

medicaid
and the uninsured

Medical Debt and Access to Health Care

Prepared by

Catherine Hoffman

Diane Rowland

Elizabeth C. Hamel

September 2005

kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

James R. Tallon
Chairman

Diane Rowland, Sc.D.
Executive Director

kaiser
commission on
medicaid
and the **uninsured**

Medical Debt and Access to Health Care

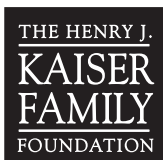
Prepared by

Catherine Hoffman

Diane Rowland

Elizabeth C. Hamel

September 2005



Medical Debt and Access to Health Care

Executive Summary

Health insurance alone is no longer a guarantee of financial protection from the costs of health care for many. Today's higher premiums, deductibles, and copayments can create a substantial financial burden for families and many learn only through an unexpected serious injury or illness that they are not well protected financially. Earlier studies document a large group of Americans who have problems paying their medical bills, i.e. have medical debt. But does medical debt affect a person's decisions about whether to and when to access needed health care services?

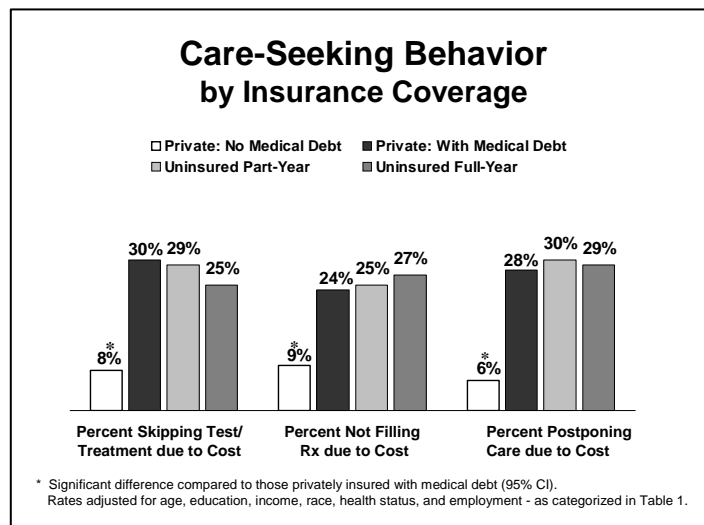
In this study, we examined the privately insured who have had problems paying medical bills and compare their access to care to those who have not had medical bill problems as well as those with no health coverage at all. Using a nationally representative survey of nonelderly adults (the Kaiser Family Foundation's 2003 Health Insurance Survey), we found that one in six adults who are privately insured—17.6 million adults—report having substantial problems paying their medical bills. Added to the 22.9 million adults who were uninsured for the full year preceding the survey and another 17.6 million uninsured for part of the preceding year, a total of over 58 million adults in this country are at higher risk of incurring medical bills they may not be able to afford.

Privately insured adults with medical debt are largely from middle-class families, not as poor as the uninsured, but not as well-off as the privately insured who have no medical debt. The large majority hold full-time jobs. An important difference between the privately insured with vs.

without medical debt is their health status. Those with medical debt are more than twice as likely to report being in only fair or poor health and they are almost twice as likely to have an ongoing or serious health problem compared to others with private coverage (38% vs. 21%).

Having medical debt was associated with a substantial decrease in their access to health care. While they were just as likely as other privately insured adults to have a medical home (i.e., having a regular source of care and having seen a doctor in the past year) decisions to seek health care were markedly different, including their decisions to postpone and forgo care, as well as skip treatments and prescriptions. In many ways, care-seeking patterns among those with private coverage but having problems paying their medical bills resembled those of the uninsured. Even after adjusting for factors that might explain the differences, compared to others with private coverage, those who were privately insured with medical debt:

- were more than three times as likely to have skipped a recommended test or treatment because of its cost (30% vs. 8%; 25% for the uninsured)
- were more than twice as likely to have failed to fill a drug prescription due to cost (24% vs. 9%; 27% for the uninsured) and
- were four times more likely to postpone care due to cost (28% vs. 6%; 29% for the uninsured).



The privately insured with medical debt were just as likely as others with private coverage to have employer-sponsored health insurance as opposed to coverage under an individual (nongroup) health plan. However, they did have fewer benefits in their health plans than others with private coverage. Perhaps not surprising, the majority of those with medical debt reported underestimating what their health plan would pay towards their medical bills (vs. a third of those without sizable medical debt) and nearly half said their plan had not paid anything for care they thought had been covered.

If current trends in greater cost-sharing continue, more low- and middle-income families with private insurance, particularly those who are in less than good health, will not have the same access to care as others with private coverage who have higher incomes. In fact, as this study shows, they will limit their care in many of the same ways and as often as those who have no health insurance at all. Financial barriers to care are not limited to the uninsured, but affect the care-seeking decisions of even those who are privately insured and have a medical home. Health insurance reforms will need to build in subsidies for both premium and out-of-pocket costs relative to family incomes if improved access to care is to be realized.

Medical Debt and Access to Health Care

At the margin of policy debates about the growing number of uninsured Americans are mounting concerns about the adequacy of health insurance for those who do have health coverage. What it means to have health insurance has changed considerably, as premiums, cost-sharing requirements, and limits on benefits have increased the amounts that individuals and families must pay out-of-pocket themselves even with “good” health plans.¹

Health insurance alone is no longer a guarantee of financial protection from the high costs of health care for many. Consumers weigh how much insurance they expect to need vs. how much they can afford—and choose from a wide range of financial risk with little knowledge of the costs of health services they’ve never used.² The difficulty of these choices leaves many underinsured, some of whom will later learn through an unexpected illness that they are not well protected financially.

The cost of health services, drugs, and supplies can be a substantial financial burden, even when a person has health insurance. Blendon and colleagues found that three-quarters of all adults who have problems paying medical bills are insured; over half have some form of private coverage.³ Selden and Banthin found that nearly a quarter (23%) of the elderly Medicare population faced financial burdens from health care exceeding 20% of their income.⁴

High medical bills impact the financial stability of even insured families, and recently researchers have begun to describe how these bills affect future health choices and decisions to seek care, given that a person has health coverage.^{5,6} In this analysis, we examine those who are

privately insured but do not have adequate financial protection—defined as those who have had problems paying medical bills—and compare their access to care to both the uninsured and those with private insurance who have not had problems paying their medical bills.

Data and Methods

Data were obtained from the Kaiser Family Foundation 2003 Health Insurance Survey, a survey designed to examine both health insurance preferences and access to health care. A nationally representative sample of 2,507 nonelderly adults (ages 18 to 64) in the continental United States was selected and interviewed by telephone, either in English or Spanish as needed.

Kaiser Family Foundation 2003 Health Insurance Survey

The questionnaire was developed collaboratively between the authors and Princeton Survey Research Associates (PSRA), following a series of 8 focus groups held in 4 cities across the country (Philadelphia, PA; Charlotte, NC; Denver, CO; and Peoria, IL) structured to gain a better understanding of public views on health insurance coverage. Content covered in the questionnaire included: health insurance coverage in the past year, views on employer-sponsored insurance (ESI), priorities in benefit packages, attitudes towards new ESI products, medical bill burden, and measures of access to health care. The questionnaire was pretested to judge how well respondents understood the questions, with changes made to the final instrument accordingly.

PSRA conducted interviews between April 30 and July 20, 2003. The response rate for the survey was 50%, measured as the proportion of all eligible respondents in the sample that were ultimately interviewed. It is calculated by taking the product of three components: the contact rate, the cooperation rate, and the completion rate. The contact rate is the proportion of working numbers where a request for an interview was made (88%); the cooperation rate is the proportion of contacted numbers where a consent for an interview was at least initially obtained (61%); and the completion rate is the proportion of initially cooperating and eligible interviews that were completed (93%).

The telephone sample was drawn using standard random digit dialing methodology. This list-assisted random method guaranteed coverage of every assigned phone number regardless of whether that number was directory listed, purposely unlisted, or too new to be listed; business numbers were purged. Interviews were conducted using a systematic respondent selection technique in order to produce samples that closely mirror the population in terms of age and gender. The sample design effect for this survey was 1.26. The sample was weighted using a sample-balancing program to ensure that the demographic characteristics of the sample closely approximated those of the national population of nonelderly adults.

Defining Medical Bill Problems. Privately insured respondents were classified as having high medical debt if they had private insurance at the time of the survey and had been covered continuously in the preceding 12 months and also reported at least one of the following:

- they rated the degree of difficulty paying for health care costs (including health insurance premiums and all other out-of-pocket costs) as “very difficult”;
- their problems paying medical bills in the past year had a major impact on them (and their family if appropriate);
- they had changed their way of life significantly in order to pay medical bills in the past year; and/or
- they had been contacted (or another household family member was contacted) by a collection agency about owing money for medical bills in the past year.

Access to Care Measures. The survey asked three questions concerning continuity of medical care: did the respondent have a regular place to go when sick or needed medical advice, at what type of health care place did the respondent usually receive care, and whether the respondent had visited a doctor in the past year. Care-seeking choices in the past year (made personally or by any household family members if appropriate) were assessed by asking: 1) if they needed medical care but did not get it and 2) if they put off or postponed seeking needed care because of the cost. In addition, respondents were asked because of the cost, whether they (or another household family member) had skipped a recommended medical test or treatment, not filled a prescription, or had problems getting mental health care (each question asked separately).

Insurance Groups. We categorized respondents into four insurance groups:

- 1) privately insured for the past full year with no substantial problems paying medical bills,
- 2) privately insured for the past full year with substantial medical bill problems—that we will refer to in this paper as having medical debt,
- 3) uninsured for part of the year, remainder of the year either privately or publicly insured, and
- 4) uninsured for the full year.

Demographic characteristics and access to care measures were compared across all four insurance groups. Characteristics of their private health plans, their experiences with the plan, and opinions about their current plans were compared between the privately insured with and without major medical bill problems.

Analysis

All descriptive unadjusted differences were statistically tested for the difference between proportions, applying a 95% significance level. A multivariate logistic regression was used to determine if access to care differences would persist after controlling for these confounding factors: age, education, household income, race and ethnicity, health status, and employment status (as categorized in Table 1). The coefficients derived from the regression were then used to calculate the adjusted rates in the access to care measures for average adults, if they were to differ only by their health insurance status.

Study Results

Just over half (54%) of all nonelderly adults in 2003 were privately insured for the full year and did not have substantial medical bill problems (Table 1). Ten percent of all nonelderly adults—or 18 million, which was 16% of all privately insured adults—were continuously covered by private insurance but reported significant problems paying their medical bills.

Almost a quarter of adults were uninsured for all or part of the year preceding the survey (13% were uninsured for the full year and 10% uninsured part-year). Of the part- and full-year uninsured, 51% reported having major medical bill problems (not shown).

Who are the privately insured with significant medical debt? As a group, privately insured adults with medical debt are largely from middle-class families; not as poor as the uninsured, but not as well-off as the privately insured without medical debt (Table 1). Two-thirds have household incomes between \$20,000 and \$75,000. Only 16% have incomes of \$75,000 or higher, compared to 38% of those with private insurance and no medical bill problems. Over 40% of the full-year uninsured have household incomes less than \$20,000.

The large majority of the privately insured with medical debt hold full-time jobs, however the share working full-time is somewhat less than other adults with private coverage (78% vs. 86%). Among the privately insured, those with medical debt are more likely to be paid by the hour vs. by salary and also are less likely to be working for the largest of businesses (1,000+ employees) compared to others.

Table 1
Demographic Profiles by Insurance Status

Nonelderly Adults

	Private: No Medical Debt	Private: with Medical Debt	Uninsured Part- Year	Uninsured Full- Year
Number in Millions:	95.0	17.6	17.6	22.9
^ Row Percent of Nonelderly Adults:	54%	10%	10%	13%
<u>Distribution within Insurance Group (Column Percents)</u>				
Age				
18-29	15%	18%	47% *	31% *
30-45	40%	39%	37%	41%
45-54	28%	25%	12% *	18%
55-64	17%	17%	5% *	10% *
Education				
Less than high school	4% *	12%	18%	34% *
High school graduate or equivalent	29%	30%	29%	37%
Some college but no degree	30%	28%	33%	21%
College graduate	21%	21%	13% *	6% *
Postgraduate	15% *	10%	6%	2% *
Income -- Household				
Less than \$20,000	3% *	9%	25% *	42% *
\$20,000 - \$39,999	17% *	32%	35%	32%
\$40,000 - \$74,999	34%	34%	20% *	12% *
\$75,000 +	38% *	16%	10%	3% *
Do not know	2%	4%	8%	8%
Refused	6%	5%	3%	3%
Race				
White non-Hispanic	78%	74%	61% *	50% *
Black non-Hispanic	8%	13%	14%	13%
Hispanic	7%	8%	19% *	31% *
Other or mixed race	5%	5%	6%	5%
Refused	1%	1%	1%	1%
Family Status				
Married	75%	73%	40% *	47% *
Living with a partner	5%	6%	12% *	14% *
Widowed	1%	2%	1%	1%
Divorced	5%	7%	10%	10%
Separated	2%	3%	4%	4%
Never married	11%	8%	32% *	24% *
Children in Household	48% *	56%	49%	58%
Anyone Else in Household Uninsured	4% *	13%	24% *	57% *
Health status				
Fair or Poor Health	9% *	21%	16%	27%
Ongoing or Serious Health Problem	21% *	38%	19% *	21% *

(Continued)

Table 1 (cont.) Demographic Profiles by Insurance Status

Nonelderly Adults

	Private: No Medical Debt	Private: With Medical Debt	Uninsured Part- Year	Uninsured Full- Year
Employment status				
Full-time	86% *	78%	54% *	42% *
Part-time	4% *	8%	10%	13%
Retired	5%	5%	1% *	4%
Student	1%	1%	8% *	6% *
Homemaker	1%	2%	7% *	15% *
Unemployed	1%	2%	16% *	14% *
Other	1% *	5%	4%	6%
<u>Self-employed</u>	5%	7%	8%	15% *
<u>Compensation:</u>				
Salary	48% *	30%	16% *	11% *
Hourly Wage	38% *	51%	39% *	35% *
Commission	4%	5%	8%	8%
Not employed	9%	12%	35% *	43% *
Do not know	1%	1%	2%	3%
<u>Firm Size</u>				
1-199	25%	27%	33%	43% *
200-999	16%	18%	8% *	5% *
1,000+	34% *	22%	14% *	4% *
Not employed	9%	12%	35% *	43% *
Do not know	15%	20%	9% *	5% *

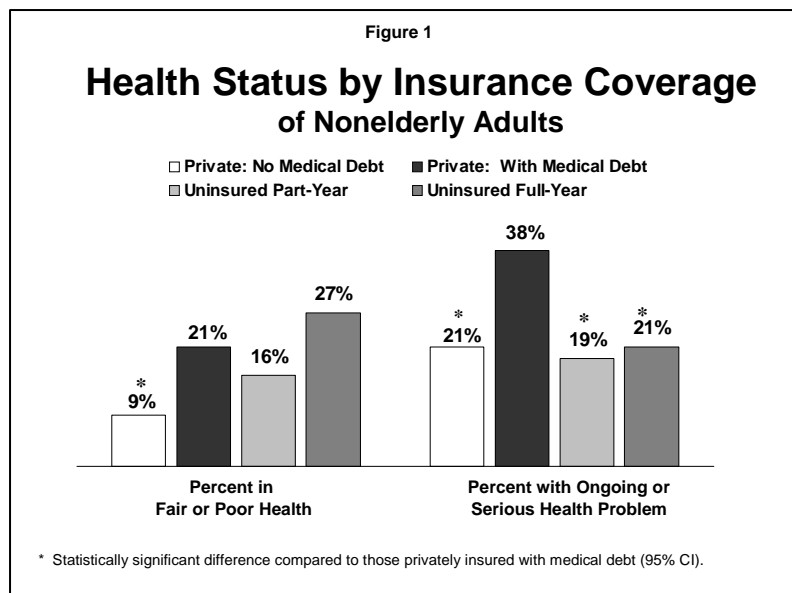
^ Remaining 13% of nonelderly adults included: respondents with full-year public coverage, those who did not respond, or didn't know their insurance coverage.

* Statistically different from Privately Insured with Medical Debt (95% confidence level)

Privately insured adults with medical debt are similar to others with private insurance in age, race, and ethnicity, but as a group are slightly less educated. In comparison to the uninsured, they tend to be older, better educated, and a larger share is white, non-Hispanic. Privately covered adults with medical debt are equally likely to be married as others with private insurance, and more likely than the uninsured to be married. They are slightly more likely than others with private insurance to have children at home, as are the uninsured. Compared to other adults with private coverage they are more likely to have someone in their household who is uninsured.

Perhaps the largest difference between the privately insured with and without medical bill problems is their health status (Figure 1). Among the privately insured, those with medical debt are more than twice as likely as those without to report their health status as fair or poor (21% vs.

9%); and their health status was statistically equal to that of the uninsured. However, about twice as many of the insured with medical debt said they had an ongoing or serious health problem (38%) compared to others with private coverage and the uninsured groups (19%-21%).



Access to Providers. Privately insured adults, regardless if they have major medical bill problems or not, are far more likely to have a regular source of care and to have seen a doctor in the past year compared to the uninsured, including those who were uninsured for only part of the year. Compared to both the part-year and full-year uninsured, both groups of privately insured are also more likely to identify a doctor’s office vs. a clinic/health center or an emergency room as their usual site of care (Appendix 1). Even while having problems paying their medical bills, most are able to maintain a relationship with a physician and are even slightly more likely to have visited a doctor in the past year compared to others with private coverage who are not dealing with medical debts – which may be a function of their greater health needs. After adjusting for health and socioeconomic factors, the difference between the two privately insured groups in having seen a doctor in the past year was no longer statistically significant, however the differences in access to providers between the insured and uninsured groups persisted (Figure 2 and Table 2).

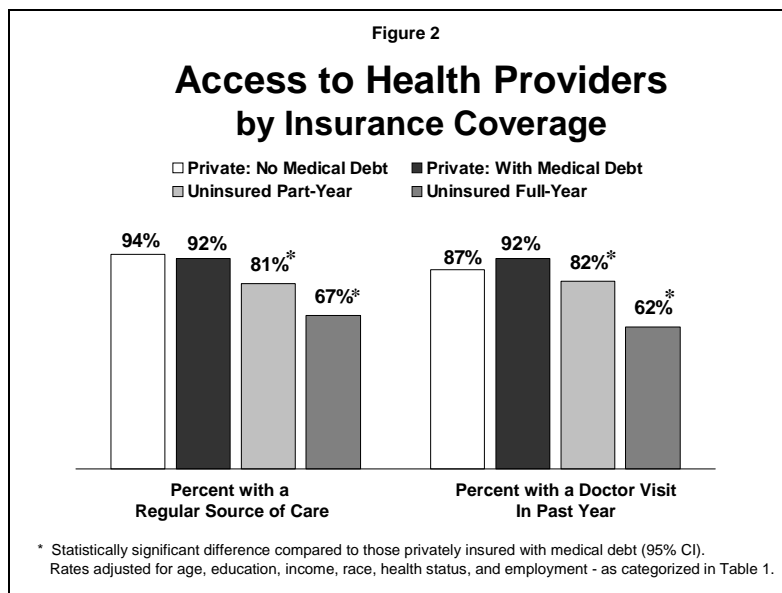


Table 2

Access to Care -- Differences by Insurance Status, 2003 -- Adjusted Rates

Nonelderly Adults

	Private: No Medical Debt	Private: With Medical Debt	Uninsured Part- Year	Uninsured Full- Year
Access to Providers:				
Regular source of care	94%	92%	81% *	67% *
Doctor visit in past year	87%	92%	82% *	62% *
Care-Seeking Decisions:				
Skipped recommended test or treatment due to cost	8% *	30%	29%	25%
Did not fill prescription due to cost	9% *	24%	25%	27%
Problems getting mental health care due to cost	1% *	5%	3%	2%
Needed medical care but did not get	3% *	12%	18%	21% *
Postponed care as couldn't afford	6% *	28%	30%	29%
Did not eventually get the care that was postponed	3% *	13%	15%	18%

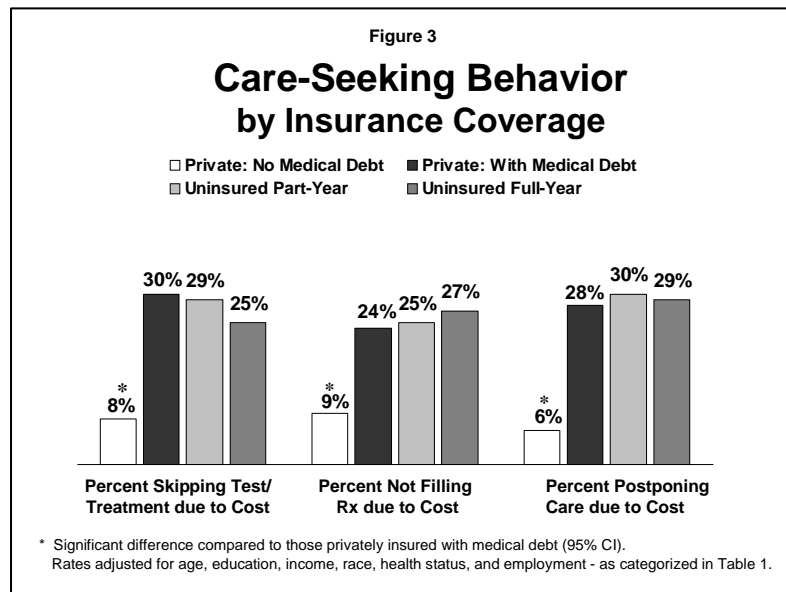
* Statistically different from Privately Insured with Medical Debt (95% confidence level)

Rates adjusted for age, education, income, race, health status, and employment status, (as categorized in Exhibit 1) in multivariate logistic regression.

Care-Seeking Decisions. Despite the continuity in physician care that private insurance provides, personal decisions about when to seek health care are markedly different between those with and without medical debt. In fact, care-seeking decisions made by those with medical debt were similar to that of the uninsured. After adjusting for social, economic, and health factors, their access to care was not statistically different from that of the part-year uninsured on all six care-seeking measures and for five of the six measures when compared to the full-year uninsured (Table 2). Compared to others

with private coverage, those with medical debt were more than three times as likely to have skipped a recommended test or treatment because of its cost (30% vs. 8%) and were more than twice as likely to have failed to fill a drug

prescription due to cost (24% vs. 9%; shown in Figure 3).



One in eight (12%) of the privately insured with medical bill problems needed medical care in the past year but did not get it compared to 3% of others with private coverage (a statistically significant difference). However, adults uninsured for the full year were the group most likely to forgo needed medical care (21%).

The insured with medical debt were over four times more likely to postpone care due to cost than those who are privately insured and are not struggling with these bills — a disparity equal to that experienced by both the part- and full-year uninsured — with over 25% of the uninsured and the insured with medical debt making the decision to postpone health care.

Among **all** those who said they personally did not get medical care they needed at some point in the last year, the most commonly reported need was treatment for an illness or an injury (44%). The other types of forgone care included laboratory and testing services (7%), mental health (6%), surgical (6%), and dental care (5%), as well as routine and preventive care (14%). Nearly half (47%) of these adults also reported that by not getting the care they needed it caused a significant loss of time at work or other important life activities. Over half (53%) said the problem had caused a temporary disability that included a significant amount of pain and suffering and one in six (17%) said the unmet need caused a long-term disability.

Characteristics of Health Plans/Options. The large majority of privately insured adults (over 90%) have employer-sponsored insurance (ESI) and we found no difference between adults with and without medical bill problems in the shares with individual, non-group coverage (Table 3). Those with medical debt are less likely to have had a choice in health plans from their employers, with about half being offered only one plan. When given options, the most commonly reported reason a plan was selected, by both insured groups, was the choice in doctors and hospitals the plan offered them.

Table 3
Descriptions of Private Health Plans,
Adults With vs. Without Medical Debt

		Private: No Medical Debt	Private: With Medical Debt
Type of insurance			
	Employer	94%	91%
	Purchased Individually	6%	9%
Offered choice of plan			
(Among those with ESI)			
	Offered choice	62%	44% *
	Only one plan	36%	53% *
	Do not know	2%	4%
Main reason plan was chosen			
(Among ESI with choice)			
	Choice of MDs and hospitals	40%	33%
	Cost Less	20%	25%
	Benefits	25%	24%
	Easy to understand	5%	1%
	Other reasons	7%	13%
	Do not know	3%	2%
Benefits			
	Prescription Drugs	94%	96%
	Dental Care	68%	56% *
	Vision Care	67%	51% *
	Maternity Services	83%	68% *
	Mental Health Services	71%	61% *
	Preventive Care	90%	81% *

* Statistically significant difference between those with and without medical debt.
(95% confidence level)

Insured adults with medical debt had fewer benefits in their health plans than others with private insurance. While almost all had prescription drug coverage, the insured with medical bill problems were less likely to have dental, vision, maternity, mental health, and preventive care coverage compared to others with private coverage.

Satisfaction with Health Plan. Health plans are not covering as much as the privately insured expect they will. Even among the privately insured who have no major medical debt, a third reported that their plan paid less than what they expected for a medical bill they received, while an even greater share (62%) of those with medical debt reported underestimating their coverage in this way (Table 4). Almost half of those with medical debt (47%) also said their plan did not pay anything for care they had received and thought was covered.

**Table 4
Experiences and Opinions about Current Private Health Plan,
Adults With vs. Without Medical Debt**

	Private: No Medical Debt	Private: With Medical Debt	
Plan paid less than expected for a bill	32%	62%	*
Plan didn't pay anything for care you thought was covered	16%	47%	*
Health plan grade			
A for excellent	29%	13%	*
B for good	49%	32%	*
C for average	18%	36%	*
D for poor	2%	12%	*
F for failing	1%	4%	*
Do not know	2%	3%	
Employer providing affordable health plan (Among those with ESI)			
Doing the best they can	83%	54%	*
Not doing the best they can	14%	44%	*
Do not know	3%	2%	

* Statistically significant difference between those with and without medical (95% confidence level)

Those who don't have large medical bills, not surprisingly, believe they have good health plans. Over three-quarters graded their plans as A or B (excellent and good) compared to 45% of those with bill-paying problems. Sixteen percent of those with medical debt graded their plan as poor or failing (compared to 3% of the other privately insured). Likewise, more of those with ESI without large medical debt compared to those with medical debt believe that their employer is doing the best they can to provide an affordable health plan (83% vs. 54%).

Discussion and Policy Implications

Until faced with a costly medical condition, many of us are not fully aware of how good our health coverage is. We estimate that one in six adults (16%) with private health insurance may have had inadequate financial protection against the medical bills they incurred in 2003 — bills they described as being very difficult to pay and/or had a major impact on their lives. These 18 million insured adults are only a subset of the larger group of both adults and children who are potentially underinsured — those who have not yet needed to test the limits of their health benefits and family incomes.

Only a few researchers have tried to determine how many Americans may be underinsured. In a sentinel study, Short and Banthin defined underinsured as a function of out-of-pocket costs, family income, and the risk of a catastrophic illness (“out-of-pocket expenses exceeding 10% of family income if they are unlucky enough to incur the large medical bills that they have only one chance in 100 of experiencing”) and estimated that 29 million nonelderly were underinsured in 1994 (18.5% of the privately insured nonelderly).⁷

That number is likely to be much greater today for several reasons. First of all, family incomes have not kept pace with the growth in overall health care costs. By the late 1990s annual premium increases alone were markedly surpassing wage growth. By 2001 premiums began to grow by more than ten percent a year, while growth in workers' wages remained fairly flat at two to four percent. The dollar amount of employees' premium contributions has risen roughly 50% for both single and family coverage since 2001. Deductibles and co-payments have also steadily increased. And while the majority of covered workers have not had their benefits changed, among those who have, more workers experienced a reduction, not an increase, in their plan's benefits.⁸

If these trends in greater cost-sharing continue, more low- and middle-income families with private insurance, particularly if they are less healthy, will not have the same access to care as others with private coverage who have higher incomes. We find that more of the privately insured with medical debt forgo and postpone health care than those without medical debt — and that they are as likely to limit their care in many ways as those who have no health insurance at all.

These findings cast light on the potential impact of cost-containment strategies recently employed by states to reduce the growth in Medicaid spending. Both reductions in benefits and increased co-payments have been implemented, often in combination with several other strategies. In a recent survey of state Medicaid programs, 19 states reported that they reduced benefits and 20 states reported increasing beneficiary copayments in fiscal year 2004.⁹ Given the eligibility income levels of the Medicaid program, even small increases in cost-sharing could

affect families' care-seeking decisions, with consequences for both the health of individuals and the program's overall costs as people wait too long to get needed care.

Proposals to expand insurance to more Americans will likely fail to achieve the end-goal of greater access to health care if families out-of-pocket health care costs remain disproportionate to their incomes. Individually-purchased premiums for family coverage averaged \$3,300 in 2003. The average cost of employer group premiums was markedly higher at \$9,100 in the same year—reflecting broader benefit packages, less cost-sharing, as well as older and less healthy beneficiaries in the group market.¹⁰ In this same year, 80% of the uninsured had family incomes less than \$40,000.¹¹

Newly enacted Health Savings Accounts have been designed in part to help those who might be able to afford less expensive health plans that carry high deductibles (currently more common in the individual market), but only if the person is able to save enough in tax-deferred accounts to cover what could be relatively large out-of-pocket costs. For example, having a \$1,500 deductible means a family with an income of \$30,000 a year would need to be saving five percent of their income for health care, on top of any premium costs. Moreover, while standard plans with larger deductibles and co-payments could potentially improve continuity of care (i.e., so that a person establishes a medical home) these plans may not provide enough financial help to allow people to seek more than basic primary medical care or to be fully treated.

In summary, access to care is substantially decreased when medical bills grow into a burdensome debt. Financial barriers to care are not limited to the uninsured, but likely affect the care-seeking

decisions of even those who are privately insured and have a medical home. Higher cost-sharing requirements leave more of the insured financially unprotected and consequently may decrease access to care. Insurance expansion proposals need to build in significant subsidies for both premium and out-of-pocket costs relative to family income if improved access to care is to be realized.

Acknowledgments:

The authors thank Mollyann Brodie, Ph.D. for her survey expertise in designing the survey used for this research and for reviewing early drafts of this paper. The survey and its analysis were funded by the Henry J. Kaiser Family Foundation.

Endnotes

¹ J. Gabel et al., “Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage,” *Health Affairs* (Sept/Oct 2004): 200-209.

² G. Shearer, “Hidden from View: The Growing Burden of Health Care Costs,” Consumers Union report summary: www.consumersunion.org/health/0122exec.htm (22 September 1998).

³ R. Blendon et al., “Paying Medical Bills in the United States,” *JAMA* (March 23/30):949-51.

⁴ T. Selden and J. Banthin, “Health Care Expenditure Burdens among Elderly Adults,” *Medical Care* (2003:41-7 Supp):III-13-III-23.

⁵ J. May and PJ Cunningham, “Tough Trade-offs: Medical Bills, Family Finances and Access to Care,” Center for Health System Change Issue Brief, July 2004.

⁶ Schoen, C, et al, “Insured But Not Protected: How Many Adults Are Underinsured?” *Health Affairs* (2005 Web Exclusive: W5):289-302.

⁷ P Farley, “Who are the Underinsured?” *Milbank Quarterly* (1985, 63):476-504 and PF Short and J Banthin, “New Estimates of the Underinsured Younger Than 65 Years,” *JAMA* October 25, 1995:1302-1306.

⁸ J. Gabel et al., “Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage”. For example, between 2003 and 2004 over twice as many covered employees who had changes in their plans experienced a reduction vs. an increase in benefits.

⁹ V. Smith et. al, *The continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) October 2004.

¹⁰ Kaiser Family Foundation/eHealthInsurance, *Update on Individual Health Insurance* (Washington, DC: Kaiser Family Foundation). August 2004; J. Gabel et al., “Health Benefits in 2003: Premiums Reach Thirteen-Year High As Employers Adopt New Forms of Cost Sharing,” *Health Affairs* (Sept/Oct 2003): 117-126.

¹¹ C. Hoffman, A. Carbaugh and A. Cook, *Health Insurance Coverage in America, 2003 Data Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2004).

Appendix 1
Access to Care Among Nondelderly Adults
Differences by Insurance Status, 2003 -- Unadjusted
Rates

	Private: No Medical Debt	Private: With Medical Debt	Uninsured Part- Year	Uninsured Full- Year
Access to Providers:				
Regular source of care	93%	92%	71% *	57% *
Usual site of care				
Doctors' office	77%	81%	60% *	32% *
Clinic or health center	17%	17%	25% *	32% *
Hospital Emergency Room	3%	1%	9% *	21% *
VA clinic	--	--	--	2%
Other	3%	1%	3%	4% *
Do not know	--	--	2%	8% *
Doctor visit in past year	85%*	91%	76% *	55% *
Care-Seeking Decisions:				
Skipped recommended test or treatment due to cost	7%*	34%	33%	33%
Did not fill prescription due to cost	8%*	27%	32%	38% *
Problems getting mental health care due to cost	1%*	8%	6%	5%
Needed medical care but did not get	3%*	16%	23%	28% *
Postponed care as couldn't afford	6%*	33%	37%	40%
Did not eventually get the care that was postponed	3%*	16%	22%	28% *

* Statistically different from Privately Insured with Medical Debt (95% confidence level)

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG / KCMU

Additional copies of this report (#7403) are available
on the Kaiser Family Foundation's website at www.kff.org.

