

REPORT



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The Uninsured: A Primer

KEY FACTS ABOUT HEALTH INSURANCE
AND THE UNINSURED IN AMERICA

Prepared by:

Melissa Majerol, Vann Newkirk, and Rachel Garfield
Kaiser Family Foundation

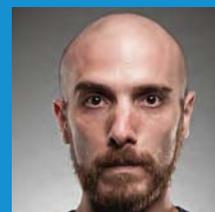


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Introduction

Millions of people in the United States go without health insurance each year. Because nearly all of the elderly are insured by Medicare, most uninsured Americans are nonelderly (below age 65). A majority of the nonelderly receive their health insurance as a job benefit, but not everyone has access to or can afford this type of coverage. Together, Medicaid and the Children's Health Insurance Program (CHIP) fill in gaps in the availability of coverage for millions of low-income people, in particular, children. However, Medicaid eligibility for adults remains limited in some states, and few people can afford to purchase coverage on their own without financial assistance.

The gaps in our health insurance system affect people of all ages, races and ethnicities, and income levels; however, those with the lowest incomes face the greatest risk of being uninsured. Being uninsured affects people's access to needed medical care and their financial security. The access barriers facing uninsured people mean they are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact also can be severe. Uninsured families struggle financially to meet basic needs, and medical bills can quickly lead to medical debt.

A major goal of the Affordable Care Act (ACA), which was passed in 2010, was to expand coverage to millions of Americans who were previously uninsured. The ACA has filled existing gaps in coverage by providing for an expansion of Medicaid for adults with incomes at or below 138% of poverty in states that chose to expand, building on employer-based coverage, and providing premium tax credits to make private insurance more affordable for many with incomes between 100-400% of poverty.¹ Most of the major coverage provisions of the ACA went into effect in 2014, and millions of people have enrolled in coverage under the law.

The Uninsured: A Primer is structured in two parts. The first presents basic information about health coverage and the uninsured population leading up to and after the implementation of the Affordable Care Act, who the uninsured are and why they do not have health coverage. The second presents information on the impact lack of insurance can have on health outcomes and personal finances, and provides an understanding of the difference health insurance makes in people's lives.

What Was Happening to Insurance Coverage Leading up to the ACA?

The coverage provisions in the ACA built on a piecemeal insurance system that left many without affordable coverage. Historically, most people in the United States obtained health insurance coverage as a fringe benefit through a job. However, many people were left out of the employer-based system, and the availability of employer-based coverage has eroded over time. Some people purchased coverage on their own, but this type of coverage could be costly or difficult to obtain. Medicaid and the Children’s Health Insurance Program (CHIP) have expanded over time to cover more low-income individuals (primarily children) and have been an important source of coverage during economic downturns. However, the gaps in our private and public health insurance systems still left over 41 million nonelderly people in the country—15% of those under age 65—without health coverage in 2013.²

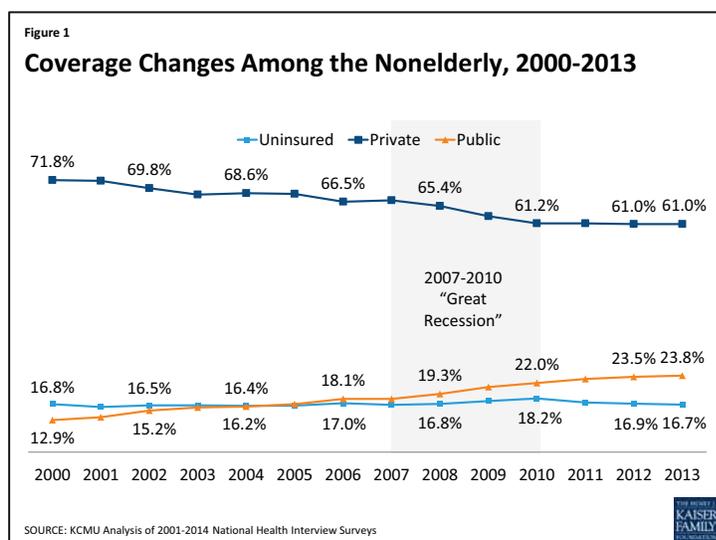
EMPLOYER- SPONSORED HEALTH INSURANCE COVERAGE

Historically, the majority of employers offered group health insurance policies to their employees and to their employees’ families. In 2013, 57% of firms offered coverage to their employees, and most firms offering coverage also covered spouses and dependents.³ When offered coverage, roughly 80% of employees participated in their employer’s health plan.⁴ Among individuals with employer-sponsored coverage, half were covered by their own employer and half were covered as an employee’s dependent.⁵

Not all workers had access to employer-sponsored insurance. In 2013, two-thirds of uninsured adult workers were not offered health insurance by their employer.⁶ Some worked in firms that did not offer coverage: small firms were less likely to offer coverage than large firms, and firms with more low-wage workers were less likely to offer coverage than firms with fewer low-wage workers.⁷ Some people worked in firms that covered some employees but were not themselves eligible for coverage, often because they had not worked for their employer for a sufficient amount of time or because they had not worked enough hours.

Cost was a barrier to expanding employer-sponsored coverage. Cost was the most common reason employers cited for not offering health coverage.⁸ In addition, when offered coverage, many low- and moderate-income workers found their share of the cost unaffordable, especially for non-working dependents.⁹ In 2013, annual employer-sponsored premiums averaged \$5,884 for individual coverage and \$16,351 for family coverage, with workers contributing \$380 per month for family coverage and \$83 for individual coverage.¹⁰ Total family premiums, as well as the employee’s share of those premiums rose by over 70% in the ten years leading up to 2013.

The availability of employer-sponsored coverage has eroded over time, and declines in employer coverage accelerated during the economic downturn. The share of the nonelderly population with employer-sponsored coverage has



declined steadily since 2000 even during years when the economy was strong and growth in health insurance premiums was slowing.¹¹ However, during the Great Recession, there was a substantial decline in employer coverage (Figure 1). Because health coverage is linked to employment, when people lose their jobs they frequently lose coverage. As unemployment spiked between 2007 and 2010, the uninsured rate for adults increased, resulting in 5.8 million more nonelderly adults without coverage.¹² As the economy began to recover starting in 2011, employer-sponsored coverage stabilized, and the uninsured rate did as well. However, rates of employer coverage in 2013 were still below pre-recession levels.

NON- GROUP HEALTH INSURANCE COVERAGE

Very few people were covered by non-group health insurance policies prior to the ACA. Private policies directly purchased in the non-group or individual market (i.e., outside of employer-sponsored benefits) covered only 5% of people under age 65 in 2013.¹³

In the past, non-group insurance premiums could be more expensive for the enrollee than group plans purchased by employers. Though, on average, non-group insurance premiums were lower than those for employer-sponsored coverage, enrollees paid 100% of the cost because they could not share that premium expense with an employer. Nationwide, the average monthly premium per person in the non-group market in 2013 was \$236, with substantial variation by state.¹⁴ In addition, deductibles and other cost sharing in non-group plans were often higher than in employer-sponsored coverage.

Obtaining coverage in the individual market could be difficult, particularly for those who were older or had had health problems. Historically, premiums in the non-group market could vary by age or health status, and people with health problems or at risk for health problems could be charged high rates, offered only limited coverage, or denied coverage altogether. In 2013, 41% of adults who previously tried to purchase non-group insurance said that the policy offered to them was too expensive to purchase, and nearly 6% said that no insurance company would sell them a policy at any price.¹⁵ Those who were in fair or poor health were twice as likely to be denied.

PUBLIC HEALTH INSURANCE COVERAGE

In the past, Medicaid and CHIP provided coverage to some, but not all, nonelderly low-income individuals and people with disabilities. In 2013, Medicaid and CHIP covered just under a fifth (19%) of the nonelderly population by primarily covering four main categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities.

Medicaid and CHIP were and continue to be particularly important sources of coverage for children. Even before the ACA, federal law required state Medicaid programs to cover school age children up to 100% of the poverty level (133% for preschool children), and states had expanded coverage for children in families with slightly higher incomes through the Children's Health Insurance Program (CHIP). As a result, Medicaid and CHIP remain the largest source of health insurance for children in the U.S., covering 78% of poor children and over half (56%) of near-poor children in 2013. Still, as of 2011, over half (53%) of uninsured children were eligible for Medicaid or CHIP but not enrolled.¹⁶ Some families may not have been aware of the availability of the programs or their eligibility. For others, burdensome enrollment and renewal requirements may have posed major obstacles to participation, despite major improvements made over the past decade.

In contrast to coverage for children, the role of Medicaid for nonelderly adults was more limited prior to the ACA. In the past, state Medicaid programs were only required to cover parents below states' 1996 welfare eligibility levels (often below 50% of the federal poverty level). Most states had much lower income eligibility for parents than for children. As of January 2013, a total of 33 states limited parent eligibility for Medicaid to less than the federal poverty level, including 16 states that limited eligibility to parents earning less than 50% of the federal poverty level.¹⁷ In addition, although Medicaid covered some parents and low-income individuals with disabilities, most adults without dependent children—regardless of how poor—have traditionally been ineligible for Medicaid. As of January 2013, just nine states (including the District of Columbia) provided Medicaid or Medicaid-comparable coverage to non-disabled adults without dependent children.¹⁸ As a result of limited eligibility, over a third (35%) of poor parents and 38% of poor adults without children were uninsured in 2013.¹⁹

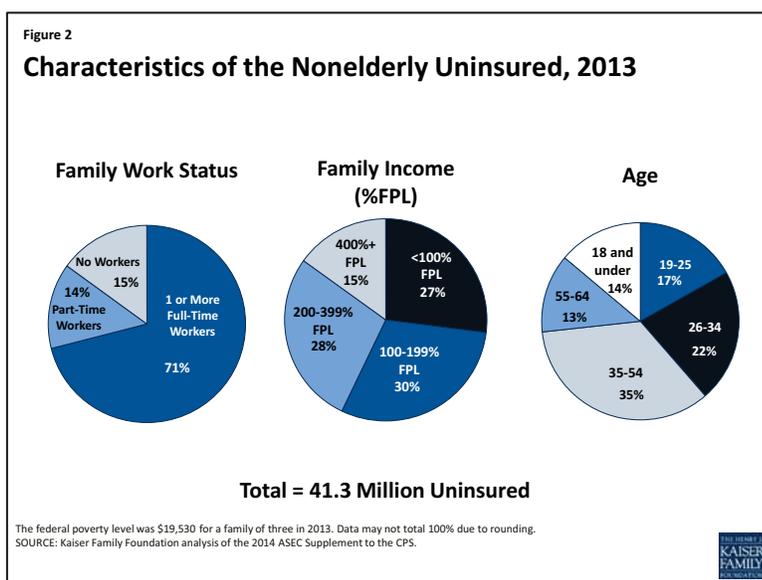
Increases in Medicaid and CHIP enrollment helped to offset declines in private coverage during the recent economic downturn and slow recovery, particularly for children. During the recent economic recession and slow recovery (2007-2012), the share of children who were uninsured actually declined slightly despite a decrease in the share of children with employer-sponsored coverage. As parents lost employment and related health coverage, incomes dropped and more children became eligible for Medicaid or CHIP. The uninsured rate among children continued to decline during the recovery that began in 2010. In comparison, because Medicaid eligibility for adults was more limited than for children, public coverage did not offset the recession-related decline in employer-sponsored coverage and uninsured rates increased considerably among non-elderly adults.

THE UNINSURED

The historical gaps in the insurance system left many without an affordable source of coverage. In 2013, 41.3 million nonelderly people in the U.S. lacked health insurance.²⁰ The main reason that people gave for being uninsured is that they could not afford coverage.²¹

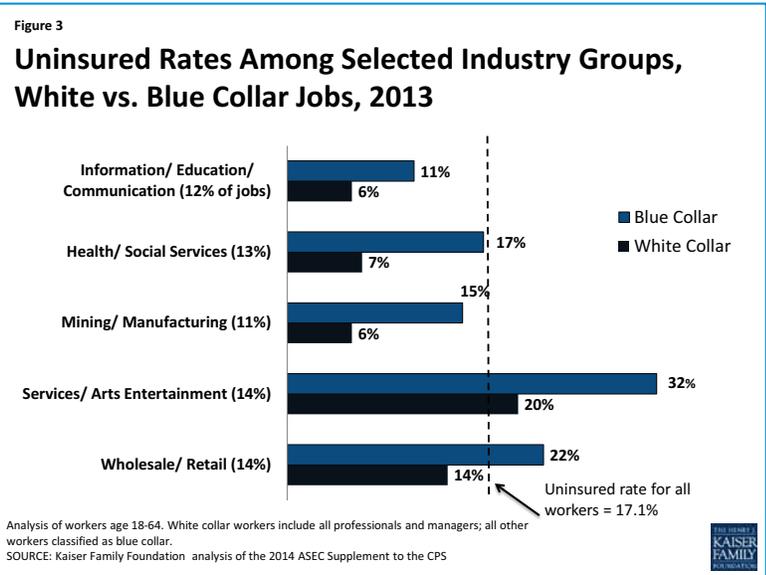
Adults were more likely to be uninsured than children. In 2013, adults made up 71% of the nonelderly population but 86% of people without health coverage (Figure 2). This pattern reflects historical exclusions or restrictions on public coverage for adults.

The vast majority of uninsured people were in low- or moderate-income families (Figure 2). Individuals below poverty are at the highest risk of being uninsured, and this group comprised 27% of the uninsured population in 2013 (the poverty level for a family of three in 2013 was \$19,530²²). In total, 85% of uninsured people were in low- or moderate-income families, meaning they were below 400% of poverty.



Most of the uninsured were in working families but did not have access to or could not afford employer-sponsored coverage.

In 2013, more than three-quarters of the uninsured population was in working families, with 71% in families with one or more full-time workers and 14% in families with part-time workers (Figure 2). Health coverage varied both by industry and by type of occupation. For example, in agriculture, uninsured rates for workers were 37% compared to just 4% in public administration.²³ But even in industries where uninsured rates are lower, the gap in health coverage between blue and white-collar workers is often two-fold or greater (Figure 3). Almost 80% of uninsured workers are in blue-collar jobs.

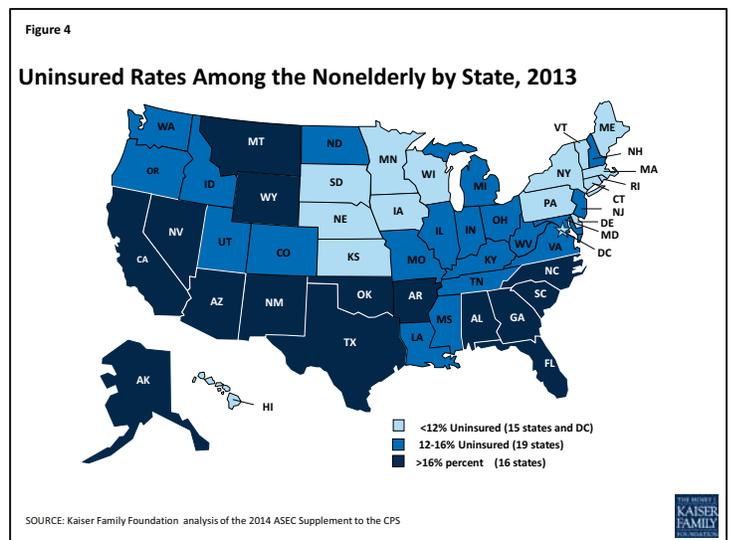


Minorities were much more likely to be uninsured than whites. A quarter (26%) of Hispanics and 17% of Black Americans were uninsured in 2013 compared to 12% of non-Hispanic Whites. Medicaid and CHIP are important sources of coverage for racial and ethnic minorities, covering around one-third of Hispanic and Black Americans.

The majority of uninsured people (80%) were native or naturalized U.S. citizens. Although non-citizens (legal and undocumented) are about three times more likely to be uninsured than citizens, they accounted for only roughly 20% of the uninsured population in 2013.²⁴ Non-citizens have poor access to employer coverage because they are disproportionately likely to have low wage jobs or work in industries that are less likely to offer insurance.^{25,26} Further, in most cases, lawfully present immigrants who have been in the U.S. less than five years are ineligible for Medicaid or CHIP, though some states cover lawfully-residing immigrant children or pregnant women who have been in the United States for less than five years.²⁷

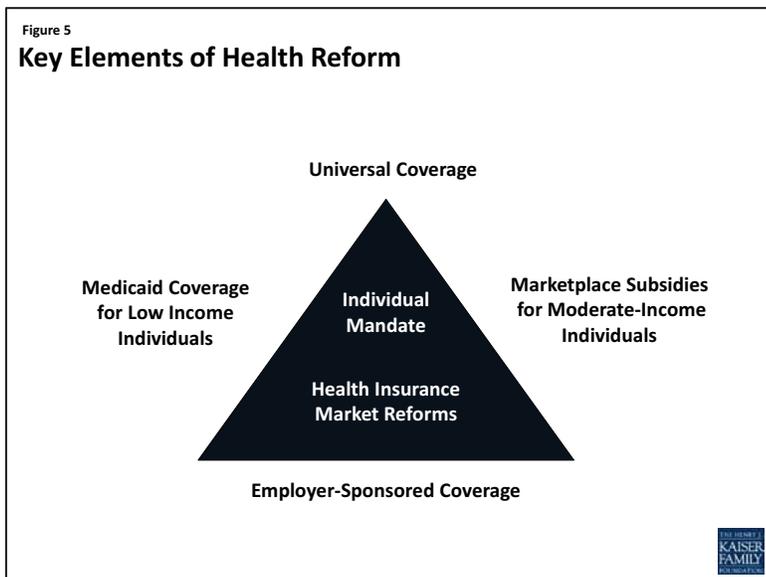
Insurance coverage varied by state depending on the income distribution in the state, the nature of employment in the state, and the reach of state Medicaid programs.

Insurance market regulations and the availability of jobs with employer-sponsored coverage also influence the insurance rate in each state.²⁸ Massachusetts has near universal coverage, with an uninsured rate of 4% due in part to health reform legislation enacted in 2006. In 2013, sixteen states had uninsured rates over 16% (Figure 4). Among these are states such as Nevada, Florida, and Texas with uninsured rates that are 20% or higher.

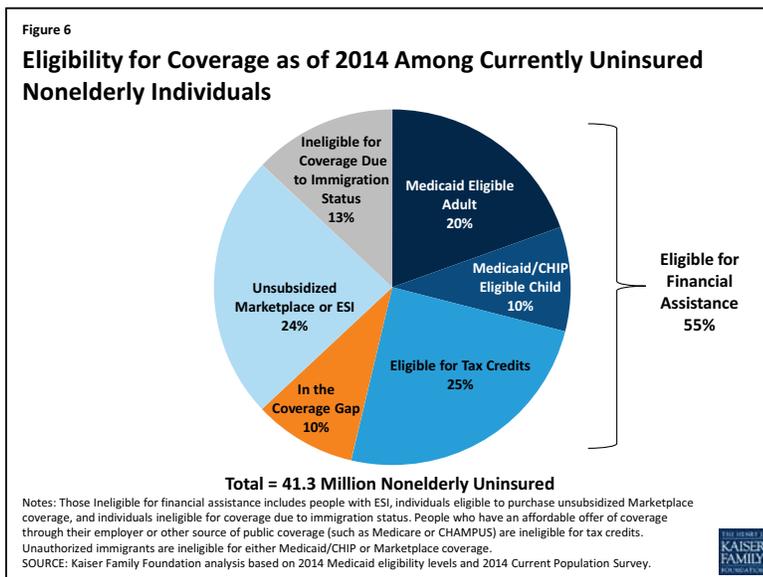


How Did Health Coverage Change Under The ACA?

A primary goal of the Affordable Care Act of 2010 (ACA) was reducing the number of uninsured people and increasing the affordability and availability of health insurance coverage. The ACA fills in existing gaps in coverage by expanding the Medicaid program, building on employer-based coverage, and providing premium subsidies to make private insurance more affordable (Figure 5). It also introduced new requirements for almost all individuals to obtain insurance coverage or pay a penalty and for insurance companies to be prohibited from denying coverage for any reason. Some of the ACA provisions went into effect as early as 2010 and others will not go into effect until 2018, but the major coverage expansions were implemented January 1, 2014.



Nationally, over half (55%) of uninsured nonelderly people are eligible for financial assistance to gain coverage through either Medicaid or the Marketplaces (Figure 6). One-quarter (25%) of uninsured individuals are eligible for premium tax credits to help them purchase coverage in the Marketplace, and approximately three in ten uninsured individuals (30%) are eligible for either Medicaid or CHIP.²⁹ However, not all uninsured individuals are eligible for assistance under the ACA. Some (24%) have incomes above the limit for tax credits or have access to coverage through a job. Others (13%) are ineligible because they are undocumented immigrants. And one in ten fall into a “coverage gap” because they are living below poverty but their state has not expanded Medicaid. Even with the ACA, many will remain uninsured. Nationally, an estimated 29 million people are expected to remain uninsured in 2018.³⁰



Early estimates indicate that the uninsured rate has dropped under the ACA. Data from the first quarter (January through March) of 2014 indicates that the uninsured rate dropped for nonelderly individuals in the first quarter of 2014 by a full percentage point relative to the first quarter of the previous year.³¹ Several private polls and surveys also indicate that the uninsured rate has been decreasing since the period prior to ACA open enrollment. While these surveys have different methodologies and often have high error margins that make point estimates unreliable, they are all in agreement that the uninsured rate has dropped in 2014.

MEDICAID EXPANSION

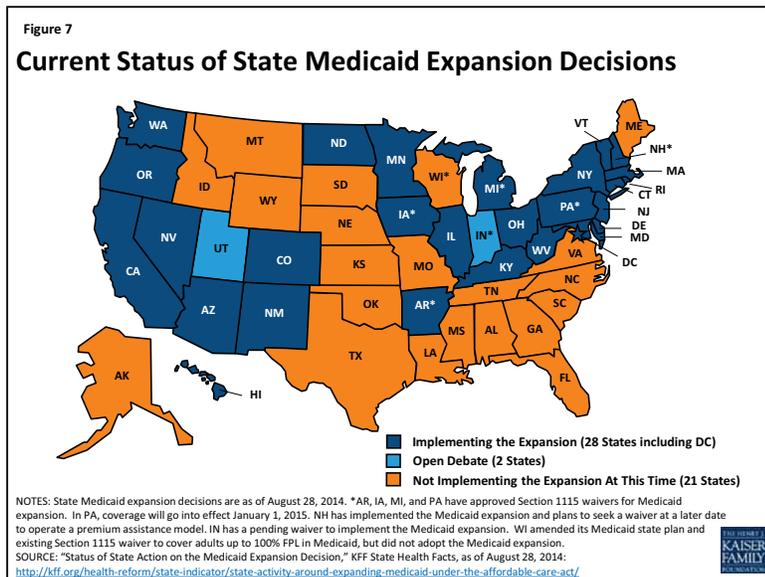
The ACA extended Medicaid eligibility to many individuals at or below 138% of poverty as of January 2014. The Medicaid expansion eliminates the historical exclusion of adults outside of traditional eligibility groups, such as those without dependent children. Overall, the median eligibility limit for parents in the 28 states (including DC) implementing the Medicaid expansion rose from 106% FPL to 138% FPL for parents and from 0% to 138% FPL for childless adults between January 2013 and July 2014. Overall, eligibility levels increased for parents in 20 states and for childless adults in 26 states (including Pennsylvania, which implemented the Medicaid expansion in August 2014 to begin January 2015).³² Among the 41.3 million nonelderly uninsured people in 2013, 19% are Medicaid-eligible adults and 9% are children who are eligible for either Medicaid or CHIP.³³

However, not all states are expanding their Medicaid programs. The 2012 Supreme Court decision effectively made the Medicaid expansion optional for states, and as of November 2014, 23 states have indicated they are not expanding Medicaid (Figure 7).³⁴ In these states, eligibility for adults is generally still very limited. There is no deadline on state decisions about whether to expand Medicaid, and some states are still debating whether and how to expand their programs.³⁵

In states that do not expand Medicaid, millions fall into a “coverage gap” of earning too much to qualify for traditional Medicaid coverage but not enough to qualify for other ACA coverage provisions. The median Medicaid eligibility levels for parents in states not implementing the ACA Medicaid expansion is just 50% of poverty, or about \$9,400 a year for a family of three, and only one of those states (Wisconsin³⁶) covers adults without dependent children. State decisions not to expand their programs will leave nearly four million people without an affordable coverage option.³⁷

Even in states that do expand Medicaid, undocumented immigrants and many recent lawfully present immigrants will remain ineligible. Because many uninsured non-citizens are in low-income working families, many are in the income range to qualify for the ACA Medicaid expansion. However, under federal rules, undocumented immigrants may not enroll in Medicaid. Many lawfully present non-citizens who would otherwise be eligible for Medicaid remain subject to a five-year waiting period before they may enroll, and some groups of lawfully present immigrants remain ineligible regardless of their length of time in the country.

Medicaid enrollment has grown under the ACA. Enrollment data show that as of July 2014, Medicaid enrollment has grown by 8 million since the period before open enrollment (which started in October 2013). This growth is an increase of 14% in monthly Medicaid enrollment. Enrollment increases were higher (20%) among states that chose to expand Medicaid eligibility under the ACA. These data suggest that Medicaid



enrollment growth is related to ACA expansions. However, some who are eligible remain unenrolled due to limited awareness about the Medicaid program and their eligibility or other enrollment challenges.

The ACA includes several provisions to streamline Medicaid enrollment. The ACA has addressed past barriers to enrollment by requiring states to implement new streamlined Medicaid application and enrollment processes by 2014. These processes allow individuals to apply online, by phone, by mail, or in-person, use new simplified income standards, and rely on electronic data matches to the greatest extent possible to verify eligibility criteria. To implement these processes, states built new eligibility and enrollment systems and are replacing or making major upgrades to their Medicaid systems, with the federal government providing significant funding for these efforts.³⁸ Even with these new streamlined enrollment processes in place, effective outreach and enrollment efforts are fundamentally important for translating the new coverage opportunities into increased coverage.

HEALTH INSURANCE MARKETPLACES AND NON- GROUP COVERAGE

The ACA establishes Health Insurance Marketplaces, also known as Marketplaces, where individuals and small employers can purchase insurance as of January 1, 2014. These new Marketplaces are designed to ensure a more level competitive environment for insurers and to provide consumers with information on cost and quality to enable them to choose among plans.

Health Insurance Marketplaces are established in each state, but only some states will run their own Marketplace. Sixteen states and DC have received approval to run their own health insurance Marketplaces, and 27 states have opted to have their Marketplace run by the federal government. The remaining 7 states use a hybrid approach and partner with the federal government to run certain aspects of their Marketplace.³⁹

Marketplaces provide insurance options to millions of uninsured individuals. Over 10 million uninsured individuals are estimated to be eligible for tax credits through the Marketplace.⁴⁰ Around 7 million additional individuals who were enrolled in other (primarily non-group) coverage prior to the ACA are estimated to be eligible for tax credits through the ACA Marketplace.⁴¹ The Department of Health and Human Services indicated that approximately 8 million people had selected a plan on the Marketplace as of the end of the open enrollment period (which extended through mid-April in most states).⁴² A survey of people with private non-group plans after open enrollment found that nearly six in ten (57%) of those with Marketplace coverage were uninsured prior to purchasing their current plan.⁴³

Premium tax credits help reduce the cost of non-group coverage premiums purchased in the Marketplace. To help ensure that coverage purchased in these new Marketplaces is affordable, the federal government provides tax credits for individuals and families with incomes between 100% of the federal poverty level (FPL) (\$11,670 for an individual or \$19,790 for a family of three in 2014) and 400% FPL (\$46,680 for an individual or \$79,160 for a family of three in 2014).⁴⁴ These tax credits limit the cost of the premium to a share of income and are offered on a sliding scale basis. As of the end of the first open enrollment period in April 2014, the vast majority of Marketplace enrollees (85%) qualified for premium subsidies.⁴⁵ In addition to the premium tax credits, the federal government also makes available cost-sharing subsidies to reduce what people with incomes between 100% and 250% of poverty will have to pay out-of-pocket to access health services. The cost-sharing subsidies are also available on a sliding scale based on income. The pending

Supreme Court decision in *King vs. Burwell* could result in the denial of such subsidies to over 13 million Americans residing in states with federally-facilitated marketplaces.⁴⁶

Lawfully present immigrants may receive tax credits for Marketplace coverage; however, undocumented immigrants are prohibited from purchasing such coverage. Lawfully present immigrants are eligible for tax credits on coverage purchased through a Marketplace without a waiting period.⁴⁷ In addition, lawfully present immigrants who would be eligible for Medicaid but are in a five-year waiting period are also eligible for tax credits for Marketplace coverage. Undocumented immigrants are not eligible for premium tax credits and are prohibited from purchasing insurance in the Marketplace at full cost.

Some people continue to purchase non-group coverage outside the Marketplace. Among the entire non-group market in Spring 2014, about half of individuals (48%) report having coverage obtained from a state or federal Marketplace, 16% have ACA-compliant coverage purchased outside of the Marketplace, and three in ten (31%) have non-ACA-compliant plans (those that have been in effect since before January 1, 2014).⁴⁸ People purchasing coverage outside the Marketplace are not eligible for ACA premium tax credits.

EMPLOYER SPONSORED INSURANCE UNDER THE ACA

The ACA includes provisions to promote coverage in small firms. Recognizing the challenges that small employers, especially those with low-wage workers, face in providing coverage to their employees, the ACA offers tax credits to small employers with no more than 25 full-time equivalent employees and average annual wages of less than \$50,000. To access the tax credit, eligible employers must purchase insurance through the Small Business Health Options Program (or SHOP Marketplace).⁴⁹ Employers may take the tax credits for a maximum of two years.⁵⁰

The ACA also extends dependent coverage. As of 2010, young adults may remain on their parents' private plans (including non-group plans or plans through an employer) until age 26. This provision has expanded coverage among young adults, even during a time when private coverage for other age groups was eroding.⁵¹

Starting next year, large employers will face penalties for not providing affordable coverage to full-time employees. Beginning in 2015, employers with 50 or more employees will be assessed a fee up to \$2,000 per full-time employee (in excess of 30 employees) if they do not offer affordable coverage and if they have at least one employee who receives a premium tax credit through a Marketplace. To avoid penalties, employers must offer insurance that pays for at least 60% of covered health care expenses, and the employee share of the premium must not exceed 9.5% of family income.⁵² This requirement does not apply to employers with fewer than 50 workers. While the employer requirements may help many uninsured individuals with a worker in their family, the majority of uninsured workers work in small firms that are not required to provide insurance coverage.

Some employer-sponsored plans will have new requirements for benefits and cost sharing. As of January 2014, all non-grandfathered plans offered by small employers must include, at a minimum, all of the benefits and consumer protections outlined in the Essential Health Benefits (EHBs) package. These benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services,

laboratory services, preventive and wellness care, chronic disease management, and pediatric dental and vision care.⁵³ The cost-sharing under an individual plan in 2014 is not to exceed \$5,000; the limit for a family is twice the dollar amount set for an individual in any given year. These requirements do not apply to large employers or to firms that self-insure; however, these employers generally offer more comprehensive coverage that already meets these standards.

Some employers will continue to offer grandfathered health plans, which are not required to include the Essential Health Benefits package. Grandfathered plans are those that were established prior to March 23, 2010 and that have not undergone significant changes in cost-sharing, premium contributions or covered benefits. Unlike other plans under the ACA, grandfathered plans are not required to cover Essential Health Benefits or preventive services without cost-sharing; provide for an internal and external appeals process for contesting coverage decisions; or allow direct access to an OB/GYN without referral.⁵⁴ Businesses wishing to keep their grandfathered plans may even change insurance carriers if benefits and cost to employees remain largely the same; however, because benefits and costs tend to change from year to year, most plans have already lost grandfather status or will lose it over time.⁵⁵

How Does Lack of Insurance Affect Access to Health Care?

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Uninsured people are far more likely than those with insurance to report problems getting needed medical care.

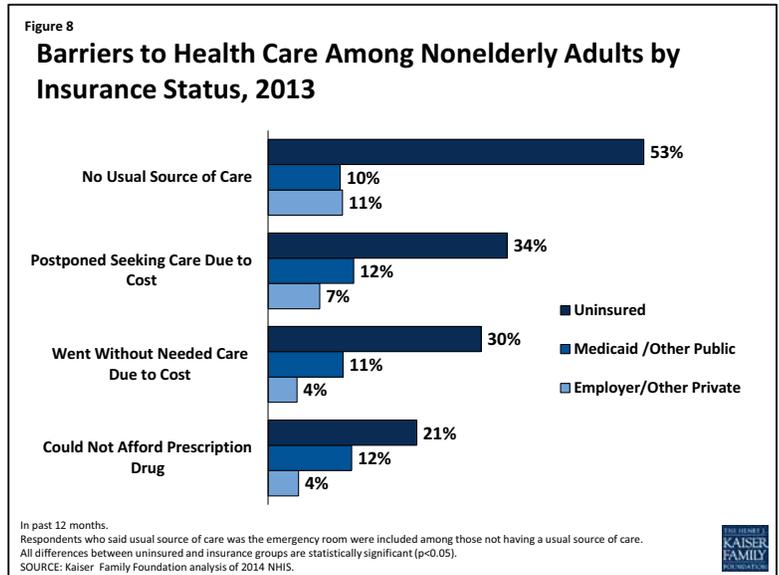
Thirty percent of adults without coverage say that they went without care in the past year because of its cost compared to 4% of adults with private coverage. Part of the reason for poor access among the uninsured is that most (53%) do not have a regular place to go when they are sick or need medical advice (Figure 8).

Uninsured people are less likely than those with coverage to receive timely preventive care.

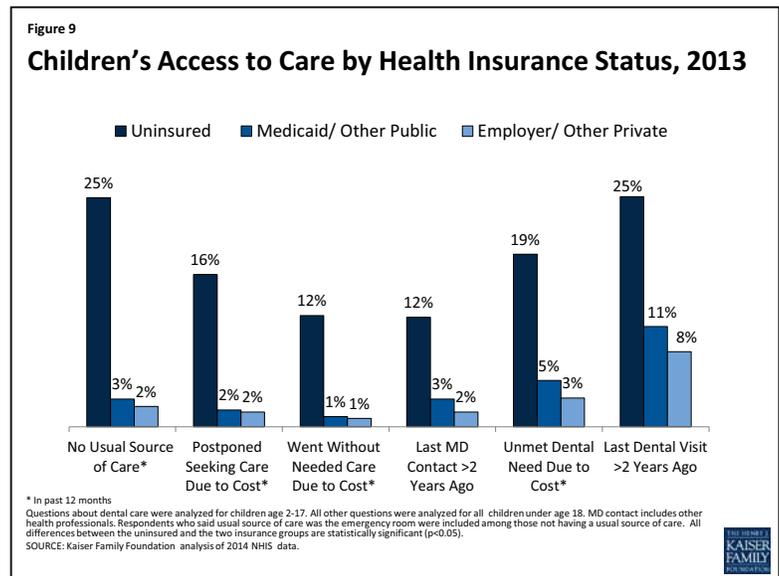
Silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. In 2013, only 1 in 3 uninsured adults (33%) reported a preventive visit with a physician in the last year, compared to 74% of adults with employer coverage and 67% of adults with Medicaid.⁵⁶ Uninsured patients are also less likely to receive necessary follow-up screenings after abnormal cancer tests.⁵⁷ Consequently, uninsured patients have an increased risk of being diagnosed in later stages of diseases, including cancer, and have higher mortality rates than those with insurance.^{58,59,60}

Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them. In 2010, nearly a quarter of uninsured adults said they did not take a prescribed drug in the past year because they could not afford it.⁶¹ Also, while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care, people without health coverage are less likely than those with coverage to obtain all the recommended services.⁶²

Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and experience declines in their overall health. When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.^{63,64,65,66}



Uninsured children also face problems getting needed care. Uninsured children are significantly more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance (Figure 9).⁶⁷ Further, uninsured children with common childhood illnesses and injuries do not receive the same level of care as others. As a result, they are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.⁶⁸ Among children with special needs, those without health insurance have less access to care, including specialist care, than those with insurance.⁶⁹



Lack of health coverage, even for short periods of time, results in decreased access to care.

Research has shown that adults who experienced gaps in their health insurance coverage in the previous year were less likely to have a regular source of care or to be up to date with blood pressure or cholesterol checks than those with continuous coverage.⁷⁰ Further, research indicates that children who are uninsured for part of the year have more access problems than those with full-year public or private coverage.⁷¹ One study found that, on a number of different measures, those lacking coverage for 12 continuous months had poorer access to care compared with either those lacking coverage for 6-11 months or 1-5 months, suggesting that even short periods of coverage results in greater access to care than no coverage at all.⁷²

Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of the impact of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care from a hospital or doctor than their counterparts who did not gain coverage.⁷³ Gaining Medicaid increased the likelihood of having an outpatient visit by approximately 35% and the likelihood prescription drug utilization by 15%. Findings two years out from the expansion showed significant improvements in access, utilization, and self-reported health, and virtual elimination of catastrophic out-of-pocket medical spending among the adults who gained coverage.⁷⁴ A separate study of Medicaid expansions for adults in three other states (New York, Maine, and Arizona) found that coverage gains were associated with reduced mortality, as well as improvements in access to care and self-reported health status.⁷⁵

Public hospitals, community clinics, and local providers that serve disadvantaged communities provide a crucial health care safety net for uninsured people; however, the safety net does not close the access gap for the uninsured. Safety net providers, such as public hospitals, community health centers, rural health centers, and local health departments, provide care to many people without health coverage. In addition, nearly all other hospitals and some private, office-based physicians provide some charity care. However, the safety net has limited capacity and geographic reach. In addition, available services may not be comprehensive, and not all uninsured people have access to safety net providers.^{76,77}

Increased demand and limited capacity means safety net providers are unable to meet all of the health needs of the uninsured population. The ability of health centers to serve uninsured people has been threatened in recent years due to increased demand and eroding financing⁷⁸, and many clinics report that they are at full capacity and cannot accept new patients.⁷⁹ Further, increasing financial pressures and changing physician practice patterns have contributed to a decline in charity care provided by physicians.⁸⁰

The ACA made a large investment in community health centers (CHCs), which provide a primary care safety-net for millions of uninsured people. However, not all underserved communities have CHCs, and, especially in states not expanding Medicaid, health centers may not have sufficient resources to serve the uninsured population. To help meet the increasing demand for health care as coverage expands, the ACA established a five-year \$11 billion dedicated trust fund to provide support for additional CHCs and expanded capacity in existing ones. In addition, the ACA Medicaid expansion was expected to generate increased patient revenues for CHCs in all states as low-income uninsured individuals, including both current and new CHC patients, gained coverage under the program.⁸¹ The trust fund, which augments annual federal appropriations for CHCs, has fueled substantial growth in health centers and their patient capacity and enabled CHCs to provide more comprehensive primary care services.⁸² However, in states not currently implementing the Medicaid expansion, millions of uninsured adults who could qualify for Medicaid remain uninsured, and by extension, the CHCs serving them are not receiving the associated increase in Medicaid revenues, reducing their potential resources for operations and expansion. Going forward, health centers' capacity to bridge the large gaps in access to primary care for the uninsured is likely to be affected by both state Medicaid expansion decisions and the expiration of the health center trust fund after September 30, 2015.

What Are The Financial Implications of Uninsurance?

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs. When people without health coverage do receive health care, they may be charged for the full cost of that care, which can strain family finances and lead to medical debt. Uninsured people are more likely to report problems with high medical bills than those with insurance. Uninsured adults and those on Medicaid are three times more likely than those with higher incomes to report having difficulty paying basic monthly expenses such as rent, food, and utilities.⁸³

Most uninsured people do not receive health services for free or at reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.⁸⁴ In 2013, only 38% of uninsured adults who received health care services report receiving free or reduced cost care.⁸⁵

Uninsured people often must pay "up front" before services will be rendered. When people without health coverage are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or can be turned away.⁸⁶ Among uninsured adults who received health care, nearly a third (31%) were asked to pay for the full cost of medical care before they could see a doctor.⁸⁷

People without health coverage spend half of what those with coverage spend on health care, but they pay for a much larger portion of their care out-of-pocket. Compared to nonelderly people who had insurance for a full year and average per capita medical expenditures of \$4,876 in 2013, nonelderly people who were without insurance for a full year used health care services valued at about half that amount, or just \$2,443 per capita per year. Nonelderly people who were uninsured for part of the year had annual medical expenditures about 30% lower than people who were insured for the full year, spending an average of \$3,439 annually per capita. Part-year uninsured individuals spent more per capita than full-year uninsured individuals largely due to higher spending in the months that they had coverage. Despite lower overall spending, people without insurance pay nearly as much out-of-pocket as insured people for their care.⁸⁸ In aggregate, the uninsured pay for almost a third (30%) of their care out-of-pocket, totaling \$25.8 billion in 2013. This total included the health care costs for those uninsured all year and the costs incurred during the months the part-year uninsured have no health coverage.⁸⁹

The remaining costs of their care, the uncompensated costs for the uninsured, amounted to about \$84.9 billion in 2013. Providers do not bear the full cost of their uncompensated care. Rather, funding is available through a wide variety of sources to help providers defray the costs associated with uncompensated care. Analysis indicates that in 2013, \$53.3 billion was paid to help providers offset uncompensated care costs. Most of these funds (62%) came from the federal government through a variety of programs including Medicaid and Medicare, the Veterans Health Administration, the Indian Health Service, the Community Health Centers block grant, and the Ryan White CARE Act. States and localities provided \$19.8 billion, and the private sector provided \$0.7 billion. While substantial, these dollars amount to a small slice of total health care spending in the U.S.⁹⁰

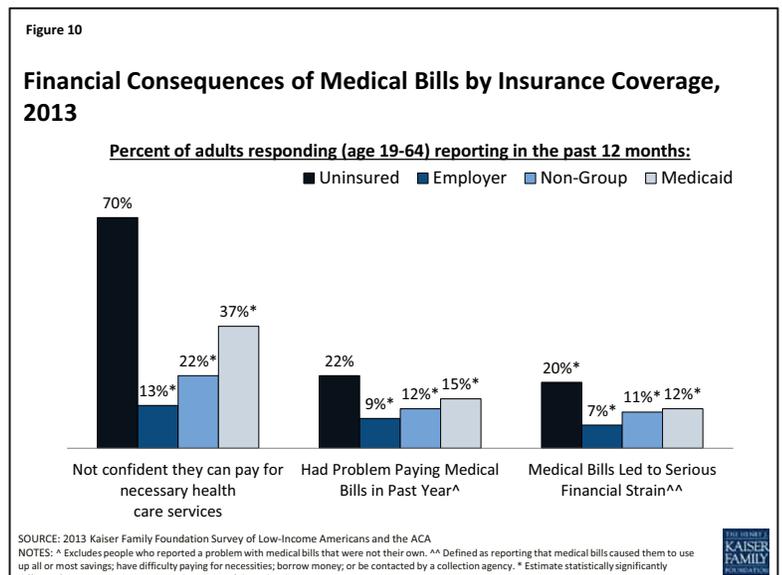
The burden of uncompensated care varies across providers. Hospitals, community providers (such as clinics and health centers), and office-based physicians all provide care to the uninsured. Given the high cost

of hospital-based care, the majority (60%) of uncompensated care is provided by hospitals. Community-based providers that receive public funds provide a little over a quarter (26%) of uncompensated care and the remainder of uncompensated care, 14%, is provided by office-based physicians.⁹¹

Safety net hospitals that serve a large number of uninsured individuals will receive a reduction in federal disproportionate share (DSH) Medicaid payments beginning in FY2016.⁹² DSH payments are federal Medicaid payments intended to cover the extra cost incurred by hospitals serving a large number of low-income and uninsured patients. Unlike other Medicaid payments, federal DSH funds are capped at a state’s annual allotted amount, determined by statutory formula, and states have two years to claim their allotments. DSH allotments currently vary considerably across states and total about \$11.6 billion a year.⁹³ Anticipating fewer uninsured and lower levels of uncompensated care, the ACA reduces federal Medicaid DSH. Cuts were originally scheduled to begin in 2014, but other legislation delayed reductions which are now scheduled to begin in 2016 with a reduction of \$1.2 billion. DSH cuts phase up to \$5.6 billion in 2019, drop to \$4 billion in 2020 and then increase by inflation until 2023. The legislation requires the Secretary of HHS to develop a methodology to allocate the reductions that must take into account factors outlined in the law.⁹⁴ For those states which have elected not to expand Medicaid eligibility, uninsured residents are left with few low-cost coverage options, and the hospitals that serve these individuals will receive less federal DSH funding.

Being uninsured leaves individuals at an increased risk of amassing unaffordable medical bills. Uninsured people are more likely (22%) than those with employer sponsored insurance (9%) or those with Medicaid (15%) to report having trouble paying medical bills in the past year (Figure 10). Medical bills may also force uninsured adults into serious financial strain. In 2013, 20% of uninsured adults reported that medical bills either caused them to use up all or most of their savings; caused them to have difficulties paying for medical necessities; caused them to borrow money; or caused them to be contacted by a collection agency. In contrast, only 7% among those with employer coverage and 12% among those with Medicaid experienced this type of financial strain due to medical bills.⁹⁵

Most uninsured people have few, if any, savings and assets they can easily use to pay health care costs. Half of uninsured families living below 200% of poverty have no savings at all,⁹⁶ and the average uninsured household has no net assets.⁹⁷ Uninsured people also have far fewer financial assets than those with insurance coverage. A recent survey found that almost three-quarters (70%) of the uninsured are not confident that they can pay for the health care services they think they need, compared to 13% of those with employer sponsored coverage and 37% with Medicaid (Figure 10).



Unprotected from medical costs and with few assets, uninsured people are at risk of having difficulty paying off debt. Like any bill, when medical bills are not paid or paid off too slowly, they are

turned over to a collection agency, and a person's ability to get further credit is significantly limited. In 2013, over half (57%) of uninsured adults reported having difficulty paying off debt due to medical expenses, compared to 30% of those with employer sponsored insurance.⁹⁸ Medical debts contribute to almost half of the bankruptcies in the United States, and uninsured people are more at risk of falling into medical bankruptcy than people with insurance.⁹⁹

Conclusion

In the wake of the ACA's major coverage expansions, millions of Americans now have affordable health insurance for the very first time, allowing them to access the health care they need while protecting them against catastrophic medical costs. Historically, the options for the uninsured population were limited in the individual market, which was often expensive and under which many were denied coverage. Medicaid and CHIP have provided coverage to many families, but pre-2014 eligibility levels were low for parents and few states provided coverage to adults without dependent children. The ACA fills in many of these gaps by expanding Medicaid to low-income adults and providing subsidized coverage to people with incomes below 400% of poverty in the Marketplaces. Nonetheless, even with the ACA, the nation's system of health insurance continues to have many gaps that currently leave millions of people without coverage, including low-wage workers who do not qualify for Medicaid or Marketplace subsidies, because they do not meet the income threshold or because they reside in a state that has not expanded Medicaid. Further, undocumented immigrants are excluded from Medicaid and the Marketplace regardless of their income. In addition, many uninsured people live in health professional shortage areas and may continue to do so even if they gain insurance under the ACA, underscoring the need to continue to develop and support safety-net providers and community health clinics.¹⁰⁰ Even so, the ACA has the potential to provide coverage to those who need it, ensuring that fewer individuals and families will face the health and financial consequences of not having health insurance.

¹ The ACA expands Medicaid eligibility, beginning in 2014, to people under age 65 who have incomes at or below 138% of the federal poverty level. The Supreme Court ruling on the ACA maintains the Medicaid expansion but limits the Secretary's authority to enforce it. If a state does not implement the expansion, the Secretary cannot withhold existing federal program funds. For more information: Musumeci M. 2012. "Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision." Kaiser Family Foundation Available at: <http://www.kff.org/health-reform/issue-brief/implementing-the-acas-medicaid-related-health-reform/>

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THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters

2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and Barbara Jordan Conference Center

1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

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