By Catherine B. Hoffman, ScD, MN, RN

Simple Truths About America's Uninsured

Many common beliefs are incorrect.

Overview: Nurses deal with the fallout of a nation with more than 46 million uninsured. Affecting the patients and families they care for, the hospitals and clinics they work in and manage, and the communities they serve, nurses have a credible standing from which to debunk any myths about who the uninsured are, why they are uninsured, and the difference that health insurance makes in their health and well-being. This article on the uninsured and health insurance coverage among low-income Americans outlines key facts about the uninsured and the primary cause of the problem—the affordability of health insurance.

How much do you know about who's uninsured in the United States? Take the following true-or-false quiz and find out.

1. Many young adults go without health insurance because they believe they don't need it.
2. Most of the uninsured are unemployed, either temporarily or for a long period.
3. The average worker's out-of-pocket share of the premium for family insurance coverage is now more than $2,500 per year.
4. Most uninsured families are poor or near-poor, and this population accounts for the continued growth in the number of uninsured.
5. New immigrants account for most of the recent growth in the number of uninsured people.
6. ED use has increased at a faster rate among the uninsured than among those who have private insurance.
7. Health care costs not paid by uninsured people directly are covered largely by federal and state dollars.
8. The recent increase in federal funding for community health centers has expanded the number of centers, but these funds have not kept up with the growth of the uninsured.
9. Being uninsured, by itself, is associated with premature death among adults under age 65.

(Answers: 1. false; 2. false; 3. true; 4. true; 5. false; 6. false; 7. true; 8. true; 9. true)

More Americans than ever go without health insurance from either government programs or private insurers, and nurses are seeing patients as worried about paying for health care as they are about lowering their blood pressure. Grasping the size of the problem can be daunting: more than 46 million U.S. residents—nearly one in five (18%) of the nonelderly population—had no health insurance at some point in 2005.[1] And according to my calculations, there are almost 20 uninsured people for every nurse in the United States, about 45 for every staffed hospital bed, and 7,800 for every registered hospital. (Statistics and cost estimates not otherwise referenced in this article represent my own analysis.)

The large number of uninsured people combined with the broader impact on families and communities across the country make this one of our nation's top public health problems. Surveys show that most Americans believe that reducing the number of the uninsured is a priority, but fixing the problem takes a degree of social consensus and political will that our nation has not been able to muster.[2, 3]

Catherine B. Hoffman is the associate director of the Kaiser Commission on Medicaid and the Uninsured, Washington, DC. Contact author: choffman@kff.org.

Photograph by Ed Kashi

Sheila Wessenberg at her home in Coppell, Texas, in 2003. Sheila died of breast cancer in May 2005, after several years of inconsistent treatment when she, her husband, Bob, and their two children lost their health insurance. In the last two years of her life Sheila received much of her care in the ED; it was the only place she couldn't be denied treatment. For more on the Wessenbergs' story, see page 44.

In the meantime, nurses manage the consequences, one patient at a time. This gives them a credible standing from which to debunk myths about who the uninsured are, why they are uninsured, and the difference that health insurance makes in their health and well-being. While a great deal is known about the issue, the basic facts often get muddled in the public debate. This article presents several simple truths about America's uninsured.

FACT: Only a small share of the uninsured choose to go without health insurance because they believe they do not need it.

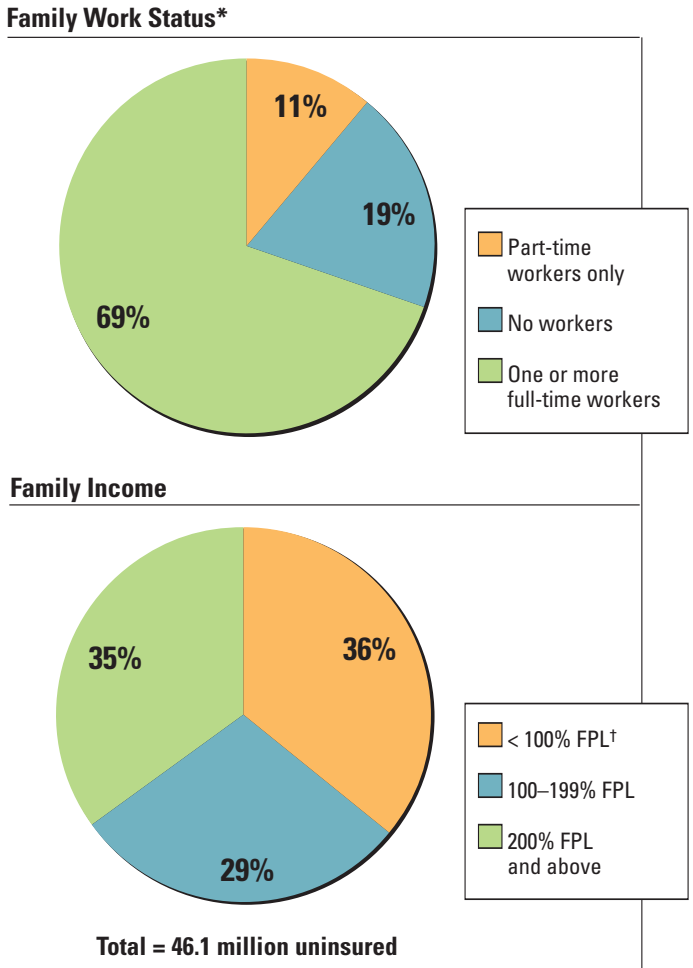
A 2003 national survey showed that the majority of people who don't have health insurance (52%) said that they forgo coverage because they cannot afford it, not because they don't need it.[4] A fifth of these (11% of the total number of uninsured) said they were offered job-based health benefits but their share of the premium was unaffordable; 11% responded that they were not eligible for their employer's benefits. Only 7% in the same survey reported that they were uninsured because they didn't need coverage. Among young adults (ages 18 to 29 years), who are generally in better health than older adults, only 13% believed they did not need health insurance. Moreover, the uninsured are nearly twice as likely as the privately insured to report their health as being either fair or poor.[1]

FACT: Most of the uninsured are either full-time workers or are related to a full-time worker.

More than two-thirds (69%) of uninsured people work full-time or come from families in which at least one person is working full-time (see Figure 1, page 42).[1] Even among those with low incomes (that is, less than 200% of the federal poverty level, or slightly less than $40,000 for a family of four in 2005), who make up the largest proportion of the uninsured, more than half (57%) are from families with full-time workers.

Low-income people have the greatest risk of being uninsured. One out of every three people from low-income families with a full-time worker is uninsured. Were it not for the Medicaid program, millions more low-income Americans would be uninsured.[1]

Figure 1. Characteristics of the Nonelderly Uninsured, 2005



* Data do not total 100% because of rounding.
† The federal poverty level (FPL) was $19,971 for a family of four in 2005.

Kaiser Commission on Medicaid and the Uninsured. *The uninsured: a primer: key facts about Americans without health insurance.* Washington, DC: Kaiser Family Foundation; 2006 Oct. Pub. #7451. http://www.kff.org/uninsured/7451.cfm.

FACT: Employer-sponsored health insurance is either not available or unaffordable for most of the uninsured; nongroup policies seldom fill the gap.

The majority of uninsured employees (56%) are not offered health benefits through their employer, while others are not eligible (14%).[5] Even when insurance is offered by employers, many low-income workers cannot afford the out-of-pocket cost for family coverage, which averaged $2,713 per year in 2005 (see Figure 2, page 43).[6]

Only about 5% of the nonelderly are insured under a private nongroup health plan; this percentage hasn't changed much over time. Nongroup policies vary greatly in terms of benefits, cost sharing, and premiums. According to a Commonwealth Fund survey, "21% of working-age adults who had ever sought coverage on the individual market were turned down, charged a higher price because of a pre-existing condition, or had a health condition excluded from their coverage. One-third of adults with health problems were similarly declined" when seeking nongroup coverage.[7]

Private nongroup insurance premiums are based on a person's health risk and age and are usually much more expensive than comparable group plans. The average nongroup premiums shown in Figure 2, while considerably lower than the total cost of employer-sponsored group premiums, reflect the different population that nongroup insurance currently serves—younger, healthier people who are buying less-generous health benefits and settling for higher cost sharing and financial risk.[6,8] Note, however, that individuals pay more on average for nongroup plans than an employee's share of a job-based group premium, even though the scope of benefits would almost always be less (for example, $4,356 versus $2,713 per year for family coverage).

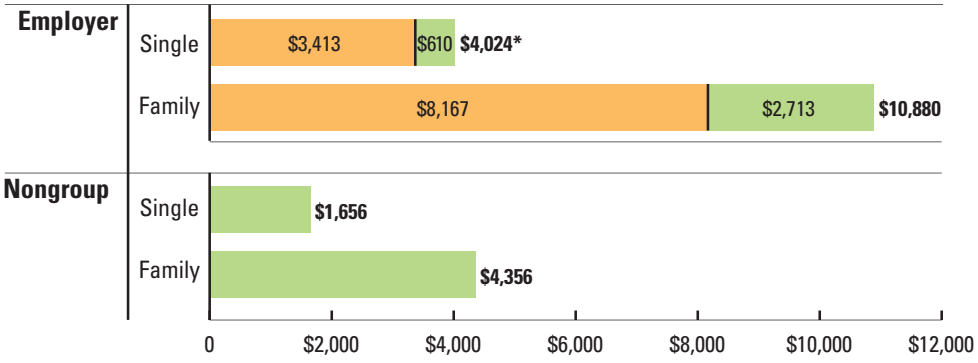
FACT: Most of the uninsured cannot afford health insurance.

Two-thirds of the uninsured earn low incomes or are from low-income families, making it difficult to afford health insurance (see Figure 1, at left).[1] Consider, as an example, a family of four with one full-time worker earning between $20,000 and $30,000 a year, placing them above the federal poverty level (see Figure 3, page 43). Applying the average spending pattern for low-income families in this range means that after the basics of housing, food, and transportation, a little less than a quarter (just under $6,000) is left for everything else—including child care, utility bills, clothing, educational costs, repairs, loan repayments, and health care.[9,10]

If they had family coverage through an employer, the employee's average annual contribution would amount to almost half of the family's remaining budget—$2,713 a year (see Figure 2). If they did not have employer health benefits and obtained a nongroup policy, the average annual premium would be even higher ($4,356), leaving them only about $1,500 per year for all expenses other than shelter, food, and transportation.

For most low-income families health insurance is seldom affordable. In this example, family coverage for the average employee through an employer would consume about 11% of the family's income, while nongroup coverage would require about 18%. In addition to premiums, they must also pay out-of-pocket costs (deductibles and copayments), which increases the financial burden and can affect their health care decisions.

Figure 2. Annual Health Insurance Premium Costs, Employer-Based vs. Nongroup Plans, 2005



Employer data from: Kaiser Family Foundation. *Employer health benefits 2005 annual survey.* Washington, DC; 2005. Pub. #7315. http://www.kff.org/insurance/7315.cfm.

Nongroup data from: United States Government Accountability Office. *Consumer-directed health plans: early enrollee experiences with health savings accounts and eligible health plans.* Washington, DC; 2006 Aug. GAO-06-798.

* Amounts do not total $4,024 because of rounding

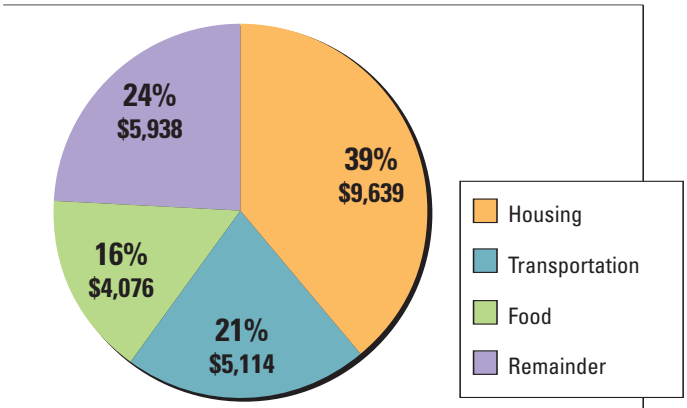
FACT: In recent years, growth in the number of uninsured Americans has been driven by low-income adults.

The number of uninsured Americans grew by almost six million between 2000 and 2004 as the country's economy turned downward.[11] More people shifted from the middle class into the poor and near-poor income groups, where the chances of being uninsured are much higher. Significant decreases in employer-based coverage affected both children and adults, but the loss for children was offset by increases in enrollment in Medicaid and the State Children's Health Insurance Program. All of the growth in this time period occurred among adults, and more than two-thirds of these adults were poor or near-poor. In 2005, even with the improving economy, the number of the uninsured grew by 1.3 million. The large majority (1.1 million) were from low-income families, and the number of uninsured children began to slightly increase for the first time since 2000.[1]

FACT: Most of the uninsured are U.S. citizens, not new immigrants with temporary employment.

Almost 80% of the uninsured are American citizens.[1] In the annual Census Bureau survey that measures health coverage, documented immigrants are not distinguished from those who are undocumented, so differences in their health insurance status are unknown. However, we do know that new immigrants (those in the United States for less than five years) are far more likely to be uninsured compared to citizens (51% versus 15%) because, even though they are as likely as native residents to work full-time, new immigrants often fill low-wage labor and service jobs that do not offer health benefits.[1] These new immigrants make up only 2% of the total nonelderly population in this country; therefore, while they have a high risk of being uninsured, they account for a relatively small portion of the uninsured population (7%). More established immigrants (those who have lived in this country for five years or more) make up another 15% of the uninsured. While the number of uninsured noncitizens increased in the past decade, so did the number of uninsured citizens, and there are simply too few noncitizens for them to dominate the overall trends in health insurance coverage.[12]

Figure 3. Annual Expenditures in Household Budgets with Incomes of $20,000–$30,000*



* Average income in this range before taxes was $24,767.

Hoffman C, Tolbert J. *Health savings accounts and high deductible health plans: are they an option for low-income families?* Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2006 Oct. Issue Brief #7568. www.kff.org/uninsured/7568.cfm.

FACT: The uninsured often cannot find sources of free or charity care that meet their needs.

Less than a quarter of families with at least one uninsured member said they had received free or reduced-rate care.[13] When asked in a 2003 survey if they knew of places in their community that offered affordable medical care for the uninsured, less than

A Losing Battle

America's broken health care system cost one woman her life.

A memorial service was held at Holy Name of Jesus Roman Catholic Church in Brooklyn, New York, in May 2005 for Sheila Wessenberg of Coppell, Texas. Scores of mourners gathered there, just a mile from where Sheila was buried. They shed tears and shared laughs about this rambunctious woman who, at 46, died from breast cancer. Her death was a statistical probability—not because she had breast cancer but because she had no health insurance. (Uninsured women with breast cancer are twice as likely to die from the disease as women with health insurance.[1]) Sheila was one of the estimated 18,000 Americans who die prematurely each year as a result of having no health insurance.[2] She is "collateral damage" in a nation that refuses to overhaul its health care system.

I first wrote about Sheila for the February 9, 2003, issue of the *New York Times Magazine*. At that time, she had gone seven months without follow-up treatment after a mastectomy because her husband, Bob, had lost his job and their health insurance. When Bob had still been employed as a software programmer, their insurance covered Sheila's mastectomy. When Bob lost his job, the couple and their two young children slid from middle-class comfort to utter desperation in less than a year. They liquidated assets, moved out of their luxury townhouse, and through a friend secured a no-money-down mortgage and bought a modest home outside of Dallas.

I contacted Sheila while researching the book *Denied: The Crisis of America's Uninsured*.[3] She was working a few hours a week as a payroll clerk and would park her van outside her office window and leave her autistic son, Alex (at that time, age four), to watch a video because she couldn't afford child care. She panhandled on weekends. The family was close to losing their home and having to split up among relatives. But after the *New York Times* article was published, the Wessenbergs received tens of thousands of dollars in unsolicited donations that helped them get by for the next year and a half.

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Bob had been in and out of work, taking short-term contracts and freelance jobs. But the sicker Sheila got, the less viable he became as an employee. He knew he would miss work when Sheila was incapacitated or in the hospital, so he kept her condition a secret during interviews. In the last year of Sheila's life, he took a job in Florida and quit after one month because she was hospitalized and he had to care for the children.

The Wessenbergs were caught in a "death spiral," in which uninsured people who can't afford to pay out of pocket for services are deprived of adequate care while their conditions are treatable, and then their families are brought down with them when they have to scramble to make ends meet.[4]

Over time, Sheila's cancer metastasized to the bone, brain, neck, and liver. One oncologist dropped her because she could not pay for care. Sheila was livid. "His attitude was 'You can't pay your bill. Get out of my face,'" she said. "It's like you're driving down the street and you hit somebody and you keep going. It's morally wrong."

The largesse of strangers intervened again when in August 2003 the *Dallas Morning News* published a series of articles on the Wessenbergs that came to the attention of Dr. Dennis Birenbaum, medical director and CEO of Texas Hematology–Oncology Center in Dallas–Fort Worth. He offered Sheila free treatment, which he provided over the next year; he also got the drug companies to supply her chemotherapy drugs. He says he gave Sheila $250,000 worth of care in 13 months.

While Sheila was dying, some 46 million other Americans also had no health insurance.[5] That's like

Julie Winokur is a writer and filmmaker currently producing a documentary film on access to health care. Photographer Ed Kashi's work appears regularly in National Geographic *and elsewhere. They are founders of Talking Eyes Media. Contact author: jwinokur@mindspring.com.*

By Julie Winokur, photograph by Ed Kashi

Sheila Wessenberg and her daughter, Amy, at their home in Texas in 2003. "It's like you're driving down the street and you hit somebody and you keep going," she said of those who denied her treatment for breast cancer. "It's morally wrong." She died in 2005.

sanctioning one-seventh of our population to drive over the speed limit without seat belts. Meanwhile, there's talk of health savings accounts, consumer-driven health care, and Medicaid cuts.

In the last two years of her life Sheila was forced to receive much of her care in the ED; it was the only place she couldn't be denied care. As is the case for millions of uninsured Americans, her treatments were given in the least cost-effective setting. Her last round of chemotherapy was delivered after an oncologist advised her to go to the ED and complain of abdominal pain and shortness of breath. Only then was she admitted. On her last trip to the ED, she died after spending four hours there.

Sheila was approved, finally, to receive Medicare benefits, after fulfilling the 24-month waiting period. It was scheduled to begin the week after her funeral.

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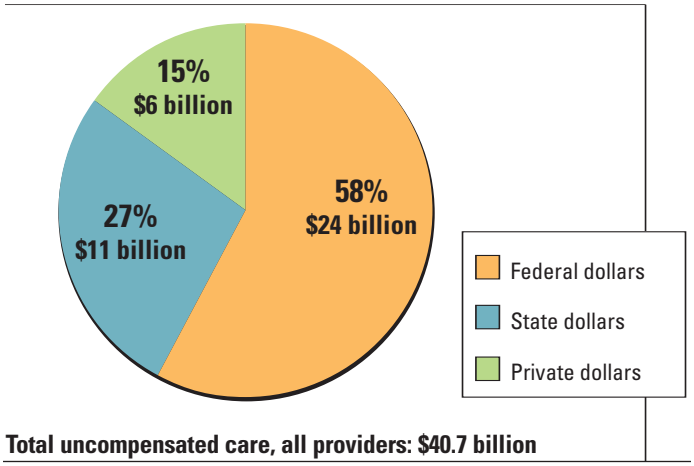
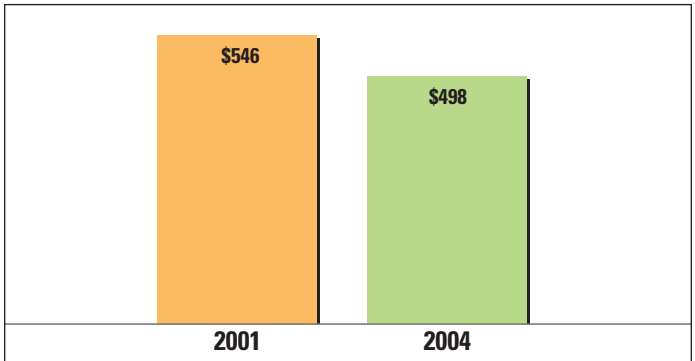
Figure 4. Payment Sources for Uncompensated Care, 2004



Hadley J, Holahan J. *The cost of care for the uninsured: what do we spend, who pays, and what would full coverage add to medical spending? Issue update.* Kaiser Commission on Medicaid and the Uninsured; 2004 May. Pub. #7084. http://www.kff.org/uninsured/7084.cfm.

Figure 5. Federal Spending on the Safety Net per Uninsured Person, 2001–2004*



* Federal spending includes payments to hospitals though Medicaid and Medicare and funding for direct care programs, such as the Veterans Health Administration, the Indian Health Service, and the Ryan White Care Act.

Hadley J, et al. *Federal spending on the health care safety net from 2001-2004: has spending kept pace with the growth in the uninsured?* Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2005 Nov. Pub. #7425. http://www.kff.org/uninsured/7425.cfm.

half of the respondents (48%) reported using or being aware of safety-net providers.[14]

Discounted services are not common and charges to uninsured patients for some services, including hospital care, may actually be higher than amounts paid by insured patients, whose charges are negotiated by third-party payers. Those who have been uninsured for at least one year pay about one-third of health care costs themselves and have substantial problems paying medical bills, even though they frequently forgo needed care.[15,16]

As fewer physicians are able or willing to treat those without health coverage, more uninsured patients have turned to the safety nets of their local hospitals for care. A study conducted from 1996 to 2001 found the number of physician's office visits among the uninsured had dropped by nearly 40%, while ED visits increased by 10%.[17] Interestingly, growth in ED visits was higher among the privately insured (24%) during this same time period.

FACT: Health care costs that the uninsured do not pay themselves are largely covered by federal and state dollars.

Contrary to common belief, there is little evidence that those who have private insurance subsidize, through higher premiums, the uncompensated costs of caring for the uninsured. However, one study suggests the premium markup may be as high as 8% because of such uncompensated care.[18] These costs are not simply absorbed by those providing care—substantial federal and state tax dollars are appropriated each year to pay providers for their care of the uninsured.[19]

In 2004 the total uncompensated costs for care of the uninsured was about $40.7 billion (see Figure 4, above left). Federal and state tax funds available to pay for these costs were $35 billion, subsidizing approximately 85% of the total.[15] The federal government pays the largest share of such costs with Medicare and Medicaid funds, as well as payments to direct service programs (for example, programs under the Department of Veterans Affairs, the Indian Health Service, and community health centers). States also use Medicaid funds for uncompensated care, as well as to subsidize direct service programs. Three-quarters of federal and state dollars for uncompensated care go to hospitals, with the rest going to direct service programs. Physicians receive no government subsidies for providing charity care unless they work for these types of organizations.

Considering the current government spending on the uninsured, the additional funding that would be needed to expand health coverage to all uninsured U.S. residents is much less than various proposals have estimated. Such a change, however, would require major shifts in the flow of government health care dollars, redistributing subsidies that go to hospitals and other providers to health insurance companies. Health care providers would be unlikely to support such a shift unless health coverage were guaranteed for all Americans.[15]

FACT: Federal funding, even with recent increases for more qualified health centers, has not kept pace with the growth in the number of the uninsured.

Recent federal policy to help the uninsured has focused on providing more care by expanding community health centers; federal spending for such centers increased by more than 50% between 2001 and 2004. Overall federal spending, however, has not kept pace with the growth in the number of the

Having health insurance could reduce mortality rates for the uninsured by 10% to 15%.

uninsured. Per capita spending on the uninsured has actually declined (see Figure 5, page 46). Overall federal spending per uninsured person decreased by roughly 9% between 2001 and 2004.[20]

FACT: Health insurance matters. It makes a difference in when, where, and whether people get necessary health care and, therefore, how healthy they are.

The uninsured are far more likely than the insured to postpone or forgo needed care. They are also less able to afford prescription drugs and follow through with treatments.[16] The consequences of these decisions are real. Because the uninsured are significantly less likely to have a consistant provider or a usual place to go for care, they receive less preventive care and health management and are more likely to be hospitalized for avoidable health problems. They are more likely, when hospitalized, to receive fewer services and to die in the hospital as compared with insured patients.[21]

It has been estimated that having health insurance improves health overall and could reduce mortality rates for the uninsured by 10% to 15%. The Institute of Medicine, in its analysis of the costs to society of having so many Americans uninsured, estimated that among adults 25 to 64 years old, the number of excess deaths associated with being uninsured is approximately 18,000 per year—a figure comparable to the number of deaths from diabetes or cerebrovascular disease.[22]

FACT: Nurses can make a difference.

Relatively few parties in the policy debates about the uninsured bring to the table what nurses can—credible, hands-on experience in dealing with the fallout of more than 46 million uninsured Americans. While hard facts are essential to shaping policy, it is the voices of the uninsured and those who care for them most intimately that, in the end, may actually move reforms forward. ▼

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