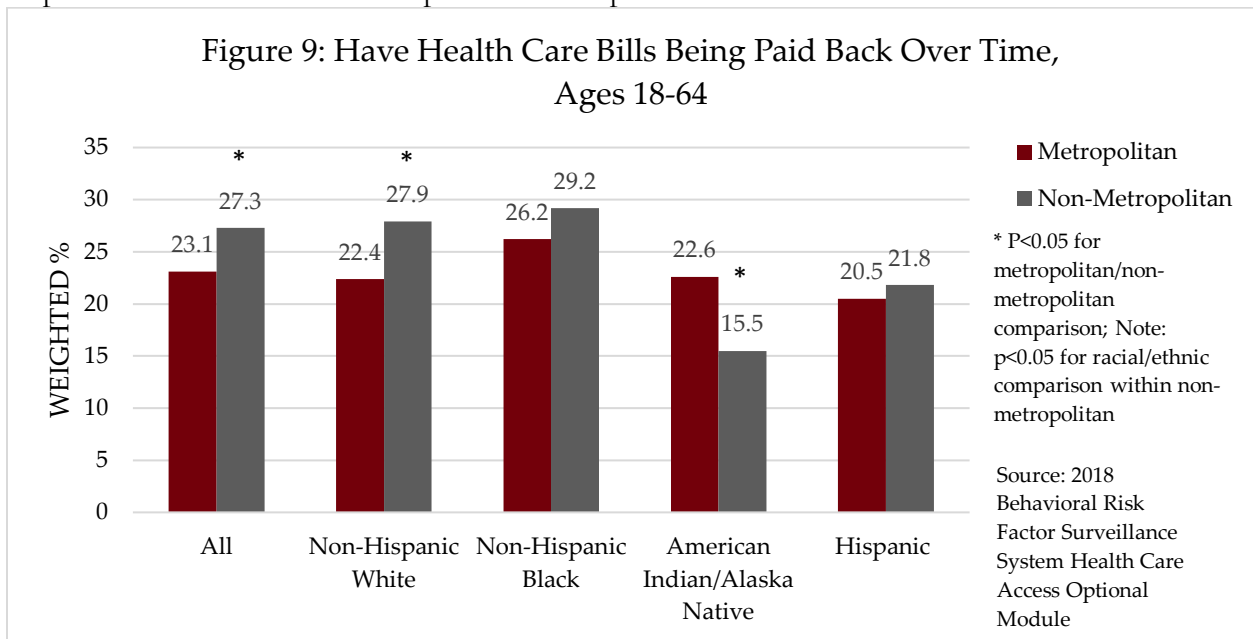
Medical Debt

There were also significant non-metropolitan/metropolitan differences in the percent of respondents who reported having health care bills that were being paid back over time (24.0% vs. 20.8%, $p < 0.05$; **Figure 8**). For all non-Hispanic white, non-Hispanic Black, and Hispanic groups, a higher percent of non-metropolitan respondents reported having health care bills being paid back

over time compared to their metropolitan counterparts: non-Hispanic white (23.4% vs. 19.4%), non-Hispanic Black (29.1% vs. 26.1%), and Hispanic (21.1% vs. 20.2%) ($p < 0.05$ for all). For American Indian/Alaska Native respondents, reported health care debt is higher among metropolitan (21.6%) respondents compared to non-metropolitan (16.5%; $p < 0.05$). There was also a statistically significant difference among racial/ethnic groups in non-metropolitan areas ranging from 16.5%-29.1% ($p < 0.05$).



Among those ages 18-64, there was a statistically significant difference in the percent of non-metropolitan respondents reporting health care bills that they were paying back over time compared to metropolitan (27.3% and 23.1%, respectively, **Figure 9**). Within racial/ethnic groups, non-Hispanic white (27.9% vs. 22.4%) and American Indian/Alaska Native (15.5% vs. 22.6%) respondents reported non-metropolitan/metropolitan differences. There were also racial/ethnic differences within non-metropolitan ranging from 15.5% of American Indian/Alaska Native respondents to 29.2% of non-Hispanic Black respondents.



CONCLUSIONS

We explored rural-urban and racial/ethnic differences within rural communities in healthcare affordability characterized by insurance coverage, foregoing care due to cost, and medical debt using 2018 BRFSS data. We found that non-metropolitan non-Hispanic white and non-metropolitan non-Hispanic Black respondents had higher rates of uninsurance compared to their metropolitan counterparts. We also found insurance coverage varied across racial/ethnic groups within rural communities with Hispanic respondents having the lowest rate of insured status. Additionally, for both all ages and those ages 18-64, non-metropolitan overall and non-metropolitan non-Hispanic Black respondents reported higher levels of not seeing a doctor due to cost compared to their counterparts. Within rural, differences were identified with American Indian/Alaska Native respondents reporting the highest percentages. A higher percentage of non-metropolitan respondents reported forgoing medication due to cost overall and among those ages 18-64. Overall and among those ages 18-64, a higher percentage of non-metropolitan respondents reported having medical bills they were paying off over time. Racial/ethnic differences were identified within non-metropolitan with a higher percentage of non-Hispanic Black respondents reporting medical debt overall and among those ages 18-64.

Our findings regarding lower levels of insured status in non-metropolitan populations are aligned with previous research but also recognized that five of the eight states administering this BRFSS optional module were states that had yet to expand Medicaid at the time of the survey administration.^{8,12} Racial/ethnic differences within rural communities are particularly important to address. Of note, non-Hispanic populations had the lowest rates of insured status among those living in non-metropolitan areas with particularly low rates among those ages 18-64. Hispanic populations represent the fastest-growing population in rural areas, and these populations are younger than other racial/ethnic groups in rural areas.¹³

Our analysis identified that roughly one in four non-metropolitan Black and American Indian/Alaska Native respondents ages 18-64 reported forgoing care due to cost. These non-metropolitan estimates (24.7%) far exceed national estimates of delayed care due to cost among Black populations (8%) during the same time period.¹⁴ As non-metropolitan Black and American Indian/Alaska Native populations have higher rates of chronic conditions and higher rates of many of the top causes of death, it is critical that they receive necessary care to manage these conditions and reduce inequities in mortality.^{11,15}

Although racial/ethnic inequities were not identified, a higher percentage of non-metropolitan respondents reported forgoing prescription medications due to cost. This corroborates previous research indicating that non-metropolitan populations were more likely to forego medications due to cost.^{9,16} Studies suggest that the prevalence of multiple chronic conditions -- many of which may be managed with prescription medication-- are higher among rural populations.¹⁷ It is important that policies prevent financial barriers to filling prescription medications and that such policies extend beyond insurance coverage mandates especially as the proportion of those who forewent prescription medication far exceeds the proportion who lack health insurance. These findings may also underscore the importance of 340B drug pricing programs that provide lower cost prescriptions through federally qualified health centers, critical access hospitals, and other safety net providers treating rural patients.¹⁸

One in four non-metropolitan respondents reported having medical debt they were paying off over time. Among non-metropolitan respondents, non-Hispanic Black respondents reported medical debt at a higher rate. Our findings are aligned with previous studies indicating higher rates of medical debt among Black persons.¹⁹ Medical debt can have notable implications for the financial,

mental, and physical well-being of individuals including lower credit scores, bankruptcy, property seizure, higher rates of anxiety and depression, and chronic pain.²⁰⁻²² As our results show, a lower percentage of rural respondents are covered by employer-sponsored insurance which may mean they need to seek insurance on the marketplace where there are fewer choices in rural communities and/or they seek high deductible plans that may lead to higher levels of medical debt.²³

Non-metropolitan populations faced more affordability barriers to care than their urban counterparts. Non-Hispanic Black and American Indian/Alaska Native populations are particularly affected reflected by higher rates of care avoidance due to cost and/or medical debt. Therefore, the current national efforts in improving access to care for all need to target affordability of care that is disproportionately affecting rural populations particularly Indigenous and people of color who often have more complex care needs.



Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org



This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1C45498 Rural Health Research Grant Program Cooperative Agreement. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

For more information about the Rural and Minority Health Research Center, contact Director Dr. Elizabeth Crouch (crouchel@mailbox.sc.edu) or Deputy Director Dr. Peiyin Hung (hungp@mailbox.sc.edu).

Suggested citation: Zahnd WE, Ranganathan R, Crouch EL, Hung P, Eberth JM, Benavidez G. Variations in Affordability of Health Care by Non-Metropolitan/Metropolitan and Race/Ethnicity Status across Eight Geographically Dispersed States. January 2023. [Link to Report](#)

REFERENCES

1. Centers for Disease Control and Prevention. About Social Determinants of Health (SDOH). Published March 10, 2021. Accessed October 15, 2022. <https://www.cdc.gov/socialdeterminants/about.html>
2. Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981;19(2):127-140.
3. Fields BE, Bigbee JL, Bell JF. Associations of Provider-to-Population Ratios and Population Health by County-Level Rurality. *J Rural Health*. 2016;32(3):235-244. doi:10.1111/jrh.12143
4. Hung P, Henning-Smith CE, Casey MM, Kozhimannil KB. Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004–14. *Health Aff (Millwood)*. 2017;36(9):1663-1671. doi:10.1377/hlthaff.2017.0338
5. Aboagye JK, Kaiser HE, Hayanga AJ. Rural-Urban Differences in Access to Specialist Providers of Colorectal Cancer Care in the United States: A Physician Workforce Issue. *JAMA Surg*. 2014;149(6):537-543. doi:10.1001/jamasurg.2013.5062
6. Hung P, Deng S, Zahnd WE, et al. Geographic disparities in residential proximity to colorectal and cervical cancer care providers. *Cancer*. Published online 2019. doi:10.1002/cncr.32594
7. Eberth JM, Hung P, Benavidez GA, et al. The Problem Of The Color Line: Spatial Access To Hospital Services For Minoritized Racial And Ethnic Groups. *Health Aff Proj Hope*. 2022;41(2):237-246. doi:10.1377/hlthaff.2021.01409
8. Turrini G, Branham DK, Chen L, et al. Access to Affordable Care in Rural America: Current Trends and Key Challenges. Accessed October 15, 2022. <https://aspe.hhs.gov/sites/default/files/2021-07/rural-health-rr.pdf>
9. Probst J, Eberth JM, Crouch E. Structural Urbanism Contributes To Poorer Health Outcomes For Rural America. *Health Aff Proj Hope*. 2019;38(12):1976-1984. doi:10.1377/hlthaff.2019.00914
10. Findling MG, Blendon RJ, Benson JM. Delayed Care with Harmful Health Consequences-Reported Experiences from National Surveys During Coronavirus Disease 2019. *JAMA Health Forum*. 2020;1(12):e201463. doi:10.1001/jamahealthforum.2020.1463
11. James CV, Moonesinghe R, Wilson-Frederick SM, Hall JE, Penman-Aguilar A, Bouye K. Racial/ethnic health disparities among rural respondents - United States, 2012-2015. *MMWR Surveill Summ*. 2017;66(23):1-9. doi:10.15585/mmwr.ss6623a1
12. Kaiser Family Foundation. Status of State Medicaid Expansion Decisions: Interactive Map. KFF. Published September 20, 2022. Accessed October 15, 2022. <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>
13. Lichter DT, Johnson KM. A Demographic Lifeline? Immigration and Hispanic Population Growth in Rural America. *Popul Res Policy Rev*. 2020;39(5):785-803. doi:10.1007/s11113-020-09605-8
14. Assistant Secretary for Planning and Evaluation. *Health Insurance Coverage and Access to Care Among Black Americans: Recent Trends and Key Challenges*. Accessed October 15, 2022.

<https://aspe.hhs.gov/sites/default/files/documents/08307d793263d5069fdd6504385e22f8/black-americans-coverages-access-ib.pdf>

15. Probst JC, Zahnd WE, Hung P, Eberth JM, Crouch EL, Merrell MA. Rural-Urban Mortality Disparities: Variations Across Causes of Death and Race/Ethnicity, 2013-2017. *Am J Public Health*. 2020;110(9):1325-1327. doi:10.2105/AJPH.2020.305703
16. Palmer NRA, Geiger AM, Lu L, Case LD, Weaver KE. Impact of rural residence on forgoing healthcare after cancer because of cost. *Cancer Epidemiol Biomark Prev*. 2013;22(10):1668-1676. doi:10.1158/1055-9965.epi-13-0421
17. Boersma P, Black LI, Ward BW. Prevalence of Multiple Chronic Conditions Among US Respondents, 2018. *Prev Chronic Dis*. 2020;17:E106. doi:10.5888/pcd17.200130
18. Health Resources and Services Administration. 340B Drug Pricing Program. Accessed October 15, 2022. <https://www.hrsa.gov/opa>
19. Kaiser Family Foundation. 1 in 10 Respondents Owe Medical Debt, With Millions Owing More Than \$10,000. KFF. Published March 10, 2022. Accessed October 15, 2022. <https://www.kff.org/health-costs/press-release/1-in-10-respondents-owe-medical-debt-with-millions-owing-more-than-10000/>
20. Consumer Financial Protection Bureau. Medical Debt Burden in the United States. https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf Accessed September 14, 2022.
21. Batty M, Gibbs C, Ippolito B. Health insurance, medical debt, and financial well-being. *Health Econ*. 2022;31(5):689-728. doi:10.1002/hec.4472
22. Himmelstein DU, Dickman SL, McCormick D, Bor DH, Gaffney A, Woolhandler S. Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US. *JAMA Netw Open*. 2022;5(9):e2231898. doi:10.1001/jamanetworkopen.2022.31898
23. Hawryluk M. High-Deductible Plans Jeopardize Financial Health Of Patients And Rural Hospitals. Kaiser Health News. Published January 10, 2020. Accessed October 15, 2022. <https://khn.org/news/high-deductible-plans-jeopardize-financial-health-of-patients-and-rural-hospitals/>

APPENDIX

Methodology

Data Source

We utilized publicly available data from the 2018 Behavioral Risk Factor Surveillance System (BRFSS). This annual telephonic survey (landline, cellphone, mail) collects information on health-related risk-behaviors, chronic health conditions, and the utilization of preventive services. Salient features include nationwide participation from all 50 states, the District of Columbia, and three U.S. territories with over 400,000 respondents being interviewed every year. Jointly administered by the CDC's Division of Behavioral Surveillance and the Office of Surveillance, Epidemiology and Laboratory services, the survey targets non-institutionalized populations who are age 18 or older at the time of interview. In addition to a core set of questions, states have the opportunity to include optional modules on topics of interest. This includes an optional module on health care access that eight states (Georgia, Louisiana, Mississippi, Nebraska, New Hampshire, New Mexico, Oregon, and Tennessee) included as part of their survey in 2018.

Measures

Health care access questions included questions about affordability such as insurance coverage, coverage type, forgoing doctor's visits due to cost, forgoing medication due to cost, and possessing medical debt. Rurality was determined by the National Center for Health Statistics' Urban-Rural Classification for Counties and dichotomized as metropolitan and non-metropolitan. Race/ethnicity was self-reported by the survey respondents and classified as non-Hispanic White, non-Hispanic Black, Hispanic, American Indian/Alaska Native, Asian/ Pacific Islander, and Other which includes multi-racial and non-specified race. Race/ethnicity is a social construct that indicates potential for exposure to interpersonal and structural disadvantage. Other sociodemographic measures include gender, marital status, language used to complete the survey, education level, and employment status. Imputed versions of race/ethnicity and age available in the BRFSS dataset were used to reduce missingness.

Analysis

We performed descriptive statistics to present the sociodemographic characteristics of survey respondents. We assessed differences in affordability factors across rurality (non-metropolitan vs. metropolitan) and race/ethnicity using Wald chi-square analysis. We also performed stratified analyses among those ages 18-64 who are not yet age-eligible for Medicare. We accounted for the complex survey design in our analyses, all of which were performed in SAS.

Table A.1 Sociodemographic Characteristics of Survey Respondents

	Non-Metropolitan N (Weighted %)	Metropolitan N (Weighted %)	P-Value
<i>Total</i>	24, 352 (25.2%)	34,111 (74.83%)	N/A
Race/Ethnicity (Imputed)			
Non-Hispanic White	18,942 (71.8%)	24,506 (74.8%)	<0.001
Non-Hispanic Black	2,560 (16.5%)	4,288 (21.0%)	
American Indian/Alaska Native	606 (1.9%)	633 (1.2%)	
Asian/Pacific Islander	79 (0.5%)	537 (2.3%)	
Hispanic	1,740 (7.7%)	3,245 (9.1%)	
Non-Hispanic/Other	425 (1.7%)	902 (2.3%)	
Age			
18-64	15,124 (75.7%)	23, 527 (80.5%)	<0.001
65 and older	9,228 (24.3%)	10, 584 (19.5%)	
Gender			
Male	10,575 (48.3%)	15,383 (48.2%)	0.94
Female	13,737 (51.5%)	18,661 (51.6%)	
Don't know/refused/missing	40 (0.2%)	67 (0.2%)	
Marital status			
Married	12,941 (50.3%)	17,159 (49.3%)	<0.001
Divorced	3,425 (12.8%)	4,915 (11.1%)	
Widowed	3,317 (8.8%)	3,441 (6.4%)	
Separated	581 (2.7%)	865 (2.7%)	
Never married	3,368 (21.1%)	6,219 (25.4%)	
A member of an unmarried couple	608 (3.7%)	1,243 (4.4%)	
Don't know/missing	112 (0.6%)	269 (0.8%)	
Language used to complete the survey			
English	23,825 (97.5%)	32,933 (96.7%)	<0.001
Spanish	527 (2.5%)	1,178 (3.4%)	
Education Level			
Less than High School	2,384 (17.5%)	2,791 (12.4%)	<0.001
High School Graduate	7,949 (34.4%)	8,855 (27.9%)	
Attended college/technical school	7,027 (30.4%)	9,236 (31.5%)	
College/technical school graduate	6,918 (17.3%)	13,102 (27.7%)	
Don't know/refused/missing	74 (0.4%)	127 (0.4%)	
Employment Status			
Employed for wages	9,097 (41.0%)	14,790 (47.4%)	<0.001
Self-employed	2,655 (9.1%)	3,026 (9.3%)	
Out of work for 1 year or more	398 (2.6%)	693 (2.4%)	
Out of work for less than 1 year	409 (2.5%)	711 (2.7%)	
Homemaker	1,291 (6.0%)	1,630 (5.0%)	
Student	457 (4.3%)	1,082 (5.3%)	
Retired	7,406 (20.8%)	8,988 (17.4%)	
Unable to Work	2,396 (12.5%)	2,705 (8.7%)	
Don't Know/Refused/Missing	243 (1.3%)	486 (1.9%)	