THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Statement before the Joint Economic Committee United States Congress

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"Health Challenges Facing the Nation"

216 Hart Senate Office Building

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Health Challenges Facing the Nation

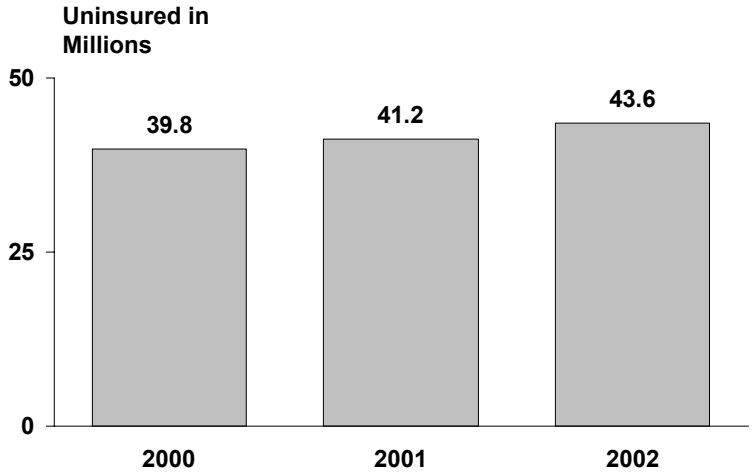
Health insurance coverage remains one of the nation's most pressing and persistent health care challenges. When asked to identify the top health care priorities for the nation, the public consistently ranks lack of health insurance coverage as a top priority. Nearly 1 in 3 Americans (31%) rated increasing the number of Americans covered by health insurance as the "most important" health issue for Congress and the President to deal with, in a public opinion survey this summer.

The most recent data -- released this week 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.

The uninsured come predominantly from working families with low and moderate incomes --- families for whom coverage is either not available or not affordable in the work place (Figure 2). Public program expansions through Medicaid and the State Children's Health Insurance Program (SCHIP) help to fill some gaps, especially for low-income children, but the fiscal crisis in the states is now putting public coverage at risk. Unfortunately, the economic downturn, coupled with rising health care costs and fiscal constraints on public coverage, all point to continued growth in our uninsured population.

Figure 1

Number of Nonelderly Uninsured Americans, 2000-2002



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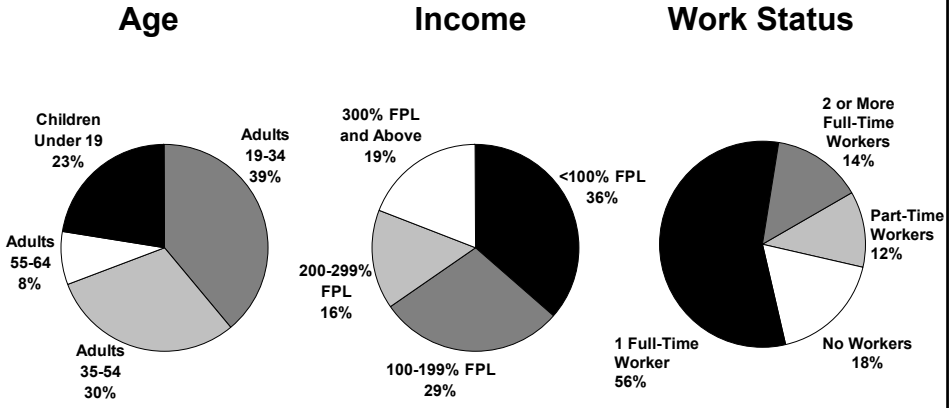
SOURCE: U.S. Census Bureau, 2002 Current Population Survey, 2003.

Figure 2

Characteristics of the Uninsured, 2001



Total = 41 million uninsured

Note: The federal poverty level was $14,128 for a family of three in 2001.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey, 2003.

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The Consequences of Lack of Insurance

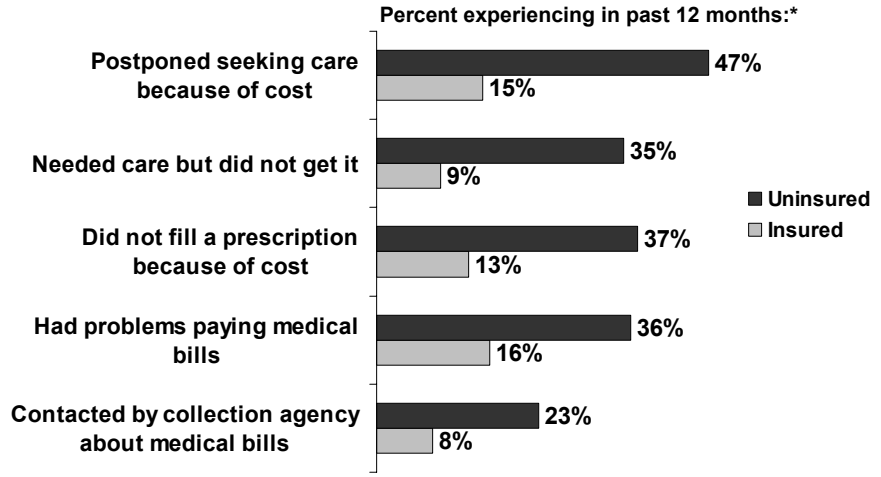
The growing number of uninsured Americans should be of concern to all of us because health insurance makes a difference in how people access the health care system and, ultimately, their health. Leaving a substantial share of our population without health insurance affects not only those who are uninsured, 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; forego needed care; and not get needed prescription medications. 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 (Figure 3). 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 8 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 (Figure 4). Lack of insurance thus takes a toll on both access to care and the financial well-being of the uninsured.

There are often serious consequences for those who forgo care. Among the uninsured, 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 (Figure 5). 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 (Figure 6). Lack of insurance compromises the health of the uninsured because they receive less preventive care, are diagnosed at more

Figure 3

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 2003 Health Insurance Survey*.

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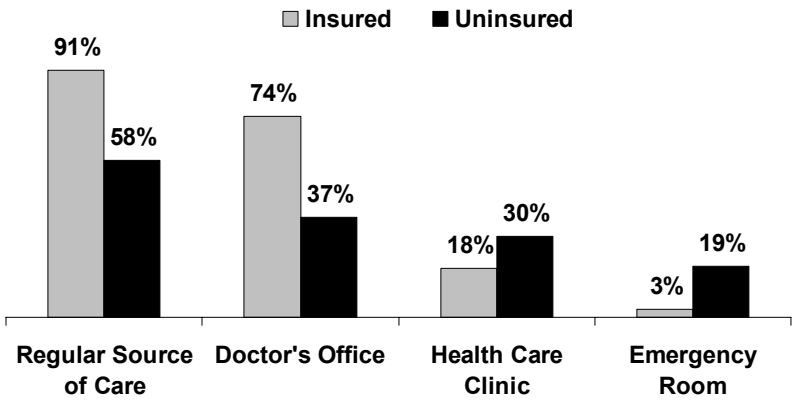
Figure 4

Sources of Care by Insurance Status, 2003



Note: Insured includes those covered by public or private health insurance.
Source: *Kaiser 2003 Health Insurance Survey*.

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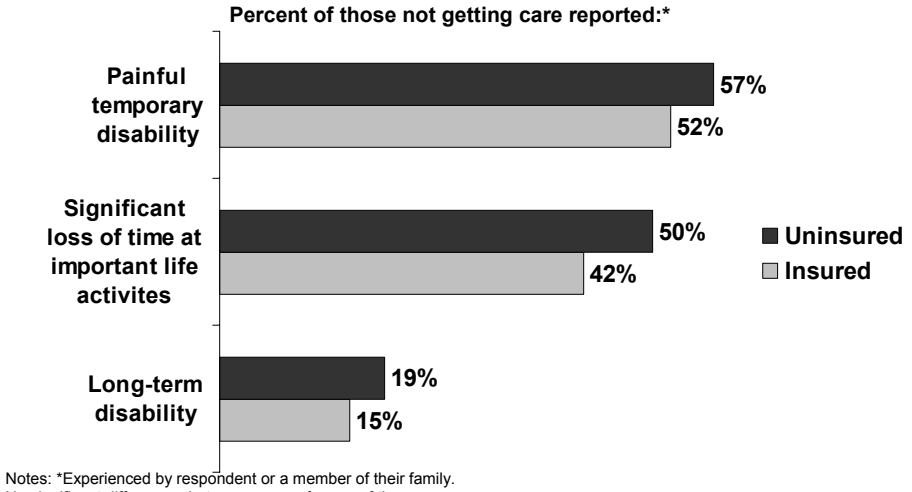
Figure 5

Consequences of Not Getting Care by Insurance Status, 2003



Notes: *Experienced by respondent or a member of their family.
No significant differences between groups for any of these measures.
Insured includes those covered by public or private health insurance.

Source: *Kaiser 2003 Health Insurance Survey*.

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Figure 6

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.

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advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than the insured. 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.

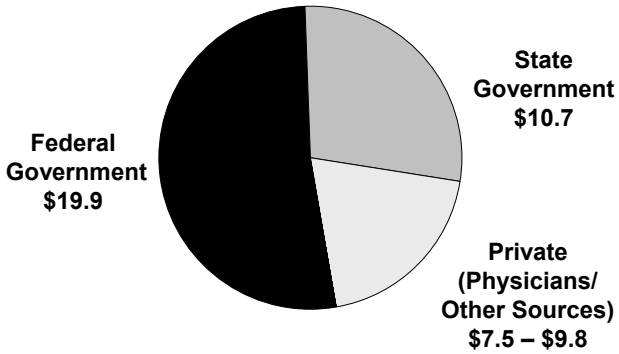
Urban Institute researchers Jack Hadley and John Holahan, drawing from a wide range of studies, conservatively estimate that a reduction in mortality of 5 to 15 percent could be achieved if the uninsured were to gain continuous health coverage. The Institute of Medicine (IOM) in its analysis of the consequences 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 75-80 percent of all uncompensated care funding (Figure 7). The poorer health of the uninsured adds to the health burden of communities because those without insurance often forego preventive services, putting them

Figure 7

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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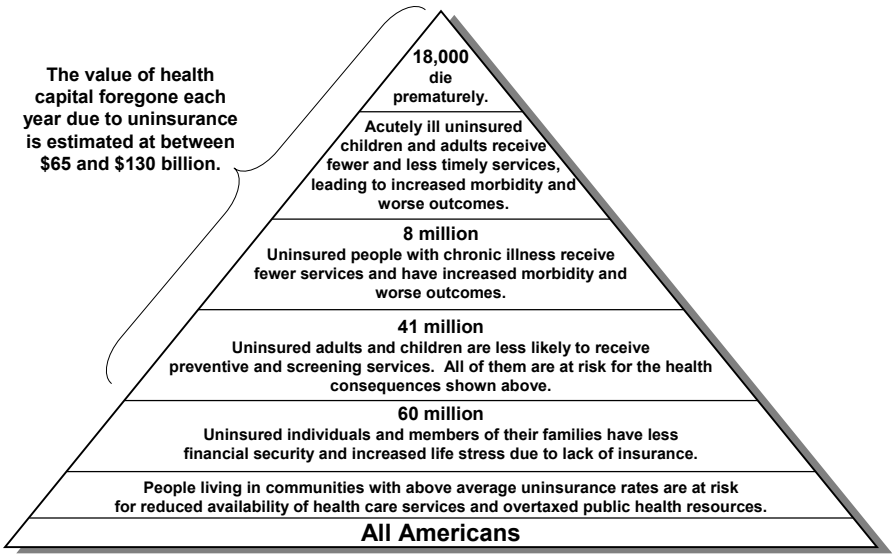
Figure 8

The Consequences of Uninsurance



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

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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 8). 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. Research currently underway at the Urban Institute by Hadley and Holahan 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.

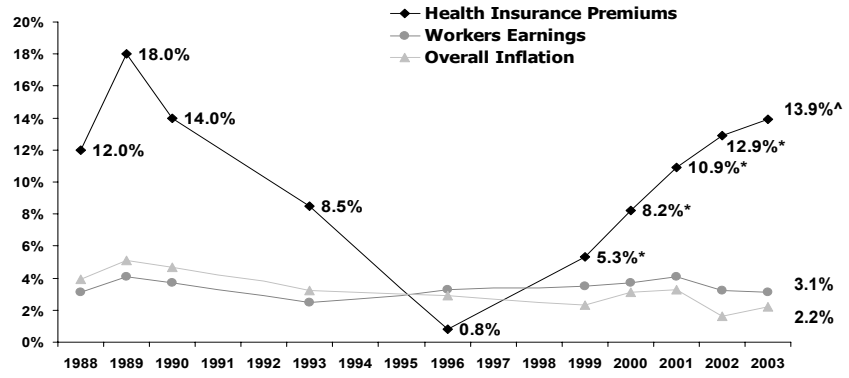
The Current Environment

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. However, all indicators point to this year as one in which we can expect little action on coverage, despite the significant growth in our uninsured population.

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 9). 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

Figure 9

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: KFF/HRET Survey of Employer-Sponsored Health Benefits; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1989, 1990, 1993, 1996.

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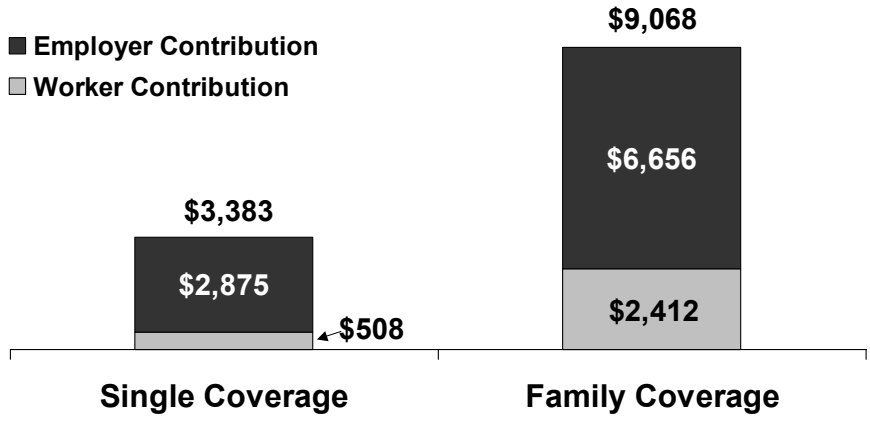
Figure 10

Average Annual Premium Costs for Covered Workers, 2003



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

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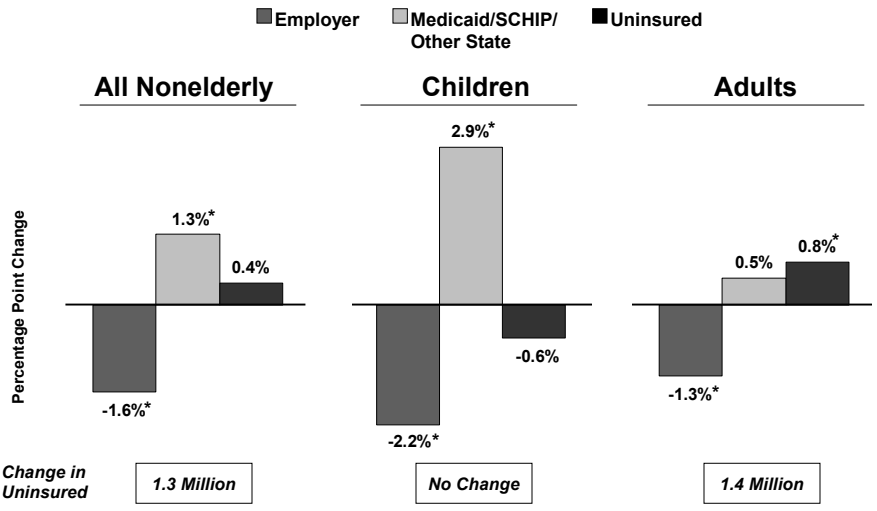
premiums now exceeding $9,000 per year and the workers' contribution to premiums averaging $2,400, the cost of coverage is likely to be increasingly unaffordable for many families (Figure 10). For many low-wage workers, the employee share of premiums may now equal 10 to 20 percent of total income, causing those who are offered coverage to be unable to take it up. However, for most low wage workers, especially those in small firms, it is not a question of affordability --- because the firms they work in do not offer coverage.

From 2000 to 2001, employer-based health insurance coverage declined for low-income adults and children. However, Medicaid and SCHIP enrollment increased in response to the sharp decline in employer-based coverage for children, offsetting a sharper increase in the number of uninsured (Figure 11). The latest Census Bureau statistics on the uninsured for 2002 underscore the important relationship between public coverage and loss of employer-sponsored coverage. Between 2001 and 2002, health insurance provided by the government increased, but not enough to offset the decline in private coverage. 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.

For many low-income families, Medicaid is the safety net that provides health insurance coverage for most low-income children and some of their parents. However, Medicaid coverage provides neither comprehensive nor stable coverage of the low-income population. In 2001, 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 (Figure 12). 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 ($28,256 for a family of 3 in 2001) in 39 states, parents' eligibility levels are much lower. A parent working full-time at minimum wage earns too much to be eligible for Medicaid in 22 states

Figure 11

Changes in Health Insurance Coverage Among Low Income Nonelderly Americans, 2000-2001



*Indicates change is significant at the 95% confidence level
Low Income is less than 200% FPL
SOURCE: Urban Institute, 2002, based on data from the March Current Population Surveys, 2001 and 2002.

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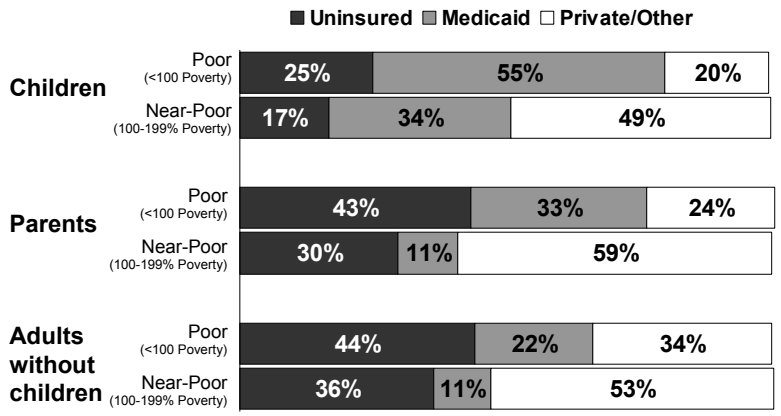
Figure 12

Health Insurance Coverage of Low-Income Adults and Children, 2001



Note: Adults age 19-64. Federal Poverty Level was $14,128 for a family of three in 2001.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey, 2002.

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(Figure 13). 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, over 40 percent of poor adults and a third of near- poor adults are uninsured.

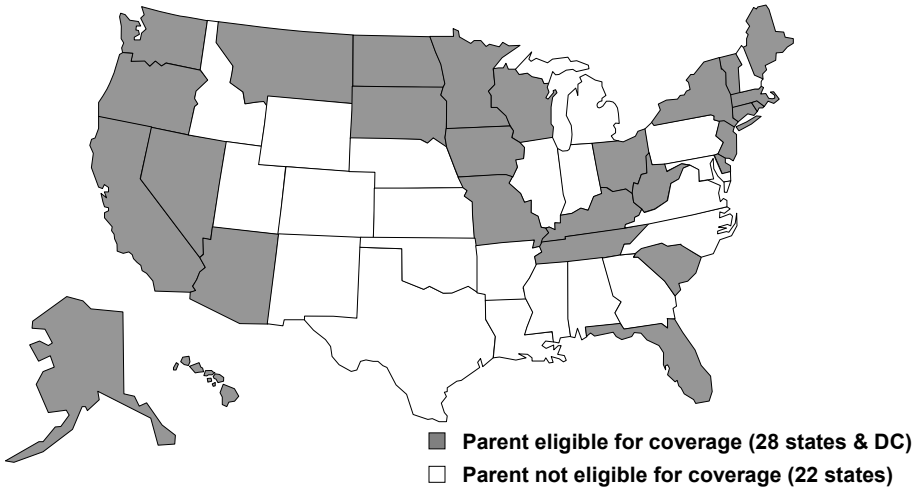
In recent years, with SCHIP enactment and Medicaid expansions, states have made notable progress in broadening outreach, simplifying enrollment processes, and extending coverage to more low-income families. Participation in public programs has helped to reduce the number of uninsured children and demonstrated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

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. In 2002, state revenue collections declined for the first time in at least a decade, falling 5.6 percent from the previous year (Figure 14). 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, it is not the primary cause of state budget shortfalls. While state Medicaid spending rose in FY2002 by $7 billion more than projected based on recent trends, this contribution to state budget deficits is modest compared to the $62 billion gap in state revenue collections relative to projections.

The state revenue falloff is placing enormous pressure on state budgets and endangering states' ability to provide the funds necessary to sustain

Figure 13

Medicaid Coverage of Parents Working Full-Time at Minimum Wage, 2001



Note: Assumes parent works 35 hours per week at $5.15 per hour.
SOURCE: KCMU analysis of Maloy et al. and Broaddus et al. in conjunction with Elizabeth Schott and Matthew Broaddus.

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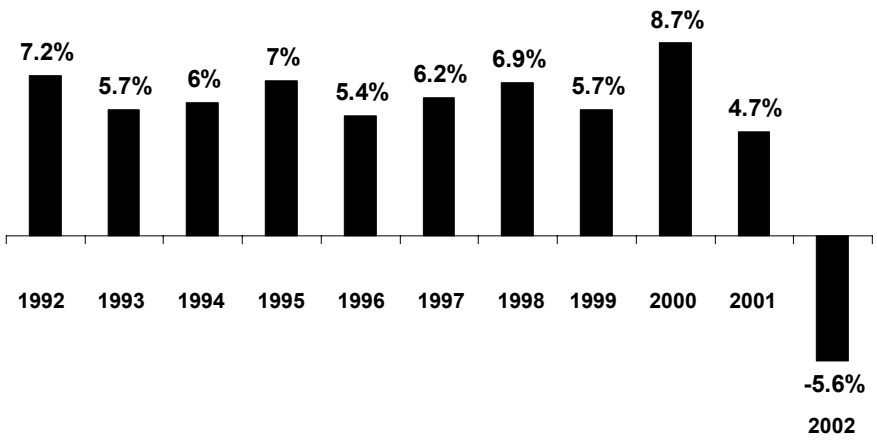
Figure 14

Change in State Tax Revenue Collections, 1992-2002



SOURCE: Rockefeller Institute of Government, Fiscal Year 2002 Tax Revenue Summary, May 2003. Changes are shown in nominal terms and are not adjusted for tax-related legislative changes.

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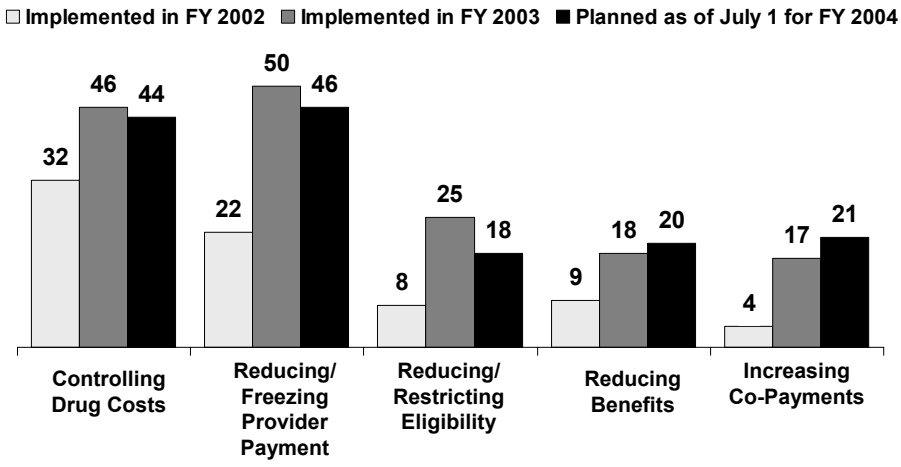
Medicaid coverage. Turning first to "rainy day" and tobacco settlement funds, states have tried to preserve Medicaid and keep the associated federal dollars in their programs and state economies. But, as the sources of state funds become depleted, states face a daunting challenge in trying to forestall 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 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 15).

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.

Figure 15

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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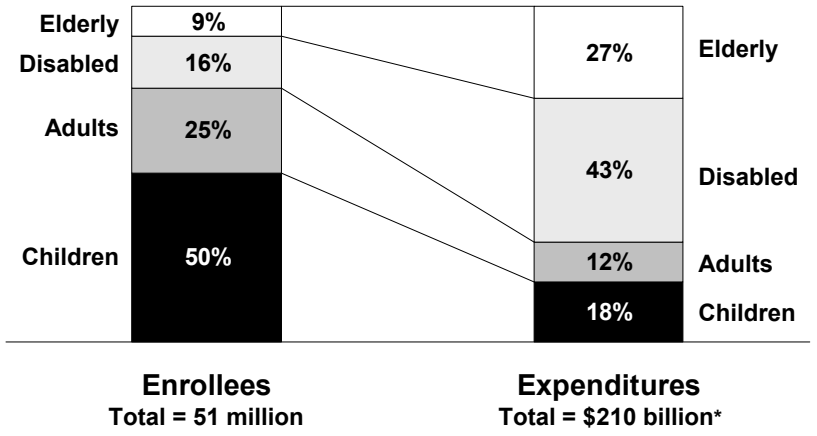
Figure 16

Medicaid Enrollees and Expenditures by Enrollment Group, 2002



*Expenditures on services based on historical state share data.
SOURCE: Kaiser Commission estimates based on CMS and March 2003 CBO data.

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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 16). 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 (Figure 17).

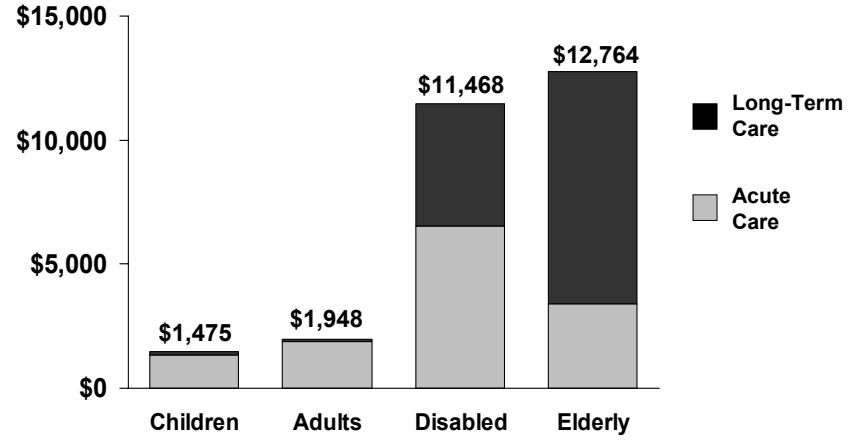
It is these broader roles for the elderly and disabled population that drive Medicaid's costs. Most notably, for 7 million low-income elderly and disabled Medicare beneficiaries, Medicaid provides prescription drug coverage, long-term care assistance, vision care, dental care, and other services excluded from Medicare. While these dual eligibles represent 10 percent of the Medicaid population, they account for over 40 percent of Medicaid spending. Most of the growth (77%) in Medicaid spending last year 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. 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 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. This week's 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

Figure 17

Medicaid Expenditures Per Enrollee, 2002



*Expenditures on services based on historical state share data.
SOURCE: KCMU estimates based on CBO March 2003 Baseline and Urban Institute data.

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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.