



# **Health Care Affordability and the Uninsured**

**Testimony of Diane Rowland, Sc.D.**

**Executive Vice President, Henry J. Kaiser Family Foundation  
and  
Executive Director, Kaiser Commission on Medicaid and the Uninsured**

**For Hearing on the Instability of Health Coverage**

**Before the Congress of the United States  
House of Representatives  
Committee on Ways and Means  
Health Subcommittee**

**April 15, 2008**

## **SUMMARY OF TESTIMONY BY DIANE ROWLAND, SC.D.**

- The patchwork health insurance system in the United States left nearly 47 million people without health coverage in 2006—two thirds of the uninsured are low-income and eight in ten come from families with a full- or part-time worker. Uninsured workers are more likely to work for small firms and in industries such as agriculture, construction, and services where fewer employers offer coverage.
- For low-income families, Medicaid and the companion State Children's Health Insurance Program (SCHIP) play a critical role in providing coverage. However, the reach of Medicaid and SCHIP is limited and leaves many of the poor and low-income population without health coverage.
- Having health insurance makes a difference in whether, when, and where people get needed care and how well that coverage promotes access to preventive and primary care services and protects them from medical expenses when illness strikes. The uninsured are more likely to postpone or forego needed care and preventive services than the insured.
- As a society, we bear a substantial cost for leaving so many of our fellow Americans without health coverage—it is estimated that in 2006 some 22,000 Americans died prematurely as a consequence of being uninsured, and the lost productivity due to the diminished health and shorter life span of the uninsured had an annualized economic cost of \$102-\$204 billion.
- Rising health care costs are exacting a financial toll on both insured and uninsured families. In 2007, the average total premium for a family policy was \$12,106—about the same amount as the annual earnings of a full-time minimum wage worker.
- Low- and moderate-income families face greater financial strain from both increasing premium costs and more limited coverage that increases out-of-pocket costs for care.
- The increasing costs and limits on the scope of medical care covered by insurance are impacting families. For a family earning \$1,600 per month, basic necessities consume 90% of income—making a \$400 monthly premium or \$500 deductible unaffordable.
- As the availability, affordability and scope of insurance decrease, both insured and uninsured Americans are now dealing with budget-consuming medical bills and debt. In 2004, 45 million Americans were in families that spent more than 10 percent of family income on health care, and those at higher risk include the near-elderly and those with chronic illnesses.
- It is clear that for many, health insurance alone is no longer a guarantee of financial protection from the costs of health care and financial stress when illness strikes. As Congress moves forward to address the growing uninsured population and the impact of rising health care costs on America's families, promoting improved access to affordable health care and adequate health coverage for all Americans is an important but challenging objective.

Mr. Chairman and Members of the Subcommittee on Health, thank you for the opportunity to testify today on the growing share of Americans who are uninsured and without adequate health insurance coverage. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. I also hold an appointment as an Adjunct Professor in the Bloomberg School of Public Health at the Johns Hopkins University.

Health insurance coverage can provide a valuable lever to help gain access to primary and preventive health care services as well as peace of mind and financial security for many facing serious health care problems. Yet, our latest statistics show nearly 47 million Americans, including 9 million children, were without health insurance coverage in 2006. Our growing uninsured population gets care later, if at all, and ends up sicker than those with coverage. For the one in six Americans under age 65 who are uninsured, lack of affordable coverage can both compromise health and leave families with substantial medical debt.

The continued growth in our uninsured population also takes a toll on society. Based on work of the Institute of Medicine, it is estimated that in 2006 some 22,000 Americans died prematurely as a consequence of being uninsured, and the lost productivity due to the diminished health and shorter life span of the uninsured had an annualized economic cost of \$102-\$204 billion. Leaving 47 million Americans without health coverage affects not only the uninsured but also puts a growing burden on our health care system and adds additional strain on the economy.

And, even for those with health insurance coverage, rising insurance premiums, the increasing out-of-pocket costs from more limited coverage, and the decreasing availability of employer-based coverage make obtaining and paying for health care an increasing financial burden. For many, health insurance coverage through the workplace now has higher deductibles and more cost-sharing as well as higher premiums that can put health coverage out of reach for low-wage workers. As a result, even those who have health coverage find health care increasingly unaffordable, leading many analysts to conclude America has both a growing uninsured and underinsured population.

My testimony today will highlight the key characteristics and issues with regard to the uninsured as well as assess the financial burdens for medical care faced by America's families.

### The Uninsured

Whether or not one has health insurance coverage in the U.S. today depends on a variety of factors: age, income, workplace, and state of residence all affect whether health insurance is available and affordable. For those over age 65 and those with permanent disabilities who qualify for Social Security, Medicare provides health insurance protection, keeping them from the ranks of the uninsured (*Figure 1*). Slightly more than half (54%) of all Americans receive employer-sponsored health coverage and 5% purchase coverage through the non-group or individual market. Medicaid and other public programs assist 12% of individuals primarily from low-income families. The remaining 16% of Americans are uninsured. The likelihood of being uninsured is higher in some states due to the nature of their economy and the scope of public programs, with over 20% of the nonelderly population uninsured in 10 states (*Figure 2*).

The 47 million uninsured Americans in 2006 included 9 million children, but the uninsured population is primarily composed of low- and moderate-income adults under age 65 (*Figure 3*). The uninsured primarily come from working families – 80% of the uninsured come from families with a full or part time worker, but most work in places where health insurance is not a benefit offered through their job. Many, but not all, employers voluntarily offer health coverage to their workers and are encouraged by the federal tax system to do so. In 2007, 60% of firms offered health benefits to workers, down from 69% in 2000. Even if a firm offers health benefits, some employees (about 15% of all employees) are ineligible because they work part-time, are recent hires, or do not meet other eligibility criteria.

Only three in ten poor workers have coverage through their own or a spouse's employer, compared to 92% of higher-income workers (*Figure 4*). More than half of poor workers are not offered coverage through their own or a spouse's employer. Another 15% of poor workers decline coverage when offered, most likely due to the cost of their share of the health insurance premium. For a worker earning \$30,000 per year, the employee share (\$3,281) of the average 2007 family premium would be more than 10% of their income.

The rising cost of health insurance premiums also means that for low wage workers, if coverage is offered, the employee share of premiums is becoming more and more unaffordable—or in some cases, the scant coverage provided makes the premium share a poor investment. As a result, the uninsured tend to be in families with lower wage workers. Almost two-thirds (65%) of the uninsured are from families with incomes below twice the poverty level (about \$40,000 a year in income for a family of four in 2006 (*Figure 5*). Uninsured workers are more likely to work for small firms and in industries such as agriculture, construction, and services where fewer employers offer coverage.

For low-income families, Medicaid and the companion State Children's Health Insurance Program (SCHIP) play a critical role in covering 29 million children and 24 million nonelderly adults, including 8 million low-income adults with severe disabilities for whom private insurance is not a viable option. However, the reach of Medicaid and SCHIP is limited and leaves many of the poor and low-income population without health coverage.

Most low-income children qualify for Medicaid or SCHIP, but low-income adults can only qualify for Medicaid if they are disabled, pregnant, or have dependent children. Beyond the categorical exclusions from Medicaid coverage, income eligibility levels are generally much lower—well below the poverty level—for adults compared to children. Most states (45 total) have authorized Medicaid and SCHIP eligibility levels for children at 200% of poverty or higher (*Figure 6*). In contrast, eligibility for parents is below 50% of poverty in 12 states (*Figure 7*). In 29 states, a parent working full-time at minimum wage has an income too high to qualify for Medicaid. As a result, adults are more likely to be uninsured than children, making up eight in ten of our uninsured population.

While young adults have the highest likelihood of being uninsured, adults age 55-64 are a particularly vulnerable group. They are not yet eligible for Medicare or, in some cases, are the spouse of someone on Medicare who lost employer-based coverage when their spouse retired. Because of their age, coverage from the individual market is likely to be very expensive because policy premiums are age-rated and likely to exclude coverage for many pre-existing health problems. Public coverage through Medicaid is mostly unavailable unless then can qualify as the parent of a dependent child or as disabled.

Minorities are also much more likely to be uninsured than Whites. About one-third of the nonelderly Hispanic population and 22% of African Americans are uninsured, compared to 13% of Whites. This disparity reflects the fact that minorities are more likely to have lower incomes than Whites and less likely to have health insurance offered through their jobs, to be eligible for benefits, and to be able to afford their share of premiums. However, public programs play a particularly important role for minorities – 44% percent of African American children and 14% of nonelderly African American adults count Medicaid or SCHIP as their health coverage. In the absence of public coverage, millions more would join the ranks of the uninsured.

While there is much discussion and debate about the role of immigrants in our society, the uninsured population is largely comprised of native or naturalized citizens. Immigrants have high rates of uninsurance (47% vs. 15% for citizens) due to their lower-wage job base and ineligibility for public coverage. Although immigrants, especially recent immigrants, are likely to be uninsured, they are not the driving force behind America's growing uninsured problem because they comprise only a small share of the U.S population. Our uninsured problem is created by the nature and fragmentation of our health insurance system—not the presence of an immigrant population in the U.S.

### The Consequences of Inadequate Health Coverage

The uninsured tend to be in worse health than our nation's privately insured population (though better off than those who qualify for Medicaid). One in ten (11%) uninsured report being in fair or poor health compared to one in twenty (5%) of those with private insurance. Almost half of all uninsured adults have a chronic condition. Those with health problems are likely to find private non-group coverage unavailable or unaffordable if job-based coverage is not an option. Policies sold in the non-group or individual market can be more expensive than employer-sponsored coverage because insurers can vary the premium based on age and health status. Insurers in the non-group or individual market can also deny coverage or exclude pre-existing conditions and charge higher premiums for older adults, putting such policies out of reach for many of the uninsured.

Without insurance to cover health care costs, access to health care and ultimately health suffers. Having health insurance makes a difference in whether, when, and where people get

needed care and how well that coverage promotes access to preventive and primary care services and protects them from medical expenses when illness strikes. The uninsured are much more likely to postpone or forego care due to cost than those with coverage (*Figure 8*). More than half of uninsured adults do not have a place where they regularly go when they are sick. As a result, they are less likely than those with insurance to receive preventive care and even standard treatment for chronic conditions.

Limited access puts the uninsured at risk for worse health outcomes. Lack of access to early and ongoing medical care leaves the uninsured more likely to be hospitalized for avoidable health problems and to risk being diagnosed at a later disease stage, leading to poorer health outcomes. When they are hospitalized, the uninsured are less likely to receive diagnostic and therapeutic services and are more likely to die in the hospital than insured patients. Being uninsured has been correlated with a 10-25% increased risk of mortality and an estimated 22,000 excess deaths in 2006 were linked to lack of health insurance coverage.

As a society, we also bear a substantial cost for leaving so many of our fellow Americans without health coverage. Children who are uninsured are more likely not to receive early and preventive care, to miss school due to illness, and not to get the healthy start in life our children deserve. Uninsured adults compromise our nation's productivity when work is missed due to unattended health problems, and financial burdens for health care strain family resources. It is estimated that in 2006, the diminished health and shortened lifespan of the uninsured had an economic cost of between \$102 and \$204 billion due to the lost productivity of uninsured individuals.

### Financial Burden and Health Care

Health care is not free, even for the poorest among the uninsured. High health care costs and fear of medical debt result in many of the uninsured going without care. Their annual medical costs are about half as much as those who are privately insured. Most of the uninsured do not receive health services for free or at reduced cost, nor do they benefit from the discounted rates negotiated by insurance companies. They are often billed at full charge and left to pay what they can—sometimes accumulating large medical debts and notices from collection agencies.

However, rising health care costs are also exacting a financial toll on families with health insurance and their employers. The cost of employer-sponsored health coverage increased 78% from 2001 to 2007, rising faster than wages and inflation. In 2007, the average total premium for a family policy was \$12,106—about the same amount as the annual earnings of a full-time minimum wage worker (*Figure 9*). Employees have seen their average share of annual premiums for a family policy double from \$1,619 in 2000 to \$3,281 in 2007. As premiums rise, firms may find it difficult to maintain the level of health benefits they offer workers, particularly in times of economic downturn and slowed profits. In response, employers have attempted to increase efficiency and limit expenditures, shifted more costs to employees, or elected not to offer coverage. Thus, low- and moderate-income families face greater financial strain from both increasing premium costs and more limited coverage that increases out-of-pocket costs for care.

In interviews the Foundation is currently conducting, we see the impact the inadequate health system is having on family finances. Paying for health coverage and care is challenging for families, especially in light of rising gas prices and increased costs for other basic necessities. For example, one family in Houston demonstrates the gaps in coverage that exist. Sam works at a home improvement store and his wife Carmen is at home with their three children. Though the children qualify for public coverage, the parents are uninsured—they are not eligible for Medicaid, and Sam cannot yet enroll in coverage through his job. Once he does become eligible for employer-sponsored coverage, he will be required to pay a \$400 per month insurance premium, which is a quarter of his \$1,600 monthly take-home income. Nearly 90% of the family's spending already goes toward basic necessities other than medical care, leaving little room in their budget for additional spending on health care.

Even if the uninsured may be able to afford lower premiums by enrolling in high deductible health plans, the high level of required cost sharing is likely to be out of reach for most of the uninsured. Three quarters of the uninsured population come from families with incomes below 300% of poverty (\$63,600 for a family of four in 2008). A new study by Kaiser researchers found that the lower-income uninsured population (below 300% of poverty) had very limited (median was \$300) liquid financial resources that could be tapped to help pay deductibles and other out-of-pocket expenses. In contrast, higher-income uninsured workers had median financial assets of \$2,560—a level still inadequate to meet the cost-sharing requirements that

would accompany a hospital stay or other catastrophic health event. Only about one in five uninsured households had enough net financial assets to meet the minimum deductibles in health savings account-qualified high deductible plans.

The growing limits on the scope of medical care costs covered by insurance are impacting families. Health insurance policies do not provide complete “100 percent” coverage for health care needs. Depending on their policy, individuals with insurance can face deductibles for physician or hospital services, co-payments or cost-sharing for physician visits and other medical services, and pay additional amounts for using providers outside a plan’s network. Even people who are insured can face significant out-of-pocket costs. Our Kaiser/HRET Annual Employer Health Benefits Survey for 2007 found that 11% of workers in employer-sponsored Preferred Provider Organizations (PPOs) who have deductibles are in plans with a deductible for single coverage of \$1,000 or more and about half of all covered workers are in plans that have cost-sharing in addition to a hospital deductible.

As the availability, affordability and scope of insurance decrease, both insured and uninsured Americans are now dealing with budget-consuming medical bills and debt. Researchers from AHRQ in the Department of Health and Human Services estimate that in 2004, 45 million Americans were in families that spent more than 10 percent of family income on health care (*Figure 10*). Financial burden, defined as having out-of-pocket expenses for health care service and insurance premiums that exceeded 10 percent of a family’s disposable (after tax) income, provides a measure of “underinsurance” faced by many families whose health coverage leaves them without protection for catastrophic level health costs. Sadly, individuals at high risk for these levels of financial burden include those age 55-64 who are not yet eligible for Medicare, those in fair or poor health, and especially those with diabetes, stroke, heart disease and other chronic illnesses (*Figure 11*).

Financial burden also varied considerably depending on the type of health insurance a person had. About one in ten (11%) individuals with a high health care financial burden were from uninsured families, but two-thirds were individuals in families with employer-sponsored coverage reflecting their larger share of the population. People with private, non-group coverage were the most at risk for high financial burden—more than half spent 10% or more of their

family income on health care. This group also experienced the highest percentage point increase in high financial burden from 2001-2004. Without a subsidy from their employer, individuals are exposed to the full cost of the premium. With insurers' ability to deny coverage and exclude pre-existing conditions, finding coverage can be difficult for those who have health conditions. In 2005, nearly three in five adults who sought coverage in the non-group market had difficulty finding a plan they could afford, and one in five were denied coverage, charged a higher price, or had a specific health condition excluded from coverage.

It is clear that for many, health insurance alone is no longer a guarantee of financial protection from the costs of health care and financial stress when illness strikes. Today's higher premiums, deductibles, and co-payments 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. A 2005 Kaiser Family Foundation report examined the privately insured who have had problems paying medical bills, comparing their access to care to those who did not have medical bill problems as well as those with no health coverage at all. Those with medical debt were in worse health and reported having 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 and nearly half said their plan had not paid anything for care they thought was covered.

Having medical debt was associated with a substantial decrease in access to health care. While those with medical debt were just as likely as other privately insured adults to have a medical home, decisions to seek health care were markedly different, including their decisions to postpone and forgo care as well as to skip treatments and prescriptions. In many ways, care-seeking patterns among those with private coverage who had problems paying their medical bills resembled those of the uninsured.

## The Challenge Ahead

Health insurance coverage is closely tied to the strength of the nation's economy. Given the current slowdown in the economy after a brief period of recovery and the challenge that creates for employers and states to maintain their coverage programs, the number of uninsured Americans is likely to continue to grow in the near future. Even in good economic times, however, it can be difficult to reverse the rise in the uninsured. Employer-sponsored coverage is not likely to increase again until the growth in health insurance premiums is checked or competition for workers again becomes intense. In the current economic environment especially, the costs of health insurance premiums are a major impediment to improving health coverage.

During the economic downturn from 2000-2004, Medicaid and SCHIP were an essential safety-net as unemployment grew and median household incomes fell. The number of uninsured people increased by 6 million during this time, primarily as a result of declines in employer-sponsored coverage, but enrollment growth in Medicaid—assisted by Congress' temporary increase in the federal matching rate—counteracted additional growth in the uninsured. However, the continued ability of Medicaid and SCHIP to absorb all the losses from employer-sponsored coverage is strained by growing demand and limited resources, as evidenced by an increase in the number of uninsured—including children—during the economic recovery from 2004-2006. The current economic downturn is likely to mean more substantial increases in America's uninsured population, especially if Medicaid and SCHIP are limited in their ability to meet the rising demand for coverage from the declining economy. In the absence of additional federal assistance, the fiscal crises in the states are likely to compromise further their ability even to maintain coverage through the Medicaid and SCHIP programs, much less expand coverage.

Health insurance provides families with an important source of financial security when illness strikes and helps to promote access to health care services that can often stave off more serious illness. Although the majority of nonelderly Americans receive health care coverage through their employer today, the availability and affordability of employer-based coverage is declining—putting more and more middle- and low-income working families at risk of being uninsured and without coverage for their health needs. For those with coverage, the value of that

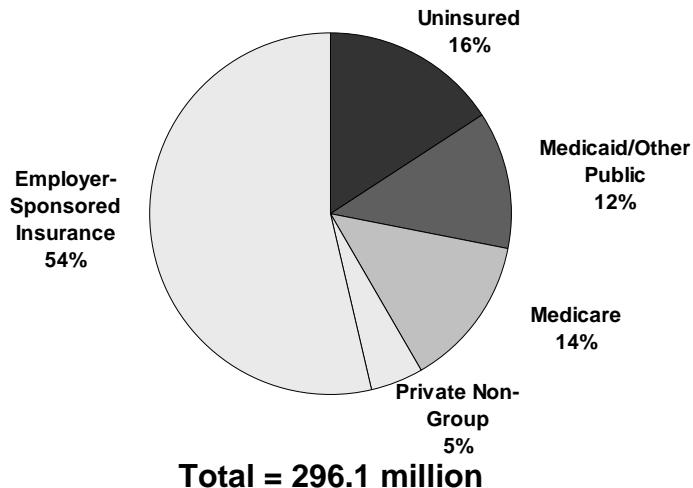
coverage has begun to erode as limits on the scope of coverage leave more and more insured Americans to face increased out-of-pocket costs when they seek care.

Rising costs for both health care services and insurance coverage are placing a heavy load on family budgets, businesses, and public programs. The cost of health care and health insurance is a dimension of the growing economic worries concerning the public, along with the price of gas, housing, and other aspects of family budgets (*Figure 12*). The financial burden resulting from these growing costs is already squeezing out good health practices, leading many to defer care due to costs and contributing to increases in the uninsured. As Congress moves forward to address the growing uninsured population and the impact of rising health care costs on America's families, promoting improved access to affordable health care and adequate health coverage for all Americans will be an important but challenging objective.

I appreciate the opportunity to testify before the Committee today and welcome your questions. Thank you.

Figure 1

## Health Insurance Coverage in the U.S., 2006



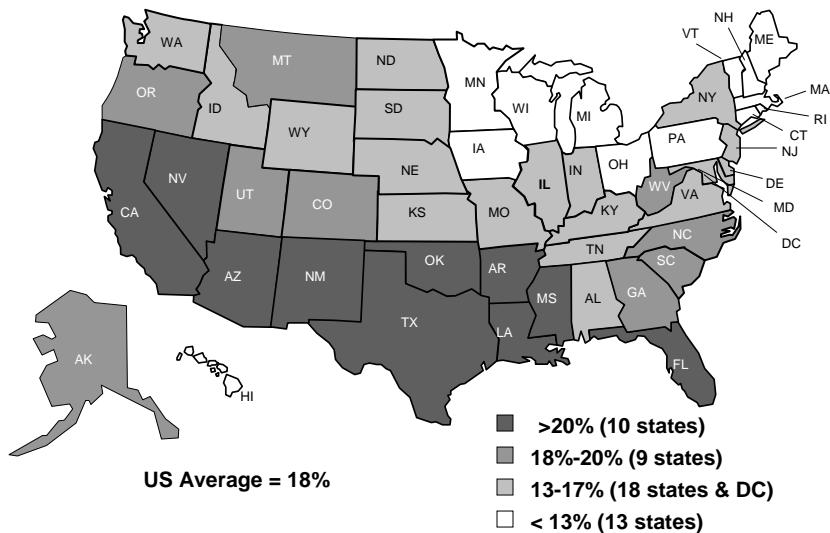
NOTE: Includes those over age 65. Medicaid/Other Public includes Medicaid, SCHIP, other state programs, and military-related coverage. Those enrolled in both Medicare and Medicaid (1.8% of total population) are shown as Medicare beneficiaries.

SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.



Figure 2

## Uninsured Rates Among the Nonelderly, by State, 2005-2006



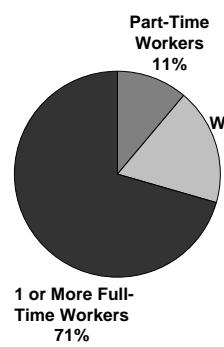
SOURCE: Urban Institute and KCMU analysis of the March 2006 and 2007 Current Population Survey. Two-year pooled estimates for states and the US (2005-2006).



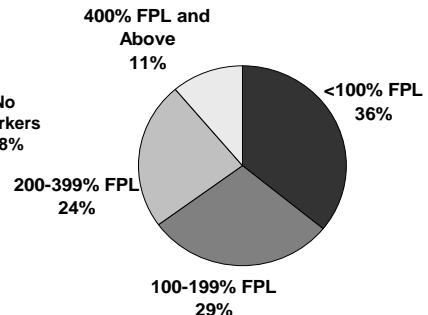
Figure 3

## Characteristics of the Nonelderly Uninsured, 2006

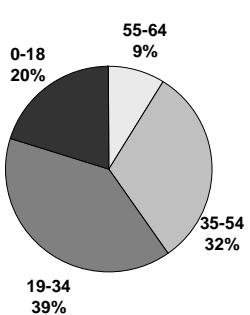
### Family Work Status



### Family Income



### Age



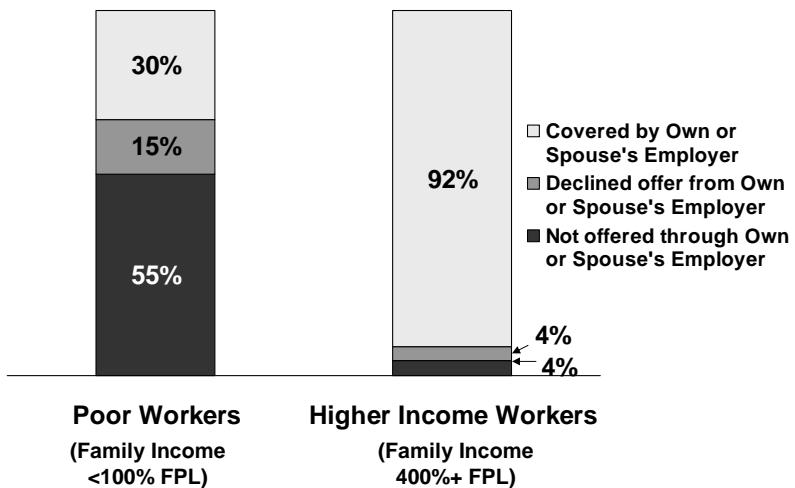
**Total = 46.5 million uninsured**

The federal poverty level was \$20,614 for a family of four in 2006.  
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.



Figure 4

## Access to Employer-Based Coverage by Family Income, 2005

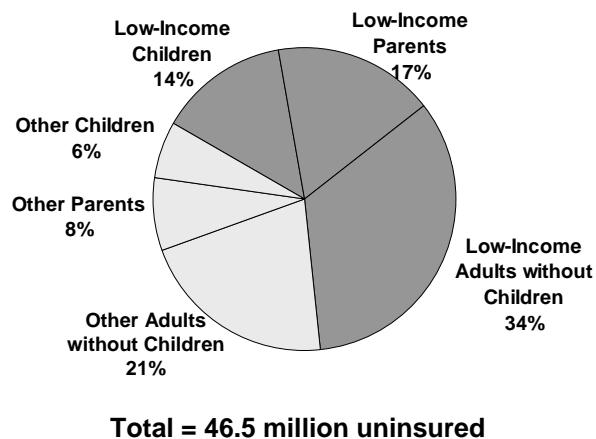


SOURCE: Garrett B. and Clemens-Cope. *Changes in Employer-Sponsored Health Insurance Coverage: 2001-2005*. KCMU report. June 2006



Figure 5

## The Nonelderly Uninsured, by Age and Income Groups, 2006

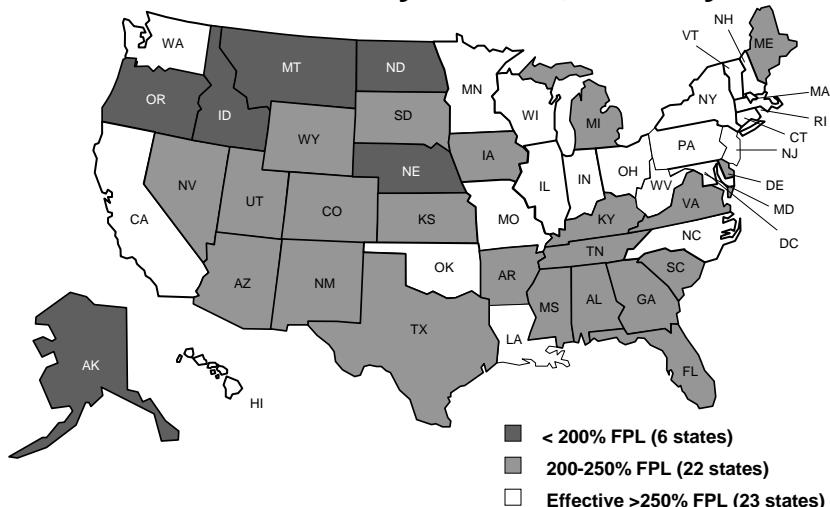


Low-income includes those with family incomes less than 200% FPL.  
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.



Figure 6

## State Authorized Children's Eligibility for Medicaid/SCHIP by Income, January 2008

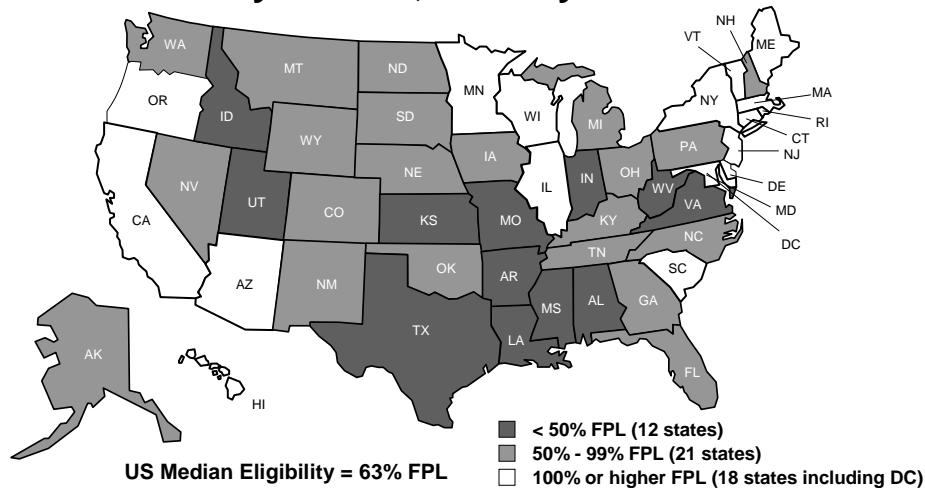


SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.



Figure 7

## Authorized Medicaid Eligibility for Working Parents by Income, January 2008



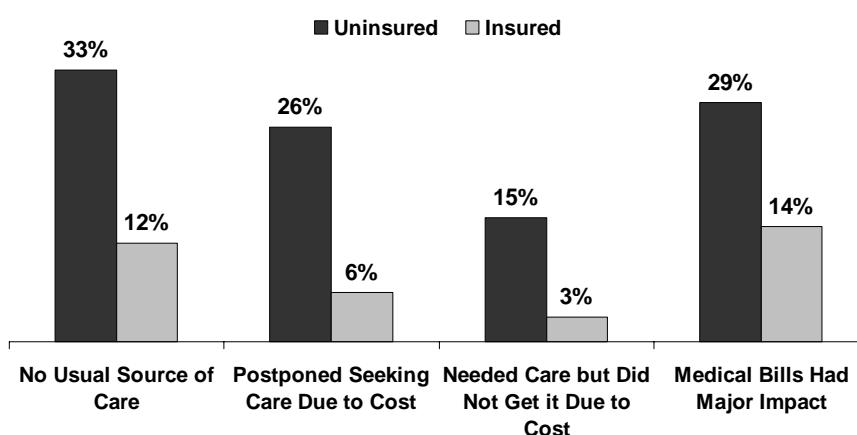
NOTE: The Federal Poverty Line (FPL) for a family of three in 2008 is \$17,600 per year. AR, IN, & UT operate waivers allowing higher-income parents to enroll, but the coverage has higher cost-sharing and reduced benefits.

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SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

Figure 8

## Barriers to Health Care Among Nonelderly Adults, by Insurance Status, 2006

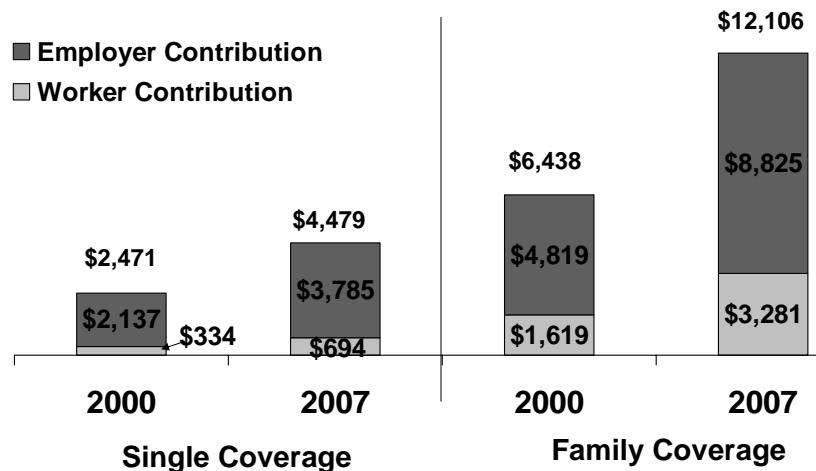


Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. Other than the question about usual source of care, all questions are about access problems in the past 12 months.

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Figure 9

### Average Annual Premium Costs for Covered Workers, 2000 and 2007

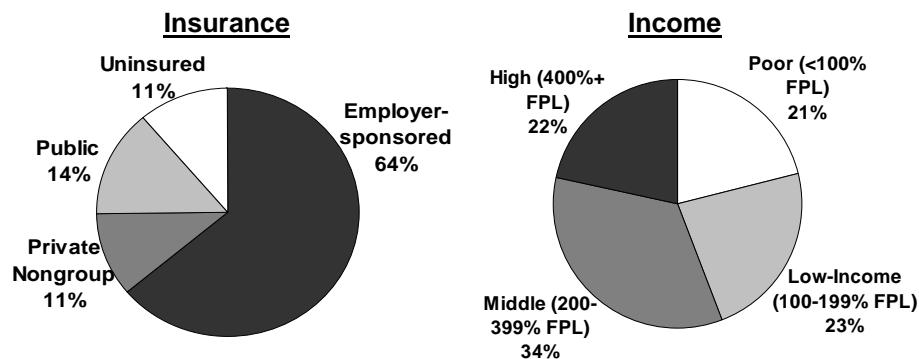


Note: Family coverage is defined as health coverage for a family of four. Data represents average for all types of plans.  
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007.

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Figure 10

### 45 Million Nonelderly in Families with High Financial Burden for Health Care, by Insurance and Income Groups, 2004



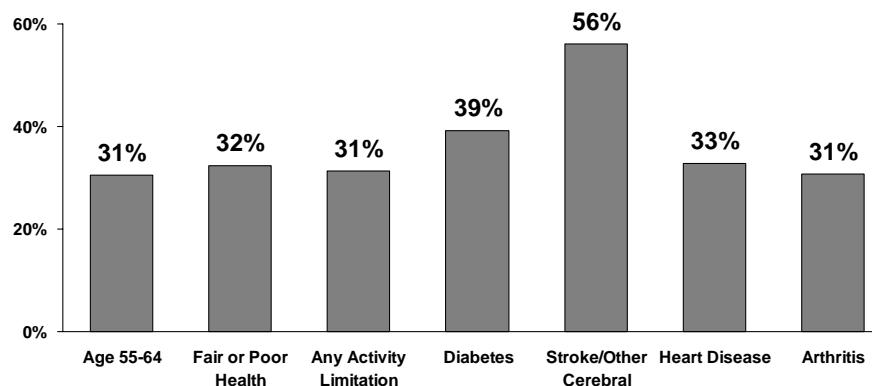
**High Financial Burden = Individuals in Families spending more than 10% of Family Income on Health Care**

SOURCE: Banthin, JS, P Cunningham, and DM Bernard. 2008. *Financial Burden of Health Care, 2001-2004*. Health Affairs 27(1).

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Figure 11

## Groups at High Risk of Having High Financial Burden for Health Care, 2003



NOTE: High Financial Burden defined as families spending more than 10% of their after-tax income on health care, including premiums and out-of-pocket health costs.

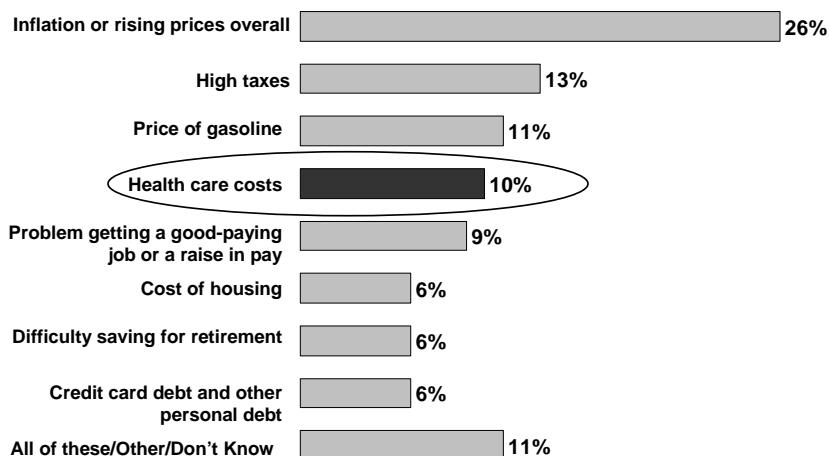
SOURCE: Banthin, JS and DM Bernard. "Changes in Financial Burdens for Health Care," JAMA 296(22), December 2006.



Figure 12

## Health Care as an Economic Issue

*Which of the following is the single most important economic issue facing you and your family? (Feb. 2008, registered voters)*



SOURCE: Kaiser Health Tracking Poll: Election 2008 Issue 6: March 2008 (conducted February 7-16, 2008)





**The Henry J. Kaiser Family Foundation**

**Headquarters**

2400 Sand Hill Road

Menlo Park, CA 94025

(650) 854-9400 Fax: (650) 854-4800

**Washington Offices and  
Barbara Jordan Conference Center**

1330 G Street, NW

Washington, DC 20005

(202) 347-5270 Fax: (202) 347-5274

[www.kff.org](http://www.kff.org)

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