

Issue Brief

The Domino Effect of the Uninsured



THE
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FOR
Health
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The Numbers Are Rising

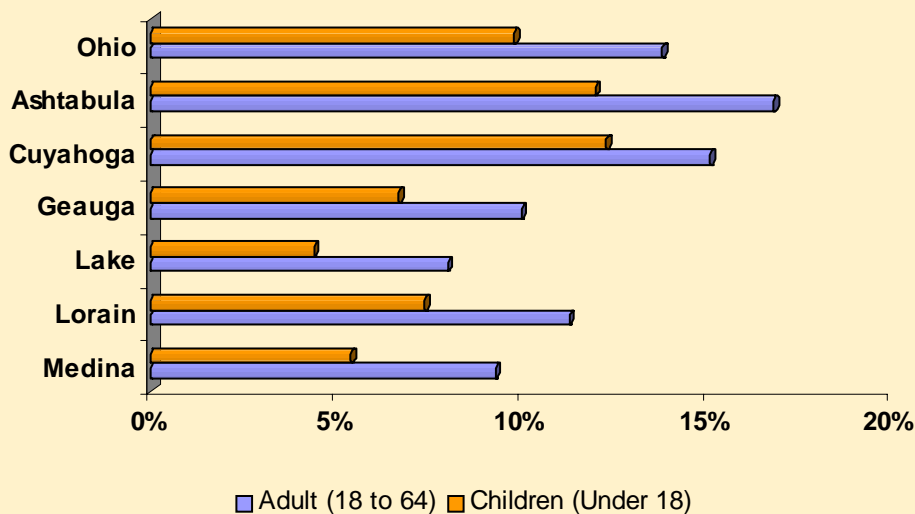
According to the U.S. Census Bureau, 43.6 million people, or 15.2 percent of the U.S. population, went without insurance for the entire year in 2002. This represents an increase from the 41.2 million people, 14.6 percent, who were uninsured in 2001.²

In Ohio, 11.9 percent, or 1.34 million people, were uninsured in 2002, up from roughly 1.25 million Ohioans, 11.2 percent, in 2001.³ Ohio's lower uninsured rate has been attributed to a higher rate of employer-based health coverage.

In Northeast Ohio, uninsured rates vary widely from county to county. Cuyahoga County had the region's highest rate of uninsured children in 1998 at 12.3 percent. In comparison, only 4.4 percent of Lake County children were uninsured. Similar

variation exists for adults. While 16.8 percent of adults in Ashtabula County were uninsured in 1998, only 8.0 percent of adults in Lake County were uninsured that year.⁴

Percentage of Child & Adult Population Without Health Insurance: 1998



Source: Federation for Community Planning and United Way Services. Social Indicators 2003: Community Health. Published December 2003.

Americans benefit from some of the highest quality, most advanced healthcare available in the world. Rarely does a week pass without the announcement of a new procedure, drug or technological advance that promises to improve medical care. But for millions, the system is nearly inaccessible. Nationwide, almost 44 million people find themselves in the situation of being uninsured. Without insurance, they lack even the most basic preventive care. Often it is only when they have reached a crisis that they seek treatment.

The system bears the cost of providing healthcare to the uninsured, but it is an expensive and inefficient investment. Because of their limited options for accessing services, the uninsured tend to be sicker when they finally do seek care, and they access it in costlier settings. Lack of insurance is a quality-of-life issue for those directly affected and a matter of economics for the system as a whole. And unless the issue is addressed, the problem is only likely to worsen. As the system absorbs the cost of caring for the uninsured, healthcare becomes more expensive overall, leading to higher insurance costs and a growing uninsured population.

While experts of all types – from healthcare providers to policymakers to human services advocates – agree that something must be done, a solution has been evasive. The best and brightest have put forth countless proposals at the federal level designed to address the growing number of uninsured, but the price tags on the proposals and the politics of large-scale change have thwarted attempts to implement a remedy.

According to the National Conference of State Legislatures, 43 states are likely to address access to health insurance in their 2004 legislative sessions, and the National Governor's Association reports that 42 percent of governors cited the need to expand health insurance coverage for the uninsured in their 2004 state-of-the-state addresses. But at the same time, 34 states have reduced their Medicaid budgets by cutting services and reducing eligibility.¹ In an attempt to plug the dam, many communities are taking the driver's seat and designing local solutions to address the growing problem.

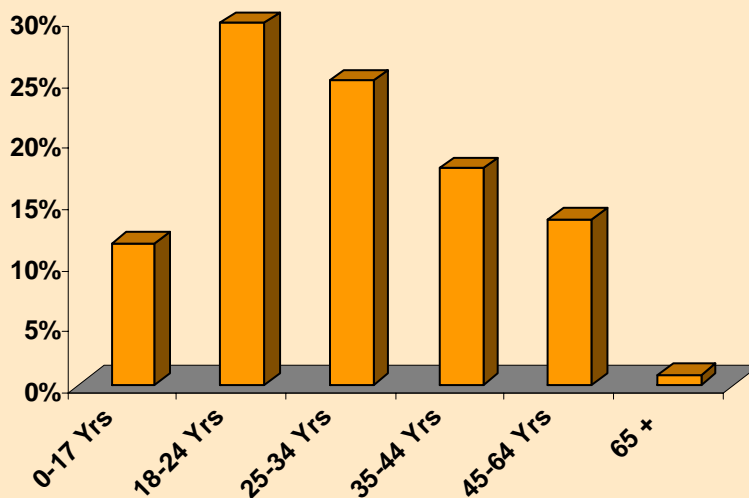
This issue brief illustrates the domino effect of the uninsured on individuals, providers, and society.

Who are the uninsured?

While the uninsured are a diverse population, the problem tends to affect some demographic groups more than others. Age, ethnicity, gender and income level all play a role in determining whether an individual is likely to have health coverage.

Age is one of the more significant factors impacting insured status. Because Medicare is available to most people age 65 and over, and eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP)⁵ tends to be more extensive for children than for adults, the majority of the uninsured fall in the middle. Young adults between the ages of 18 and 34 were more likely to be uninsured than other age groups in 2002. Gender plays a much smaller role than age. In 2002, 13.9 percent of females were uninsured, compared to 16.7 percent of men.

Percentage of Age Group Uninsured in U.S.: 2002



Source: U.S. Census Bureau. Health Insurance Coverage in the United States: 2002. Current Population Reports. September 2003.

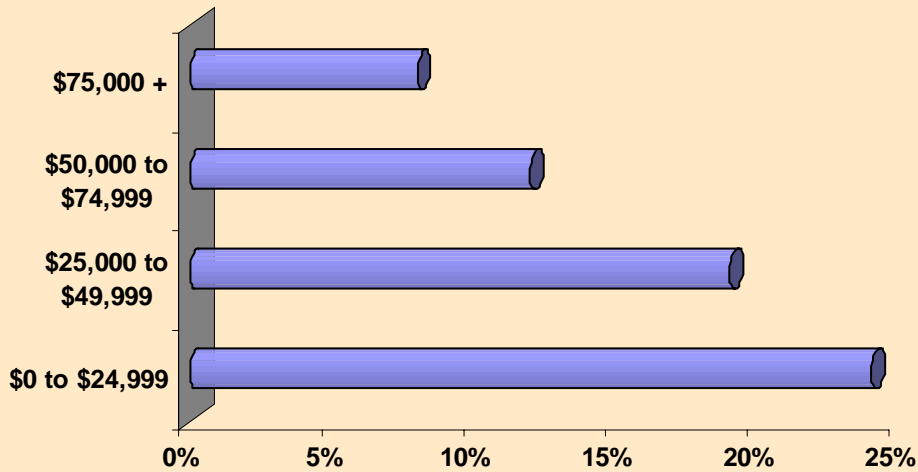
Racial and ethnic background, as well as whether individuals are born in the U.S. or elsewhere, are associated with different rates of health insurance coverage. Racial and ethnic minorities are more likely to be uninsured than whites. Almost one in three Hispanics, 32.4 percent, was uninsured in 2002, compared to 20.2 percent of African Americans, 18.4 percent of Asians and 14.2 percent of whites. That same year, a greater percentage of foreign-born people residing in the U.S. were uninsured,

33.4 percent, compared to native-born people, 12.8 percent. Of foreign-born people, non-citizens were more than twice as likely as naturalized citizens to be without health insurance. Yet in terms of sheer numbers, there were more uninsured native-born people than uninsured foreign-born people.

Not surprisingly, insurance coverage is directly related to household income, with those living in poverty reporting the highest uninsured rates. Almost one in every three people living in poverty, or 30.4 percent, did not have health insurance coverage in 2002. Employment status is also closely linked. When examining the entire working population ages 18 to 64, workers were more likely, 82.0 percent, than nonworkers, 74.3 percent, to be insured.

Yet contrary to popular belief, many of the uninsured worked at some point during the previous year. When focusing on those living below the poverty level, those who did not work were actually *less* likely to be uninsured than either part- or full-time workers in 2002. During that year, 38.1 percent of those who were unemployed and living at or below the poverty level were uninsured, compared to 44.4 percent of part-time workers living in poverty and 49.3 percent of full-time workers in poverty.⁶

Percentage Uninsured by Household Income in U.S.: 2002



Source: U.S. Census Bureau. Health Insurance Coverage in the United States: 2002. Current Population Reports. September 2003.

Why are 43.6 million people uninsured?

Why does there remain a sizeable uninsured population in the U.S.? To answer this question, it is important to understand what health insurance coverage is available.

Public Programs

Government health insurance plans cover one quarter of the population, but they are not available to everyone. To receive Medicaid or Medicare, the two largest public health insurance programs, individuals must meet eligibility criteria. Medicare is generally available to people age 65 and over as well as to certain persons under age 65 with disabilities or with end-stage renal disease. Medicaid is administered by states, and while minimum coverage standards must be met, eligibility can vary by state.

In Ohio, children up to 200 percent of the federal poverty level (FPL), pregnant women up to 150 percent of the FPL and parents up to 100 percent of the FPL are eligible for Medicaid (in 2004, the federal poverty level is \$15,670 for a family of three). Subject to some limitations, individuals with disabilities and Ohioans aged 65 or older up to 64 percent of the FPL are also eligible for Medicaid. Note, however, that in Ohio, single, childless adults who are not disabled and have not reached 65 years of age are not eligible for Medicaid, regardless of how low their income might be.⁹

Nationally, 40 million people are enrolled in Medicaid.¹¹ In 2002, Medicaid provided healthcare for 1.75 million Ohioans.¹²

More than 40 million people are enrolled in Medicare nationwide.¹³ In Ohio, 1.7 million people were covered by Medicare in 2002.¹⁴

Ohio Medicaid Enrollees

Ages	Covered Families	
	and Children	Aged, Blind or Disabled
0 to 18	923,292	31,479
19 to 64	413,775	236,480
65+	261	149,678
Total	1,337,328	417,637
Unduplicated SFY 2002 Eligibles = 1,754,965		

Source: Edwards, B.C. Ohio Medicaid Reform: What's on the Horizon for 2004 and Beyond? Ohio Osteopathic Association Teleconference. January 26, 2004.

Note: SFY = state fiscal year.

Note: Numbers include enrollees in the State Children's Health Insurance Program (SCHIP).

Participation in public programs, particularly Medicaid, has yet to reach 100 percent of those eligible. It has been estimated that between 31 and 41 percent of children eligible for Medicaid are not enrolled, have no other source of insurance and thus are uninsured. Many hypothetical reasons exist to explain why eligible people do not enroll – potential stigma associated with being in a public program, lack of awareness of eligibility, knowing that if a medical need arises they can enroll, and barriers caused by administrative requirements. However, little is known about how important each of these factors is relative to decisions about whether or not to enroll in Medicaid.¹⁰

Small Business Owners

Much has been written about the difficulty of obtaining health insurance for individuals working in small businesses and the data substantiate this concern. Of workers ages 18 to 64, those working in firms of more than 100 employees were twice as likely to be covered by their own employer-based health insurance than workers in firms with less than 25 employees.¹⁹

The rising cost of health insurance appears to contribute significantly to decisions by small employers not to offer health insurance. Seventy-six percent of small firms (3 to 199 workers) report that high insurance premiums played a very important, and 15 percent said a somewhat important, role in their decision not to offer coverage as a benefit.²⁰

In Ohio, only 52 percent of firms with fewer than 50 employees offered health insurance in 2001 compared to 98 percent of firms with 50 or more employees.²¹ Ohio's rate of uninsured adults under age 65 working in firms of fewer than 10 employees increased from 22 percent in 1999 to 29 percent in 2001.²²

Also important to remember is that Medicaid is tied to income. Thus an increase in a family's income level, even just a slight one, can cause them to lose Medicaid coverage. This might help explain why many of the uninsured cycle on and off of coverage.

Private Coverage

Private health insurance provided either through an employer or purchased directly by an individual covers nearly 70 percent of the U.S. population. Under employer-based coverage, employers contract with insurance companies to offer health insurance to their employees, and the employee and employer typically share the cost of the insurance premium. Employer-based health insurance covers more than 61 percent of the U.S. population.¹⁵

The majority of eligible workers, 83 percent, who are offered employer-based health insurance choose to participate.¹⁶ However, not all employers offer coverage. Service and labor employers are less likely to provide workers with health insurance. Furthermore, part-time workers frequently are ineligible for employer-based health insurance.¹⁷

Individuals who are self-employed or who do not receive health insurance through their employers can purchase health insurance directly from an insurance company. However, this type of insurance can place a heavy financial burden on the purchaser because there is no second party with whom to share the premium cost and the rates for individually purchased insurance tend to be more expensive than that bought in the group market. Despite these barriers, more than 9 percent of the U.S. population is covered by direct-purchase insurance.¹⁸

Rising Cost of Healthcare

A complete picture of why people lack health insurance would be impossible without considering the rising cost of healthcare. The medical care consumer price index (CPI), which takes into account both the cost of services and the cost of commodities such as prescription drugs and non-prescription medical equipment and supplies, is an indicator of the prices consumers are paying for care. Medical care prices paid by consumers rose 5.0 percent from 2001 to

2002. For five years in a row, the rate of medical care inflation was higher than in the preceding year.²³ Factors contributing to the rising cost of healthcare include increased utilization, higher labor costs, the price of technological advances and pharmaceuticals, and the cost of compliance with increasing regulation, to name just a few.

Rising healthcare costs affect all aspects of the health system, including the price of health insurance. Private health insurance premiums per enrollee were projected to grow between 10.4 percent and 13.9 percent in 2003, marking the third consecutive year of double-digit premium increases.²⁴

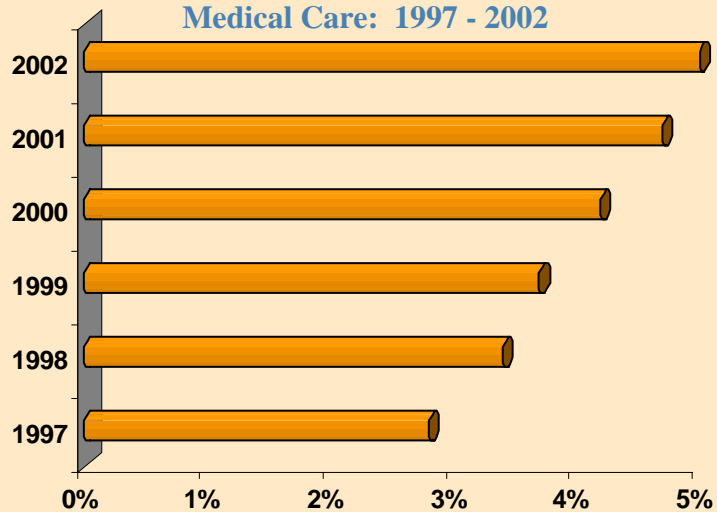
Premiums have increased far faster than the 2.2 percent overall inflation rate, and the 3.1 percent wage gains for non-supervisory workers.²⁵ As insurance costs have risen over time, employers have shifted more and more costs to employees by increasing the employee share of the premiums or increasing deductibles and co-payments.

As insurance premiums grow, so do the ranks of the uninsured. Data from the U.S. Census Bureau indicate the percent of people covered by employer-based health insurance dropped to 61.3 percent in 2002 from 62.6 percent the previous year, although it is likely that increased joblessness also played a role in these numbers.

Rising costs have more drastic financial implications for seriously ill and low-income workers. Research suggests that compared to higher-waged workers, low-income persons are more sensitive to premium prices and pay more for coverage.²⁶ Seriously-ill workers use more healthcare services than their healthier counterparts and thus face increased costs.

What does the bulk of the research on the uninsured lead us to conclude about why some people have no health insurance? There is no simple answer – there are multiple reasons for people to be without health insurance in this country. Cost is clearly a factor. Some healthy people can afford to purchase health insurance, but do not feel the benefits outweigh the price tag. Others want to purchase a health insurance product offered to them, but cannot afford the coverage. Access also factors into the equation. Unfortunately, some people with serious health problems want and would pay for health insurance, but find that insurance companies will not insure them or exclude certain pre-existing conditions. As discussed previously, part-time employees, those employed in the labor or service industry or those working for small business owners frequently find that they are not offered health insurance as a benefit.²⁷

Annual Change in the Consumer Price Index for All Urban Consumers Medical Care: 1997 - 2002



Source: Bureau of Labor Statistics, Another Rise in Medical Care Inflation, April 16, 2003.

Intermittent and Cyclical

An uninsured individual might not have insurance for an entire year or longer, or might go without health insurance for several months out of a year.

Of uninsured spells that occurred between January 1996 and December 1999, 44.1 percent lasted two to four months and close to three-quarters, 74.7 percent, ended within one year.⁷ Only 9.1 percent lasted longer than two years.

However, some research suggests that many of the uninsured cycle on and off coverage.⁸

What are the effects of a large uninsured population?

Just as the explanations for why individuals lack insurance are varied and complex, so are the ramifications. But it is clear that in the end, we are all affected by the higher costs of healthcare and the poorer public health that results.

Uncompensated Care

Uncompensated care is care that is provided but for which payment is not received, or is only partially received. Uncompensated care can include losses that result from free or charity care, government shortfalls and bad debt.

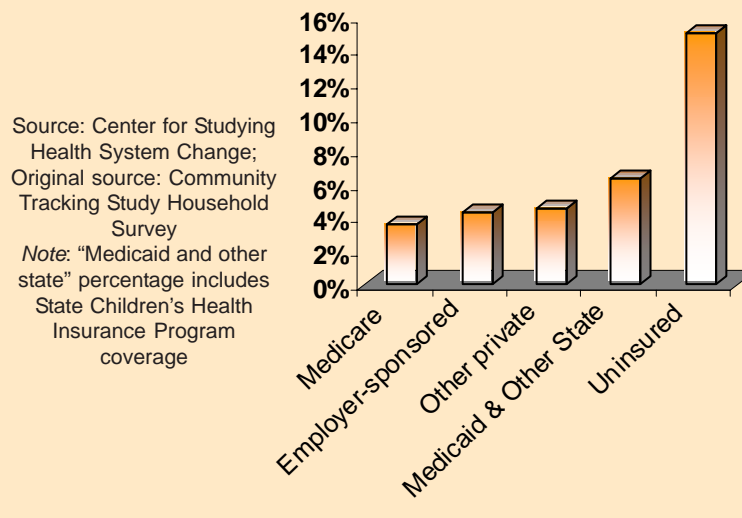
U.S. hospitals provided \$22.3 billion in uncompensated care resulting from charity care and bad debt in 2002, up from \$21.5 billion provided in 2001. In 2001, Ohio hospitals provided \$716 million in uncompensated care from charity care, bad debt and Medicaid shortfalls, with almost \$237 million of that occurring in Northeast Ohio hospitals.³⁷

Note: *Uncompensated care provides a measure of how the uninsured impact hospitals' ability to deliver care. However, it is not a perfect measure because bad debt may result from bills not paid by uninsured and insured individuals and government shortfalls represent a reimbursement problem for publicly insured programs.*

Access is Limited

While reasons can vary, research has shown a lack of insurance results in compromised access to care. According to a 2001 survey, 15.0 percent of the uninsured reported having an unmet medical need over a 12-month period compared to 6.3 percent of Medicaid recipients, 4.3 percent of those with employer-sponsored coverage, 4.5 percent of those with other private coverage and 3.6 percent of Medicare recipients.²⁸ In addition to reporting unmet needs, uninsured individuals are found to receive less care overall than insured individuals. People who were uninsured for the full year received roughly half as much care, an average of \$1,253 per person, as the privately insured, at \$2,484 per person.²⁹

Percentage of People Reporting Unmet Medical Needs in the U.S.: 2000-01



Preventive care is cited as one of the most commonly unmet needs of the uninsured. Results from the Urban Institute's National Survey of America's Families showed that children enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP) were 1.5 times more likely than uninsured children to receive preventive care, any type of office visit, and dental care. Another study found that the uninsured face consistently lower access to, and satisfaction with, substance abuse treatment and mental healthcare.³⁰

The uninsured are also more likely to put off or postpone necessary medical care. In a 12-month period during 2000 and 2001, 15.7 percent of the uninsured reported delaying medical care compared to only 7.9 percent of Medicaid recipients, 8.9 percent of those with employer-sponsored coverage, 10.8 percent of those with other private coverage and 6.4 percent of Medicare recipients.³¹

Turning to Emergency Rooms

It should come as no surprise that the unmet medical needs and delayed care that the uninsured report translate into higher rates of emergency room care. The uninsured are more likely to seek emergency room care either because a health problem has escalated or because of a lack of access to primary care in another setting.

Uninsured adults are four times more likely to use the emergency room as a regular source of care compared to those with health insurance. Children who are uninsured are five times as likely to use the emergency room as a regular source of care compared to insured children.³²

Most healthcare professionals would agree that the emergency room is not the ideal setting in which to receive non-emergency, routine, primary care. Care received in an emergency room is designed to quickly address an acute problem. Patients who frequently use emergency rooms to access care for non-emergent conditions are not benefiting from the continuity of care and emphasis on prevention that can be acquired through a primary care provider.

Yet many of the problems that present in an emergency room might have been prevented if necessary, ongoing disease management services had been provided or if a health problem, such as an infection, had been treated at the onset. From 1980 to 1998, the number of hospitalizations for avoidable conditions³³ increased from 2.2 million to 3.7 million, resulting in a change from 5.9 percent to 11.5 percent of all hospitalizations. The uninsured experience these types of avoidable hospitalizations disproportionately. While 11.6 percent of hospital stays for the uninsured were for preventable conditions, only 7.5 percent of privately insured individuals' hospital stays were for preventable conditions.³⁴ In 2002, the average cost of a hospitalization for an avoidable condition was \$3,300.³⁵

The sting of high emergency room costs are not felt solely by the uninsured individual. While uninsured families pay 88 percent of their prescription drug costs and 47 percent of their outpatient costs, they pay just 7 percent of their hospital costs. Despite well-intentioned attempts by many of the uninsured to pay for their own hospital care, providers frequently incur a high level of unreimbursed expenses or uncompensated care when they take care of uninsured persons.³⁶

Poorer Health Outcomes

Intuitively, healthcare professionals conclude that because of the effects on access, lack of insurance can lead to poorer health. But because of the many factors that impact health and the difficulty of designing a study that can isolate these factors, it has been difficult for researchers to measure the direct effects of a lack of insurance on health. However, the Kaiser Commission on Medicaid and the Uninsured suggests that some conclusions about the relationship between health insurance and health outcomes can be drawn from the bulk of observational studies and natural experiments that have been conducted. In their review of research findings over the past 25 years, they found that the uninsured are diagnosed at more advanced disease stages. They also found that having health insurance would reduce mortality rates for the uninsured by 10 to 15 percent.³⁸

The Institute of Medicine (IOM) has arguably gone further than others in drawing links between a lack of health insurance and poorer health outcomes.

Hospitals in urban areas with higher uninsured rates have less total inpatient capacity, offer fewer services for vulnerable populations (such as AIDS care), and are less likely to offer trauma and burn care [than urban hospitals with lower uninsured rates]. Hospitals in rural areas with higher uninsured rates have lower financial margins and fewer intensive care unit beds, offer fewer psychiatric inpatient services, and are less likely to offer high-technology services (such as radiation therapy).⁴³

– Institute of Medicine



What are Other Communities Doing?

In the absence of a solution at the national level, some states and communities have implemented creative approaches to assisting the uninsured in their areas.

Maine's Dirigo Health

Maine created the Dirigo Health program. This state-private partnership aims to ensure health insurance access to all of the currently 140,000 uninsured individuals in Maine by 2009. Participation is voluntary and initially open to small businesses with fewer than 50 employees, the self-employed and uninsured individuals. The first enrollee will be signed up in July 2004.

Dirigo Health is funded through a combination of employer and enrollee payments, Medicaid dollars and in year one, state funds. After the first year, state funds are replaced by an assessment on the gross premium revenues of insurers if, and when, healthcare cost savings occur. Employees and individuals below 300 percent of the federal poverty level will receive subsidies, with the poorest residents not having to pay.⁴⁹

New York's Healthy NY

In January 2001, New York launched the Healthy NY program to help small businesses, including sole proprietors, and uninsured workers afford health insurance. Nearly 40,000 people are currently enrolled in the program. Since its inception, almost 60,000 people have enrolled.

(Continued on next page)

A report by the IOM concluded that uninsured women and their newborns were more likely to have maternal complications and higher rates of infant death. Furthermore, compared to insured adults, uninsured adults face a 25 percent greater mortality risk resulting in roughly 18,000 unnecessary deaths in the U.S. every year.³⁹

Economic and Societal Consequences

Besides poorer health outcomes, being uninsured may have economic consequences. Because a lack of insurance can negatively impact health status, it can result in reduced productivity in the workplace and increased absenteeism in schools. The Kaiser Commission on Medicaid and the Uninsured found that annual earnings would improve by roughly 10 to 30 percent if people had better health. The commission also found that increased educational attainment would be achieved.⁴⁰

Lest people think that the uninsured are the only ones affected by a lack of health insurance, some research suggests there is a spillover effect to the rest of the community. Poorer health and higher mortality rates of the uninsured are estimated to cause the economy to lose between \$65 billion and \$130 billion each year.⁴¹ When the uninsured substitute emergency rooms for primary and preventive care, the healthcare system suffers rising costs and there is reduced access to ER services for all. And ultimately, the unreimbursed costs of caring for uninsured individuals are subsidized by the public through higher taxes and higher prices for services and insurance.⁴²

What can be done?

Given the negative effects on health status as well as the systemwide ramifications that affect everyone, the lack of health coverage by nearly 44 million people is a dire problem in need of a solution. History has proven that the right public policy solutions can decrease the ranks of the uninsured. Before the Medicare and Medicaid programs were created in 1965, a much greater percentage of people, particularly the elderly and children, went without health insurance. In a 1962-1963 study of health insurance coverage, 29.7 percent of all people had no hospital insurance and 34.8 percent had no surgical coverage. In 2002, 15.2 percent of the population went without health insurance, an improvement from 40 years ago, but higher than the 1987 rate of 12.9 percent.⁴⁴

Medicare and Medicaid have changed the face of the uninsured. From 1962 to 1963, only 54.0 percent of those over age 65 had hospital insurance compared to 71.9 percent of those under age 65. Today less than 0.8 percent of those 65 and over are uninsured. Clearly, Medicare is in large part responsible for the huge strides we have made in providing coverage to the elderly. Medicaid and SCHIP have succeeded in decreasing the percentage of low-income children who do not have health insurance. Between 1962 and 1963, 78.1 percent of children under 15 in the poorest income category had no hospital insurance. While not directly comparable, in 2002 the rate of uninsured children under 18 living in poverty had been reduced to

20.1 percent.⁴⁵



We should be proud of the strides we have made in reducing uninsured rates among the populations served by the Medicare and Medicaid/SCHIP programs, but our work is not done. While Medicare and Medicaid have covered greater percentages of the population over the years, U.S. Census data show that private coverage declined from 75.5 percent in 1987 to a 15-year low of 69.9 percent in 2002.

With private coverage rates declining and public programs only covering certain eligibility groups, a health insurance gap remains for a sizeable portion of the U.S. population. Experts in the field will assert that the uninsured need access to a coordinated system of care with a preventive focus, not the fragmented system they currently face. To ensure everyone is receiving the care that they need and the system is being used as efficiently as possible, we must be able to provide the right care at the right time in the right setting.

This will likely only be achieved by providing everyone with healthcare coverage that adequately reimburses providers. There is nothing new or earth-shattering in this solution. Efforts in the U.S. to assure coverage to all extend back many decades. Many have fought for and continue to advocate this position, despite the stumbling blocks before them. All the while, the number of uninsured continues to grow and free care clinics, hospitals, and other healthcare providers continue to struggle to meet the growing demand.

The biggest obstacle to providing coverage to all is the price tag. One analysis estimates the additional cost of medical care that would be incurred if the uninsured were fully insured at between \$33.9 billion and \$68.7 billion. This represents a 3 to 6 percent increase in total health spending and would create a less than one percentage point rise in healthcare's share of gross domestic product (GDP).⁴⁶ Some have noted that additional government spending would be needed as privately-insured individuals switch to publicly-insured programs and other costs are shifted to the government.⁴⁷ But it is important to remember that the government is already spending about \$30.6 billion on payments and programs to serve the uninsured.⁴⁸

Many think that the vast numbers of uninsured, which are constantly on the rise, are causing growing instability of the nation's healthcare system. While hospital closures in recent years cannot be pinned exclusively on lack of insurance coverage, it is certainly one of many closely linked factors. Yet the problem seems poised to worsen. Legislation pending in Congress calls for potential reductions in federal Medicaid funding totaling almost \$2.2 billion in fiscal years 2005 through 2009.

It is important that we not take a step backwards. Our current economic environment has left millions jobless. Coupled with the high cost of health insurance, the resulting scenario is one of many employed and unemployed workers forgoing health insurance. Barring an overhaul of the system and the creation of health insurance coverage for all, at the very least Medicaid must be preserved. For many low-wage earners and vulnerable populations, Medicaid offers a safety net that, if taken away, would be devastating.

All health maintenance organizations in the state are required to offer standardized benefit packages, which the state subsidizes to reduce costs. Plan coverage includes inpatient and outpatient hospital care, emergency services, physician services, maternity care, diagnostic and X-ray services and therapeutic services. Eighty-nine percent of surveyed enrollees report being either "satisfied" or "highly satisfied" with the Healthy NY program.⁵⁰

Muskegon, Michigan's Access Health

Muskegon's Access Health program, begun in 1999, helps small to medium-sized businesses provide healthcare services to their employees. This program is available to businesses paying workers a median wage of \$11.50 or less per hour. Employees must have been uninsured for at least a year. Access Health is not a health insurance plan, but contracts directly with local doctors and hospitals to provide basic and specialty care to enrollees.

A community collaborative that brings together providers, government, employers and employees, Access Health's financing is split three ways between employers (30 percent), employees (30 percent) and the community (40 percent). Funds from the local government, community, foundations and the federal disproportionate share program comprise the community share. To pay for ongoing third-party administrative costs, 10 percent of provider fees are donated back to the program.⁵¹





The Center for Health Affairs is a hospital trade association representing 35 hospitals in Northeast Ohio and serving those organizations and others through a variety of advocacy and business management services. CHA also works to educate the public on issues that affect the delivery of healthcare. Formed by a visionary group of hospital leaders more than 85 years ago, CHA continues to operate on the principle that by working together hospitals can ensure the availability and accessibility of healthcare services. For more on CHA and to download additional copies of this brief, go to www.chanet.org.

Endnotes

- ¹ Note: Includes State Children's Health Insurance Program (SCHIP) and state-funded health insurance program. Ku, L. and Nimalendran, S. "Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs." *Center on Budget and Policy Priorities*. December 22, 2003. <http://www.cbpp.org/12-22-03health.pdf>.
- ² Mills, R.J. and Bhandari, S. "Health Insurance Coverage in the United States: 2002." *U.S. Census Bureau: Current Population Reports*. September 2003. <http://www.census.gov/prod/2003pubs/p60-223.pdf>.
- ³ U.S. Census Bureau. "Table HI-4. Health Insurance Coverage Status and Type of Coverage by State All People: 1987 to 2002." September 30, 2003. <http://www.census.gov/hhes/hlthins/historic/hihist4.html>.
- ⁴ Federation for Community Planning and United Way Services. *Social Indicators 2003: Community Health*. December 2003. Note: People were classified as uninsured if they stated they were without health insurance in the previous week. This differs from how the U.S. Census Bureau classifies the uninsured (no insurance throughout the calendar year).
- ⁵ States have flexibility in how they design their SCHIP programs: States may expand their Medicaid programs, create a separate state program, or create a program that combines Medicaid and SCHIP. Ohio implemented SCHIP as an expansion of Medicaid. Ohio Department of Job and Family Services. "The State Children's Health Insurance Program (SCHIP) in Ohio." <http://jfs.ohio.gov/ohp/bcps/schip/index.stm>
- ⁶ Statistics in this section come from: Mills, R.J. and Bhandari, S. "Health Insurance Coverage."
- ⁷ Mills, R.J. and Bhandari, S. "Health Insurance Coverage."
- ⁸ Short, P. F. and Graefe, D.R. "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured." *Health Affairs*, November/December 2003, 22(6), 244-255.
- ⁹ The Ohio Department of Job and Family Services. "Office of Ohio Health Plans Fact Sheet." March 2004. <http://jfs.ohio.gov/ohp/bcps/factsheets/MedicaidPrograms.pdf>.
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- ¹² Edwards, B.C. "Ohio Medicaid Reform: What's on the Horizon for 2004 and Beyond?" Ohio Osteopathic Association Teleconference. January 26, 2004. <http://www.ooanet.org/pdf/Medicaid.pdf>.
- ¹³ Centers for Medicare and Medicaid Services. "Medicare Information Resource." Last modified on Friday, September 12, 2003. <http://www.cms.gov/medicare/>.
- ¹⁴ Kaiser Family Foundation. "Ohio: Medicare." *State Health Facts Online*.
- ¹⁵ Note: Some privately insured individuals also qualify for Medicare and/or Medicaid benefits. Mills, R.J. and Bhandari, S. "Health Insurance Coverage."
- ¹⁶ Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 2003 Annual Survey*. 2003. p.50. <http://www.kff.org/insurance/ehbs2003-1-set.cfm>.
- ¹⁷ Families USA. "Who's Uninsured in Ohio and Why?" November 2003. http://www.familiesusa.org/site/DocServer/Ohio_uninsured.pdf?docID=2396.
- ¹⁸ Mills, R.J. and Bhandari, S. "Health Insurance Coverage."
- ¹⁹ Ibid.
- ²⁰ Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits*.
- ²¹ Kaiser Family Foundation. "Ohio: Private Sector Coverage." *State Health Facts Online*.
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