
**State of Ohio
High-Risk Pool Feasibility Study**

**Supplement
May 2006**

Prepared by



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ABOUT THIS SUPPLEMENT

In June 2005, Leif Associates completed a study on behalf of the Ohio Department of Insurance to determine whether a qualified high-risk pool is an appropriate mechanism for providing health coverage to federally eligible individuals and uninsured Ohioans. In May 2006, the Department of Insurance requested an update to that study to include new information that has become available since the original study was completed.

This supplement was paid for with a federal grant obtained by the Ohio Department of Insurance from funding made available by Congress in the Trade Adjustment Assistance Reform Act of 2002 for implementation of qualified high-risk pools.

SUMMARY OF FINDINGS

The key findings of this supplement include the following:

- Based on the original analysis described in our June 2005 report, supplemented with the updated information contained in this supplemental report, we still believe that a high-risk pool is a viable option for the state of Ohio.
- Approximately 1.3 million persons in Ohio are still uninsured. We believe our original estimates of potential participants (initially 2,800 enrollees, growing to 17,250) are still valid. Although the overall number of potential enrollees under the age of 65 has decreased slightly due to the aging population of Ohio, and more people are on government programs, we believe our earlier estimates of enrollment in a high-risk pool will be the same. High-risk pool participants will have to contribute a significant amount towards the cost of premium and health care and thus probably do not qualify for Medicaid.
- There have not been any major changes in the high-risk pool market since our original report. The pools continue to charge premium rates to participants that are high, and therefore do not entirely solve the problem of the affordability of coverage for uninsurable individuals. While cost does present a barrier to many potential participants, high-risk pools are a valuable mechanism for the portion of the uninsurable population that can afford the premiums. Also, many states have adopted discount programs to assist low-income participants.
- Historically, no high-risk pools have become insolvent, largely because of adequate oversight, continued federal funding, and initiatives to reduce costs through care management, benefit revisions, and increased member cost-sharing.



OVERVIEW OF THE SUPPLEMENTAL REPORT

Using updated information provided by the Ohio Department of Insurance, existing state high-risk pools, and publicly available sources, we have compiled a supplement to our original report containing the following sections:

- Trends in the Ohio Health Insurance Market. This section summarizes the changes in Ohio since June 2005, including uninsured estimates, demographic information, and industry costs.
- Trends in High-Risk Pools In Other States. In this section, we provide updates to federal legislation concerning high-risk pools, changes seen in membership, rating practices and cost containment strategies.
- Impact of Trends on Original Estimates. This section discusses how the updated information for both Ohio and high-risk pools nationally affect our original June 2005 report.

This supplemental report does not update the detailed calculations such as the starting premium costs, projected premiums, claims expense and administrative costs. It is expected that all of these previously determined costs would increase with a later start date to the program. However, we do provide some general estimates of what we expect these costs to be assuming a January 1, 2007 start date.

The cost and enrollment projections included in this study are estimates of future events based on many assumptions. It is important to understand that while we believe we have used reasonable assumptions based on the information available to us, actual future results may be influenced by unforeseen events that we have not anticipated.



TRENDS IN THE OHIO HEALTH INSURANCE MARKET

OHIO POPULATION ESTIMATES

Based on updated information released by the US Census Bureau, Ohio's population in 2004 was 11,450,143. This is only a slight increase, 0.16%, over the 2003 population estimate of 11,431,748. The 2005 population estimate reflects an even smaller increase of 0.12% over 2004.

As the Ohio high-risk pool is intended to be only available to persons under age 65, we have segmented the following statistics by age grouping. Although the total number of Ohioans has not changed significantly, there was a shifting by age between 2003 and 2004 as shown in the following two tables.

Distribution of Total Ohio Population By Age Group

Age	2003	2004	Change
0-17	25.4%	24.9%	-1.9%
18-64	63.2%	62.9%	-0.3%
65+	11.4%	12.2%	+7.4%
All	100%	100%	

Estimate of Ohioans By Age Group

Age	2003	2004	Change
0-17	2,903,664	2,851,086	(52,578)
18-64	7,224,865	7,202,140	(22,725)
65+	1,303,219	1,396,917	93,698
All	11,431,748	11,450,143	18,395

Combined with the overall stable population, these updated statistics show that the under age 65 group has decreased from 2003. The under age 65 populations represented 88.6% of all Ohioans in 2003, dropping to 87.8% in 2004. The age 65 and over group increased from 11.4% in 2003 to 12.2% in 2004.

The median age for Ohioans continued to increase from 37.1 years old in 2003 to 37.3 years old in 2004.



HOSPITAL UTILIZATION TRENDS

According to data provided by the Ohio Hospital Association, Ohioans used more inpatient, outpatient and emergency services in 2004 than they did in 2003. However the rate of surgeries (inpatient and outpatient) decreased, as did the number of births.

Hospital Utilization per 1,000 Ohioans By Service Type

Service Type	2003	2004	Change
Inpatient Admissions	127.5	128.7	0.9%
Inpatient Days	656	673.6	2.7%
Emergency Visits	468.2	471.4	0.7%
Other Outpatient Visits	2,157.1	2,194.4	1.7%
Surgeries (Inpatient and Outpatient)	106.3	105.3	-0.9%
Births	12.9	12.8	-0.8%

Total inpatient days grew from 7,501,323 in 2003 to 7,718,229 in 2004.

The gross total revenue of Ohio's 166 hospitals was up 14.7% in 2004. This could be attributable to higher costs of technology, the aging of the population, increased number of services, inflation and other factors.

THE UNINSURED IN OHIO

Updated studies released by the US Census Bureau related to how many people have health insurance (whether provided by the government or purchased privately through employers or individually) show that the number of persons without any health insurance during the year in Ohio dropped from 12.1% in 2003 to 11.4% in 2004. This is a reduction of 6.1%. Decreases in uninsured rates were realized in both the under age 65 and over age 65 groupings.

Percent of Ohioans Uninsured for Entire Year By Age Group

Age	2003	2004	Change
0-17	8.3%	7.6%	-8.5%
18-64	15.8%	15.1%	-4.6%
65+	0.2%	0%	
Total	12.1%	11.4%	-6.1%



Count of Ohioans Uninsured for Entire Year By Age Group

Age	2003	2004	Change
0-17	241,004	216,683	(24,322)
18-64	1,141,529	1,087,523	(54,005)
65+	2,606	-	(2,606)
Total	1,385,139	1,304,206	(80,934)

A greater percentage of Ohioans have health insurance compared to national figures.

Percentage of Persons Having Health Insurance At Some Time in 2004

Age	National Rate	Ohio Rate
0-17	88.8%	92.5%
18-64	79.5%	84.9%
65+	99.2%	100.0%
All Ages	84.3%	88.6%

Ohio also experienced better trends from 2003 to 2004 than seen nationally. Nationally the uninsured rates increased by about 2% for both the over age 65 and age 18 to 65 populations, whereas uninsured rates in Ohio held stable for the over age 65s and decreased for those aged 18-64. The only age group that experienced decreases nationally was the under age 18 group that saw a decreased uninsured rate of about 2%.

THE INSURED IN OHIO

Based on updated US Census Bureau data, the tables summarize by age the Ohio distribution of coverage in the three major insured coverage types for 2003 and 2004.

Ohio Percent of Insured by Coverage Type and Age Group*

Age 0-17	Type	2003	2004
	Private Insurance	73.4%	73.1%
	Medicaid	23.4%	23.9%
	Medicare	0.6%	0.4%

Age 18-64	Type	2003	2004
	Private Insurance	76.6%	76.7%
	Medicaid	6.5%	7.5%
	Medicare	3.0%	3.0%



The Ohio Health Insurance Market

Age 65+	Type	2003	2004
	Private Insurance	67.8%	68.1%
	Medicaid	6.1%	4.5%
	Medicare	97.3%	95.6%

All Ages	Type	2003	2004
	Private Insurance	74.8%	74.7%
	Medicaid	10.7%	11.2%
	Medicare	13.1%	13.6%

*These categories are not intended to add up to 100% as members may be enrolled in more than one type of coverage during the year and this summary is not inclusive of all coverage types.

The following tables summarize the number of persons covered by age and coverage type. Some of these changes are due to population changes. For example, the number of covered persons aged 0-17 shows a reduction of approximately 51,000 people at the same time the overall population for aged 0-17 dropped by about 53,000.

Ohio Count of Insured by Coverage Type and Age Group

Age 0-17	Type	2003	2004	Change
	Private Insurance	2,131,289	2,084,144	(47,146)
	Medicaid	679,457	681,409	1,952
	Medicare	17,422	11,404	(6,018)

Age 18-64	Type	2003	2004	Change
	Private Insurance	5,534,246	5,524,041	(10,205)
	Medicaid	469,616	540,160	70,544
	Medicare	216,745.94	216,064.20	(682)

Age 65+	Type	2003	2004	Change
	Private Insurance	883,583	951,301	67,718
	Medicaid	79,496	62,861	(16,635)
	Medicare	1,268,032	1,335,453	67,421

All Ages	Type	2003	2004	Change
	Private Insurance	8,549,118	8,559,486	10,367
	Medicaid	1,228,570	1,284,431	55,861
	Medicare	1,502,200	1,562,922	60,721



The Ohio Health Insurance Market

Age 0-64	Type	2003	2004	Change
	Private Insurance	7,665,536	7,608,185	(57,351)
	Medicaid	1,149,074	1,221,570	72,496
	Medicare	234,168	227,469	(6,699)

The individual insurance carriers reported total enrollment in the open enrollment program of just under 1,800 individuals for 2003. There was a slight decrease in 2004. The following table shows the number of open enrollment insureds and their average premium and claims in 2003 and 2004. This information is from the Ohio Department of Insurance Annual Report of Ohio Health Insurance Business.

Count of Open Enrollment Insureds

Type	2003	2004	Change
Non-Federally Eligible	934	779	(155)
Federally Eligible	863	1,009	146
Total	1,797	1,788	(9)

Average Monthly Premium of Open Enrollment Insureds

Type	2003	2004	Change
Non-Federally Eligible	\$595	\$641	\$46
Federally Eligible	\$596	\$705	\$109
Total	\$595	\$676	\$81

Average Monthly Claims Cost of Open Enrollment Insureds

Type	2003	2004	Change
Non-Federally Eligible	\$632	\$785	\$153
Federally Eligible	\$692	\$733	\$41
Total	\$662	\$757	\$95

This report shows an annual increase in premium of 13.6% and an annual increase in claims expense of 14.4%.



TRENDS IN HIGH-RISK POOLS IN OTHER STATES

ENROLLMENT

The participation in existing high-risk pools has held relatively stable in 2004, increasing by less than 1% nationally. The enrollment inched up slightly to average 0.135% of a state's population from an average of 0.134% in 2003. The participation rates by state ranged from a low of 0.003% to a high of 0.643%. In absolute terms, the range is from 118 participants in Iowa to 32,949 in Minnesota. Eleven of the 32 states for which we have data experienced a decrease in enrollment in 2004, while 21 states had increases.

One new state implemented a high-risk pool in 2005. The West Virginia Health Insurance Plan, called Access WV, began enrollment in July 2005. No high-risk pools ceased operations in 2004 or 2005.

PLAN ADMINISTRATION

The average cost of administering a high-risk pool in 2004 was \$436 per participant per year. This is an increase of 6.2% from 2003 levels. The amount varied by the number of participants, with the smallest pools having the highest administration costs per participant and the largest having the lowest, as shown in the table below. Administrative costs represented approximately 5.4% of total plan expenditures in 2004.

2004 Annual Administrative Expenses	
Number of Participants	Per Participant
Under 1,000	\$623
1,000 to 9,999	\$515
Over 10,000	\$376
Total	\$436

CLAIM COSTS AND LOSS RATIOS

Since the purpose of a high-risk pool is to provide coverage for persons who are high-risk, it is not an unexpected result that the participants' claims are much larger than those of a normal population. In fact, the average claim cost per high-risk participant nationwide in 2004 was about \$7,578 per year or \$631 per month. This is an increase of approximately 9% over 2003.

The claim costs for high-risk pools tend to fluctuate considerably from one year to the next, especially in the smaller pools, because of the catastrophic nature of certain very large claims experienced by this population. However, the overall



loss ratio nationally (claims expense divided by premium) held stable at 159% from 2003 to 2004.

FUNDING OF THE PLAN

The funding for high-risk pools comes from a combination of premiums and additional revenue sources.

Premiums

In 2004, existing high-risk pool premiums averaged approximately \$4,800 per year, or \$398 per month per covered individual. This is an increase of 9% over 2003. The average premium from state to state ranged from under \$1,500 per year in Idaho to \$9,023 per year in Iowa. The majority of states have average premiums that fall in the range of \$3,500 to \$6,500 per year.

The average premium collected still provides about 60% of the funding for high-risk pools, the same as in 2003.

Additional Revenue

The amount of additional revenue needed by a high-risk pool is dependent on its level of enrollment, eligibility requirements, premium levels, plan designs, provider reimbursement levels, cost containment efforts, and program management. In calendar year 2004, the additional revenue required for the 182,000 participants in state high-risk pools totaled approximately \$590 million, an average of about \$3,200 per participant. This is an increase of 9% over 2003. The amount of additional funding needed in 2004 by the states ranged from \$88,000 in South Dakota (a new plan in 2003 with only 532 participants in 2004) to over \$110 million in Minnesota, which had almost 33,000 participants and has been in operation since 1976.

States use a variety of methods to obtain this additional revenue beyond premium. Some examples include hospital assessments, carrier assessments, State appropriations, premium tax credits, and tobacco funds. The details of these funding sources vary for each state. One state that changed funding methods recently is Texas, which switched from an assessment model based on total health premium to one based on covered lives.

Grants established through the Trade Adjustment Assistance Reform Act of 2002 is one source of additional funding used by most states. These funds were distributed to qualified high-risk health pools to help offset operating losses. In 2004, the Department of Health and Human Services (HHS) distributed \$40 million as shown in the following table.



High-Risk Pools In Other States

State	HHS Grant
Alaska	\$483,555
Arkansas	\$1,892,658
Colorado	\$3,096,266
Connecticut	\$1,502,721
Illinois	\$7,472,921
Indiana	\$3,358,254
Iowa	\$367,670
Kansas	\$1,297,042
Kentucky	\$2,291,952
Maryland	\$3,175,868
Massachusetts	\$132,271
Minnesota	\$1,971,749
Mississippi	\$2,037,628
Montana	\$621,040
Nebraska	\$751,032
New Hampshire	\$531,515
New Mexico	\$1,738,727
North Dakota	\$292,703
Oklahoma	\$2,730,738
Utah	\$1,395,360
Wisconsin	\$2,500,578
Wyoming	\$357,751

In recent legislation, the federal government has committed to increase historical grants from \$40 million per year to \$75 million per year through the year 2010. In addition they are providing seed grants through 2006 of \$1 million per state that has yet to implement a pool to offset startup costs.

SOLVENCY HISTORY

There is a misconception by some that high-risk pools are on the verge of insolvency and vulnerable to shutting down at any time. Premiums set at 60% of program expense obviously cannot sustain a program for very long. However, if alternative funding mechanisms are used, such as federal funds, state funds, carrier assessments, hospital surcharges, and so forth and with ongoing fiduciary review, the programs nationally have been long running. As of 2004 only one plan had closed to new participants (Florida closed its pool in 1991) and only two other plans (Illinois and Louisiana) have placed caps on new portions of their enrollment.

Tennessee has redesigned its entire Medicaid program (TennCare) in recent years due to funding issues. Part of their overall Medicaid program included coverage for uninsurables. The Tennessee Comprehensive Health Insurance



Pool (TCHIP) closed in 1995 due to the inclusion of coverage in TennCare. In May 2006, different versions of legislation passed the state House and Senate for a new program, Cover Tennessee, which is a multifaceted approach to provide health care to the uninsured in Tennessee. As part of this initiative there is an updated version of TCHIP, called Access Tennessee. If the premium subsidy portions remain in the final legislation, they expect to cover up to 15,000 members in the first year. The program as currently designed is funded by carrier assessments, state appropriations and member premiums. Differences between the House and Senate versions must be resolved before the governor can sign it into law.

Historical assessments by the high-risk pools have fluctuated from year to year. Many factors affect the need for assessments, most importantly the number of individuals enrolled in the pool. In most states there have been changes in funding mechanisms, insurance laws, and eligibility rules in recent years, which have all affected the need for funds. But no high-risk pool has become insolvent or had to terminate current members in order to avoid insolvency.

Here is a count of the number of high-risk pools by year established:

Year	# Of High-Risk Pools Established
1976	2
1981	1
1982	2
1983	1
1986	1
1987	2
1988	2
1989	1
1990	2
1991	4
1992	3
1993	2
1996	2
1998	2
2001	2
2002	1
2003	2
2005	1

In addition to Ohio, other states currently considering establishing high-risk pools include Georgia, Arizona, Maine, Nevada and North Carolina. Each of these states has recently considered high-risk pool legislation or has a feasibility study currently underway. The legislation in Georgia passed the state House, but failed in a Senate subcommittee in late March 2006. In mid-April 2006, the bill



before the Maine legislature was defeated in the state Senate after passing the House. Arizona legislation experienced the same fate. It is expected that legislation will be introduced again next session.

BENEFIT TRENDS

Disease Management

Comprehensive disease management programs are ideal for high-risk pools as by definition the participants have been or are sicker than the general population, thus unable to purchase coverage in the commercial market. Measuring outcomes of disease management programs is challenging for many reasons such as obtaining baseline data, the need for a large enough population to be statistically valid and the voluntary nature of participation. As a result, empirical data is not easy to find. There are some targeted studies that show disease management does save money and improve health.

For example, as published in 2004 in Health Affairs, Victor G Villagra and Tamim Ahmed released results of a study of over 43,000 diabetics in 10 urban areas in twelve states that showed significant savings in costs within a year. Specifically, they showed a decrease in hospitalization of between 22 and 30 percent for those that were in the disease management program versus those that were not.

Disease management programs typically target specific diseases, such as diabetes, high-risk pregnancies, depression, and asthma. The Indiana Comprehensive Health Insurance Association (ICHIA) implemented a program for Hemophilia in 2004 and has reported positive outcomes. According to Doug Stratton, the ICHIA Executive Director, their results for year one of the program “exceeded all our expectations by a significant measure.” They recently added a program for Crohn’s Disease.

As of 2005, half of the high-risk pools have implemented comprehensive disease management programs. We expect this to continue to increase in future years as federal grants have been established as incentives for pools to establish disease management programs.

Premium Subsidies

Approximately 25% of the pools have implemented formalized premium reduction programs for lower income participants. Several more have reduced their rates across their whole pools to encourage participation. We expect more pools to add premium subsidy programs for lower income members or move to lower all their rates due to the additional federal grants available to the pools that implement such programs.



CoverColorado recently expanded their premium subsidy program to allow discounts of up to 50% off the July 1, 2006 rate schedule, which is set at 150% of the individual commercial market equivalent rates. The pool expects membership in the premium subsidy program to grow from just under 800 participants to approximately 1,500 with the new premium levels.

The New Mexico Medical Insurance Pool also has introduced bigger discounts to its members. The new income guidelines allow premium reductions for all members with an annual household income of less than 400% of the federal poverty level. Discounts of up to 75% are available.

RECENT CHANGES IN FEDERAL LAWS

Public Law 109-172

The State High Risk Pool Funding Extension Act of 2006 was signed into law on February 10, 2006. This law appropriates for federal fiscal year 2006, \$1 million to each state that has not created a high-risk pool for creation and operation expenses incurred by the state. It also appropriates \$75 million for federal fiscal year 2006 through 2010 to be provided to the states for ongoing operating expenses. Two thirds of the \$75 million is dedicated to state allotments while one third is to be used specifically for supplemental benefits, such as premium subsidies and establishing disease management programs.

HDHPs

The federal law that established Health Savings Accounts (HSAs) took effect in December 2003. It allows individuals to purchase qualifying high deductible health plans (HDHPs) and in conjunction make tax free contributions into savings accounts to be used for medical expenses under the deductible. At least ten high-risk pools have implemented qualifying HDHP plans in 2005 and 2006. We are aware of two others that are planning to introduce the plans in late 2006 or early 2007.

Medicare Part D

With the implementation of Medicare Part D states offering drug coverage to Medicare enrollees are redesigning their own plans to best coordinate with this new coverage. Having seniors covered by Part D instead of the high-risk pool will save the pools money and the states must decide how best to communicate options to their members and perhaps have plans available that provide gap coverage as needed. Thirteen high-risk pools offer Medicare supplement coverage and thus are affected by the implementation of Medicare Part D. As the legislation is currently written for the Ohio high-risk pool, coverage for Medicare eligibles is not allowed, so Medicare Part D will not affect it.



IMPACT OF TRENDS ON THE ESTIMATES IN THE ORIGINAL REPORT

Since our original analysis there has been no major insurance reform, either nationally or in Ohio. Several factors have reduced the overall pool of potential participants in Ohio, such as Medicaid enrollment growth and fewer residents under the age of 65. However, since the high-risk pool targets higher income participants we do not expect our original projections to be significantly different from our original projections if implemented in the next couple of years.

We previously projected premiums to increase by an average 13.9% based on the previously surveyed Ohio carriers. The updated reports for 2004 show the average for all Ohio carriers' premiums grew by 13.6%. The calculation for the high-risk pools premium is tied to the commercial market, thus we see no significant changes required for expected premium levels.

In our original analysis we projected that claim costs would grow by approximately 16.1% per year. In total for 2004, the Ohio carriers reported an increase in claim costs of 14.4%. Although lower than our best estimate, we feel the higher trend is still justified, as the high-risk pool population by definition is more likely to be sicker, thus using more services and higher cost technology on a regular basis than the healthy population.

We projected administration costs to increase at a rate of 5% per year. The national average of high-risk pools showed a 6.2% increase in 2004 over 2003.

As a result, we expect the overall enrollment estimates of year one to remain the same, regardless of when implemented, but the costs for claims and admin to continue to increase at the underlying expected trend rates. The high-risk pool premium rates will continue to trend along with the market.

The primary consideration to not further delay implementation of the Ohio high-risk pool is that Public Law 109-172 only appropriates the \$1 million per state for implementation of a high-risk pool through FY06. It is not carried forward to future years in the current law although other federal grants are available to operating pools through 2010.



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