
# WIDENING GAPS IN HEALTH INSURANCE COVERAGE IN THE UNITED STATES: THE NEED FOR UNIVERSAL COVERAGE

**Sara R. Collins, Ph.D.**
**Assistant Vice President**
**The Commonwealth Fund**
**One East 75th Street**
**New York, NY 10021**
**src@cmwf.org**

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# WIDENING GAPS IN HEALTH INSURANCE COVERAGE IN THE UNITED STATES: THE NEED FOR UNIVERSAL COVERAGE

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## Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on the impact of gaps in health coverage on income security. As rising health care costs and premiums are making it more difficult for many employers, particularly small firms, to provide affordable health insurance to their workers, increasing numbers of people under age 65 are finding themselves without access to employer-based coverage and ineligible for enrollment in public insurance programs. The number of uninsured people climbed to 47 million in 2006, and an estimated 16 million adults are inadequately insured. Health insurance coverage is the most important determinant of access to health care. People who lack coverage have fundamentally different life experiences than those who have it; many die prematurely, and many suffer lost productivity and earnings.

With so many people left outside the health care system, it is no wonder that the U.S. system performs poorly compared with systems in industrialized nations that have universal health insurance. It is critical on moral and economic grounds that the nation move affirmatively to guarantee affordable, comprehensive and continuous health insurance for everyone.

### The Gap Between Employer-Based and Public Coverage Is Widening

- Employer-based coverage forms the backbone of the United States's voluntary, mixed private–public health insurance system; more than 160 million workers and their dependents, or 62 percent of the under-65 population, has job-based coverage.
- Medicaid and the State Children's Health Insurance Program (SCHIP) play a critical supporting role, covering an additional 28 million adults and children, or 11 percent of the under-65 population. Medicare covers 39 million people, mostly those over age 65.
- The most gaping hole in the current system is for people under age 65 do not have access to employer coverage and are not eligible for Medicaid, SCHIP, or Medicare, as in the case of those too disabled to work.

- With their high premiums and underwriting, individual insurance plans—which cover just 6 percent of the under-65 population—have proven to be an inadequate substitute for employer group coverage.

**Who Is Most at Risk for Lacking Coverage?**

- **Low- and moderate-income families**
    - More than two-thirds (67%) of adults under age 65 who do not have health insurance are in families where at least one member works full time.
    - The likelihood of low- and moderate-income families having coverage through an employer has always been lower than that of higher-income families and has declined over the last six years.
    - In 2005, 53 percent of people with incomes less than $20,000, and 41 percent of people in households with incomes between $20,000 and $40,000, reported a time when they were uninsured in the prior year.
- **Small-firm and low-wage workers**
    - Workers who are employed in firms with fewer than 50 employees are less likely to have coverage through an employer than are those employed by larger companies.
    - Lower-wage workers in small firms are at particularly high risk for not being offered health benefits, not being eligible for such benefits, or not having the financial means to "take up" coverage. Nearly two of five lower-wage workers in small firms are uninsured—more than twice the rate of higher-wage workers in small firms.
- **Nonstandard workers**
    - An estimated 34 million workers are in nonstandard jobs, meaning they are either self-employed or in temporary, part-time, or contract positions.
    - Just one of five nonstandard workers has health insurance through his or her employer, compared with three-quarters of regular, full-time employees.
    - About one-quarter (24%) of nonstandard workers are uninsured, versus 12 percent of regular full-time workers.
- **Young adults**
    - More than 13 million young adults ages 19 to 29 are uninsured, the fastest growing age group among the uninsured population.

- Turning 19 is a critical milestone. Employer health plans often do not cover young adults as dependents after age 18 or 19 if they do not go on to college. Medicaid and SCHIP reclassify all teenagers as adults on their 19th birthday.
- The loss of employer coverage, Medicaid coverage, and SCHIP coverage shows up dramatically in uninsured rates of young adults, particularly those in low-income families. Among 19-to-29-year-olds in families with incomes below the poverty level, more than half are uninsured, compared with about one of five low-income children age 18 and under. About 42 percent of young adults in families with incomes between 100 percent and 199 percent of poverty are uninsured.

- **Minorities**
  - Sixty-two percent of working-age Hispanics and 33 percent of African Americans were uninsured for some time during 2005, compared with 20 percent of whites in the same age group.
  - Eighty percent of Hispanics in households with incomes under 200 percent of poverty experienced a time when they were uninsured over a four-year period, compared with 66 percent of African Americans and 63 percent of whites in that income group. This is in spite of the fact that Hispanics in lower-income households were more likely than either African-Americans or whites in the same income group to have been continuously employed full-time over that period.

- **Unemployed**
  - Despite the availability of COBRA coverage, over half of unemployed adults under age 65 are uninsured, more than three times the rate for employed adults.
  - Just as they are less likely to be offered employer-based coverage in general, lower-wage workers are far less likely to be eligible for COBRA. Many who leave their jobs were uninsured while they were working.
  - Even when lower-wage workers are eligible for COBRA benefits, the full cost of the premium is often unaffordable, particularly as a share of an unemployment benefit. COBRA-eligible low-income workers who leave their jobs are much more likely to be uninsured than higher-wage workers. They have fewer options than higher-wage workers have for coverage through a new job or through a spouse.

- **People with disabilities in two-year waiting period for Medicare**
    - There are an estimated 1.7 million disabled people in the waiting period for Medicare. Of those, about one-third have coverage through a former employer or though a spouse's employer, just over a third are covered by Medicaid, 9 percent purchase coverage through the individual insurance market, and 15 percent, or nearly 265,000 people, are without health insurance.
    - More than two of five disabled Medicare beneficiaries ages 50 to 64 said that they had been uninsured just prior to entering Medicare

**Consequences of Gaps in Health Insurance Coverage for the Health and Economic Security of Families**

- **Poor access to care**
    - People who spend any time without coverage report significantly higher rates of cost-related access problems, are significantly less likely to have a regular doctor or medical home, and less likely to say that they always or often receive the health care they need when they need it.
    - Poor-quality health care is particularly devastating and can have long-term implications for uninsured adults with chronic health problems.
- **Health and economic implications for families and the nation**
    - More than half of working-age adults who had been uninsured during 2005 reported problems paying medical bills during that time or were paying off accrued medical debt, compared with 26 percent of those who had been insured all year.
    - Medical debt forces families to make stark tradeoffs. For example, 40 percent of uninsured adults with medical bill problems were unable to pay for basic necessities like food, heat, or rent, and nearly 50 percent had used all their savings to pay their bills.
    - The Institute of Medicine estimates that 18,000 avoidable deaths occur each year in the U.S. as a direct result of individuals being uninsured
    - The aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter lifespans falls between $65 billion and $130 billion for each year without coverage.

- Gaps in coverage for uninsured people with chronic health conditions may have long-run cost implications for the health system, and the Medicare program in particular.

**Health Care Reform Is Necessary to Fill the Gaps**

It is essential on both moral and economic grounds that the United States move forward to guarantee affordable, comprehensive, and continuous health insurance for everyone. Without universal coverage, our health system will not be able to provide more effective, higher-quality, and more efficiently delivered care, and it will not be able to ensure longer, healthier, and more productive lives. It is unacceptable that people without health insurance collectively lose between $65 billion and $130 billion a year in lost productivity and earnings, and are greater risk of dying prematurely. Several proposals for universal coverage have been put forth—or implemented, as in the case of Massachusetts—by governors, members of Congress, and the 2008 presidential candidates. This is a welcome development, and highly promising for reversing the inexorable climb in the uninsured population over the past several years.

In the absence of universal coverage, there are several policies that would help fill the gaps in the existing system by building on existing public and private group insurance and also create an essential foundation for universal coverage.

- **Build on Public and Private Group Insurance to Extend Coverage to Vulnerable Age Groups and the Disabled**
  - Allow states to extend eligibility for Medicaid and SCHIP coverage beyond age 18. The Foster Care Independence Act of 1999, which allows states to extend Medicaid coverage to children in foster care beyond age 18, could be expanded to cover all children in Medicaid. Depending on the income eligibility levels, extending coverage up to age 25 would cover 3.3 million uninsured young adults 19 to 25 in families with incomes under 100 percent of poverty and 5.7 million with incomes under 200 percent of poverty.
  - Seventeen states have already redefined the age at which a young adult is no longer a dependent for purposes of insurance, ranging from 24 to 30. Other states should follow their lead to ensure that young adults can remain on their parents' plans while they make the transition to college, graduate school, or work.
  - Allow older adults ages 55 to 64 to "buy in" to Medicare.
  - End Medicare's two-year waiting period for coverage of the disabled.

- **Build on Public and Private Group Insurance to Extend Coverage to Low-Income Workers and Families**
    - Expand Medicaid to cover everyone under 150 percent of poverty; consider providing federal matching funds for sliding-scale premiums at higher income levels.
    - Require employers to finance COBRA coverage for up to two months for employees who lose their jobs. The federal government could provide premium assistance for 70 percent of COBRA premiums for unemployed workers.
- **Connect Public and Private Group Insurance to Realize Efficiencies from Pooling Large Groups of People**
    - Create a national health insurance "connector" based on the Federal Employees Health Benefits Program or Medicare, with sliding-scale premium subsidies, restrictions against risk selection on the part of carriers, and federal reinsurance.

We stand as a nation at a crossroads. A majority of the public is asking its leaders to address our health insurance problem through comprehensive reform, even if it requires a substantial investment of public and private funds. States like Massachusetts are leading the nation in this effort, and national policy leaders are responding with well-thought-out proposals. We are a wealthy and innovative country, and we have the resources and the technology to move affirmatively toward universal coverage in a way that improves quality and controls costs. The time is upon us to resolve ideological differences over strategies and find consensus based on pragmatism and fact.

Thank you.

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Thank you, Mr. Chairman, for this invitation to testify on the impact of gaps in health coverage on income security. Increasing numbers of people under age 65 are finding themselves without access to employer-based coverage and ineligible for enrollment in public insurance programs. The number of uninsured people climbed to 47 million in 2006, and an estimated 16 million adults are inadequately insured. Those most affected are low- and moderate-income families, people who are self-employed or work for companies with fewer than 50 employees, those employed in nonstandard jobs, young adults, unemployed individuals, minorities, and people who are too disabled to work and in Medicare's two-year waiting period. Health insurance coverage is the most important determinant of access to health care. People who lack coverage have fundamentally different life experiences than those who have it: many die prematurely, and many suffer lost productivity and earnings.

With so many people left outside the health care system, it is no wonder that the U.S. system performs poorly compared with systems in industrialized nations that have universal health insurance.[1] It is critical on moral and economic grounds that the nation move affirmatively to guarantee affordable, comprehensive, and continuous health insurance for everyone.

## The Gap Between Employer-Based and Public Coverage Is Widening

Employer-based coverage forms the backbone of the United States's voluntary, mixed private–public health insurance system: more than 160 million workers and their dependents, or 62 percent of the under 65 population, has job-based insurance (Figure 1). Medicaid and the State Children's Health Insurance Program (SCHIP) play a critical supporting role, covering an additional 28 million adults and children, or 11 percent of the under-65 population. Medicare covers 39 million people, mostly over age 65.

The most gaping hole in the current system is for people under age 65 who do not have access to employer coverage and are not eligible for Medicaid, SCHIP, or Medicare, in the case of those too disabled to work. Rising health care costs and premiums have

[1] C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive (Oct. 31, 2007):w717–w734; C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475; and Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, Sept. 2006).

made it increasingly difficult for many employers, particularly small companies, to continue offering affordable health insurance to their employees. The individual insurance market—where just 6 percent of the under-65 population buys coverage—has proven to be an inadequate substitute. In 2006, the number of uninsured people in the United States climbed to 47 million, an increase of 8.6 million since 2000. Sixteen million more adults under age 65 are estimated to be underinsured, meaning their out-of-pocket costs are high relative to their income.[2]

The individual insurance market presents significant challenges for families seeking coverage, because the premiums charged by individual plans are high, and many individual plans will not enroll people with preexisting health problems. The Commonwealth Fund Biennial Health Insurance Survey found that of the 58 million adults under age 65 who sought coverage in the individual insurance market over a three-year period, 90 percent never purchased a plan (Figure 2).[3] More than 70 percent of people with health problems or incomes under 200 percent of the poverty level said that it was very difficult or impossible to find a plan they could afford. Enrollment is also far more transitional than that in employer-based plans. Klein and colleagues found that just 53 percent of people under age 65 with individual market coverage were still enrolled in the plan two years later, compared with 86 percent of people in employer-based plans (Figure 3).

Although increasing numbers of adults lost access to employer-based coverage over 2000–2006, there has been virtually no change in the number of people covered by individual market insurance. Loss of employer coverage has led to higher levels of uninsured individuals, not to higher levels of individual coverage.[4]

If not for state expansions in eligibility in Medicaid and SCHIP over the last decade, this trend would have also extended to children. The number of states where 16 percent or more of children under age 18 were uninsured fell from nine in 1999–2000 to five in 2005–2006 (Figure 4). In contrast, the number of states where 23 percent or more of the adult population under age 65 was uninsured jumped from two in 1999–2000 to nine in 2005–2006 (Figure 5).

Coverage eligibility for parents and adults without children in Medicaid and SCHIP varies greatly across states: 14 states cover parents with incomes up to 50 percent of poverty, which is approximately equivalent to an annual income of just over $10,000 for

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[2] C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302.

[3] S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[4] C. DeNavas-Walt, B. D. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C.: U.S. Census Bureau, Aug. 2007).

a family of four.[5] Thirty-four states provide no Medicaid coverage at all for adults who do not have children. Increasing the income eligibility levels in Medicaid for parents and adults without children would help counteract the erosion in access to employer-based health insurance that is disproportionately affecting working families with low and moderate incomes.

**Who Is Most At Risk of Lacking Coverage?**

Who is most at risk of lacking access to employer-based health insurance and public insurance coverage? Families that have low and moderate incomes, people who are self-employed or who work for companies of fewer than 50 employees, those employed in nonstandard jobs, young adults, people who are unemployed, minorities, and people who are too disabled to work and in the two-year waiting period for Medicare.

**Low- and moderate-income families.** More than two-thirds (67%) of uninsured adults under age 65 are in families where at least one member works full-time (Figure 6).[6] Compared with those with high incomes, people in families with low and moderate incomes are most at risk of lacking coverage through an employer and are the most at risk of being uninsured. Indeed, the likelihood of low- and moderate-income working families having coverage through an employer has declined over the last six years. Only 22 percent of adults under age 65 in families with incomes of $20,000 or less had coverage through an employer in 2006, down from 29 percent in 2000 (Figure 7). Employer-based coverage in the next-higher income category—under $37,800 annually—declined from 62 percent in 2000 to 53 percent in 2006. Nearly 90 percent of people in the highest-income households have coverage through employers, and this has remained relatively constant over time.

Uninsured rates for moderate-income families are rising rapidly, so much that the margin between reported rates of coverage instability in these families and in the lowest-income households has narrowed significantly. According to the Commonwealth Fund Biennial Health Insurance Surveys, in 2001, 28 percent of people with incomes between $20,000 and $35,000 experienced a time whey they were uninsured, compared with 49 percent of people with incomes less than $20,000—a difference of 21 percentage points (Figure 8).[7] In 2005, 41 percent of people in households with incomes between $20,000

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[5] Kaiser Family Foundation, "Income Eligibility Levels for Children's Separate SCHIP Programs, 2006" and "Income Eligibility for Parents applying for Medicaid, 2006" (Washington, D.C.: KFF). Available at http://www.statehealthfactsonline.org.

[6] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

[7] L. Duchon, C. Schoen, M. M. Doty, K. Davis, E. Strumpf, and S. Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk—Findings from the 2001 Health Insurance Survey* (New York: The Commonwealth Fund, Dec. 2001); S. R. Collins, M. M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Mar. 2004); and Collins, Davis, Doty, Kriss, Holmgren, *Gaps in Health Insurance,* 2006.

and $40,000 reported a time uninsured, compared with 53 percent of families with incomes less than $20,000—a difference of 12 percentage points.[8] The lowest-income workers have always been most at risk of not being offered job-based coverage. Now, more moderate-income earners and their families are also in jeopardy.[9]

Most people who experience gaps in their insurance coverage are uninsured for long periods. In the 2005 Commonwealth Fund Biennial Health Insurance Survey, of those adults who were uninsured at the time of the survey, 82 percent had been uninsured for one year or more.[10] Of those who had coverage when surveyed but had experienced a time uninsured in the past year, one-quarter (26%) were without coverage for a year or longer. One-third (34%) had been uninsured for three months or less.

**Small-firm and low-wage workers.** Workers who are employed in firms of fewer than 50 employees are less likely to have coverage through an employer than are those employed in larger companies. Small employers face higher premium and administrative costs per worker than large firms and thus are less likely to offer coverage. Gabel found that employees in companies with fewer than 10 employees pay an average of 18 percent more in health insurance premiums than those in the largest firms, after taking into account the plans' actuarial values. He also found that premiums varied widely across the country.[11]

Rapid growth in health care costs and premiums over the last several years has exacerbated the problem. The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped $12,106 in 2007—more than the average yearly earnings of a full-time worker earning minimum wage.[12]

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[8] In 2001, 2003, and 2005, the Commonwealth Fund health insurance surveys asked respondents what their approximate annual incomes were by offering them income ranges to select from. In 2001 and 2003, the midpoint of the income ranges offered was $35,000. In 2005, the midpoint was increased to $40,000 to account for inflation and increases in poverty thresholds defined by the U.S. Census Bureau. In 2005, an income of $40,000 for a family of four was 200 percent of poverty (poverty was $20,000 for a family of four); in 2003 an income of $37,000 was 200 percent of poverty; and in 2001 $36,000 was 200 percent of poverty. See http://www.census.gov/hhes/www/poverty/threshld/thresh01.html.

[9] See S. R. Collins, K. Davis, C. Schoen, M. M. Doty, and J. L. Kriss, *Health Coverage for Aging Baby Boomers: Findings from the Commonwealth Fund Survey of Older Adults* (New York: The Commonwealth Fund, Jan. 2006); J. Holahan and A. Cook, "Changes in Economic Conditions and Health Insurance Coverage, 2000–2004," *Health Affairs* Web Exclusive (Nov. 1, 2005):w5-498–w5-508; S. R. Collins, K. Davis, M. M. Doty, and A. Ho, *Wages, Health Benefits, and Workers' Health* (New York: The Commonwealth Fund, Oct. 2004); and S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, Apr. 2003).

[10] Collins, Davis, Doty et al., *Gaps in Health Insurance*, 2006.

[11] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums In Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs,* May/June 2006 25(3):832–43.

[12] G. Claxton, J. Gabel, B. DiJulio et al., "Health Benefits in 2007: Premium Increases Fall to An Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs,* Sept./Oct. 2007 26(5):1407–16; Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2007 Annual Survey* (Washington, D.C.: KFF/HRET, 2007). Available at http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf.

From 2000 to 2007, the share of business with fewer than 10 employees that offer coverage dropped from 57 percent to 45 percent.[13]

Lower-wage workers in small firms are at particularly high risk of not being offered health benefits, not being eligible for such benefits, or not having the financial means to "take up" coverage. The Commonwealth Fund Biennial Health Insurance Survey found that in 2005, two of five workers in firms with fewer than 50 employees who earned less than $15 an hour worked for an employer that offered coverage. Moreover, only one-third were eligible for that coverage, and just one of five actually enrolled in a plan (Figure 9). In contrast, half of higher-wage workers in small firms worked for companies that offered coverage, half were eligible and 45 percent enrolled in coverage. While lower-wage workers in larger companies are much better off than their lower-wage counterparts in small firms, they are still less likely than higher-wage workers to be employed by firms that offer coverage, to be eligible for that coverage, and to enroll. Nearly two of five lower-wage workers in small firms are uninsured—more than twice the rate of higher-wage workers in small firms (Figure 10). Seventeen percent of lower-wage workers in large firms are uninsured.

**Nonstandard workers.** An estimated 34 million workers are in nonstandard jobs-either self-employed or in temporary, part-time, or contract positions. Ditsler and colleagues found that of those, just one of five has health insurance through his or her employer, compared with three-quarters of regular full-time employees (Figure 11).[14] About one-quarter (24%) of nonstandard workers are uninsured, compared with 12 percent of regular full-time workers. Eighteen percent of the children and 16 percent of the spouses of nonstandard workers are uninsured. Nonstandard workers are far more likely than standard workers to rely on government health insurance coverage—5 percent of nonstandard workers are covered by Medicaid or Medicare, compared with 1 percent of standard workers. Ten percent of the children and 6 percent of the spouses of nonstandard workers rely on public health insurance for coverage.

**Young adults.** New entrants to the labor force are at high risk of not having insurance through their jobs. Young adults ages 19 to 29 are the fastest-growing age group among the uninsured population. The number of uninsured young adults ages 19 to 29 climbed to 13.3 million in 2005, from 12.9 million in 2004.[15] Even though they comprise just 17 percent of the under-65 population, young adults account for 30 percent of the nonelderly uninsured.

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[13] Ibid.

[14] E. Ditsler, P. Fisher, and C. Gordon, *On the Fringe: The Substandard Benefits of Workers in Part-Time, Temporary and Contract Jobs* (New York: The Commonwealth Fund, Dec. 2005).

[15] S. R. Collins, C. Schoen, J. L. Kriss, M. M. Doty, and B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated Aug. 2007).

By far, the young adults most at risk of lacking coverage are those from low-income households. About 24 percent of adults ages 19 to 29 live in households with incomes below 100 percent of the poverty level, but more than two-fifths (41%) of the 13.3 million young adults who are uninsured live in households with incomes below poverty (Figure 12).[16]

Nearly half of uninsured young adults are white. But Hispanics are disproportionately represented among the young and uninsured. While Hispanics represent 19 percent of adults ages 19 to 29, they represent 32 percent of uninsured young adults. Hispanics and African Americans are both at greater risk of being uninsured than white young adults: 34 percent of African Americans and 52 percent of Hispanics ages 19 to 29 are uninsured, compared with 23 percent of whites in that age range.

Nineteenth birthdays are crucial milestones in U.S. health insurance coverage. Both public and private insurance plans treat this age as a turning point for coverage decisions. Employer health plans often do not cover young adults as dependents after age 18 or 19 if they do not go on to college. Public programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), also typically have one set of income and eligibility standards for children and another for adults—with the 19th birthday as the critical divide.

Medicaid and SCHIP reclassify all teenagers as adults the day they turn 19. As a result, young adults who had been insured under Medicaid or SCHIP as children typically do not have an option to stay on public coverage, unless they are able to qualify for Medicaid as adults. Regardless of school, work, or dependent status, they lose their eligibility as dependents or children. Most low-income young adults become ineligible for public programs, since eligibility for adults generally is restricted to very-low-income parents or disabled adults.

Even teenagers with disabilities who qualified for Medicaid before their 19th birthdays have to go through a new set of screening tests to determine whether they will still be eligible for benefits as disabled adults.[17] This means that young adults with disabilities or chronic health conditions who are able to work are at much higher risk of being uninsured than children with disabilities. In an analysis of data from the 1999 Survey of Income and Program Participation, Fishman found that 22 percent of young adults with disabilities were uninsured, compared with about 10 percent for disabled children 11 to 18 years of age.

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[16] In 2005, the under-65 poverty thresholds were $10,160 for one person, $13,078 for two adults, $15,720 for two adults and one child under 18, and $19,806 for two adults and two children under 18. See C. DeNavas-Walt, B. D. Proctor, and C. H. Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, Current Population Reports, Consumer Income (Washington, D.C.: U.S. Census Bureau, Aug. 2006).

[17] E. Fishman, "Aging Out of Coverage: Young Adults with Special Health Needs," *Health Affairs,* Nov./Dec. 2001 20(6):254–66.

The needs of foster children aging off Medicaid have been addressed through federal law, but few states have taken advantage of it. The Foster Care Independence Act of 1999 allows states to continue Medicaid coverage for former foster children up to age 21.[18] In October 2007, North Carolina implemented the Expanded Foster Care Program, which extends Medicaid coverage to children who were in foster care at their 18th birthday through the month they turn 21. These young adults are automatically enrolled in this program without regard to income or assets.[19] So far, only a handful of states have implemented programs to cover former foster children up to age 21 through Medicaid, including Texas[20] and recently Ohio.[21]

As a result of the combined impact of public and private insurance rules, uninsured rates jump sharply at age 19. Turning 19 increases the uninsured rate nearly threefold; it rises from 11 percent among children age 18 and under to 30 percent among those ages 19 to 29 (Figure 13). Low-income young adults are particularly vulnerable to being uninsured. Among those in families living below the poverty level, more than half (51%) are uninsured, compared with about one of five (20%) low-income children age 18 and under. Those young adults with slightly higher incomes (100%–199% of poverty) fare only marginally better—roughly two of five (42%) are uninsured.

**Minorities.** Minorities, particularly those with low incomes, are at higher risk of lacking health insurance. Doty and Holmgren found that 62 percent of working-age Hispanics and 33 percent of African Americans were uninsured for some time during 2005, compared with 20 percent of whites in the same age group (Figure 14).[22] The authors found that Hispanic adults are particularly disconnected from the health system: they are substantially less likely than whites to have a regular doctor, to have visited a doctor in the past year, or to feel confident about their ability to manage their health problems. In earlier research, the authors found that 80 percent of Hispanics in households with incomes under 200 percent of poverty had experienced a time uninsured over a four-year period, compared with 66 percent of African Americans and 63 percent of whites in that income group.[23] This is in spite of the fact that Hispanics in lower-

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[18] U.S. Social Security Administration, Legislative Archives of the 106th Congress, The Foster Care Independence Act of 1999, http://www.ssa.gov/legislation/legis_bulletin_112499.html, accessed Nov. 9, 2007.

[19] North Carolina Department of Health and Human Services, Family and Children's Medicaid MA-3230 Eligibility of Individuals Under Age 21, http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/MA3230-08.htm, accessed Nov. 9, 2007.

[20] Texas Department of Family and Protective Services, Medicaid for Young People Transitioning from Foster Care, http://www.dfps.state.tx.us/Documents/Child_Protection/pdf/transitionalmedicaid.pdf, accessed Nov. 9, 2007.

[21] Voices for Ohio's Children, Summary of Child Health Expansions in Amended Substitute House Bill 119, http://www.vfc-oh.org/cms/resource_library/legislation/0331e68e882ad01e/, accessed Nov. 9, 2007.

[22] M. M. Doty and A. L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults* (New York: The Commonwealth Fund, Aug. 2006).

[23] M. M. Doty and A. L. Holmgren, *Unequal Access: Insurance Instability Among Low-Income Workers and Minorities* (New York: The Commonwealth Fund, Apr. 2004).

income households were more likely to have been employed full-time continuously over that period than either African Americans or whites in the same income group.

**Unemployed.** A provision in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more workers to continue offering health insurance coverage to employees who leave their jobs either voluntarily or involuntarily (except for reasons of gross misconduct), or to employees whose hours are reduced below insurance-qualifying levels. Eligible employees and their dependents can purchase COBRA coverage for 102 percent of the premium for 18 to 36 months, depending on the reason for eligibility.[24] The Trade Act of 2002 created advanceable and refundable Health Coverage Tax Credits to subsidize 65 percent of the cost of COBRA or individual market coverage for workers displaced by international trade who receive Trade Adjustment Assistance and for certain early retirees. The target population is under 250,000 and take-up has been relatively limited.[25]

Despite COBRA, more than half of unemployed adults under age 65 are uninsured, greater than three times the rate of employed adults (Figure 15).

Like employer-based coverage in general, lower-wage workers are far less likely to be COBRA-eligible than higher-wage workers (Figure 16). Kapur and Marquis found that of workers with household incomes of less than 200 percent of poverty who left a job voluntarily, 53 percent were uninsured one month after leaving their job, compared with 28 percent of higher-income workers.[26] But 50 percent of lower-income job leavers were uninsured prior to leaving their job, versus 22 percent of workers with incomes at or exceeding 200 percent of poverty. Higher-income workers who voluntarily left their jobs were somewhat more likely to have COBRA than their lower-income counterparts (8% vs. 3%), much more likely to gain coverage through a new job (16% vs. 4%), and much more likely to gain coverage through a family member's employer (31% vs. 10%)

Even when lower-wage workers are eligible for COBRA benefits, the full cost of the premium, now averaging more than $12,000 a year for a family plan, plus the 2 percent fee may be unaffordable, particularly as a share of an unemployment benefit.[27] Kapur and Marquis found, for example, that of lower-income workers who were eligible for COBRA through their jobs and left their jobs, 48 percent were uninsured one month

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[24] Employees and their beneficiaries are eligible to buy coverage for 18 months after the employee leaves a job. If an employee dies, divorces, separates, becomes eligible for Medicare, or a dependent ages off a policy, dependents can qualify for COBRA for 36 months. People who the Social Security Administration certifies as too disabled to work can also purchase COBRA for up to 29 months from the date of the defining event.

[25] S. Dorn, J. Varon, and F. Pervez, *Limited Take-Up of Health Coverage Tax Credits: A Challenge to Future Tax Credit Design* (New York: The Commonwealth Fund, Oct. 2005).

[26] K. Kapur and M. S. Marquis, "Health Insurance for Workers Who Lose Jobs: Implications for Various Subsidy Schemes," *Health Affairs,* May/June 2003 22(3):203–13.

[27] J. M. Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (New York: The Commonwealth Fund, Nov. 2001).

later, compared with 27 percent of higher-income COBRA-eligible workers who left their jobs. Lower-income workers and higher-income workers took up COBRA at about the same rate (18%), but higher-income workers were much more likely to have gained coverage through a new job (29% vs. 9%).

**People with disabilities in Medicare's two-year waiting period.** There are an estimated 1.7 million people who are disabled and in the waiting period for Medicare (Figure 17). Of those, about one-third have coverage through a former employer or though a spouse's employer, just over a third are covered by Medicaid, 9 percent purchase coverage through the individual insurance market, and 15 percent, or nearly 265,000 people, are without health insurance. Those who have COBRA coverage through a former employer, or who purchase it through the individual market, are financially burdened with the full premium.

In a 2005 Commonwealth Fund study of older adults, 41 percent of disabled Medicare beneficiaries ages 50 to 64 said that they had been uninsured just prior to entering Medicare (Figure 18).[28] More than four of five (84%) said that becoming eligible for Medicare was very important to them.

## Consequences of Coverage Gaps for Family Health and Economic Security

The widening gap in our health insurance system, in which growing numbers of people find themselves each year, is unacceptable on both moral and economic grounds. It also contributes to the overall poor performance of our health care system. In an extensive review of the evidence in 2003, the Institute of Medicine (IOM) concluded that the most important determinant of access to health care is adequate health insurance coverage.[29] People who lack health insurance have fundamentally different life experiences than do those who are insured.[30]

**Poor access to care.** In three nationally representative telephone surveys of U.S. adults conducted in 2001, 2003, and 2005, The Commonwealth Fund found that people who spent any time without coverage over a 12-month period had significantly higher rates of cost-related access problems.[31] Specifically, respondents were asked if, because of cost, they did not go to a doctor or clinic when sick, did not fill a prescription, skipped a doctor-recommended medical test, treatment, or follow-up visit, or did not see a specialist when they or their doctor thought it was needed. In 2005, about three of five

[28] S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, and A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund, June 2005).

[29] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, June 2003).

[30] Institute of Medicine, Committee on the Consequences of Uninsurance, *Care Without Coverage: Too Little, Too Late*, (Washington D.C.: National Academies Press, 2002).

[31] Duchon, Schoen, Doty et al., *Security Matters,* 2001; Collins, Doty, Davis et al., *Affordability Crisis,* 2004; Collins, Davis, Doty et al., *Gaps in Health Insurance,* 2006.

adults reported any one of these cost-related access problems, more than two times the rate for adults who were insured all year (Figure 19). Using data from The Commonwealth Fund 2006 Quality of Care Survey, Beal and colleagues found that adults who spent any time uninsured in the prior year were significantly less likely to have a regular doctor or medical home and significantly less likely to say that they always or often receive the health care they need when they need it.[32]

Poor-quality health care is particularly devastating and can have long-term implications for uninsured adults with chronic health problems. In five chronic disease categories that the IOM studied, uninsured adults were less likely to receive appropriate care for management of their conditions and had worse clinical outcomes than insured adults with chronic illness.[33] In a recent article in the *Journal of the American Medical Association*, Hadley found that uninsured patients who experienced an injury or were newly diagnosed with a chronic health condition received less medical care, were more likely to report not being fully recovered but no longer receiving care, and were more likely to report lower health status seven months after the event than were insured patients who experienced a similar medical event.[34]

The Commonwealth Fund Commission on a High Performance Health System found that only one-quarter (24%) of uninsured adults with diabetes had received all three recommended services for diabetes in the last year (i.e., HbA1c test, retinal exam, and foot exam), less than half the rate of privately insured adults with diabetes (54%).[35] Collins and colleagues found that nearly 60 percent of non-elderly adults with a chronic health condition who had been uninsured for some time in 2005 did not fill a prescription or skipped a dose of their medication for their condition because of cost, compared with 18 percent of those who had coverage all year (Figure 20).[36] The authors also found that more than one-third (35%) of uninsured adults with a chronic condition went to an

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[32] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

[33] Specifically, the IOM found in its review of the literature that uninsured cancer patients died more quickly from their illnesses; uninsured diabetes patients were less likely to receive recommended care and far more likely to go without checkups for two years or more; uninsured patients with cardiovascular disease were much less likely to take recommended prescription medications and were in worse health than insured patients; uninsured patients with end stage renal disease were more likely to be in more severe renal failure when they begin dialysis than insured patients; and uninsured adults with mental illness were less likely to receive care consistent with clinical guidelines.

[34] J. Hadley, "Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury of the Onset of a Chronic Condition," *Journal of the American Medical Association,* Mar. 14, 2007 297(10):1073–84.

[35] C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475; Commonwealth Fund Commission, *Why Not the Best?* 2006.

[36] Collins, Davis, Doty et al., *Gaps in Health Insurance,* 2006.

emergency room or stayed overnight in a hospital for their condition, compared with 16 percent of those who were insured all year.

**Health and economic implications for families and the nation.** What are the consequences of such poor-quality care? People without coverage have both poorer health status and shorter life expectancies. The IOM estimates that 18,000 avoidable deaths occur each year in the United States as a direct result of individuals being uninsured. Moreover, the IOM estimated that the lost "health capital" of going without coverage ranges between $1,645 and $3,280 for each additional year without health insurance. Based on this estimate the IOM projected that the aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter lifespans falls between $65 billion and $130 billion for each year without coverage. Considered another way, the nation stands to gain $65 billion to $130 billion in potential economic value if it provided insurance coverage to the approximately 40 million uninsured people at the time of the IOM study.

Recent research suggests that gaps in coverage for uninsured people with chronic health conditions may have long-run cost implications for the health system, and the Medicare program in particular. McWilliams and colleagues found that among adults with chronic conditions, previously uninsured adults who acquired Medicare coverage at age 65 reported significantly greater increases in the number of doctor visits and hospitalizations and in total medical expenditures than did previously insured adults, with the difference persisting through age 72. The findings suggest that the costs of providing health insurance for uninsured near-elderly adults may be partially offset by subsequent reductions in health care use and spending once they enter Medicare.[37]

Being uninsured or underinsured can also have immediate financial consequences—from minor to catastrophic. In recent years, hospitals have become increasingly aggressive in obtaining payment from uninsured patients, charging self-pay patients rates that are much higher than those negotiated by private insurers. In 2004, Anderson found that hospitals charged self-pay patients rates that were often 2.5 times those paid by most insurers, and greater than three times the costs that hospitals are allowed under Medicare.[38]

Using the Commonwealth Fund Biennial Health Insurance Survey, Collins and colleagues found that more than half of working-age adults who had been uninsured during 2005 reported problems paying medical bills during that time or were paying off accrued medical debt, compared with 26 percent of those who had been insured all year

[37] J. M. McWilliams, E. Meara, A. M. Zaslavsky et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine,* July 12, 2007 357(2):143–53.

[38] G. F. Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing," *Health Affairs*, May/June 2007 26(3):780–89.

(Figure 21).[39] Confronted with medical bills and debt, many people are forced to make stark trade-offs between spending and saving. In the survey, 40 percent of uninsured adults with medical bill problems were unable to pay for basic necessities like food, heat, or rent, and nearly 50 percent had used all their savings to pay their bills (Figure 22).[40]

**Costs of uncompensated care.** The financing of care for people who are uninsured is inefficient and is characterized by cost-shifting. Hadley and Holahan estimate that the total costs of uncompensated care in the United States were $40.7 billion in 2004.[41] Hospitals incurred about 63 percent of the uncompensated care costs, physicians about 18 percent, and clinics and direct care programs, like Veterans Affairs and the Indian Health Service, 19 percent. Federal, state, and local funding available in 2004 to reimburse uncompensated care costs amounted to $34.6 billion, or 85 percent of the total. More than two-thirds of that funding is provided through the federal government, primarily in the form of payments to hospitals through disproportionate-share hospital payments.

Physicians are unlikely to receive government funds for providing uncompensated care unless they practice in community health centers or direct-service programs. Some researchers have argued that private payers finance uncompensated care costs that are not covered by public funds through surcharges on private patients, with these higher costs ultimately leading to higher private insurance premiums. Estimates of this "hidden tax" range from 8.5 percent of premiums nationally to 10.6 percent in California.[42]

Uncompensated care costs might be far higher if uninsured people used as much health care as insured people do. Hadley and Holahan estimate that adults and children without insurance for a full year receive just 55 percent of the medical care that those who are insured for the full year receive.[43]

Physicians also report inefficiencies in securing pharmaceuticals, as well as follow-up medical care, for uninsured patients. In a study of 12 cities across the country, Hurley and colleagues found that community health centers carefully guarded limited drug supplies and dollars because only a few patients with chronic conditions could quickly exhaust the facility's supplies.[44] Gusmano and colleagues found that physicians practicing in health centers often encounter difficulties obtaining specialized services for

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[39] Collins, Davis, Doty et al., *Gaps in Health Insurance*, 2006.

[40] Ibid.

[41] J. Hadley and J. Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2004). Available at http://www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We-Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf.

[42] L. M. Nichols and P. Harbage, *Estimating the "Hidden Tax" on Insured Californians Due to the Care Needed and Received by the Uninsured* (Washington, D.C.: New America Foundation, May 2007).

[43] Hadley and Holahan, *Cost of Care for Uninsured*, 2004.

[44] R. E. Hurley, H. H. Pham, and G. Claxton, "A Widening Rift in Access and Quality: Growing Evidence of Economic Disparities," *Health Affairs* Web Exclusive (Dec. 6, 2005):w5-566–w5-576.

their uninsured patients.[45] According to the Hurley study, physicians practicing in these facilities often cope with this limitation by sending patients to emergency departments, which are required by law to provide emergency care regardless of ability to pay, and which maintain call lists of specialists. Yet the researchers found that specialty call lists have been weakened by the opportunities increasingly available to specialists for lucrative practices in freestanding facilities. Moreover, even when specialty care can be secured in emergency departments, it is very difficult for uninsured patients to gain access to follow-up care.

**Health Care Reform Is Necessary to Fill the Gaps**

It is essential on both moral and economic grounds that the United States move forward to guarantee affordable, comprehensive, and continuous health insurance for everyone. The Commonwealth Fund Commission on a High Performance Health System released a report in October that argues that universal coverage is essential to a high performance health system.[46] Without universal coverage, our health system will not be able to provide more effective, higher-quality, and more efficiently delivered care, and it will not be able to ensure longer, healthier, and more productive lives. It is unacceptable that people without health insurance collectively lose between $65 billion and $130 billion a year in lost productivity and earnings, and are more at risk of premature death. Several proposals for universal coverage have been put forth, or implemented in the case of Massachusetts, by governors, members of Congress, and the 2008 presidential candidates. This is a welcome development and is highly promising for reversing the inexorable climb in the uninsured over the past several years.

The Commission on a High Performance Health System recommended in its report that any health insurance reform proposal should do the following:

- Provide equitable and comprehensive insurance for all.
- Insure the population in a way that leads to full and equitable participation.
- Provide a minimum, standard benefit floor for essential coverage with financial protection.
- Ensure that premiums, deductibles, and out-of-pocket costs are affordable relative to family income.

[45] M. K. Gusmano, G. Fairbrother, and H. Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs,* Nov./Dec. 2002 21(6):188–94.

[46] S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. C. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007).

- Ensure that coverage is automatic and stable, with seamless transitions that enable people to remained enrolled at all times.
- Provide a choice of health plans or care systems.
- Pool health risks across broad groups and over a person's lifespan, and eliminate insurance practices designed to avoid poor health risks.

In the absence of universal coverage, there are several policies that would help fill gaps in the nation's current system by building on existing public and private group insurance, and also create an essential foundation for universal coverage that would meet the principles outlined above:

- **Build on Public and Private Group Insurance to Extend Coverage to Vulnerable Age Groups and the Disabled**
    - Allow states to extend eligibility for Medicaid and SCHIP coverage beyond age 18. The Foster Care Independence Act of 1999, which allows states to extend Medicaid coverage to children in foster care beyond age 18, could be expanded to cover all children in Medicaid. Depending on the income eligibility levels, extending coverage up to age 25 would cover 3.3 million uninsured young adults ages 19 to 25 in families with incomes under 100 percent of poverty, and 5.7 million with incomes under 200 percent of poverty.
    - Seventeen states have already redefined the age at which a young adult is no longer a dependent for purposes of insurance, ranging from age 24 to age 30. Other states should follow their lead, insuring that young adults can remain on their parents' plans while they make the transition to college, graduate school, or work.
    - Allow older adults ages 55 to 64 to "buy in" to Medicare.
    - End Medicare's two-year waiting period for coverage of the disabled. The Lewin Group estimates that the cost to the federal government of immediately ending the waiting period would be about $9.1 billion in 2007, but that figure is expected to decline over time, since there would be fewer people enrolling all at once and less pent-up demand for health services from uninsured or underinsured people in the waiting period.[47]

[47] S. R. Collins, K. Davis, and J. L. Kriss, *Analysis of Leading Congressional Health Care Bills 2005–2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund, Mar. 2007).

- **Build on Public and Private Group Insurance to Extend Coverage to Low-Income Workers and Their Families**
    - Expand Medicaid to cover everyone under 150 percent of poverty; consider providing federal matching funds for sliding-scale premiums at higher income levels.
    - Require employers to continue COBRA coverage and finance it for up to two months for employees who lose their jobs. Federal government could provide premium assistance for 70 percent of COBRA premiums for unemployed workers.
- **Connect Public and Private Group Insurance to Realize Efficiencies from Pooling Large Groups of People**
    - Create a national health insurance "connector" based on either the Federal Employees Health Benefits Program or Medicare, with sliding-scale premium subsidies, restrictions on carriers with regard to risk selection, and federal reinsurance.

We stand as a nation at a crossroads. A majority of the public is asking its leaders to address our health insurance problem with comprehensive reform, even if it requires a substantial investment of public and private funds.[48] States like Massachusetts are leading the nation in this effort, and national policy leaders are responding with well-thought-out proposals. If we do not rise to the occasion and move forward with policy strategies designed to cover everyone effectively and address the health system's quality and efficiency shortcomings, then health care costs will continue to climb apace and our uninsured problem will continue to ascend the income scale.

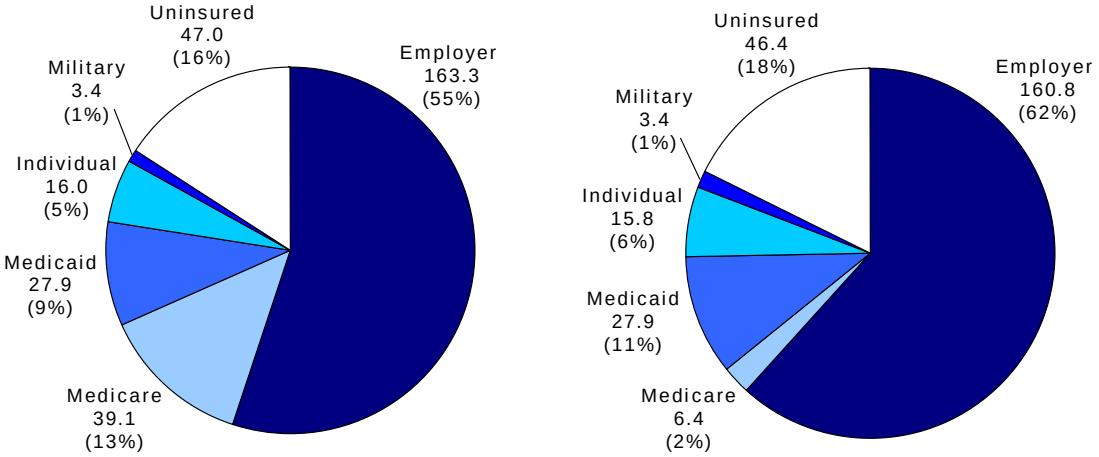
We are a wealthy and innovative country. We have the resources and the technology to move affirmatively toward universal coverage in a way that improves quality and controls costs. The time is upon us to resolve ideological differences over favored strategies and find consensus based on pragmatism and fact.

Thank you.

[48] Kaiser Family Foundation Health Tracking Poll: Election 2008, Aug. 2007.

## Figure 1. Employers Provide Health Benefits to More than 160 Million Working Americans and Family Members

Numbers in millions, 2006




Total population = 296.7

Under-65 population = 260.7

Source: S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007). Data: Current Population Survey, Mar. 2007.

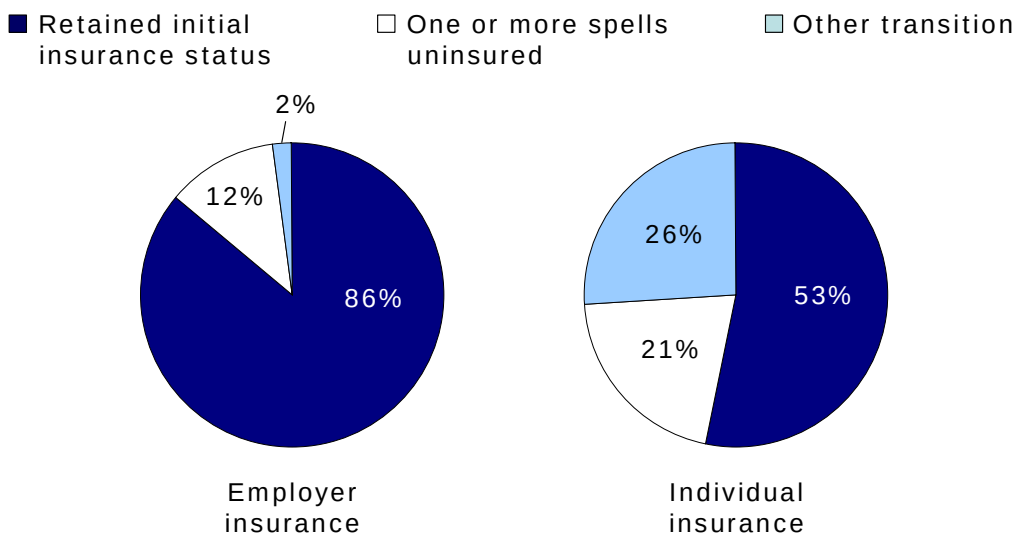
## Figure 2. Individual Market Insurance Is Not an Affordable Option for Many People

| Adults ages 19–64 with individual coverage or who thought about or tried to buy it in past three years who: | Total | Health problem | No health problem | <200% poverty | 200%+ poverty |
|---|---|---|---|---|---|
| Found it very difficult or impossible to find coverage they needed | 34% | 48% | 24% | 43% | 29% |
| Found it very difficult or impossible to find affordable coverage | 58 | 71 | 48 | 72 | 50 |
| Were turned down or charged a higher price because of a pre-existing condition | 21 | 33 | 12 | 26 | 18 |
| Never bought a plan | 89 | 92 | 86 | 93 | 86 |

Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

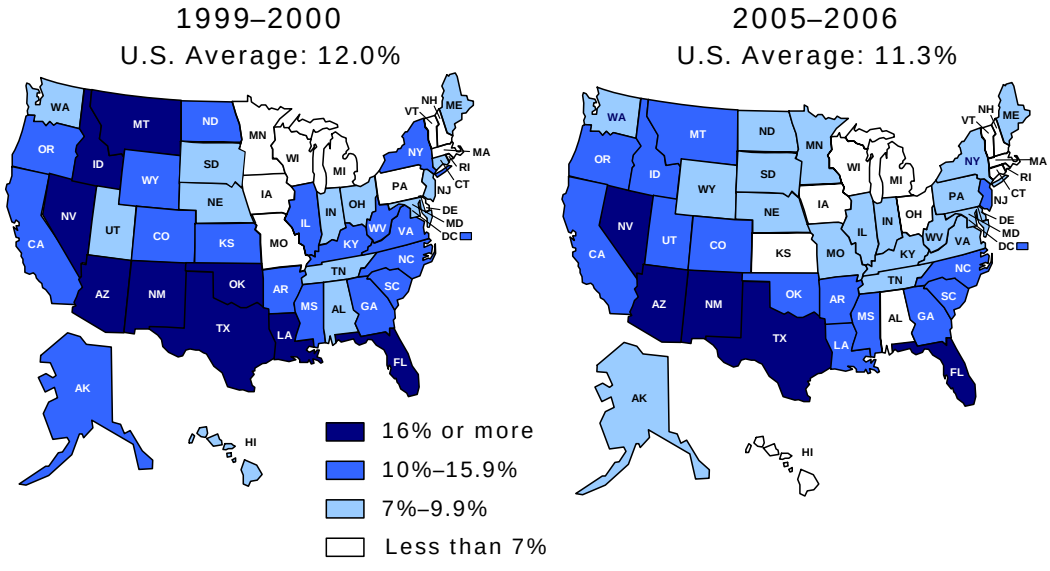
## Figure 3. People with Employer Insurance Have More Stable Coverage than Those with Individual Market Insurance

Retention of initial insurance over a two-year period, 1998–2000



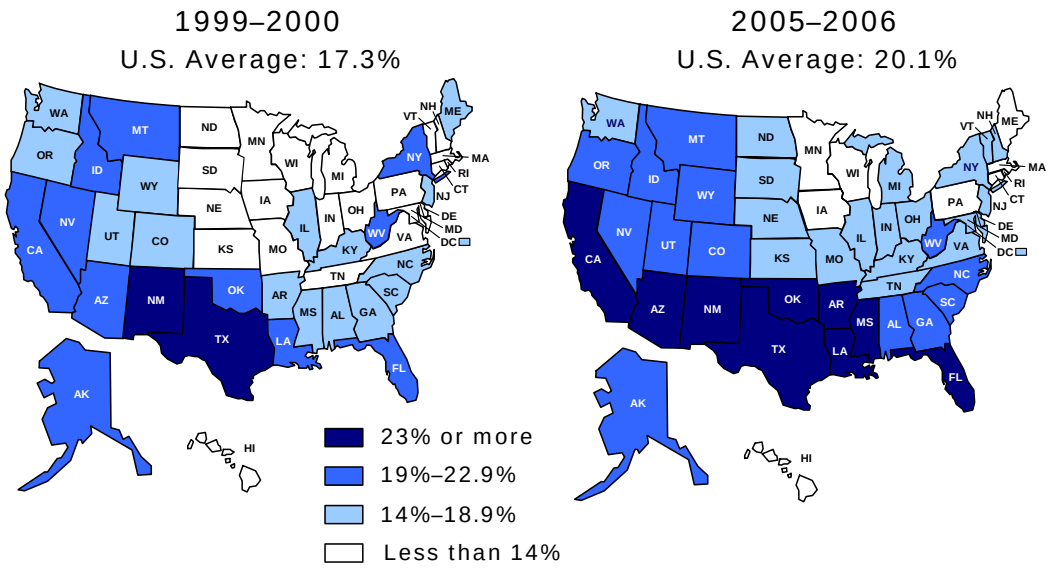

Source: K. Klein, S. A. Glied, and D. Ferry, *Entrances and Exits: Health Insurance Churning, 1998–2000* (New York: The Commonwealth Fund, Sept. 2005). Data: Authors' analysis of the 1998–2000 Medical Expenditure Panel Survey.

## Figure 4. Percent of Uninsured Children Declined Since Implementation of SCHIP, But Gaps Remain



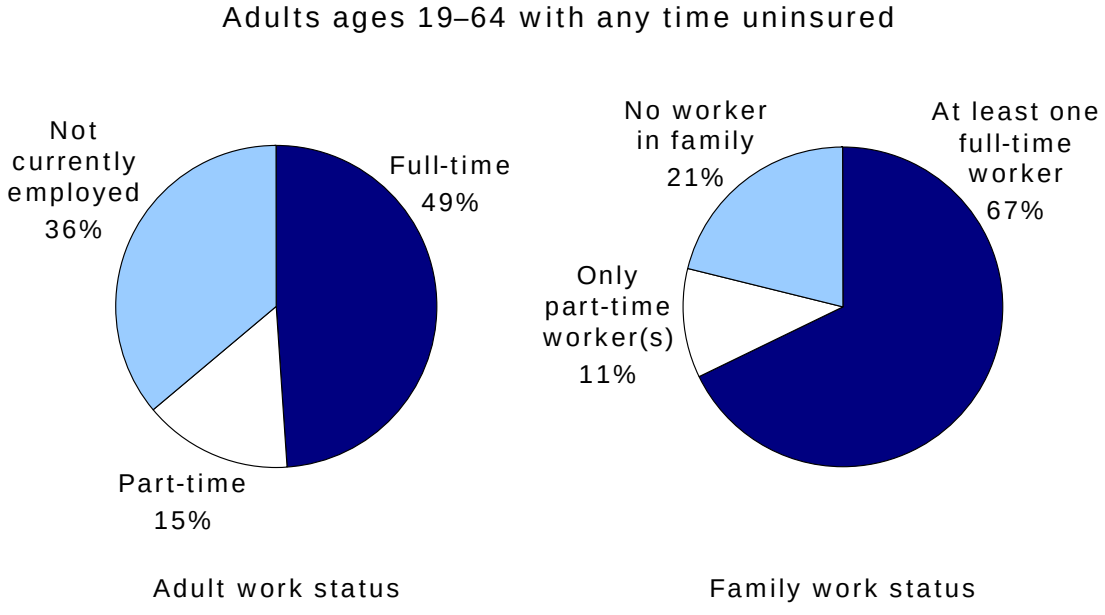

Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007). Updated data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

## Figure 5. Number of States with 23 Percent or More Uninsured Nonelderly Adults Rose from 2 to 9 in Last Six Years




Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007). Updated data: Two-year averages 1999–2000, updated with 2007 CPS correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

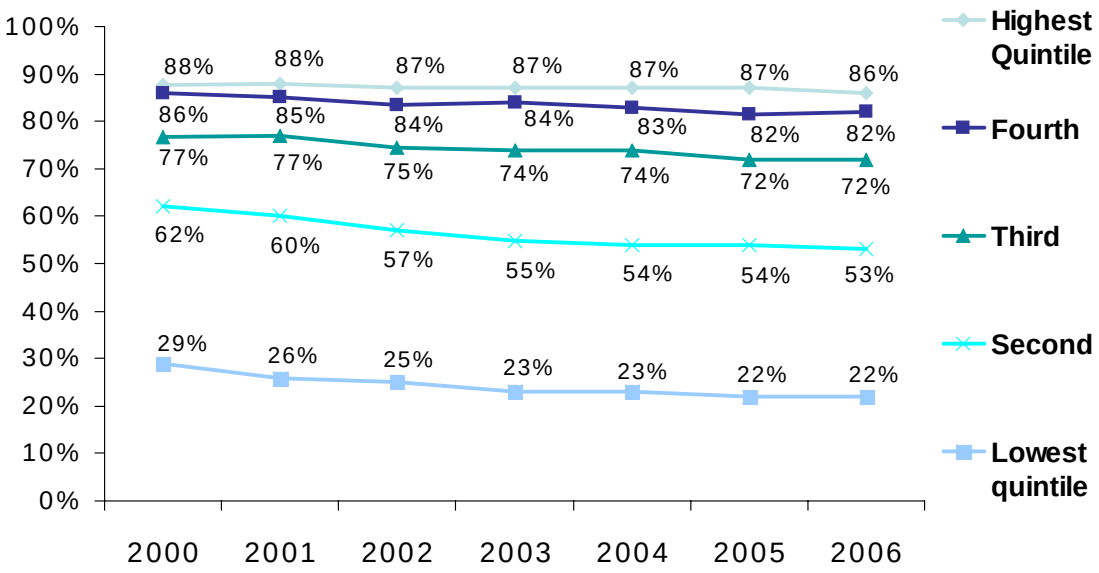
## Figure 6. The Majority of Uninsured Adults Are in Working Families




Note: Percentages may not sum to 100% because of rounding.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

## Figure 7. Employer-Provided Health Insurance, by Income Quintile, 2000–2006

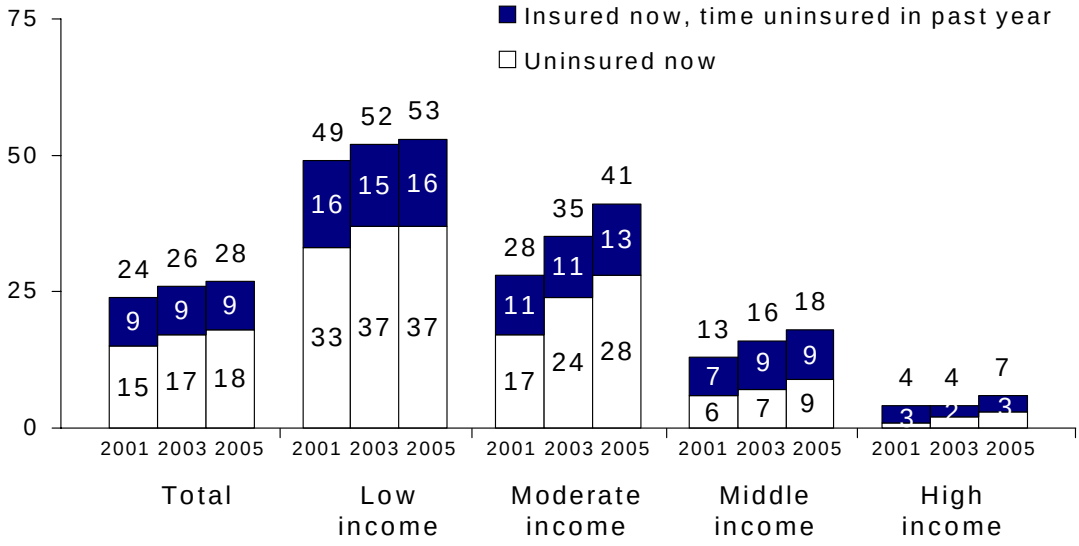
Percent of population under age 65 with health benefits from employer




Source: E. Gould, *The Erosion of Employment-Based Insurance: More Working Families Left Uninsured,* EPI Briefing Paper No. 203 (Washington, D.C.: Economic Policy Institute, Nov. 2007).

## Figure 8. Uninsured Rates High Among Adults with Low and Moderate Incomes, 2001–2005

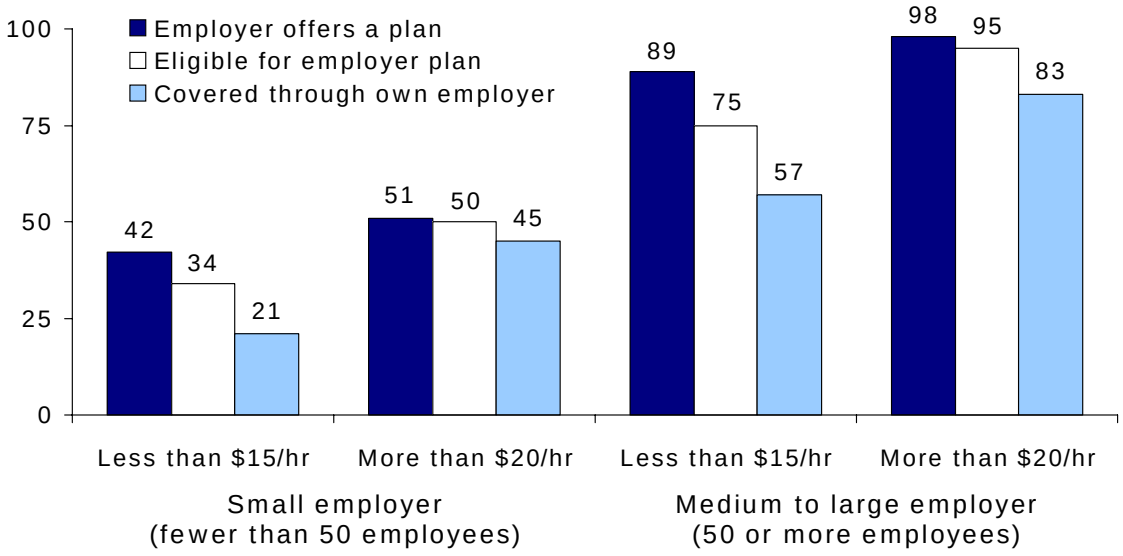
Percent of adults ages 19–64




Note: Income refers to annual income. In 2001 and 2003, low income is <$20,000, moderate income is $20,000–$34,999, middle income is $35,000–$59,999, and high income is $60,000 or more. In 2005, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source: The Commonwealth Fund Health Insurance Surveys (2001, 2003, and 2005).

## Figure 9. Workers Who Are Offered, Eligible for, and Participate in Their Employer's Health Plan, by Firm Size and Hourly Wage

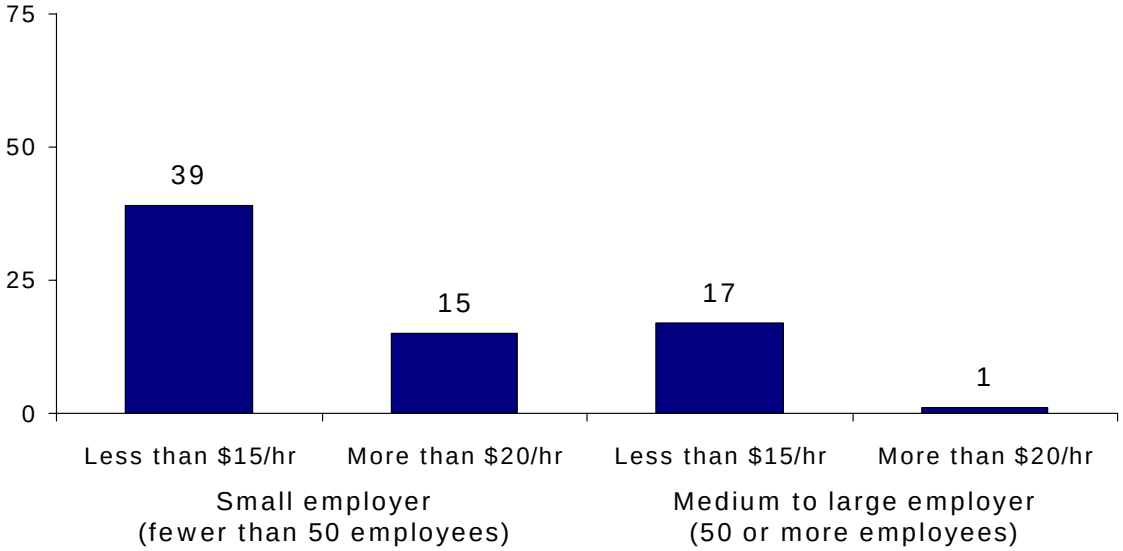
Percent of working adults^ ages 19–64




^ Includes both part-time and full-time workers.
Source: S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, Apr. 2003).
Updated data from The Commonwealth Fund Biennial Health Insurance Survey (2005).

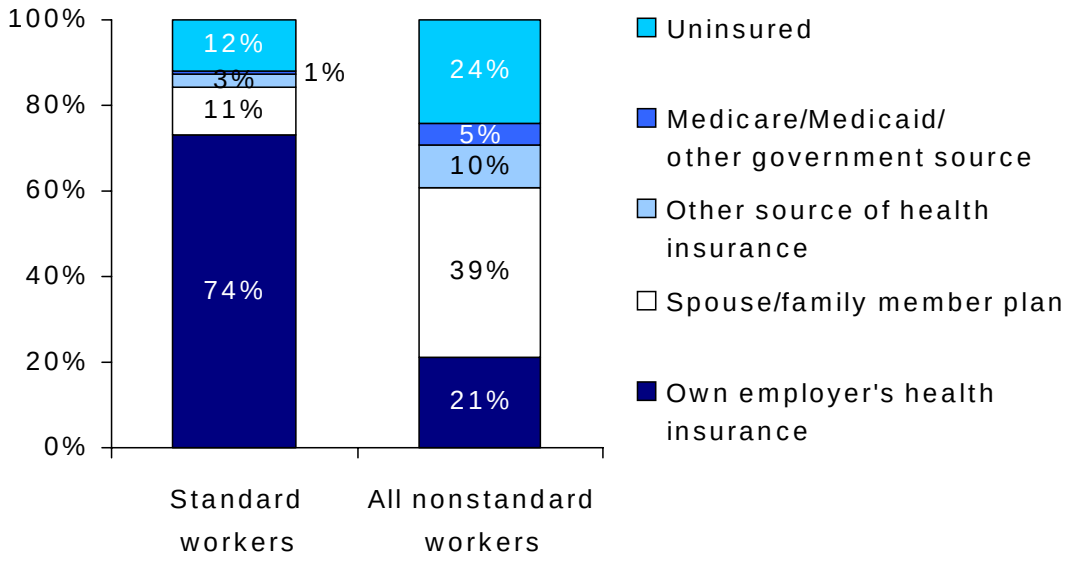
## Figure 10. Percent Uninsured Workers by Firm Size and Hourly Wage

Percent of working adults^ ages 19–64 who are uninsured



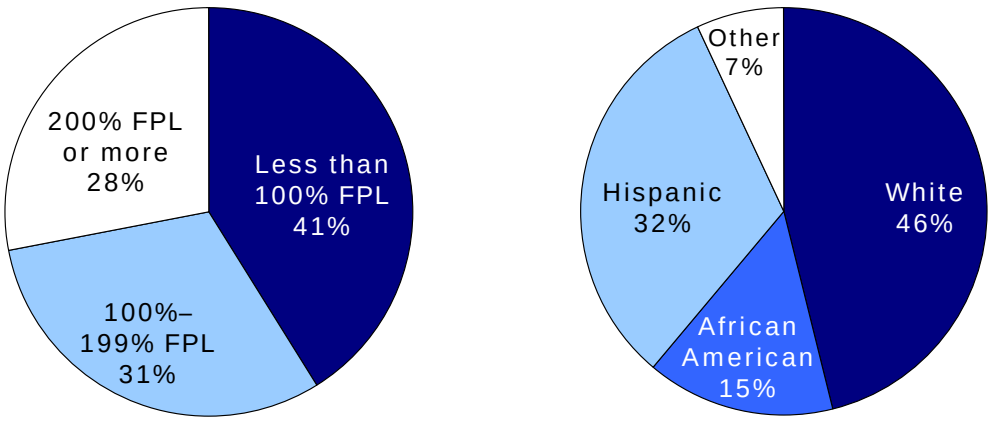

^ Includes both part-time and full-time workers.
Source: S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, Apr. 2003).
Updated data from The Commonwealth Fund Biennial Health Insurance Survey (2005).

## Figure 11. Nonstandard Workers Are Less Likely to Have Health Insurance Coverage Through Their Own Job, 2001




Notes: Self-employed independent contractors are excluded from analysis. "Other source of health insurance" includes insurance from the individual market, from another job, from a previous job, or from an association, school, or other unidentified source.
Source: E. Ditsler, P. Fisher, and C. Gordon, *On the Fringe: The Substandard Benefits of Workers in Part-Time, Temporary, and Contract Jobs* (New York: The Commonwealth Fund, Dec. 2005).
Data: Authors' analysis of the 2001 Contingent Work Supplement to the Current Population Survey.

## Figure 12. Distribution of Uninsured Young Adults Ages 19–29, by Poverty Status and Race/Ethnicity, 2005




Uninsured young adults = 13.3 million

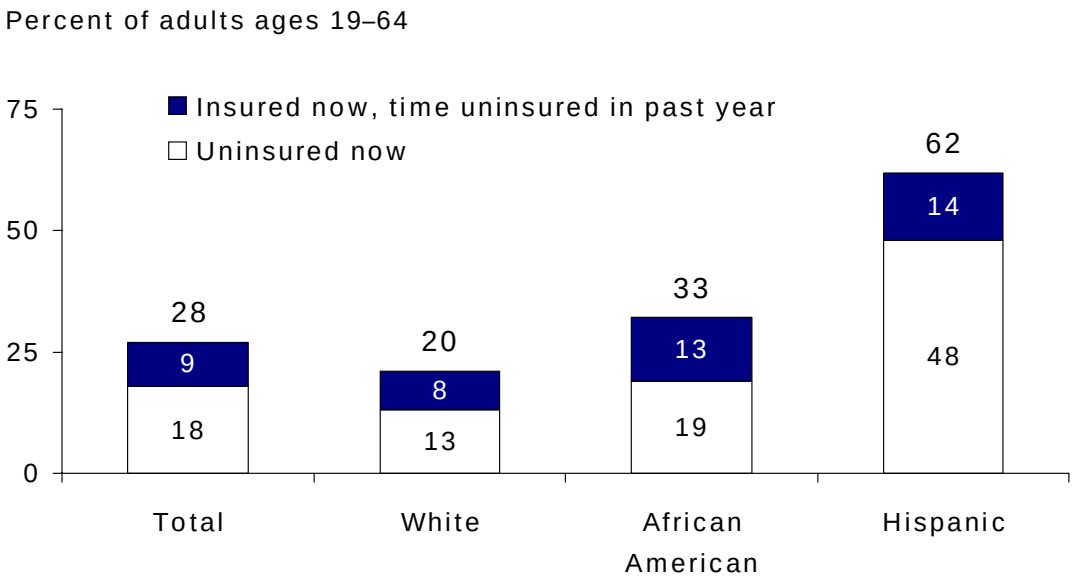
Source: S. R. Collins, C. Schoen, J. L. Kriss, M. M. Doty, and B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated Aug. 8, 2007).
Data: Analysis of the March 2006 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

## Figure 13. Percent Uninsured, Children and Young Adults, by Poverty Level, 2005

| Percent Uninsured | Children Age 18 and Under | Young Adults Ages 19–29 |
|---|---|---|
| Total | 11% | 30% |
| <100% FPL | 20 | 51 |
| 100%–199% FPL | 16 | 42 |
| ≥200% FPL | 7 | 16 |

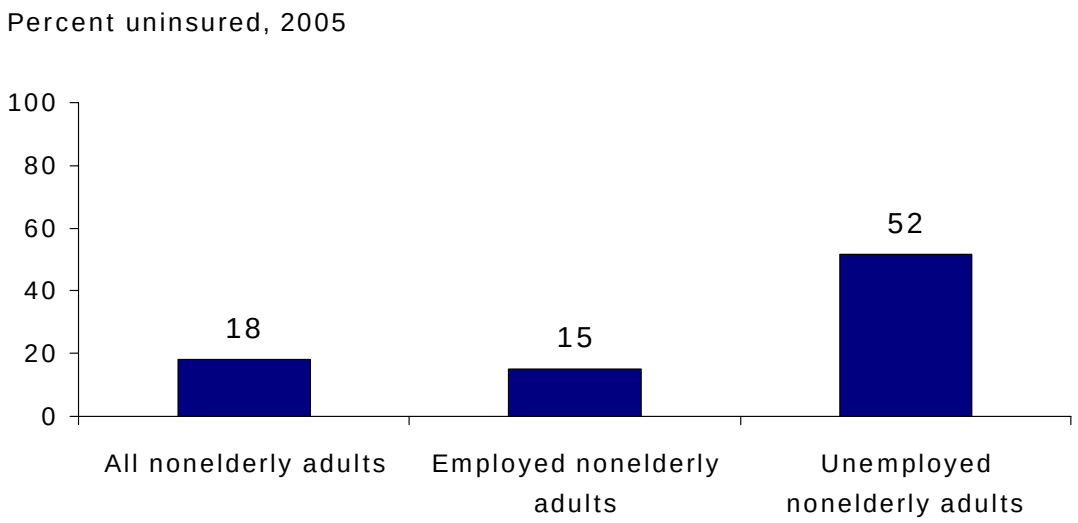
Source: S. R. Collins, C. Schoen, J. L. Kriss, M. M. Doty, and B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated Aug. 8, 2007).
Data: Analysis of the March 2006 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

## Figure 14. Uninsured Rates Are High Among Hispanics and African Americans, 2005



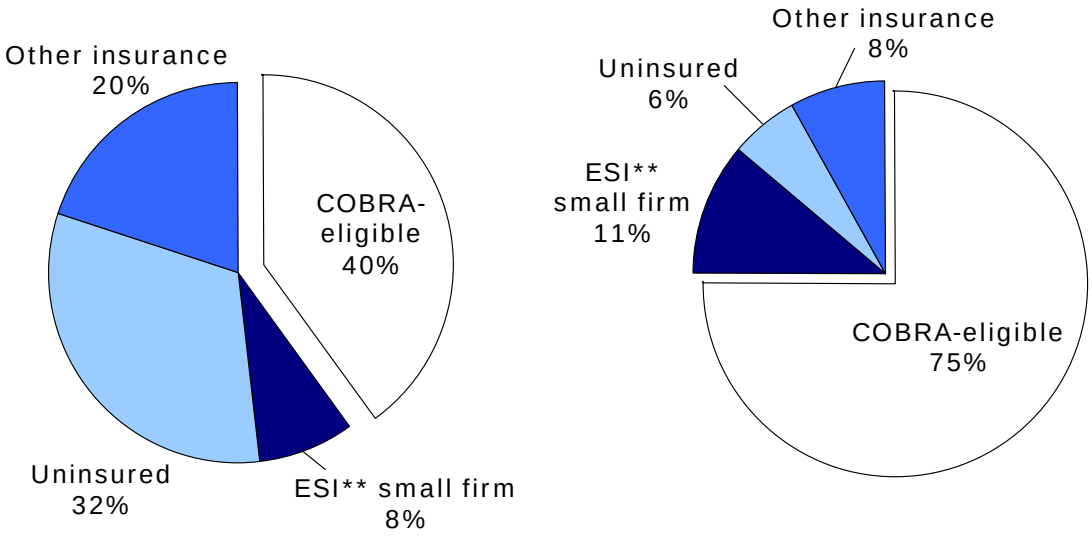

Note: Because of rounding, totals above stacked bars may not reflect the sum of each insurance category.
Source: M. M. Doty and A. L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults* (New York: The Commonwealth Fund, Aug. 2006).

## Figure 15. More Than Half of Unemployed Adults Are Uninsured



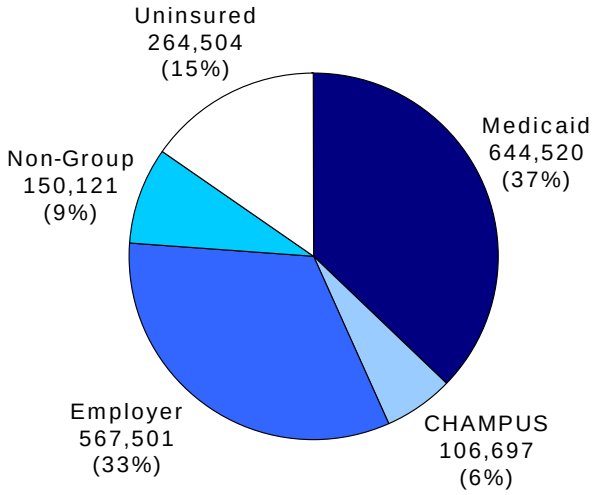

Source: J.L. Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (New York: The Commonwealth Fund, Nov. 2001).
Updated with data from the Commonwealth Fund Biennial Health Insurance Survey (2005).

## Figure 16. Lower Income Workers Are Least Likely to Be Eligible for COBRA*




* The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer continuation of health insurance coverage to former employees. ** Employer-sponsored insurance coverage.
Source: L. Duchon, C. Schoen, M. M. Doty, K. Davis, E. Strumpf, and S. Bruegman, *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (New York: The Commonwealth Fund, Dec. 2001).

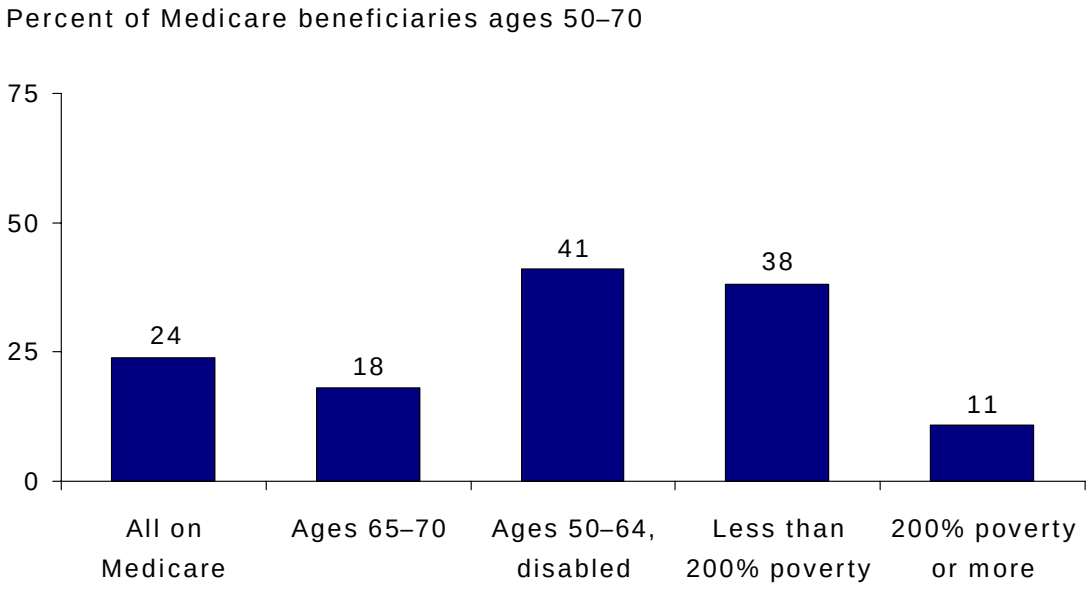
## Figure 17. People with Disabilities in the Waiting Period for Medicare in 2007, by Source of Coverage




Total people currently in waiting period = 1,733,343

Note: Number of people in the waiting period was estimated using the number of SSDI awards to disabled workers, widowers, and adult children in 2004 and 2005 from the Social Security Administration Annual Statistical Supplement (2005 and 2006).
Source: S. R. Collins, K. Davis, and J. L. Kriss, *An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part I, Insurance Coverage* (New York: The Commonwealth Fund, Mar. 2007).

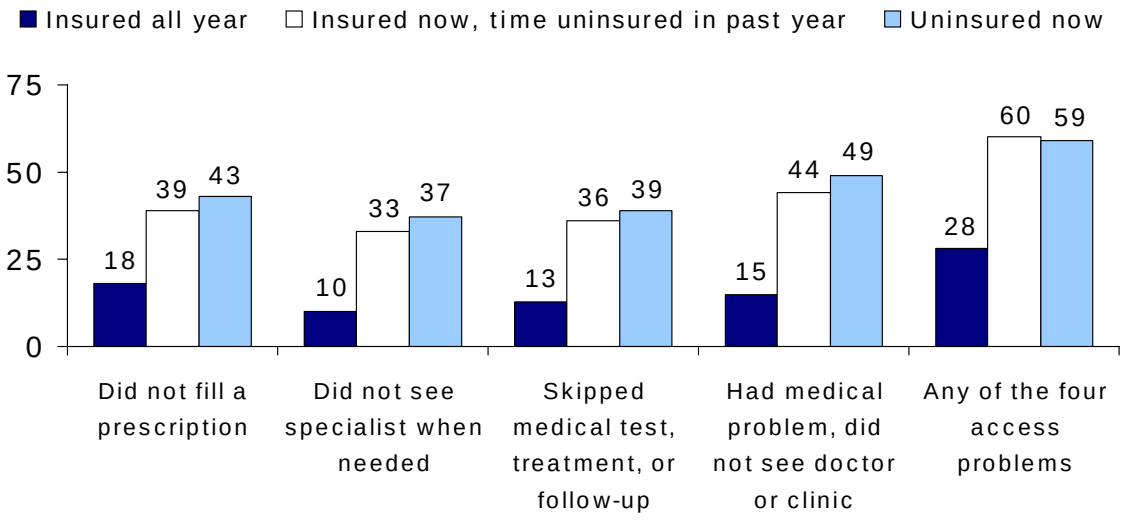
## Figure 18. Nearly One-Quarter of Medicare Beneficiaries Were Uninsured Just Before Enrolling




Source: S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, and A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund, June 2005).
Data from the Commonwealth Fund Survey of Older Adults, 2004.

## Figure 19. Lacking Health Insurance for Any Period Threatens Access to Care

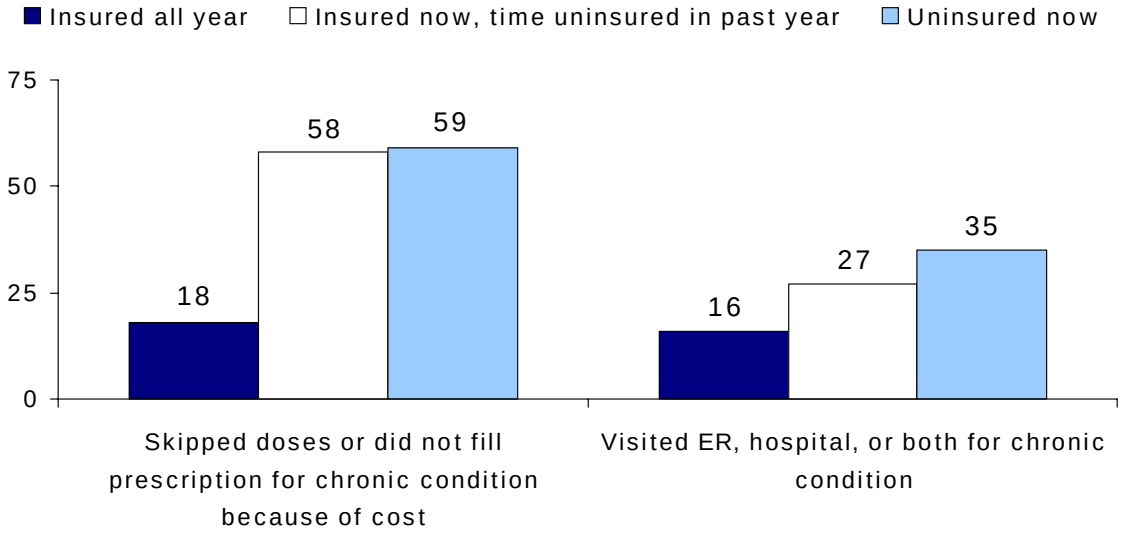
Percent of adults ages 19–64 reporting the following problems in past year because of cost:




Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

## Figure 20. Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions

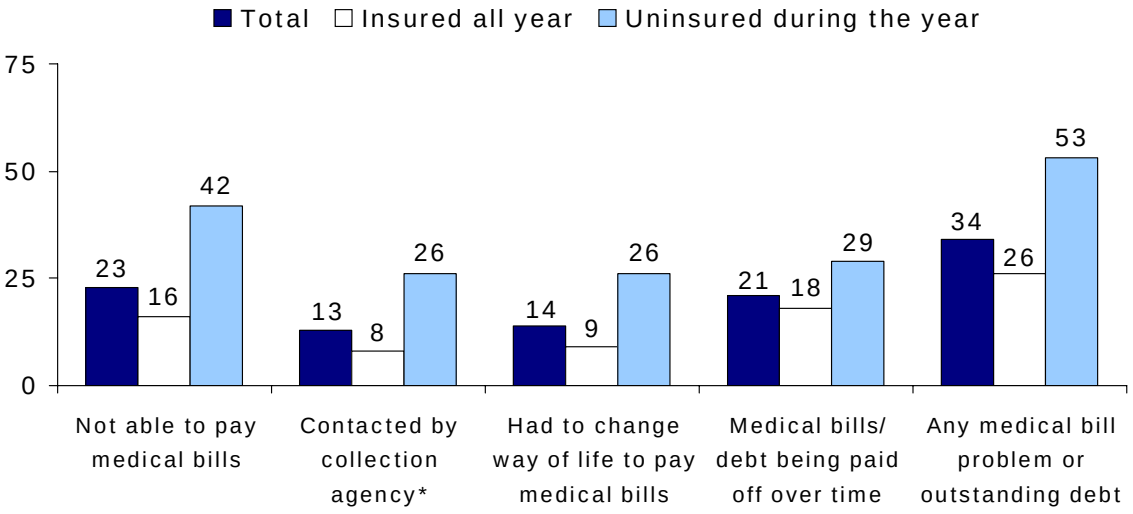
Percent of adults ages 19–64 with at least one chronic condition*




* Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

## Figure 21. Many Americans Have Problems Paying Medical Bills or Are Paying Off Medical Debt

Percent of adults ages 19–64 who had the following problems in past year:




* Includes only those who had a bill sent to a collection agency when they were unable to pay it.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

## Figure 22. One-Quarter of Adults with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

Percent of adults ages 19–64 with medical bill problems or accrued medical debt:

| Percent of adults reporting: | Total | Insured all year | Insured now, time uninsured during year | Uninsured now |
|---|---|---|---|---|
| Unable to pay for basic necessities (food, heat or rent) because of medical bills | 26% | 19% | 28% | 40% |
| Used up all of savings | 39 | 33 | 42 | 49 |
| Took out a mortgage against your home or took out a loan | 11 | 10 | 12 | 11 |
| Took on credit card debt | 26 | 27 | 31 | 23 |

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York: The Commonwealth Fund, Apr. 2006).

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