

December 8, 2009

To: Catherine Osten, President
Patrice Peterson, Secretary/Treasurer
Members of the CSEA SEIU Local 2001 Executive Council

From: Robert D. Rinker, Executive Director

Re: Health Care Reform

For the past several years, I, on behalf of CSEA SEIU Local 2001, have been involved in a number of task forces and committees to address health care reform on the state level. I have reported my involvement to the CSEA SEIU Local 2001 Executive Council. Last month at the Executive Council meeting, we began a discussion on health care reform. I wanted to share with you some of my thoughts on the issue.

First, each of the task forces or committees that I was on adopted as its principles the Institute of Medicine's five principles for guiding health care reform. The Institute of Medicine (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public.

Established in 1970, the IOM is the health arm of the National Academy of Sciences, which was chartered under President Abraham Lincoln in 1863. Nearly 150 years later, the National Academy of Sciences has expanded into what is collectively known as the National Academies, which comprises the National Academy of Sciences, the National Academy of Engineering, the National Research Council, and the IOM.

The IOM's five principles are:

1. Health care coverage should be universal.
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

I would add two further caveats that have been expressed by Executive Council members and the membership:

1. Our current health care plans should not be negatively affected by health care reform.
2. There should not be a tax on Cadillac plans. Cadillac plans have been defined as those plans that pay more than certain dollar amount for coverage. For

example, the State plan for active and retiree members would not currently be considered a Cadillac plan, but the CSEA SEIU Local 2001 plan for our own employees, that is less generous than the State plan, would be considered a Cadillac plan.

Second, we need to view health care reform on how it will effect the health care benefits we currently have or do not have.

State Employees – In 1993, we agreed with the State on a plan design and provider access that was considered at that time to be a middle of the road plan. Over the years, the plan has essentially remained the same, while other plans have changed both benefits and provider access. During periods of budgetary crisis, our plan has come under attack and some modifications have been made to the plan even though the plan is provided for in an agreement that expires in 2017.

Retired State Employees – We have fought for improvements to the State Retiree Health Care Plan from funding to aligning benefits with those of active state employees. Our current plan is under attack for both issues described above for state employees and the \$24 billion of unfunded liability that has been assessed to our plan under the requirements of the General Accounting Standards Board.

Municipal Employees – We fight in every contract negotiations to maintain our existing benefits. We do so with some degree of success, but at times, at the expense of wage increases. We still have some contracts that do not provide for affordable family health care coverage.

Private Sector Employees – For our private sector and some of public sector school transportation members, there is no comprehensive affordable health insurance for them.

Finally, I have attached for your reading Fact Sheets developed by the IOM that address each of their principles for health care reform.

As a union, I would recommend that our evaluation of health care reform pending in Washington should be based upon agreed principles.

INCREMENTAL APPROACHES TO EXTEND COVERAGE ARE INSUFFICIENT

Principle: Health care coverage should be universal.

About two-thirds of Americans under age 65 have health insurance coverage either through their own jobs or that of a parent or spouse. To close the remaining gap, incremental expansions of public insurance programs have targeted discrete population groups, bringing health insurance to seniors through Medicare, and to poor adults and children through Medicaid and State Children's Health Insurance Programs (SCHIP). Despite these and other federal and state initiatives, more than 43 million people in the United States are uninsured.

Only by making coverage universal for all people living in the United States will the sizeable gap in coverage that persists be closed.

No one is immune.

- People of any age, race/ethnicity, gender, educational level, income, employment, or marital status can be uninsured. For example, half of all people who lack coverage are white, and 80 percent live in a family where someone works.

Where you live matters.

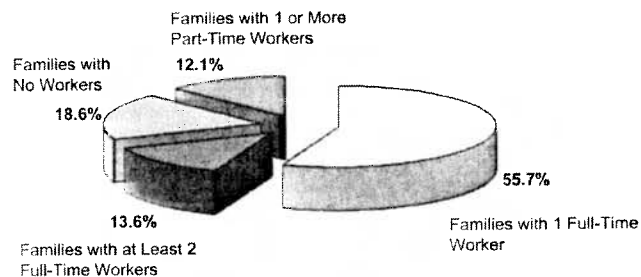
- Every state and locality has a unique mix of characteristics — including industrial base, regulatory environment, and demographics — that affects its uninsured rate. Opportunities for coverage by public programs also vary from state to state because of differing eligibility rules.
- Where you live can significantly influence your chance of being uninsured; Minnesota has the lowest rate of uninsurance at 8.8 percent among the under 65 population, while Texas has the highest rate at 28.4 percent. The rate of coverage by employers and public programs can vary substantially from state to state.

Not all jobs offer health insurance.

- Although there is a strong dependence on private employment-based insurance in the United States, more than 80 percent of uninsured children and adults under the age of 65 live in families with one or more working members.
- Employers are not required to provide health insurance. About one-fourth of workers are not offered coverage by their employer, and half of these remain uninsured, often because they cannot afford nongroup coverage and do not qualify for public programs. Nonetheless, full-time, year-round employment offers families the best chance of acquiring and keeping health insurance, as does higher family income.

Most Uninsured People Live in Working Families

Estimated 43.3 million uninsured under age 65, 2002 = 100.0%



Source: Hoffman, Cathy, and Marie Wang. 2003. *Health Insurance Coverage in America. 2002 Data Update*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

Obtaining coverage on your own is costly or impossible.

- Just 7 percent of Americans under 65 purchase nongroup health insurance policies for themselves or their families.
- People with health problems, particularly those with chronic conditions, pay premiums for nongroup insurance that are up to 40 percent higher than their healthier counterparts.

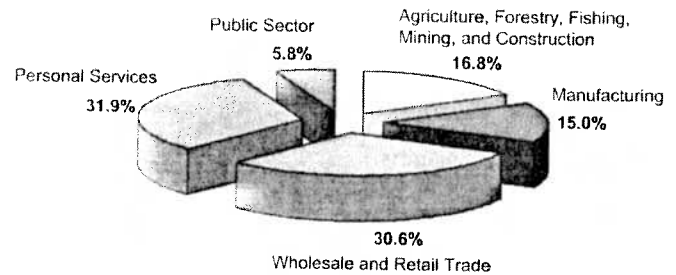
- Although federal reforms establish limited rights to purchase coverage when workers lose employment-based coverage, premium costs are not regulated.

Current approaches to extending coverage don't do the job.

- Since the mid-1980s the number of uninsured people and the country's uninsured rate have continued to grow.
- Public health insurance programs targeting lower-income individuals — those earning less than \$36,800 for a family of four — still leave many poor people without coverage. Nearly two-thirds of the 43 million uninsured are members of lower-income families.

Uninsured Workers Are Found in Every Industry

Estimated 25.7 million uninsured workers, 2002 = 100.0%



Source: Fronstin, Paul. 2003. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*. Issue Brief 264. Washington, DC: Employee Benefit Research Institute.

Barriers to enrollment are varied.

- Strict eligibility requirements often make public coverage and some private insurance difficult to obtain, including different eligibility rules for members of the same family. For example, parents may be ineligible while children are covered; younger children may be covered while teens are not. When states have expanded Medicaid programs to include parents as well as their children, enrollment of eligible children increased more than in states without parental eligibility.
- Complex enrollment and re-enrollment procedures create barriers to participating in public insurance programs. More than half of the 7.8 million children uninsured in 2002 were actually eligible for Medicaid or SCHIP coverage but were not enrolled.
- About four out of five uninsured people are U.S. citizens. Foreign-born, noncitizen residents, however, are more likely than citizens to be uninsured. Among full-time wage earners, 51 percent of noncitizen immigrants had employment-based coverage, compared with 76 percent of naturalized citizens and 81 percent of U.S.-born residents.

We can do better.

- Universal coverage would minimize gaps in coverage, which currently affect one-third of the population under 65 over a four-year period, interfering with therapeutic relationships, contributing to worse health, and heightening financial risks.
- Universal coverage makes more sense than “rescue” programs for those already seriously ill. For example, access to mammograms fosters early detection and treatment of breast cancer. Currently the uninsured are more likely than those with coverage to die from breast cancer and other treatable diseases.
- Universal coverage would alleviate the economic pressures on health service providers, particularly emergency departments, in regions with high concentrations of uninsured people.
- Public dollars that currently support uncompensated or charity care are not as well targeted to achieve improvements in health across the population as they would be if they were used for insurance-based financing for health care services.

Drawn from: *Coverage Matters*, 2001; *Insuring America's Health*, 2004. Institute of Medicine. Washington, DC: National Academies Press.

Uninsurance Facts & Figures

THE INSTITUTE OF MEDICINE
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HEALTH INSURANCE: NOW YOU'VE GOT IT, NOW YOU DON'T

Principle: Health Care Coverage Should Be Continuous

Even if insured now, all Americans under age 65 are at risk of losing coverage for some time over the course of their lives. Continuity of insurance and continuity of care go hand in hand. Uninsured spells can lead to poorer health, greater risk of early death, and exposure to significant financial risk. Health insurance is most likely to improve health outcomes if coverage is continuous rather than intermittent.

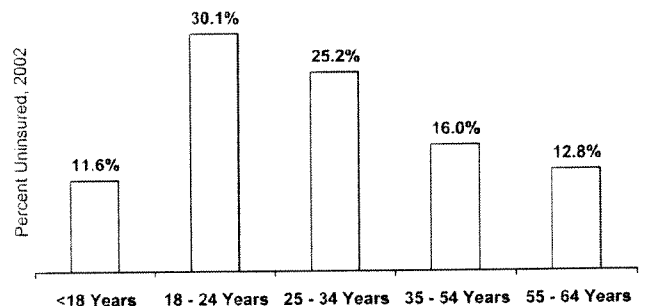
No small problem: Millions of Americans are affected.

- During 2002, census figures showed that more than 43 million Americans lacked health insurance for the entire year.
- Over a four year period (1996-1999), one out of every three Americans under age 65 – or 85 million Americans – lacked health insurance for at least one month, and 35 million were uninsured for between 25 and 48 months.
- The median spell without health insurance between 1996 and 1999 was slightly under 6 months. People with low family incomes tend to remain uninsured for longer periods.

Coverage is unstable during transitions.

- People are particularly vulnerable at life's transitions, over which they may have little control – losing or changing jobs, no longer qualifying as a dependent on a parent's policy, retiring before age 65, or losing a spouse through divorce or death.
- In poor economic times, uninsurance increases as people lose jobs, and employers drop coverage or shift more costs to their employees – which can make policies unaffordable, particularly for low-income workers.
- About 58 percent of uninsured adults report having changed or lost jobs in the previous year. "Job lock" keeps others in positions they might have left if not for fear of losing coverage. Job mobility of husbands is 25 percent to 32 percent lower when their wives do not have employment-based health insurance.
- Young adults are particularly vulnerable as they make the transition from school to work: 30.1 percent of 18- to 24-year-olds are uninsured compared with 11.6 percent of children under age 18.

Young Adults Are Most Likely To Be Uninsured



Source: Fronstin, Paul. 2003. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*. Issue Brief 264. Washington, DC: Employee Benefit Research Institute.

Program rules contribute to instability.

- Breaks in coverage can result from public programs' requirements for eligibility, enrollment, and re-enrollment. For example, two-thirds of states require that children be uninsured for a period of time before enrolling in SCHIP.

- Medicaid enrollment is particularly volatile, due to coverage rules for pregnant women and income fluctuations of poor women. More than half of the single women in Medicaid at the beginning of the year lose their coverage before the end of the year.
- Federal reforms, including the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), have not done the job. The monthly COBRA insurance premium can cost more than the entire state unemployment benefit, putting coverage out of financial reach for most unemployed workers.

The financial risk of uninsurance can be substantial.

- Medical bills are a factor in nearly half of all individual bankruptcy filings. Even healthy people can experience injuries or other unexpected health events. If one member of a family is uninsured and has an accident, a hospital stay, or a costly medical treatment, the resulting medical bills can affect the economic stability of the whole family.
- When uninsured people use health care services, they are often charged substantially more than their insured counterparts, whose insurance company can negotiate discounts.

Discontinuous coverage interrupts continuity of care and negatively affects health.

- Uninsured adults with chronic conditions are less likely to have a regular source of care. Nineteen percent of uninsured adults with heart disease and 26 percent with arthritis lack a usual source of care, compared with 8 percent and 7 percent, respectively, of their insured counterparts.
- One in five adults uninsured for a year or longer reported being in fair or poor health, compared with one in nine with continuous health insurance.
- Some studies show that Medicaid enrollees' health outcomes are more similar to the uninsured than to people with private insurance. This may stem in part from the participants' on-and-off coverage status.

Adults Under Age 65 Uninsured For At Least A Year Report Worse Health Status

Health Status	Uninsured At Least 1 Year	Uninsured Less Than 1 Year	Insured All Year
Excellent	18%	21%	27%
Very Good	27%	32%	36%
Good	35%	33%	26%
Fair	16%	11%	8%
Poor	4%	3%	3%

Source: Behavioral Risk Factor State Survey estimates for 1998. Ayanian, John Z., et al. 2000. "Unmet Health Needs of Uninsured Adults in the United States." *Journal of the American Medical Association* 284(16):2061-2069.

Continuous and universal coverage is beneficial.

- The committee's analysis suggests that, over one year, the diminished health and shorter life spans of Americans under age 65 who lack health insurance translates into between \$65 billion and \$130 billion. These are likely underestimates, given that they don't take into account additional positive effects on health and longevity after age 65 if individuals had always had coverage.
- Continuous coverage before age 65 could result in savings for the Medicare program. Now there is likely to be pent-up demand for services at age 65 among those previously uninsured.

Drawn from: *Coverage Matters*, 2001; *Health Insurance Is a Family Matter*, 2002; *Hidden Costs, Value Lost*, 2003; *Insuring America's Health*, 2004. Institute of Medicine. Washington, DC: National Academies Press.

HEALTH INSURANCE IS OUT OF FINANCIAL REACH FOR MOST OF THE UNINSURED

Principle: Health Insurance Should Be Affordable to Individuals and Families

Unaffordability is the top reason uninsured adults give for being without coverage. It is also the major reason employed individuals turn down workplace health insurance. To be affordable, contributions toward health insurance premiums should permit individuals and families to pay for the other basic necessities of life, such as rent and food, and to pay any deductibles or co-payments required when using health services.

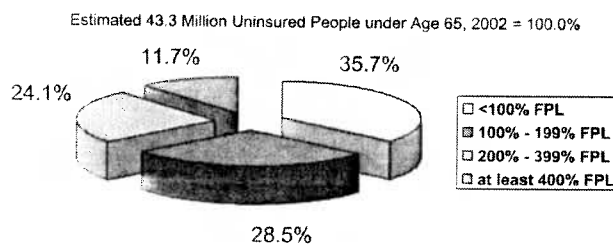
Not all employers offer coverage.

- The federal government encourages private employment-based coverage by offering favorable tax treatment of workers' health benefits, which costs the federal government an estimated \$125 billion in lost revenues in 2000. Nonetheless, more than 80 percent of uninsured children and adults live in families with one or more workers.
- Two-thirds of all firms offer health benefits to at least some of their employees — from 55 percent for small firms (three to nine workers) to 98 percent for large firms (200 or more).
- Half of workers in lower-wage firms — in which at least 35 percent of workers earn \$20,000 or less annually — are covered, compared with 71 percent of workers in all other firms.

Premiums are unaffordable for many working families.

- Growth in health care costs and insurance premiums is outstripping general inflation and family and business incomes. In constant 1998 dollars, the cost of employment-based insurance increased by 260 percent between 1977 and 1998, and the employee's share increased by 350 percent — while median household incomes only increased by 17 percent.
- The average annual premium for an employer-sponsored family policy exceeded \$9,000 in 2003, with workers picking up, on average, 27 percent of the cost. In firms with more than one-third low-wage workers, employees pay an extra \$69 per month compared to the national average.
- For workers earning \$20,000 per year — roughly \$10 per hour — the employee's share for family coverage is more than 16 percent of their pre-tax income.
- The rate of full-time male workers who declined health insurance offers from their employers rose from 6 percent to 10 percent between 1988 and 2001, due to increases in the share of premiums that employees paid.
- While three out of four workers are eligible for continuing health coverage under Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) when unemployed, only one out of five take up enrollment. Under COBRA, the unemployed person must pay 102 percent of the full premium for previous employment-based coverage, which averaged \$282 per month for individuals and \$756 monthly for family coverage in 2003.

Most Uninsured People Live in Low-Income Households



Note: FPL = federal poverty level, estimated annually (in 2002, 100% of FPL for a family of 4 = \$18,100).

Source: C. Hoffman and M. Wang, 2003, *Health Insurance Coverage in America, 2002 Data Update*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

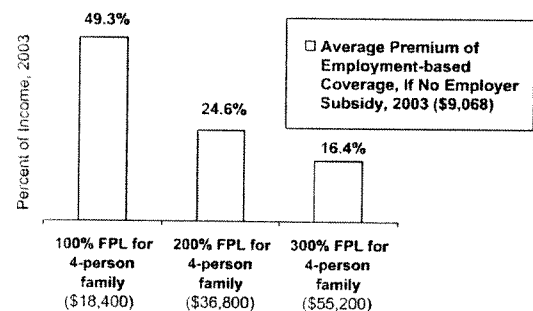
Nongroup policies are even less affordable.

- Just 7 percent of Americans under age 65 purchase individual or family policies on their own.
- A nongroup family insurance policy with a premium comparable to the average employment-based coverage would require an expenditure of roughly 25 percent of pre-tax family income for a family at 200 percent of the federal poverty level (in 2003, approximately \$36,800 annually for a family of four).
- In a recent study of eight nongroup insurance markets, individuals with health problems were quoted a premium price nearly 40 percent higher than potential buyers without health problems.
- Just 29 states have high-risk pools for persons viewed as uninsurable in the individual, nongroup market. There are often waiting lists or closed enrollments.

Uninsured families spend a relatively high proportion of family income on out-of-pocket medical expenses.

- Congress determined that families eligible for State Children's Health Insurance Programs (SCHIP) should not have to pay more than 5 percent of their income on medical costs, including premiums, co-payments, and deductibles.
- Families with no insurance for any of their members for the full year were nearly twice as likely to exceed the 5-percent threshold for out-of-pocket expenditures as were fully insured families in 1996.
- Uninsured people are often charged substantially more than their insured counterparts, whose insurance companies can negotiate discounts. The cost to an adult patient of hospital admission in 1999 for treatment of simple pneumonia ranged from \$100 to \$3,434 under fee-for-service plans, but was \$9,812 for a person with no insurance.
- More than half of all current and recently uninsured working-age adults reported difficulties paying medical bills, compared with less than a quarter of insured adults. Of those with severe bill problems, two-thirds reported borrowing from family or friends, and a quarter needed a loan or mortgage on their home.

Without Subsidies, Health Insurance Premiums Are Unaffordable to Low-Income Working Families



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Source: Institute of Medicine, 2004. *Insuring America's Health: Principles and Recommendations*. Washington, DC: National Academies Press.

Making health insurance more affordable requires public and private action.

- Most uninsured persons will need a substantial employer contribution, government subsidy, or tax incentive to purchase private insurance, or access to a nearly free public coverage program.
- Patient cost-sharing (deductibles and copayments or coinsurance) reduces use of health services and can deter use of appropriate as well as unnecessary services.

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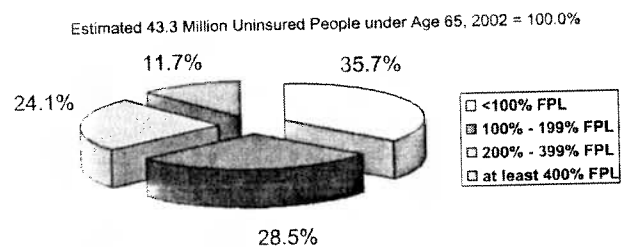
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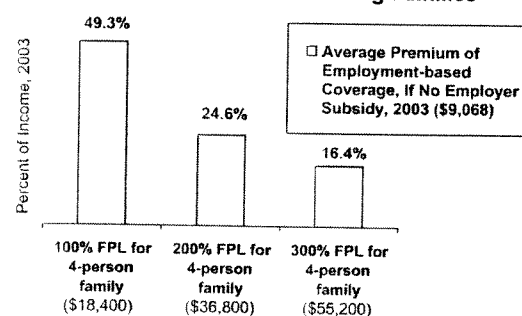
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Making health insurance more affordable requires public and private action.

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Uninsurance Facts & Figures

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UNINSURANCE COSTS THE COUNTRY MORE THAN YOU THINK

Principle: The health insurance strategy should be affordable and sustainable for society.

Having a sizeable uninsured population translates into real economic and non-economic costs for our country, including the expenses for services uninsured people use and the costs resulting from poorer health because they often forgo needed services. On the flip side, there are costs for providing universal coverage, including the expense of additional services the previously uninsured will use.

Uninsured people use fewer health services than their insured counterparts, and their health and lifespan are compromised as a result. When they do use services, they are more likely to use costly emergency room services or require hospitalization that could have been avoided if they had received timely primary care.

In addition, uninsurance has costs that extend beyond uninsured people and their families to community health care institutions, providers, and even the insured population. When the uninsured are unable to pay their own medical expenses, those costs are borne by others, particularly taxpayers. The cost of uncompensated care falls more heavily on local communities with larger concentrations of uninsured residents.

Public dollars pay most of the \$35 billion in uncompensated care.

- \$99 billion was spent on health care services for people uninsured for all or part of 2001 (Hadley and Holahan, 2003.) This includes charity care received, the \$26.4 billion the uninsured paid out of their own pockets, any private or public insurance payments made for services if they were covered for only part of the year, and worker's compensation payments.
- On average, people who are uninsured for a full year pay 35 percent of the overall cost of their medical services.
- The roughly \$35 billion for uncompensated care provided to uninsured individuals is comprised of \$23.6 billion in patients' unpaid hospital bills, \$7.1 billion in public expenditures for government grant and direct service programs (e.g., Veterans Affairs, Indian Health Services, Health Resources and Services Administration programs, local health departments), and \$5.1 billion in free or reduced-cost care provided by office-based physicians and through volunteer service in clinics.
- Approximately \$23.6 billion in tax dollars is used to reimburse hospitals that have a disproportionate share of uninsured patients.

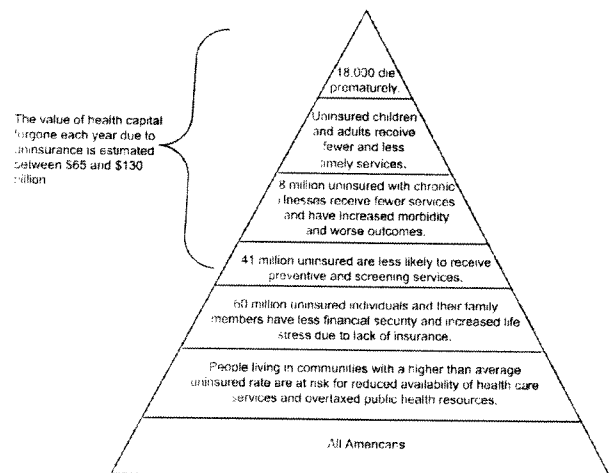
U.S. health care spending should be more effective.

- The United States spends more per capita than any other nation, 14 percent of gross domestic product in 2002, but our spending has not bought us top health status among nations or reduced the size of the uninsured population. For example, the United States ranks 25th in male life expectancy and 19th in female life expectancy among 29 developed countries.

The costs of sustaining a large uninsured population are often hidden.

- The health of a nation's populace is part of the nation's

The Consequences of Uninsurance Add Up



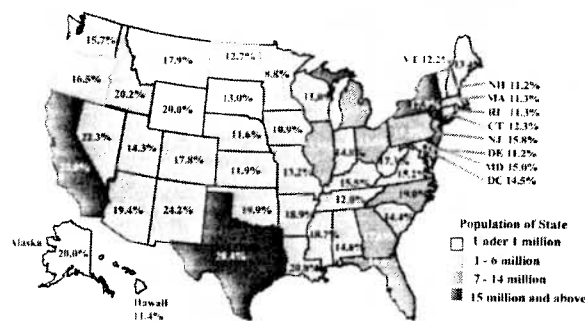
wealth. The poorer health and shorter lifespan of uninsured people can be thought of as “health capital” lost to the nation. The nation loses some \$65 billion to \$130 billion in health capital each year.

- High uninsured rates in a community can put financial pressure on certain services and institutions. Trauma center patients are more likely to be uninsured than all hospital patients. The closure of a regional trauma center or reduction in its scope of services puts the health of everyone in a community — whether insured or uninsured — at risk.
- Clinicians in community health centers located in areas with high rates of uninsurance report difficulties in obtaining specialty referrals for all of their patients, not just those who are uninsured.
- A community’s high rate of uninsurance can adversely affect the overall health status of the community. For example, underimmunization increases the vulnerability of entire communities to outbreaks of measles and influenza. Childhood and adult immunization levels are correlated with having health insurance.

A federal role is necessary to eliminate uninsurance.

- Where you live matters, whether you are insured or not. Existing local and state financing for the uninsured is spread unevenly, varies by locality, and does not necessarily match local needs.
- Acting alone, states do not have the fiscal resources to fully implement existing public coverage programs despite the use of federal Medicaid waivers to leverage state dollars. Even the states that have led major coverage reforms have not been able to eliminate large and persistent uninsured populations. The uninsurance rate is 11.4 percent in Hawaii; 11.3 percent in Massachusetts; 8.8 percent in Minnesota; 16.5 percent in Oregon; and 12 percent in Tennessee.

The Likelihood of Being Uninsured Varies By State



SOURCE: U.S. Census Bureau estimates for 2002, based on March 2003 Current Population Survey, Table HI05, Available at http://ferret.bls.census.gov/macro/032003/health/h05_00.htm.

- The federal Employee Retirement Income Security Act of 1974 (ERISA) currently constrains the ability of states to mandate employment-based coverage, one strategy to expand private coverage within their boundaries.
- State and local governments’ ability to finance health care and coverage extensions is weakest when tax revenues decline during economic downturns, precisely the times when individuals and families need such support.

Extending coverage to all requires a different national approach.

- All should contribute financially to extending coverage universally through taxes, premiums, and cost sharing, because all will benefit.
- Federal or shared federal-state financing for health insurance programs would distribute the burden of health care more broadly among taxpayers.
- The affordability and sustainability of different universal coverage strategies will largely depend on the nature of cost controls in the system, sources of revenues, the amount of patient cost sharing, and the comprehensiveness of benefit packages.

Drawn from: *A Shared Destiny*, 2003; *Hidden Costs, Value Lost*, 2003; *Insuring America’s Health*, 2004. Institute of Medicine. Washington, DC: National Academies Press.

THE UNINSURED ARE SICKER AND DIE SOONER

Principle: Health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient centered, and equitable.

Health insurance is the key to obtaining needed health care services, and those who lack insurance are less likely to get timely and appropriate care than their insured counterparts. Evidence from the scientific literature overwhelmingly shows that those without insurance — children as well as adults — suffer worse health and die sooner than those who have coverage.

Insurance is more important than ever, given the array of effective new medical interventions, technologies, and pharmaceuticals. Without insurance, people have less access to state-of-the-art services and drugs which often improve health and longevity. Thus the gap between insured and uninsured persons widens, raising questions of justice and equity.

The uninsured use less health care.

- On average, uninsured persons use one-half to two-thirds the number and value of services compared with their privately insured counterparts and are more likely to use no health services at all.
- In the last year, 43 percent of working-age adults without health insurance reported that they did not seek a physician's care when they had a medical problem, compared to 10 percent of those who had coverage all year.

Lack of health insurance undermines health on multiple levels.

- Uninsured people are more likely to receive too little medical care and receive it too late; as a result, they are sicker and die sooner.
- Uninsured adults have a 25 percent greater mortality risk than adults with coverage. About 18,000 excess deaths among people younger than 65 are attributed to lack of coverage every year. This mortality figure is similar to the 17,500 deaths from diabetes and 19,000 deaths from stroke within the same age group in 2001.
- Uninsured women with breast cancer have a risk of dying that is between 30 percent and 50 percent higher than for insured women.
- Uninsured car crash victims were found to receive less care in the hospital and had a 37 percent higher mortality rate than privately insured patients.
- Uninsured individuals with diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness have consistently less access to preventive care and have worse clinical outcomes than do insured patients.

Uninsured Adults Are More Likely Than Insured Adults To Die Prematurely

Age	U.S. Population, 2000 (millions)	Percent Uninsured (within age group)	Deaths per Million, 1999 (estimated)	Total Deaths Estimated for 2000 Population	Estimated Excess Deaths for Uninsured Adults
25-34	37.4	21	1,083	40,548	1,930
35-44	44.8	15	1,992	89,202	3,431
45-54	38.0	12	4,273	162,545	4,734
55-64	23.8	14	10,219	243,049	8,219
Total	144.0	16	3,717	535,344	18,314

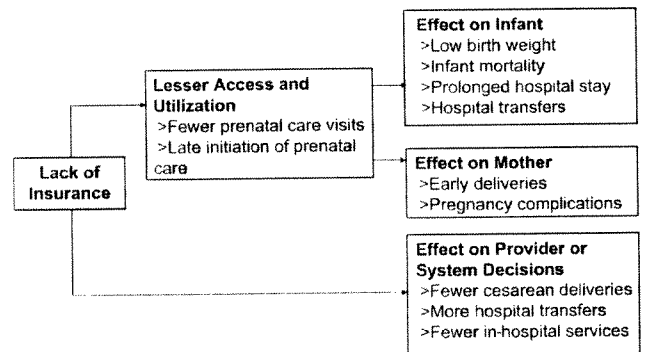
SOURCE: Table D.1, based on Census estimates for 2000, in Institute of Medicine. 2002. *Care Without Coverage: Too Little, Too Late*. Washington, DC: National Academies Press.

- If common childhood conditions such as asthma, anemia, and middle-ear infections are left untreated or improperly controlled — which can happen if a family lacks insurance — they can affect mental and language development, school performance, and hearing.
- In 1996 and 1997, 15 percent of uninsured pregnant women never went to the doctor before giving birth, compared with 4 percent of women with private or public coverage. Figure 2 outlines the related consequences: more low-birth-weight babies and increased infant mortality.

Coverage is related to better outcomes.

- People with any kind of health insurance are more likely to receive screening services than are those with no coverage. Chronically ill people, (e.g., those with hypertension, diabetes, schizophrenia) who have health insurance are more likely to receive appropriate care than those who are uninsured.
- Uninsured people are more likely to require expensive crisis care in emergency rooms or hospitals for conditions that would have been responsive to earlier, more appropriate ambulatory care. For instance, uninsured patients are more likely to develop severe, uncontrolled hypertension that requires emergency hospital admission.

How Lack of Coverage Can Hurt Pregnant Women and Infants



Source: Institute of Medicine. 2002. *Health Insurance Is A Family Matter*. Washington, DC: National Academies Press.

Having coverage can promote receipt of high-quality care.

- The uninsured are less likely than their insured counterparts to receive recommended preventive and screening services, or medicines and treatments that meet the professional standard, including medications for depression, revascularization for acute myocardial infarction, and breast-conserving surgery with mastectomy.
- Having a regular provider of care, particularly for primary care and chronic conditions, is considered a predictor of quality. Uninsured children were more than three times as likely as children with Medicaid coverage to have no regular source of care (15 percent vs. 5 percent), and uninsured adults were more than three times as likely as those with public or private insurance to lack a regular source of care (35 percent vs. 11 percent).
- Uninsured adults with chronic diseases are less likely to receive evidence-based, recommended care for their condition than those who have health insurance. For example, uninsured adults with diabetes are less likely to receive recommended regular foot or eye exams, which can prevent foot ulcers and blindness.

Providing health insurance is cost-effective for society.

- The economic value to be gained in terms of better health outcomes once those now uninsured become insured would likely exceed the additional costs of providing them with same level of services used by those with public or private coverage.
- If all uninsured individuals gained coverage, the estimated costs for their increased use of services range from \$34 billion to \$69 billion, which is between 3 percent and 5.6 percent of national spending for personal health care services in 2001.

Drawn from: *Coverage Matters*, 2001; *Care Without Coverage*, 2002; *Health Insurance Is a Family Matter*, 2002; *Hidden Costs, Value Lost*, 2003; *Insuring America's Health*, 2004; Institute of Medicine, Washington, D.C.: National Academies Press.