# Senate Democratic Policy Committee Hearing

"America's Uninsured: Myths, Realities and Solutions"

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Thank you for the opportunity to offer testimony this morning on the critical issue of the uninsured and the consequences of leaving 43 million Americans without health insurance coverage. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

Health insurance coverage remains one of the nation's most pressing and persistent health care challenges. The most recent data – released this September from the Census Bureau – show that 43.6 million adults and children were without health insurance in 2002 — more than one in every seven Americans. The new statistics reveal that this is not only a large problem, but a growing problem for millions of Americans. From 2001 to 2002, the number of Americans lacking health insurance increased by 2.4 million due to the decline in employer-sponsored coverage (Figure 1). Public coverage expansions through Medicaid helped to moderate the growth in the uninsured, most notably by providing coverage to children in low-income families, but were not enough to offset the decline in private coverage (U.S. Census Bureau, 2003).

## THE UNINSURED POPULATION

Who are America's 43 million people without health insurance coverage? The uninsured are predominantly adults from low-income working families — three-quarters of the uninsured are between age 18 and 65; two-thirds have incomes below 200 percent of the federal poverty level or $28,696 for a family of three in 2002; and the majority (eight in 10) come from working families (Figure 2). The complexities of coverage through the workplace combined with gaps in public coverage through Medicaid and the State Children's Health Insurance Program (SCHIP) mean millions of Americans are outside of the reach of health insurance coverage. Health coverage in America is very much a patchwork where having health insurance depends on where you live, where you work, and too often what you earn.

Two out of three nonelderly Americans receive their health insurance coverage through an employer-sponsored health plan offered through the workplace, but for millions of working families such coverage is either not offered or is financially out of reach. Among the 43 million uninsured, eight in ten come from working families — nearly 70 percent come from families where at least one person works full-time and another 12 percent from families with part-time employment.

Most uninsured workers, and consequently their dependents, are not offered job-based coverage either through their own or a family members job. The likelihood of obtaining coverage through the workplace depends largely on where one works and what one earns. Most large firms offer coverage, but many smaller firms do not. Low-wage workers are often employed in small businesses, particularly in the retail and service industries, where health insurance is not widely offered as a fringe benefit.

When health insurance is offered in the workplace, most employees opt for coverage even though the share of premium they must pay often represents a substantial share of their income. In 2003, the average annual premium for employer-sponsored group insurance for a family was $9,068 with the employee contributing roughly a quarter (27 percent) of the premium or $2,412 per year (Figure 3).

If health insurance coverage is not available through a group policy from an employer, families are hard pressed to be able to find and pay for a policy in the individual insurance market. Most directly purchased policies are expensive and have more limited benefits and more out-of-pocket costs than group coverage plans. Moreover, the cost of these policies is based on age and health risk, and any preexisting health conditions are generally excluded from coverage. For the average low-income family, a $9,000 family policy in the individual market would consume a third or more of their income, provide only limited protection, and could exclude coverage for any family members with health problems.

Medicaid and SCHIP help fill in the gaps for some of the lowest income people, but this publicly sponsored coverage is directed primarily at children and pregnant women and varies in availability across the states. Most low-income children are eligible for assistance through Medicaid or SCHIP, but in most states parents' eligibility lags far behind that of their children. While eligibility levels for children are at 200 percent of the federal poverty level ($30,520 for a family of three in 2003) in 39 states, parents' eligibility levels are much lower (Figure 4). A parent working full-time at minimum wage earns too much to be eligible for Medicaid in 19 states. For childless adults, Medicaid funds are not available unless the individual is disabled or lives in one of the few states with a waiver to permit coverage of childless adults. As a result, in 2002, Medicaid provided health insurance coverage to over half of all poor children, and a third of their parents, but only 22 percent of poor childless adults. Over 40 percent of poor adults and a third of near-poor adults were uninsured.

Low-income individuals are disproportionately represented among the uninsured – nearly two-thirds (64%) of the uninsured come from low-income families earning less than 200 percent of the poverty level and over a third (36%) come from families living below the poverty level. Employer-sponsored coverage is extremely limited for the low-income population; only 15 percent of the poor and 42 percent of the near-poor receive coverage through their employer (Figure 5). Medicaid helps to offset the lower levels of private insurance for over a third (38%) of the poor and 20 percent of the near-poor, but many parents of low-income children as well as childless adults do not qualify for Medicaid assistance.

This confluence of factors relating to the characteristics of the uninsured places low-income adults at the center of the nation's uninsured problem. In 2002, 48 percent of the 43 million uninsured Americans were low-income adults – 16 percent parents of low-income children and

32 percent low-income adults without children (Figure 6). Assuring coverage for this group, as well as extending coverage to the parents of the low-income children who are now largely eligible for public coverage, poses the next challenge in coverage expansions. Focusing attention on the lack of coverage for low-income adults and continuing to push for better enrollment of low-income children offers the potential to reach two in three uninsured Americans.

## THE CONSEQUENCES OF LACK OF INSURANCE

The growing number of uninsured Americans should be of concern to all of us because health insurance makes a difference in how people access the health care system and, ultimately, their health. Leaving a substantial share of our population without health insurance affects not only those who are uninsured, but also the health and economic well-being of our nation.

There is now a substantial body of research documenting disparities in access to care between those with and without insurance. Survey after survey finds the uninsured are more likely than those with insurance to postpone seeking care; forgo needed care; and not get needed prescription medications (Figure 7). Many fear that obtaining care will be too costly. Over a third of the uninsured report needing care and not getting it, and nearly half (47%) say they have postponed seeking care due to cost. Over a third (36%) of the uninsured compared to 16 percent of the insured report having problems paying medical bills, and nearly a quarter (23%) report being contacted by a collection agency about medical bills compared to eight percent of the insured. The uninsured are also less likely to have a regular source of care than the insured, and when they seek care, are more likely to use a health clinic or emergency room. Lack of insurance thus takes a toll on both access to care and the financial well-being of the uninsured.

Moreover, there is a growing body of evidence showing that access and financial well-being are not all that is at stake for the uninsured. There are often serious consequences for those who forgo care. Among the uninsured surveyed, half report a significant loss of time at important life activities, and over half (57%) report a painful temporary disability, while 19 percent report long-term disability as a result. Lack of insurance compromises the health of the uninsured because they receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than the insured (Figure 8). Uninsured adults are less likely to receive preventive health services such as regular mammograms, clinical breast exams, pap tests, and colorectal screening. They have higher cancer mortality rates, in part, because when cancer is diagnosed late in its progression, the survival chances are greatly reduced. Similarly, uninsured persons with heart disease are less likely to undergo diagnostic and revascularization procedures, less likely to be admitted to hospitals with cardiac services, more likely to delay care for chest pain, and have a 25 percent higher in-hospital mortality.

Urban Institute researchers Jack Hadley and John Holahan, drawing from a wide range of studies, conservatively estimate that a reduction in mortality of five to 15 percent could be achieved if the uninsured were to gain continuous health coverage. The Institute of Medicine (IOM) in its analysis of the consequences of lack of insurance estimates that 18,000 Americans die prematurely each year due to the effects of lack of health insurance coverage.

Beyond the direct effects on health, lack of insurance also can compromise earnings of workers and educational attainment of their children. Poor health among adults leads to lower labor force participation, lower work effort in the labor force, and lower earnings. For children, poor health leads to poorer school attendance with both lower school achievement and cognitive development.

These insurance gaps do not solely affect the uninsured themselves, but also affect our communities and society. In 2001, it is estimated that $35 billion in uncompensated care was provided in the health system with government funding accounting for 75 to 80 percent of all uncompensated care funding (Figure 9). The poorer health of the uninsured adds to the health burden of communities because those without insurance often forgo preventive services, putting them at greater risk of communicable diseases. Communities with high rates of the uninsured face increased pressure on their public health and medical resources.

A recent IOM report estimates that in the aggregate the diminished health and shorter life spans of Americans who lack insurance is worth between $65 and $130 billion for each year spent without health insurance (Figure 10). Although they could not quantify the dollar impact, the IOM committee concluded that public programs such as Social Security Disability Insurance and the criminal justice system are likely to have higher budgetary costs than they would if the U.S. population under age 65 were fully insured. A new study by Hadley and Holahan of the Urban Institute suggests that lack of insurance during late middle age leads to significantly poorer health at age 65 and that continuous coverage in middle age could lead to a $10 billion per year savings to Medicare and Medicaid.

## PROSPECTS FOR THE FUTURE

Given the growing consensus that lack of insurance is negatively affecting not only the health of the uninsured, but also the health of the nation, one would expect extending coverage to the uninsured to be a national priority. All indicators point to significant growth in our uninsured population if action is not taken to both broaden and secure coverage.

With the poor economy and rising health care costs, employer-based coverage – the mainstay of our health insurance system – is under increased strain. Health insurance premiums rose nearly 14 percent this year – the third consecutive year of double-digit increases – and a marked contrast to only marginal increases in workers' wages (Figure 11). As a result, workers can expect to pay more for their share of premiums and more out-of-pocket when they obtain care, putting additional stress on limited family budgets. With average family premiums now exceeding $9,000 per year and the workers' contribution to premiums averaging $2,400, the cost of coverage is likely to be increasingly unaffordable for many families, especially low-wage workers. However, for most low-wage workers, especially those in small firms, it is a question of availability, not affordability — because the firms they work in do not offer coverage.

In recent years, with SCHIP enactment and Medicaid expansions, states have made notable progress in broadening outreach, simplifying enrollment processes, and extending coverage to more low-income families (Figure 12). Participation in public programs has helped to reduce the number of uninsured children and demonstrated that outreach and streamlined enrollment can

improve the reach of public programs. However, the combination of the current fiscal situation of states and the downward turn in our economy are beginning to undo the progress we have seen.

From 2001 to 2002, employer-based health insurance coverage declined for low-income adults and children while Medicaid and SCHIP enrollment increased, muting a sharper climb in the number of uninsured. Most notably, while the number of uninsured adults increased, the number of uninsured children remained stable because public coverage helped fill in the gaps resulting from loss of employer coverage (Figure 13). Recent reports of enrollment freezes in SCHIP programs and reductions in Medicaid coverage are troubling.

States are now experiencing the worst fiscal situation they have faced since the end of World War II. Over the last two years, state revenues have fallen faster and further than anyone predicted, creating substantial shortfalls in state budgets. These worsening fiscal pressures mean that state budget shortfalls will reach at least $70 billion in FY2004. At the same time, Medicaid spending has been increasing as health care costs for both the public and private markets have grown and states face growing enrollment in the program, largely as a result of the weak economy. However, even as Medicaid spending grows, revenue shortfalls – not Medicaid – remain the primary cause of state budget shortfalls.

The state revenue falloff is placing enormous pressure on state budgets and endangering states' ability to provide the funds necessary to sustain Medicaid coverage. Turning first to "rainy day" and tobacco settlement funds, states have tried to preserve Medicaid and keep the associated federal dollars in their programs and state economies. But, as the sources of state funds become depleted, states face a daunting challenge in trying to forestall new or deeper cuts in Medicaid spending growth. Earlier this year in the Jobs and Growth Tax Relief Reconciliation Act, Congress provided $20 billion in state fiscal relief, including an estimated $10 billion through a temporary increase in the federal Medicaid matching rate. This has helped states avoid making deeper reductions in their Medicaid spending growth. However, this fiscal relief will expire next year, and it seems unlikely that states' fiscal conditions will substantially improve by then.

Because Medicaid is the second largest item in most state budgets after education, cuts in the program appear inevitable – in the absence of new revenue sources – as states seek to balance their budgets. Indeed, survey data the Kaiser Commission on Medicaid and the Uninsured released at the end of September indicates that every state and the District of Columbia put new Medicaid cost containment strategies in place in fiscal year 2003, and all of these states planned to take additional cost containment action in fiscal year 2004 (Figure 14).

States have continued to aggressively pursue a variety of cost containment strategies, including reducing provider payments, placing new limits on prescription drug use and payments, and adopting disease management strategies and trying to better manage high-cost cases. However, the pressure to reduce Medicaid spending growth further has led many states to turn to eligibility and benefit reductions as well as increased cost-sharing for beneficiaries. Although in many cases these reductions have been targeted fairly narrowly, some states have found it necessary to make deeper reductions, affecting tens of thousands of people.

The fiscal situation in the states jeopardizes not only Medicaid's role as the health insurer of low-income families, but also its broader role as the health and long-term assistance program for the elderly and people with disabilities. Although children account for half of Medicaid's 51 million enrollees, they account for only 18 percent of Medicaid spending (Figure 15). It is the low-income elderly and disabled population that account for most of Medicaid spending — they represent a quarter of the beneficiaries, but account for 70 percent of all spending because of their greater health needs and dependence on Medicaid for assistance with long-term care. Most of the growth (60%) in Medicaid spending between 2000 and 2002 was attributable to elderly and disabled beneficiaries, reflecting their high use of prescription drugs – the fastest growing component of Medicaid spending – and long-term care, where the bulk of spending on these group goes (Figure 16). These are all areas in which states will find it difficult to achieve painless reductions and understandably areas where states are seeking more direct federal assistance, especially with the costs associated with the elderly and disabled who are covered through both Medicare and Medicaid (the dual eligibles).

## CONCLUSION

Looking ahead, it is hard to see how we will be able to continue to make progress in expanding coverage to the uninsured or even maintaining the coverage Medicaid now provides. The latest statistics on the uninsured from the Census Bureau show that lack of health coverage is a growing problem for millions of American families. The poor economy combined with rising health care costs make further declines in employer-sponsored coverage likely. The state fiscal situation combined with rising federal deficits complicate any efforts at reform. In the absence of additional federal assistance, the fiscal crisis at the state level is likely to compromise even the ability to maintain coverage through public programs. Although Medicaid has demonstrated success as a source of health coverage for low-income Americans and a critical resource for those with serious health and long-term care needs, that role is now in jeopardy.

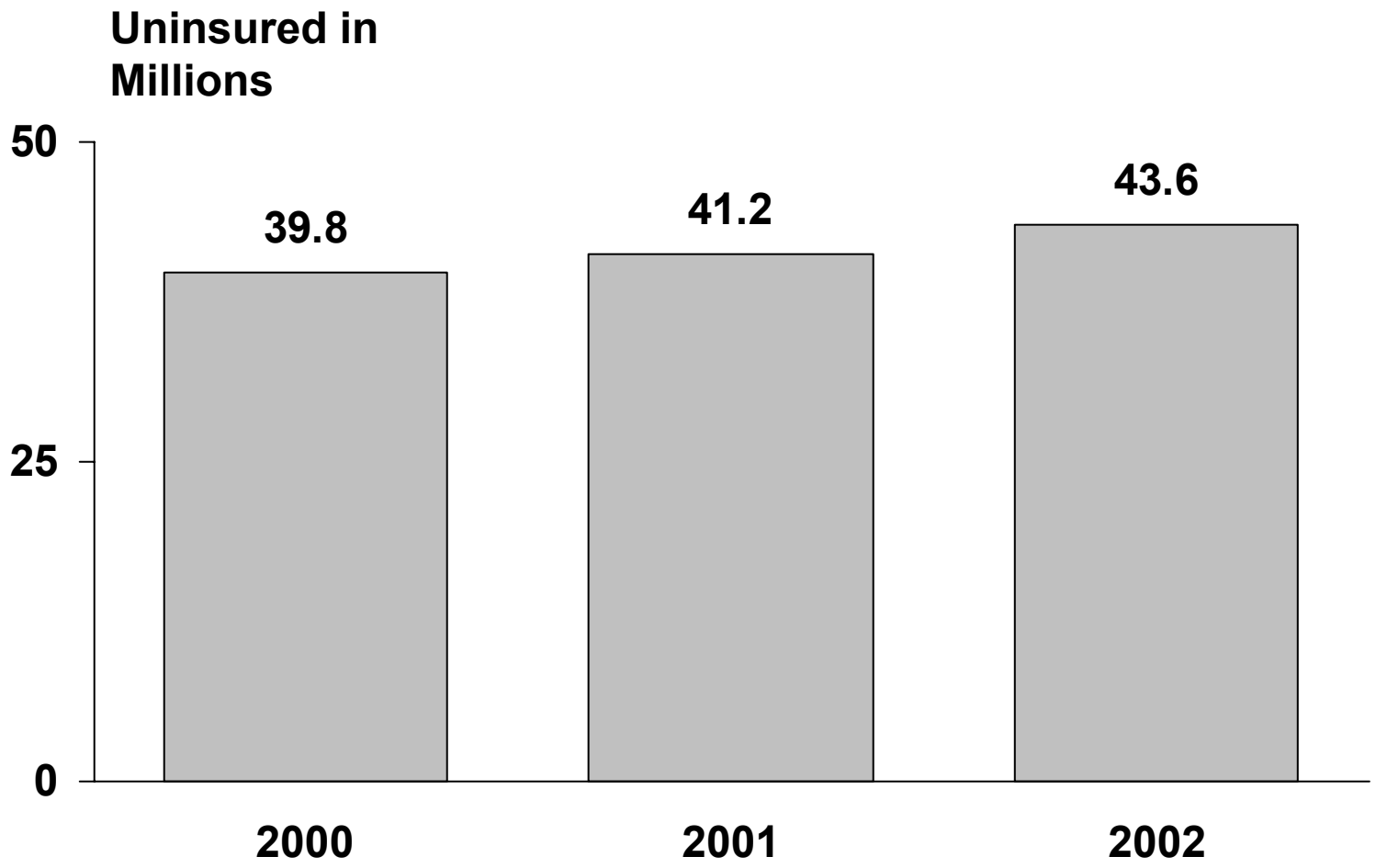
Assuring the stability and adequacy of financing to meet the needs of America's most vulnerable and addressing our growing uninsured population ought to be among the nation's highest priorities. Maintaining the coverage now provided through Medicaid and SCHIP and building on that foundation to extend coverage to more of the low-income uninsured population provides both a tested and cost-effective approach to reducing the number of uninsured Americans. But, like all solutions to the uninsured, this too requires additional resources and given the fiscal straits of the states, undoubtedly means a greater commitment of federal support to address this national problem.

I commend your efforts to highlight the plight of the 43 million Americans without health insurance coverage and to identify options that could help address this growing problem. I look forward to working with you to meet the challenge of making health care coverage a reality for all Americans.

Thank you for the opportunity to testify today. I welcome any questions.

Figure 1

# Number of Uninsured Americans, 2000-2002




SOURCE: U.S. Census Bureau, 2003 Current Population Survey. Estimates based on total population.

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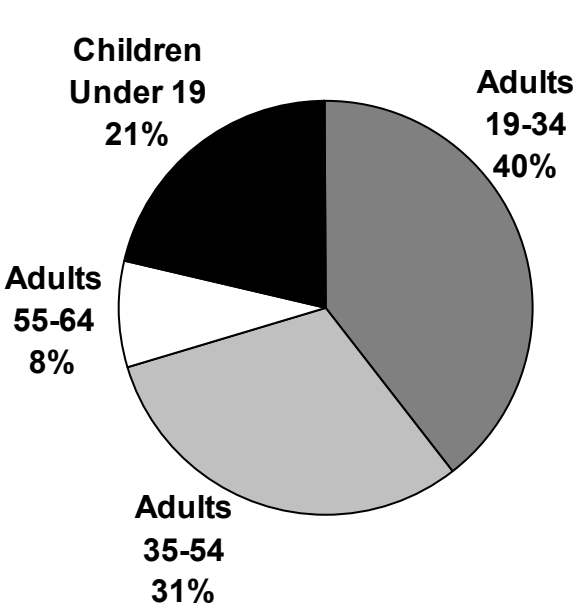
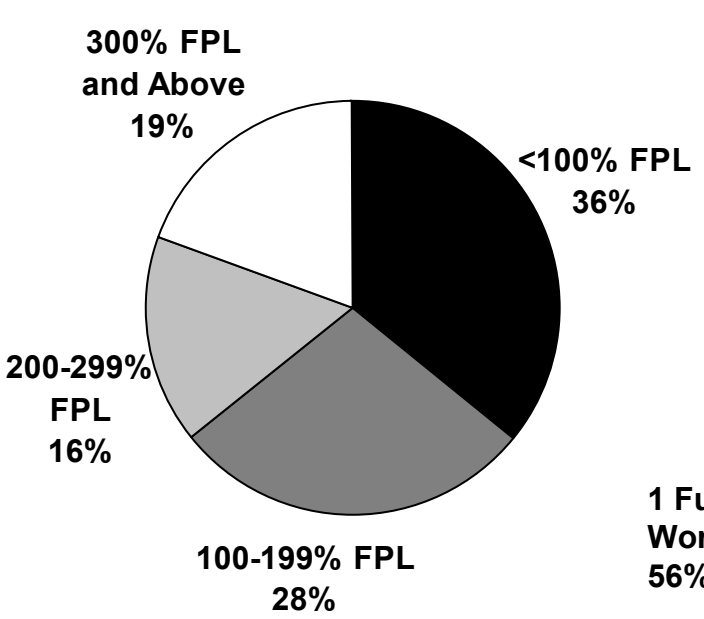
Figure 2

# Characteristics of the Uninsured, 2002

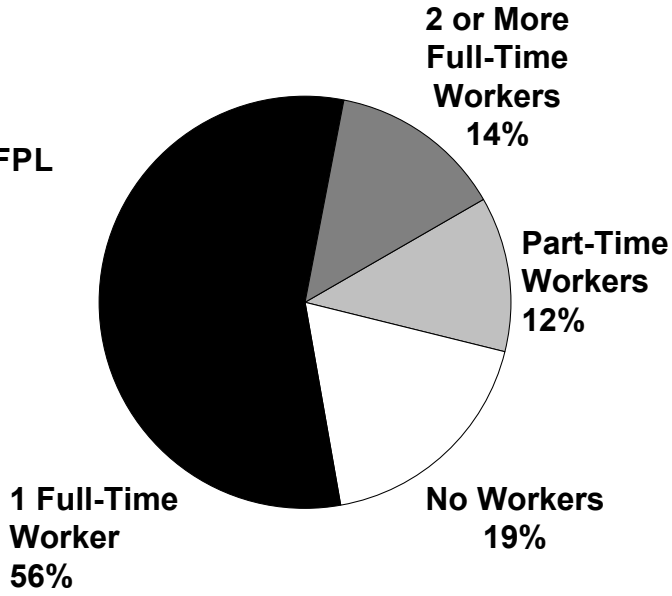
## Age




## Income




## Work Status




**Total = 43.3 million uninsured**

Note: Percentages may not total 100% due to rounding.
SOURCE: KCMU and Urban Institute analysis of the March 2003 Current Population Survey.

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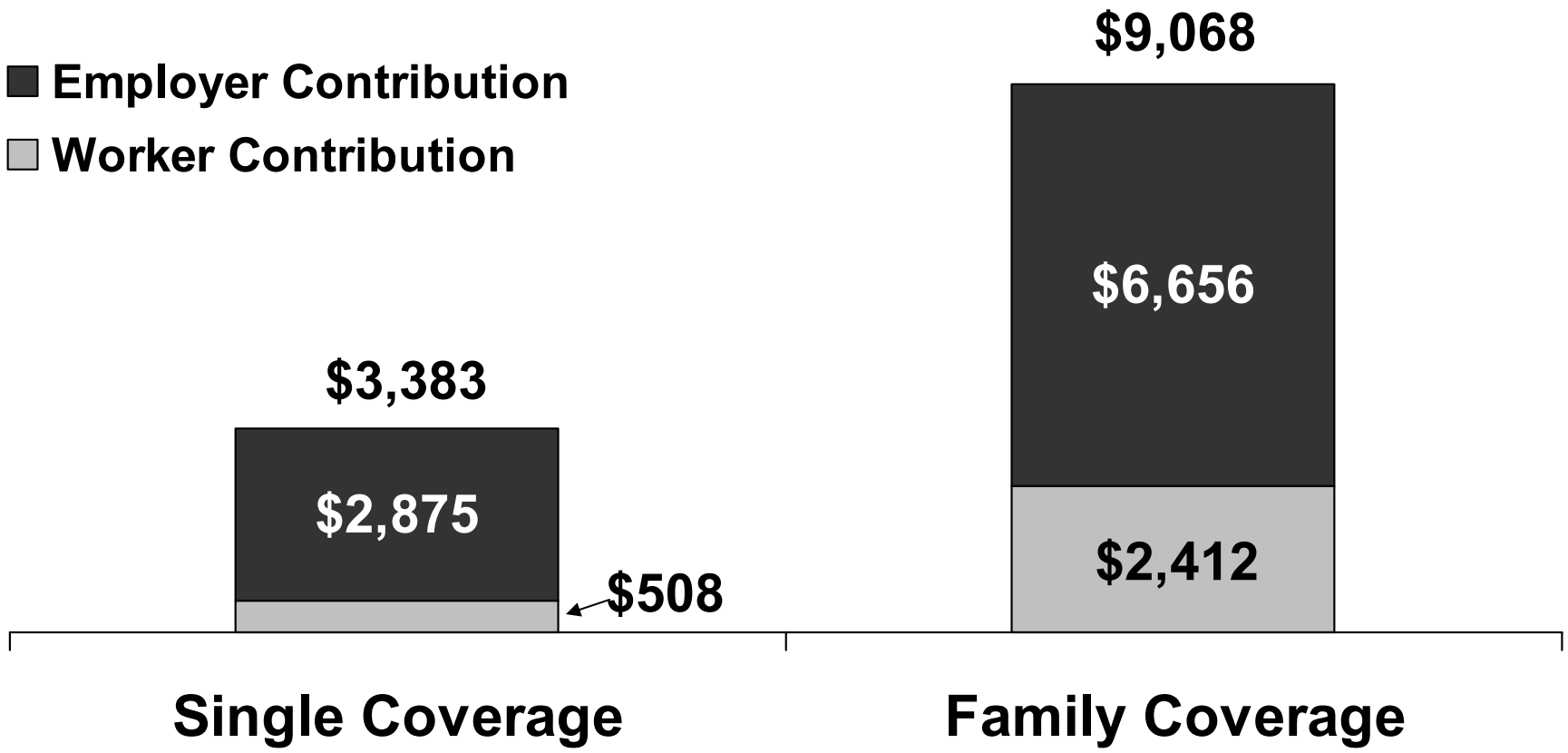
Figure 3

# Average Annual Premium Costs for Covered Workers, 2003




SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003.

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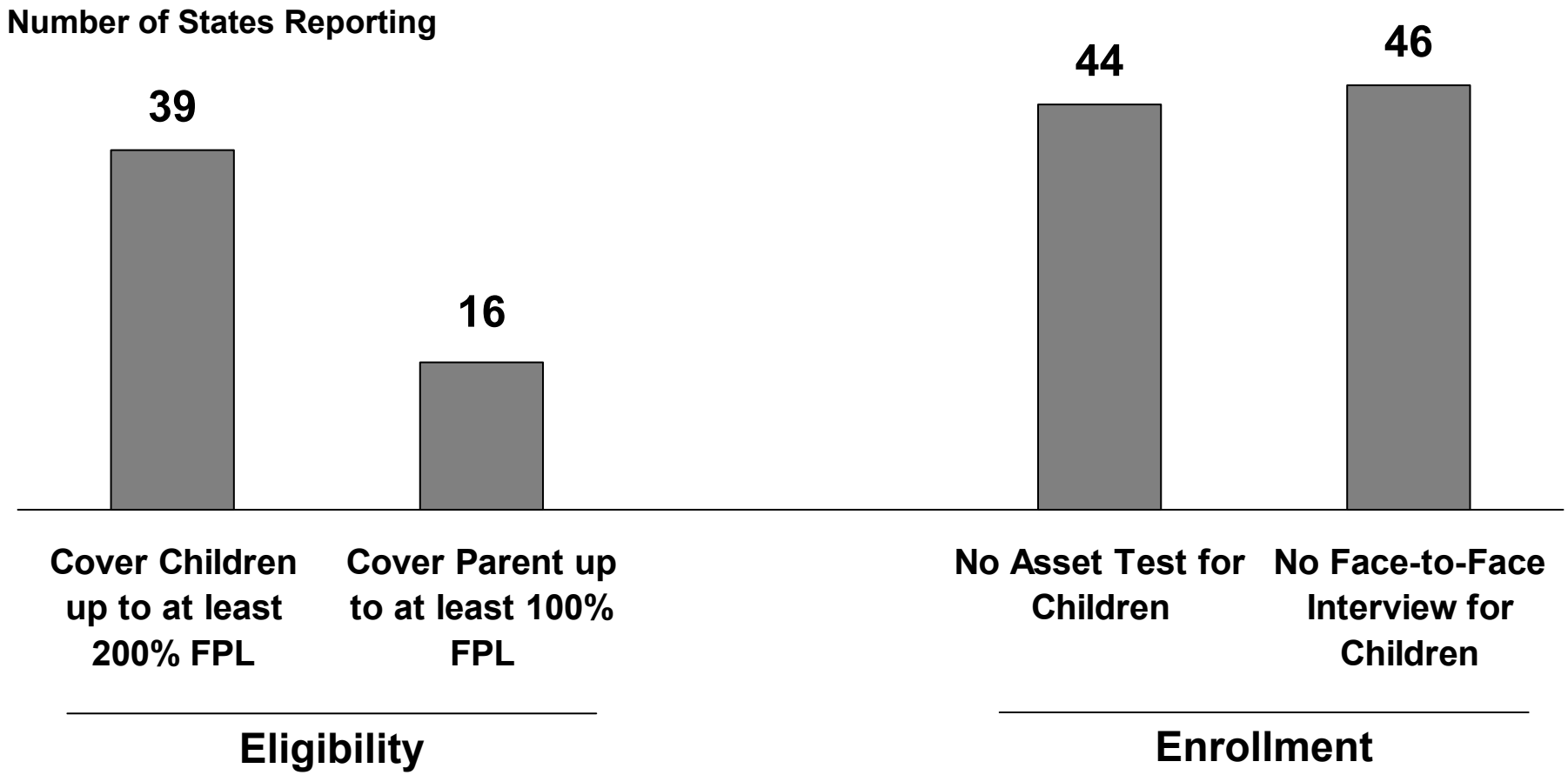
Figure 4

# Improvements in Medicaid and CHIP Coverage, April 2003




SOURCE: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, July 2003.

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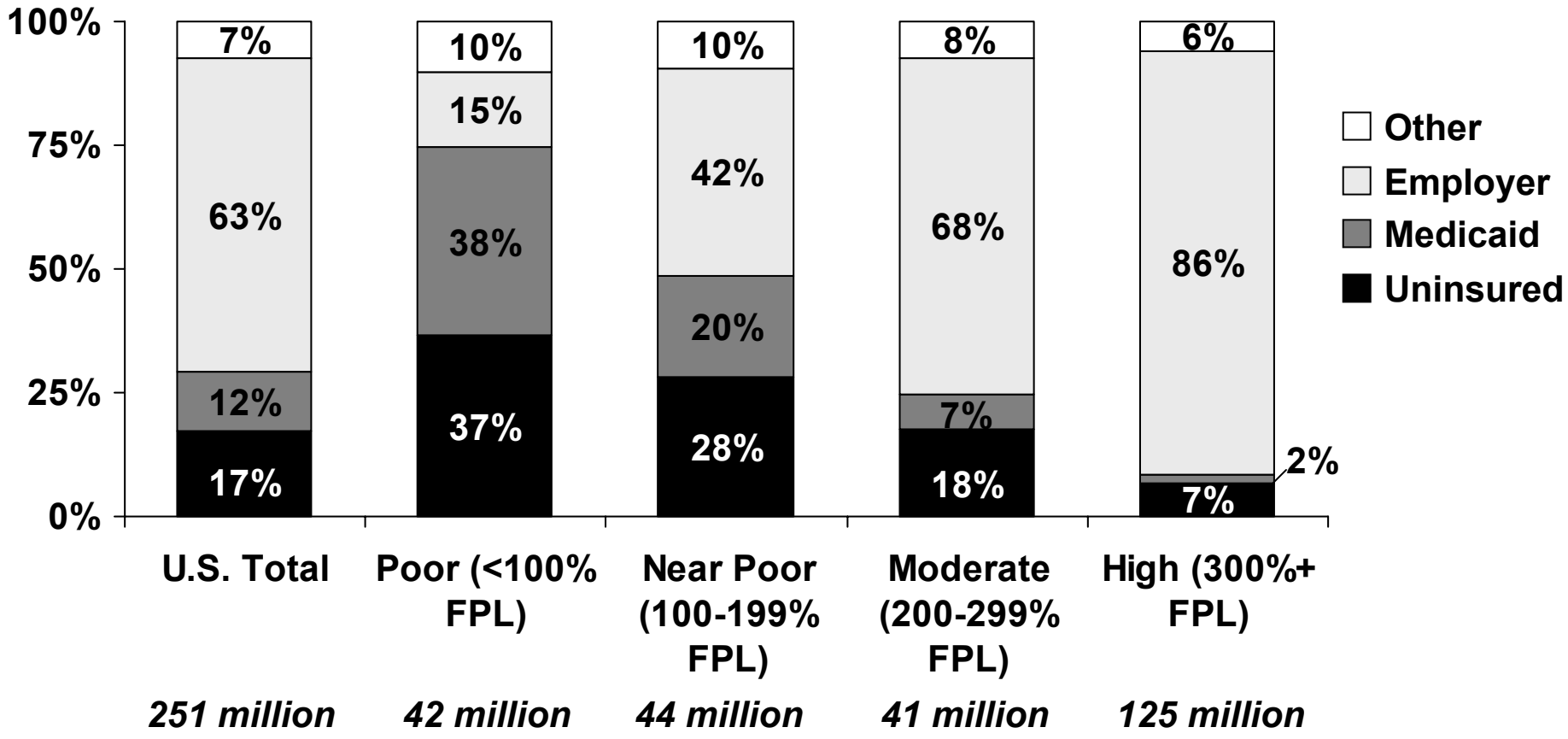
Figure 5

# Health Insurance Coverage by Poverty Level, 2002




Notes: The federal poverty level was $14,348 for a family of three in 2002.
Percentages may not total 100% due to rounding.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of the 2003 Current Population Survey.

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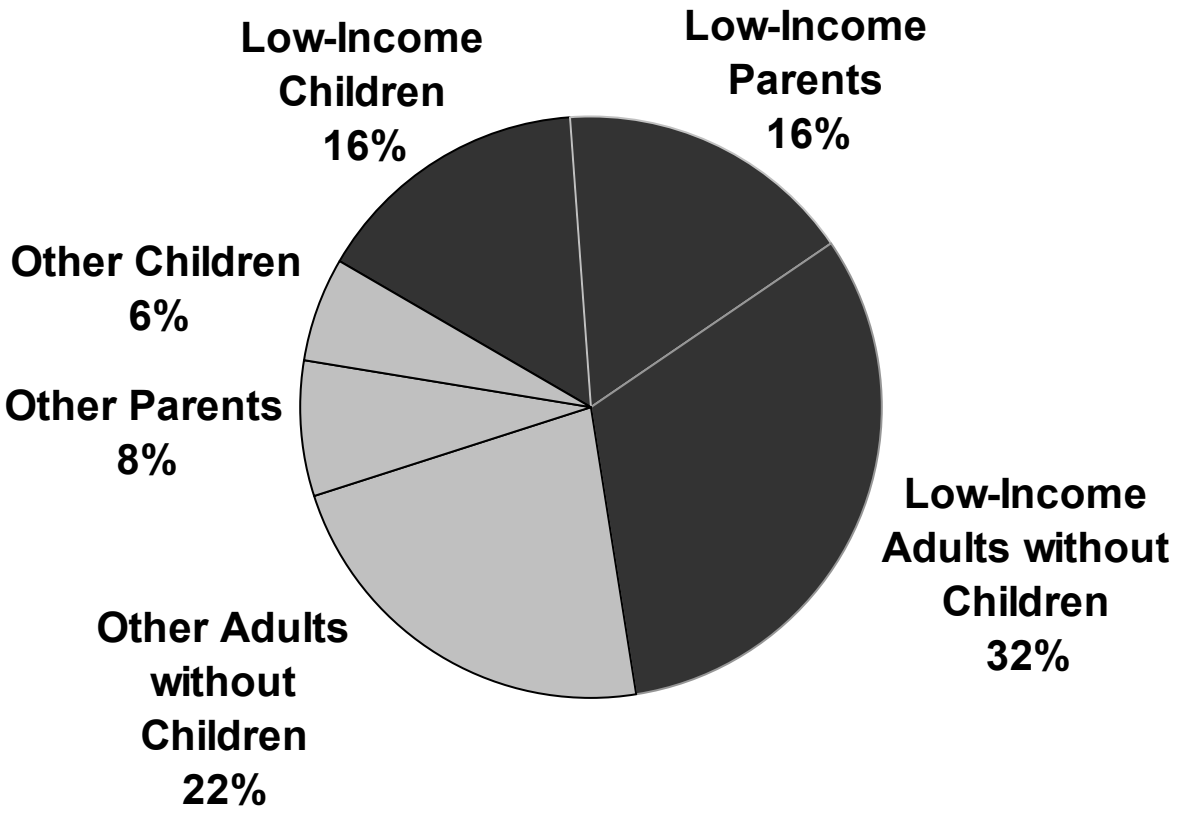
Figure 6

# The Nonelderly Uninsured, by Age and Income Groups, 2002

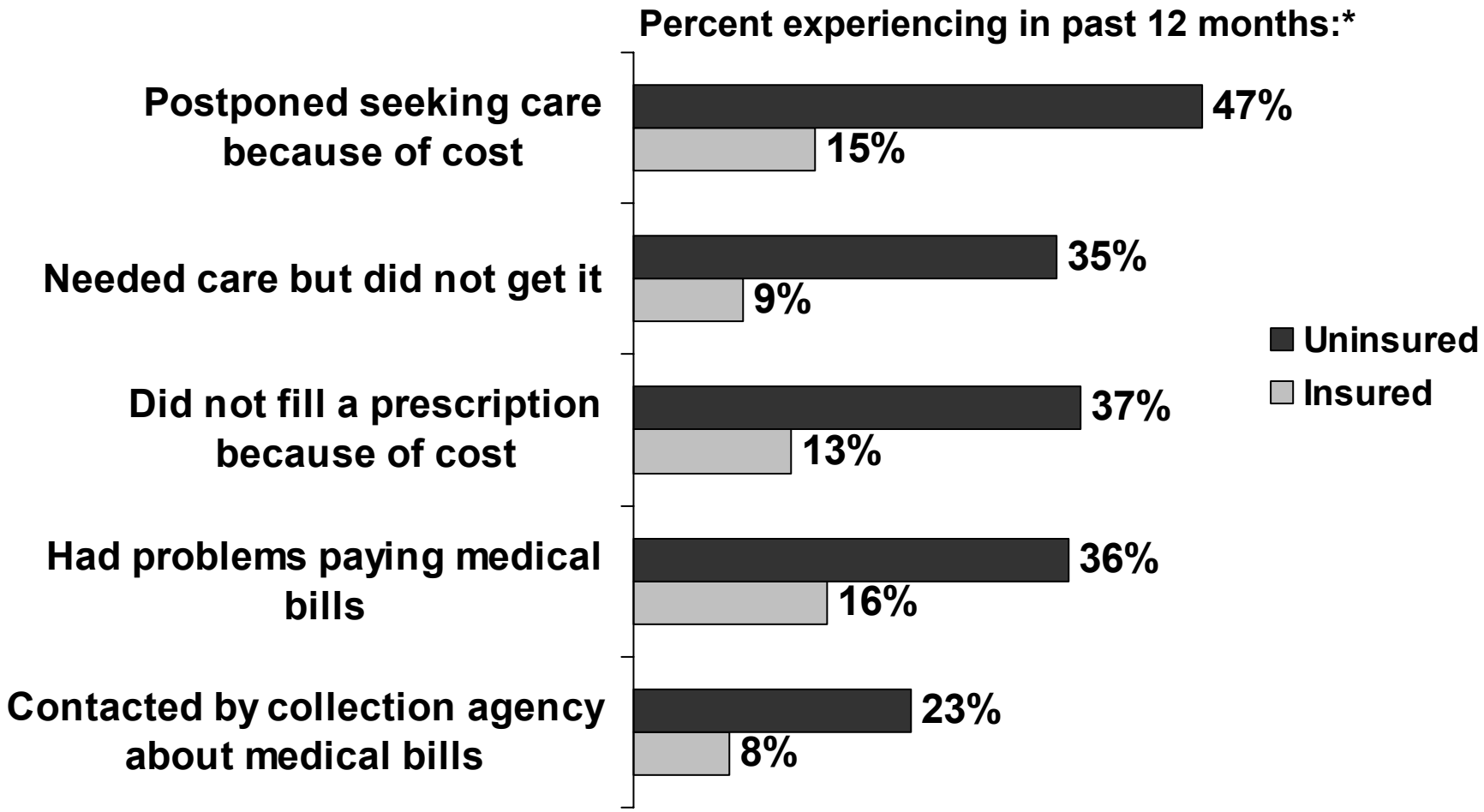



**Total = 43.3 million**

SOURCE: KCMU and Urban Institute analysis of the March 2003 Current Population Survey.

Figure 7

# Barriers to Health Care by Insurance Status, 2003




Notes: *Experienced by the respondent or a member of their family.
Insured includes those covered by public or private health insurance.

Source: Kaiser Family Foundation, *Kaiser 2003 Health Insurance Survey*.

# The Consequences of Being Uninsured

**Research demonstrates that the uninsured:**

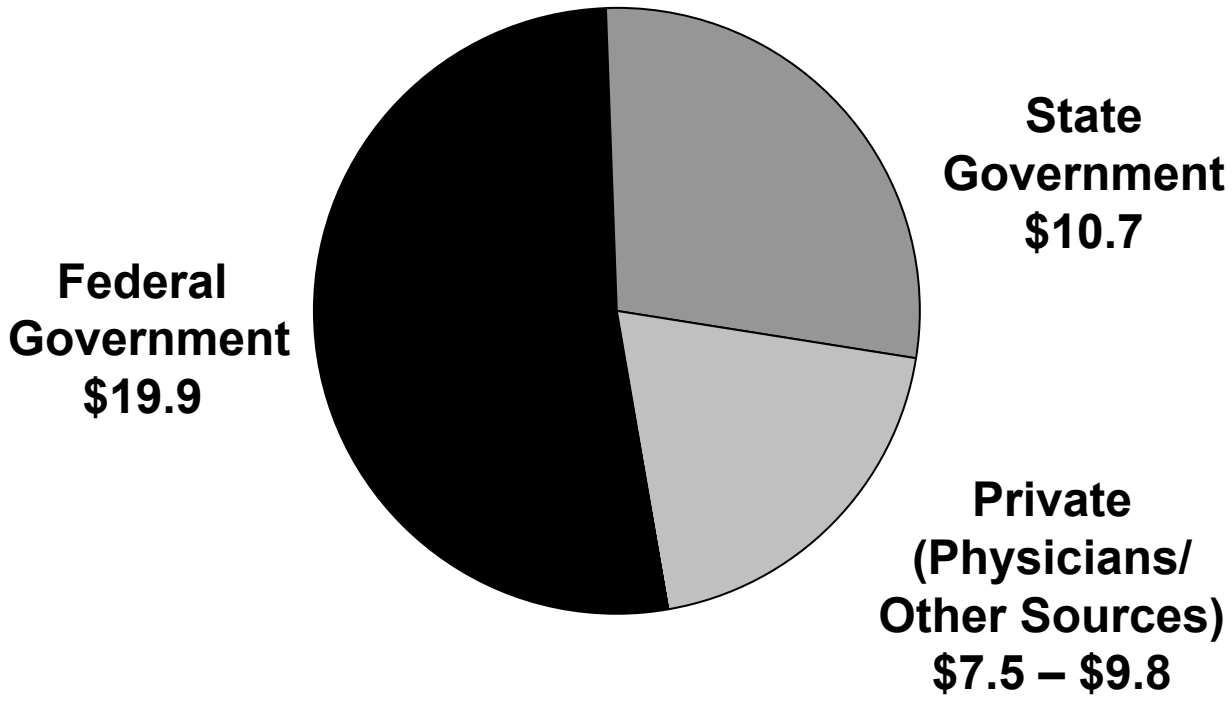
- **use fewer preventive and screening services;**
- **are sicker when diagnosed;**
- **receive fewer therapeutic services;**
- **have poorer health outcomes (higher mortality and disability rates); and**
- **have lower annual earnings because of poorer health.**

SOURCE: Hadley, Jack. "Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* (60:2), June 2003.

Figure 9

# Sources of Funding Available for Uncompensated Care, 2001

(in billions)




**Total = $38.1 – 40.4 Billion**

SOURCE: Hadley and Holahan, February 2003.

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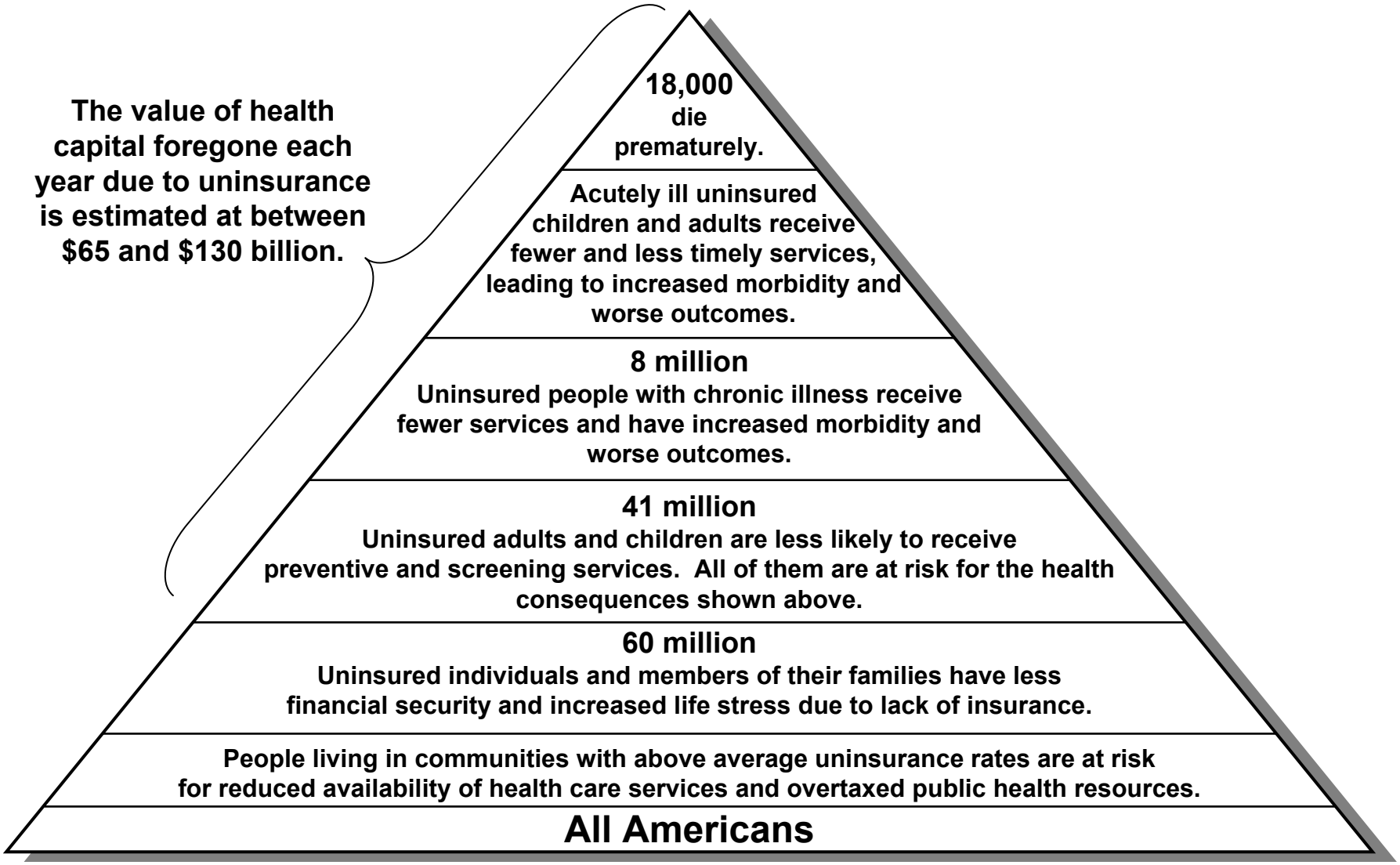
Figure 10

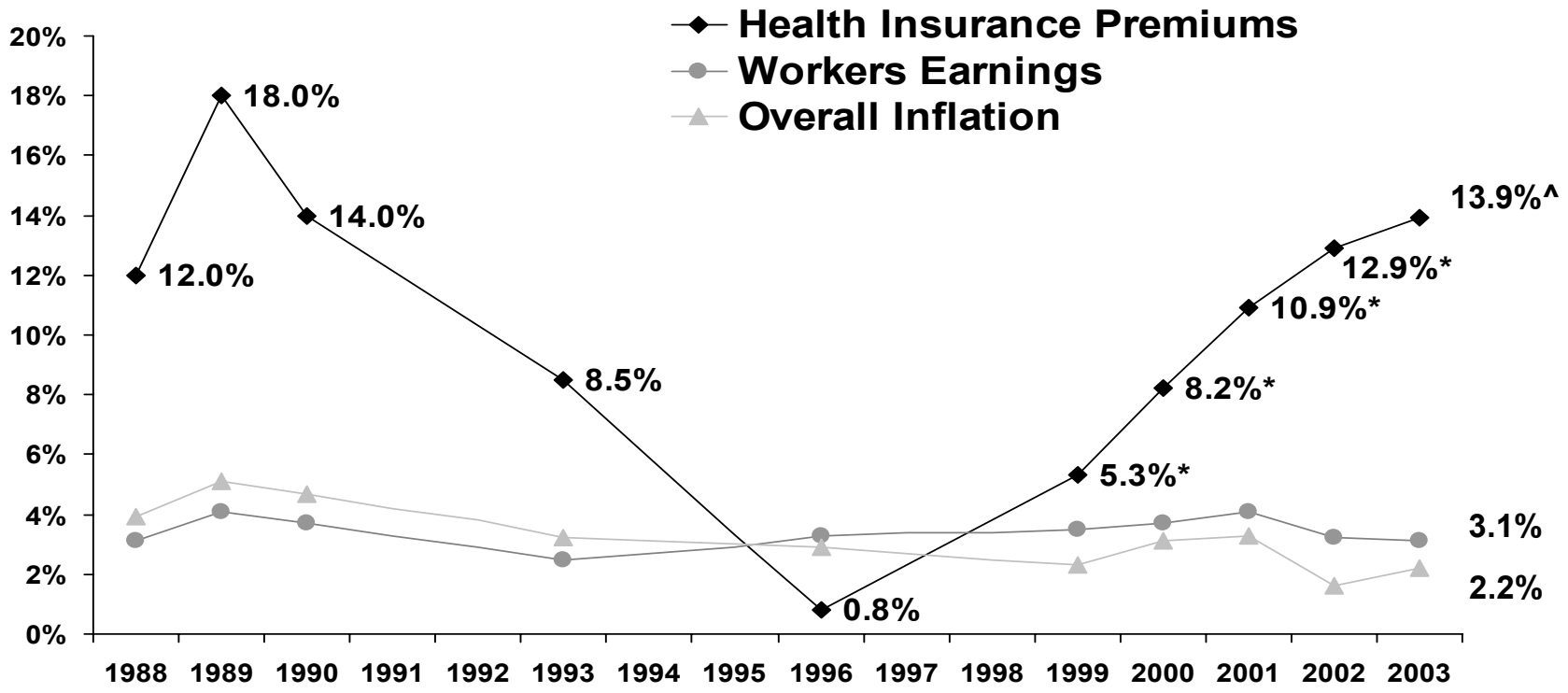
# The Consequences of Uninsurance




SOURCE: Institute of Medicine, *Hidden Costs, Value Lost*, June 2003.

Figure 11

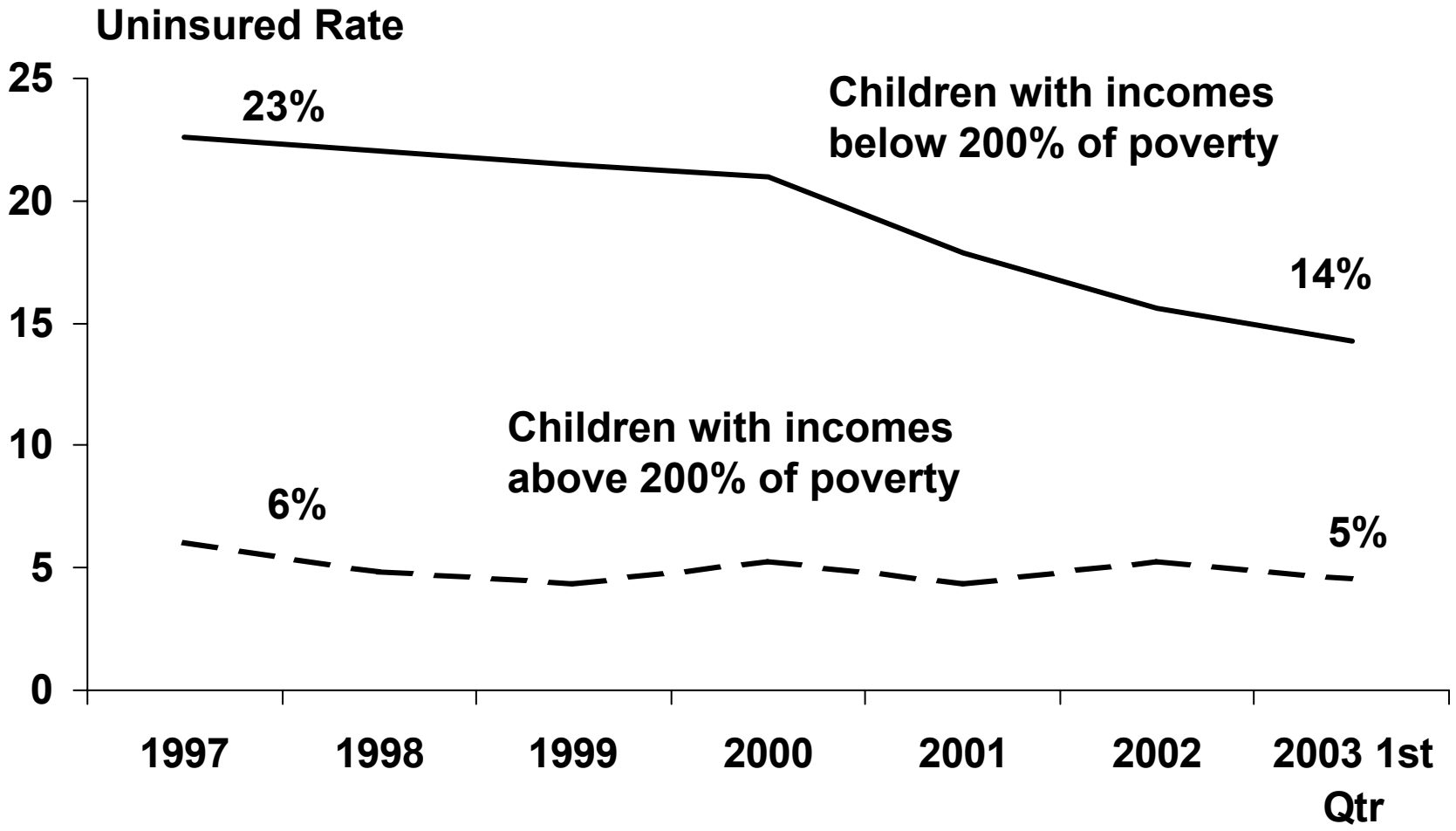
# Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003




Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four.
*Estimate is statistically different from the previous year shown at p<0.05: 1996-1999, 1999-2000, 2000-2001, 2001-2002.
^ Estimate is statistically different from the previous year shown at p<0.1: 2002-2003.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America: 1988, 1989, 1990.

Figure 12

# Trends in the Uninsured Rate of Children, by Income Level

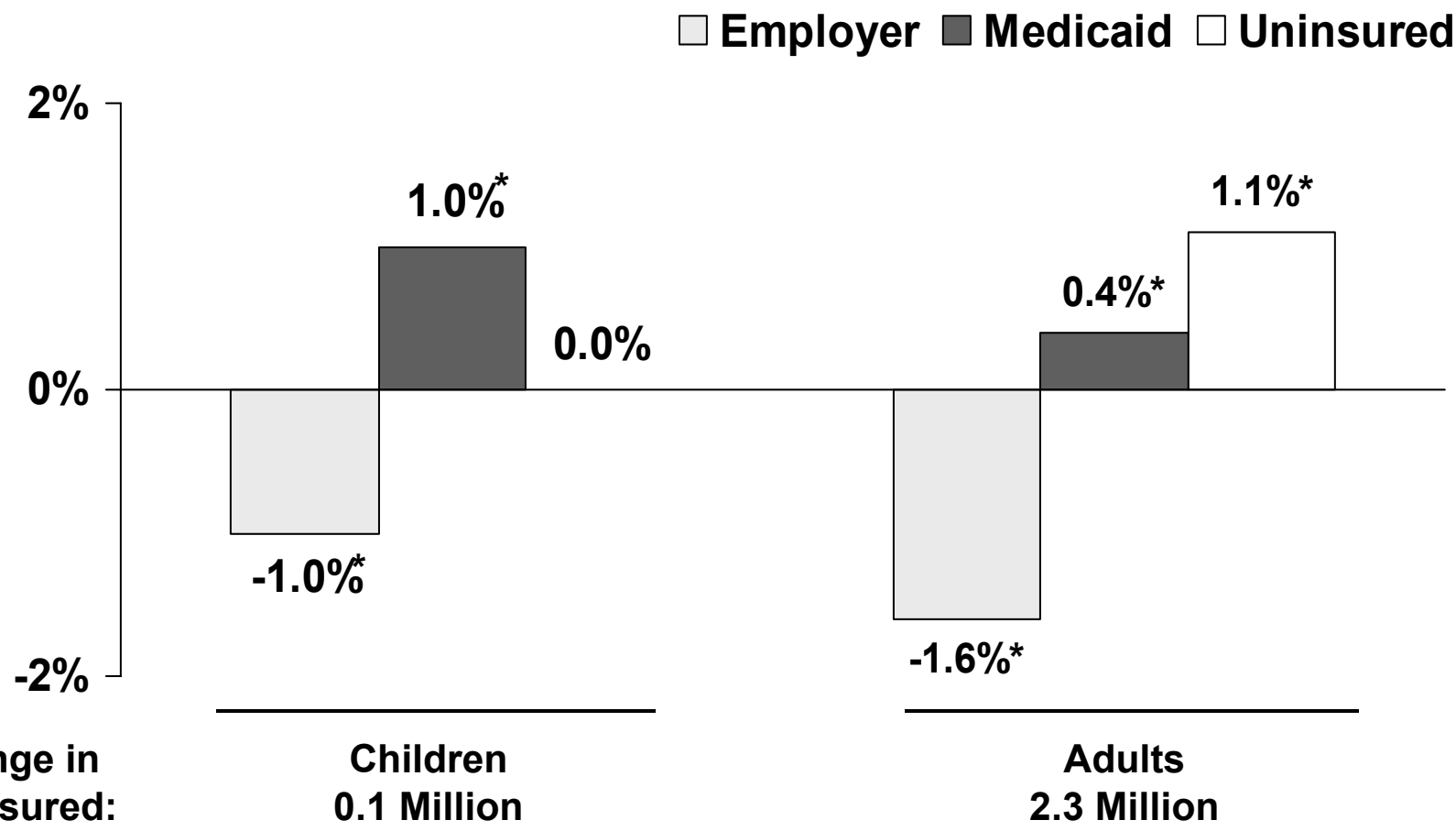



SOURCE: Center on Budget and Policy Priorities analysis of NHIS data.

Figure 13

# Changes in Health Insurance Coverage, Children vs. Adults, 2001-2002

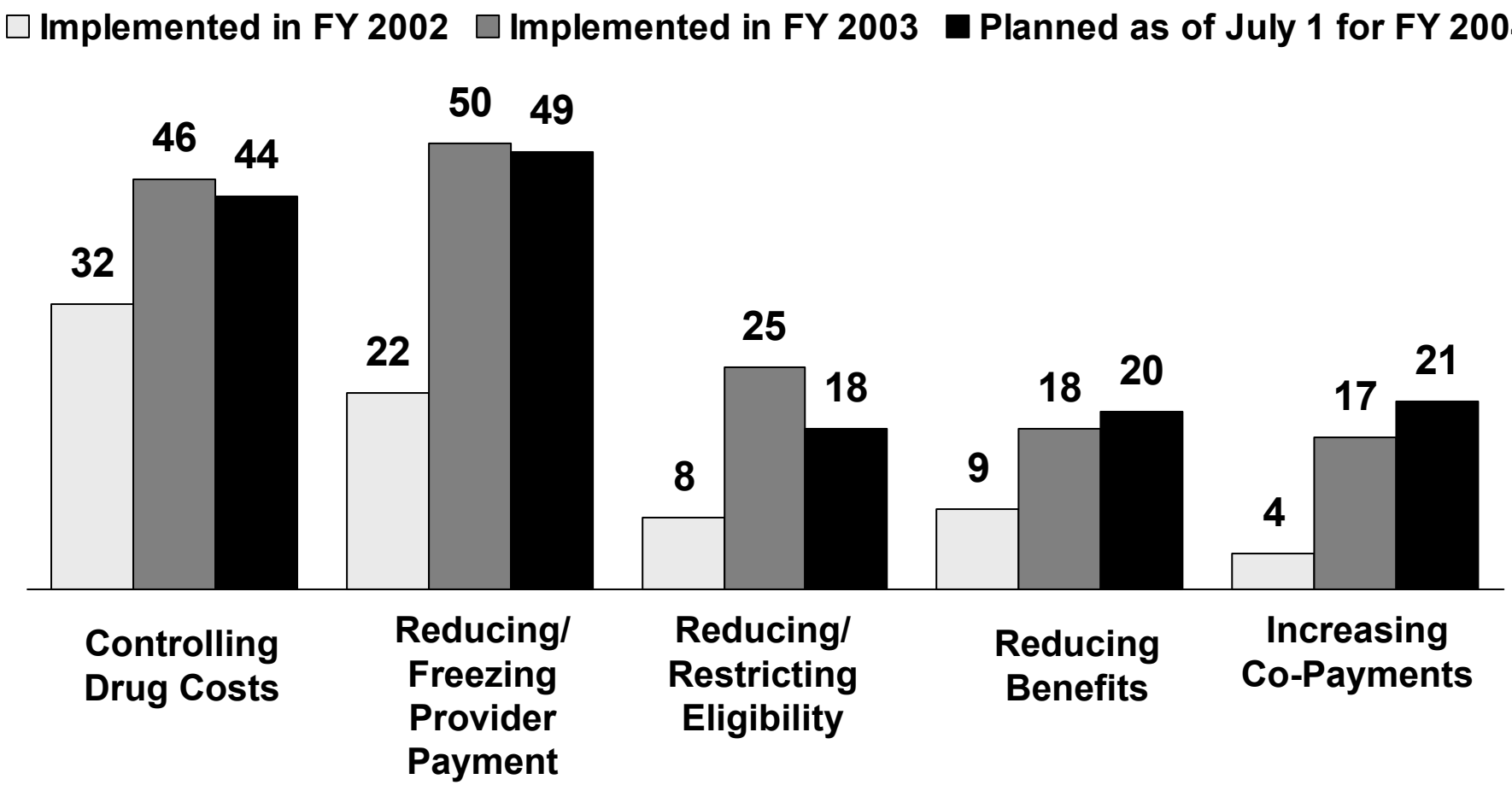
**(Percentage Point Differences)**




Notes: * Statistically significant change between 2001 and 2002 (p<.10)
Medicaid also includes SCHIP, other state programs, Medicare and military-related coverage.
SOURCE: KCMU and Urban Institute analysis of March Current Population Survey, 2002 and 2003.

Figure 14

# States Undertaking Medicaid Cost Containment Strategies FY 2002 - FY 2004




SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and September 2003.

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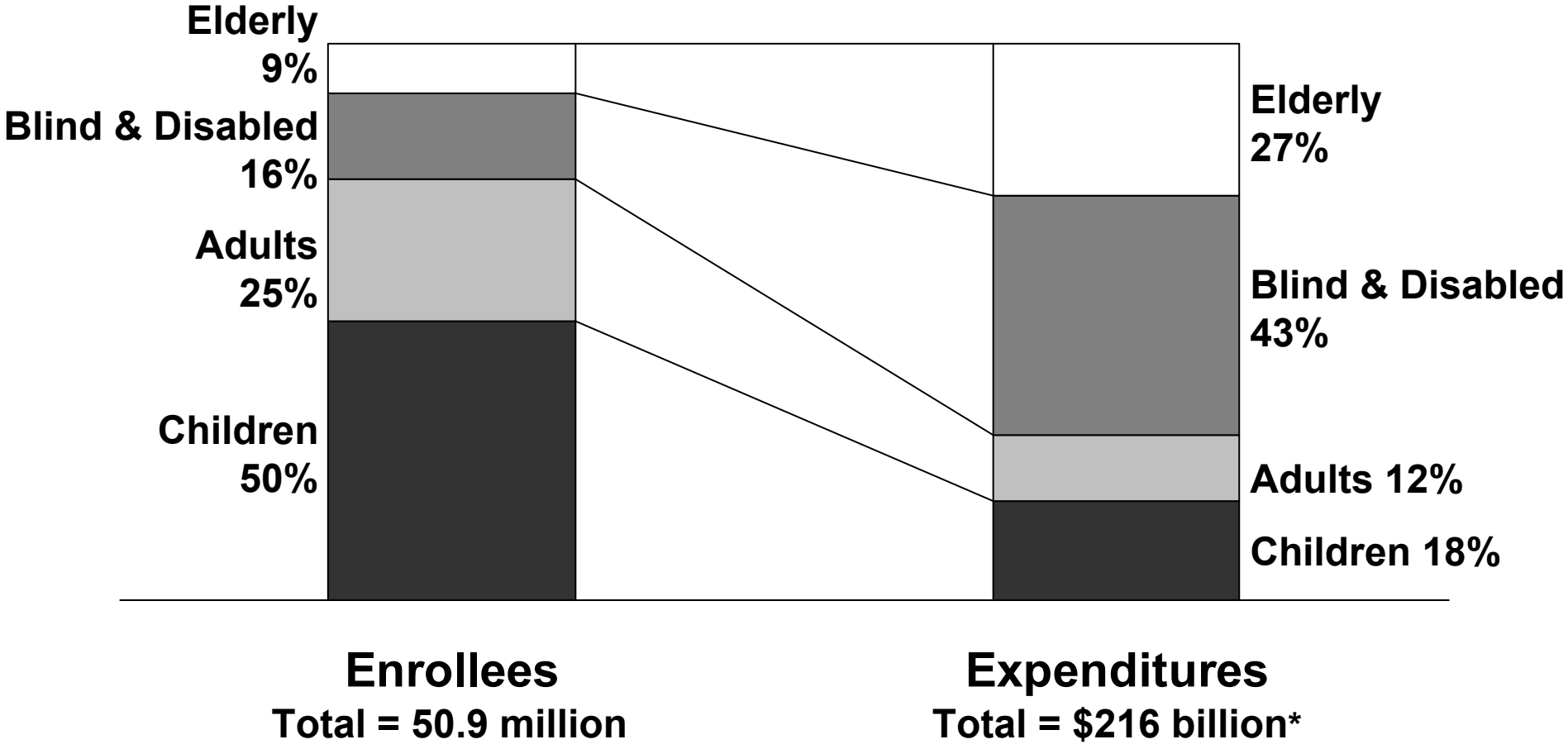
Figure 15

# Medicaid Enrollees and Expenditures by Enrollment Group, 2002

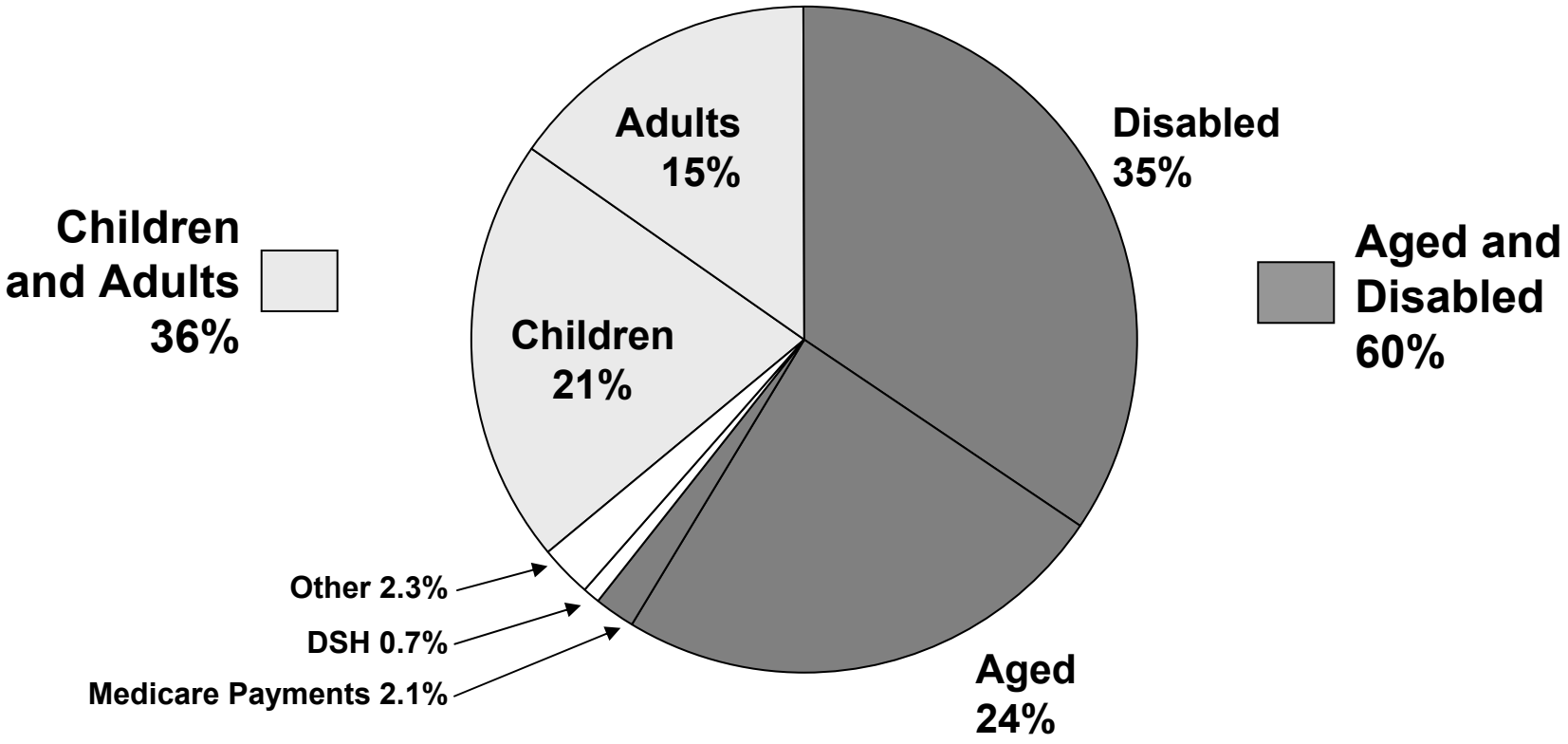



Expenditure distribution based on CBO data that includes only spending on services and excludes DSH, supplemental provider payments, vaccines for children, and administration.

SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2003.

Figure 16

# Contributors to Medicaid Expenditure Growth by Enrollment Group, 2000-2002




SOURCE: Estimates for KCMU prepared by the Urban Institute, 2003.