

**Testimony**  
**Hearing on Access to Health Care**

Jeanne M. Lambrew, PhD

Associate Professor  
Lyndon B. Johnson School of Public Affairs  
University of Texas at Austin

Senior Fellow  
Center for American Progress

Before the  
**Subcommittee on Labor, Health and Human Services, and Related Issues**  
**Committee on Appropriations**  
**United States House of Representatives**

**March 5, 2007**

I thank you for the opportunity to testify on expanding access to health care. This subcommittee has jurisdiction over programs that have served as a literal lifeline for millions of Americans. These activities range from immunizing children to distributing AIDS drugs to placing health workers in underserved communities. Your interest in the broader context within which these programs operate is commendable and consistent with a record of advancing the nation's health.

The evidence suggests that health reform should be at the top of the policy agenda. In this testimony, I will review this evidence by offering a snapshot of the system, a description of key trends, and a review of the research on the implications of our broken health system. In addition, I will offer several observations on the solutions that are being debated.

But before doing so, I want to note that you are in good company in focusing on this challenge. Economists from the Congressional Budget Office, the Governmental Accountability Office, and most major think tanks agree on the imperative of tackling the health system problems. The Director of CBO recently noted, "No other single factor will exert as much influence over the federal government's long-term fiscal balance as the future growth rate of costs in the health care sector."<sup>1</sup> Addressing health costs requires addressing access, as another economist observed: "Covering nearly all Americans is a precondition for effective measures to limit overall health care spending."<sup>2</sup> This is echoed by business leaders ranging from the CEOs of General Motors to Wal-Mart and organizations from the Business Roundtable to the National Federation of Independent Businesses. Patient groups have picked up the refrain. For example, the American Cancer Society has dedicated its entire advertising budget this year to ads on the importance of coverage. And public opinion is strong: addressing health care is a top, if not the top, domestic policy priority among voters.

## **Snapshot**

Nearly one in five of all Americans reports needing health care but not being able to access it due to cost.<sup>3</sup> This largely results from lack of health insurance. About one in six Americans lacks health insurance at any point in time. To put this into perspective, 47 million uninsured Americans is double the number of people with diabetes. It is also more the number of people who live on the entire west coast of the United States or in Canada (Figure 1). This estimate does not capture all the people affected by gaps in coverage. Looking over a two-year period, a government study found that 82 million – one-third – of all non-elderly Americans experienced a gap in coverage (Figure 2). Research suggests that access for people with short gaps in coverage is more similar to the long-term uninsured than insured population.

Even though the lack of coverage is common, certain populations are at greater risk of being uninsured than others. Health coverage varies by age (Figure 3). Medicare provides universal coverage for our nation's seniors, while Medicaid and the State Children's Health Insurance Program (SCHIP) have given children the second-lowest rate of uninsurance. Young adults have the highest uninsured rate, largely because they experience significant work and family transitions. While older adults have a relatively low uninsured rate, they face a different risk. They have less employer-sponsored insurance and greater difficulty accessing affordable insurance in the individual market.

Contrary to popular perceptions, about four in five uninsured are in working families. The majority of people with access to employer-based health insurance – 83 percent – enroll in it. However, this access to job-based health insurance depends on a number of factors. Only about 45 percent of firms with three to nine workers offer health benefits compared to 99 percent of those with 200 or more workers.<sup>4</sup> The type of firm affects its health benefits as well as its size. Firms in the retail industry are half as likely to offer health insurance as state and local governments (Figure 4). While manufacturers were one-third more likely to offer health benefits than service industry employers, service-providing industries are projected to generate approximately 15.7 million new jobs over the 2006 to 2016 period. Goods-producing industries are expected to experience overall job loss during this same period.<sup>5</sup> In addition, part-time and temporary workers are less likely to have job-based coverage. The uninsured rate among part-time workers – 29 percent in 2006 – was the same as that of non-workers.<sup>6</sup>

People's insurance status is related to their income. About two-thirds of the uninsured have income below 200 percent of the poverty threshold (\$21,200 for a family of four in 2008).<sup>7</sup> Low-income workers are less likely to be offered health insurance. Only about 36 percent of low-wage firms (defined as having 35 percent or more of workers earning \$21,000 or less annually) offered health benefits, nearly half the rate of firms with higher-wage workers.<sup>8</sup> Additionally, when offered it, low-wage workers are less likely to take it up. The alternative, purchasing coverage in the individual (i.e., non-group) market, is infrequently used by low-income people. Only from 4 to 11 percent of low-income people without access to job-based coverage or public programs purchase individual coverage.<sup>9</sup>

It is also important to recognize that “under”-insurance has become a serious problem along with uninsurance. The family share of premiums plus cost sharing have been rising faster than inflation, causing access problems for some. Researchers generally consider people under-insured when their health spending comprises a large fraction of their income (e.g., greater than 10 percent). One study found that 16 million Americans face serious medical costs even though they have insurance.<sup>10</sup> Half of all bankruptcies in 2001 were caused, in part, by medical debts, which averaged nearly \$12,000. Three-fourths of those bankrupted by medical debt had health insurance at the start of their illness or injury.<sup>11</sup> In addition, a recent study that examined health spending for low-income and high-cost people found that people in the individual market spent as much on health care as a percent of their income as did the uninsured (Figure 5).<sup>12</sup>

## **Trends**

These grim statistics result from several years of deteriorating access and climbing costs. Between 2000 and 2006, the number of uninsured Americans rose by 6 to 7 million – at a pace three times that of population growth and seven times that of job growth (Figure 6). The uninsured rate today is higher than it was in 1993, the last time that the nation engaged in a debate over health reform. But, the profile of the uninsured population has changed. Until recently, all of the growth in the uninsured has occurred among non-elderly adults. Medicaid and SCHIP have decreased the rate of uninsured children in the last decade. In addition, the income distribution of the uninsured is shifting. During the recession from 2000 to 2004, the growth in the uninsured primarily grew among low-income Americans. However, from 2004 to 2006, this

growth has occurred among higher-income Americans (Figure 7). This makes the problem harder to solve.

A main reason for the rise in the uninsured is the fall of employer-sponsored insurance. The proportion of firms offering health insurance dropped from 69 to 60 percent between 2000 and 2007, with even more rapid declines occurring among small businesses (Figure 8). The proportion of non-elderly Americans covered through employers declined from 67.8 to 63.0 percent between 2000 and 2006.<sup>13</sup> Dependent coverage has also been declining, although public programs have prevented this from resulting in an increase in the rate of uninsured children. Workers with low incomes have been particularly hard hit by the erosion of employer coverage. Between 2001 and 2005, employer-based coverage rates dropped from 37 to 30 percent among the poor and 59 to 52 percent among the near-poor.<sup>14</sup>

The deterioration of employer coverage is largely a response to the rapid rise in health costs. Since the year 2000, employer-based insurance premiums have cumulatively risen by 98 percent, five times higher than wage growth (Figure 9). If trends persist, health benefit costs of Fortune 500 companies could exceed their profits this year.<sup>15</sup> Health costs are a percent of our gross domestic product rose from 13.8 percent in 2000 to an estimated 16.6 percent this year. If trends persist, CBO estimates that the fraction of the economy dedicated to health spending will be 25 percent in 2025 and 49 percent in 2082.<sup>16</sup>

### **Differences Across States**

Both the snapshot of health coverage and costs as well as the trends vary by state. There is no simple pattern to state variation. In general, states with lower-than-average income have higher-than-average uninsured rates (Figure 10). These tend to be concentrated in the South and West. Such states also tend to have more jobs in the service, agriculture, and other industries that are less likely to offer health benefits than manufacturing or government jobs. State resources, delivery systems, and political cultures also affect the uninsured rate. Some states invest in public hospitals and clinics while others use Medicaid and SCHIP to ensure access.

States with high uninsured rates are generally not those with high health care spending per capita (Figure 11). High spending is partly driven by underlying variation in the cost of living, which tends to be higher in the Northeast. It also reflects demographics; states with higher-than-average senior populations tend to have higher health spending per capita as well. However, research has documented that there is no strong correlation between cost and quality. In fact, there is some evidence that some outcomes in high-cost areas are worse than those in low-cost areas.<sup>17</sup> This point-in-time pattern on health care costs masks the breadth of the cost problem. High average annual growth in health costs extend to states across the country (Figure 12). Explanations for why some states have experienced spending growth that is even faster than the already-high national average are hard to find.

It is also important to look at variation within states to get an accurate picture of the coverage challenges. People who live in rural areas away from cities are less likely to have job-based insurance and more likely to have low income, explaining why their uninsured rate is significantly higher.<sup>18</sup> They also face physical barriers to care: access is impeded in areas with

few health care providers. Similar problems exist in certain urban areas. The increase in the uninsured has strained public hospitals and clinics. The same holds true for emergency departments in hospitals. Between 1994 and 2004, emergency department visits rose by 26 percent while the number of emergency departments dropped by 9 percent.<sup>19</sup>

Lastly, geographic variation pales in comparison to the racial variation in health outcome and coverage. Compared to whites (12.6 percent), the uninsured rate for African Americans is nearly twice as high (21.8 percent) and for Hispanics is nearly three times as high (35.7 percent).<sup>20</sup> This contributes to – but doesn't fully explain – the lower use of prevention, delayed use of needed care, and worse outcomes for racial and ethnic minorities.<sup>21</sup>

## Consequences

These statistics, trends, and patterns help describe the landscape for access to care in this country. They do little to explain why it matters. A decade's worth of research since the last health reform debate underscores the value of health coverage. Numerous studies have documented that being uninsured is associated with delayed prevention, low adherence to recommended care, and worse outcomes. For example, about 25 percent of uninsured adults report delaying or forgoing needed health care due to cost, five times higher than the rate among insured people.<sup>22</sup> Uninsured people who were injured or developed a chronic illness were less likely to receive initial and follow-up care, impeding recovery and accelerating the worsening of the condition.<sup>23</sup> One study found that the risk of death is typically 25 percent higher for uninsured versus insured patients. Roughly, 22,000 people die each year due to lack of coverage.<sup>24</sup> This is higher than number of people who died of homicide in 2006 (17,034).<sup>25</sup>

The health system problems affect financial as well as health security. As described earlier, rising costs and underinsurance diminish families' resources. Counting employer contributions, the typical person or family with employer coverage pays 12.3 to 15.1 percent of income on health care costs.<sup>26</sup> This also affects businesses that finance roughly a quarter of our health system. The "old-line" industries are struggling to maintain coverage; new industries and businesses are struggling to offer coverage in the first place. Health care costs are limiting firms' competitiveness domestically and globally. The coverage gaps also have implications for our economy. The Institute of Medicine estimated that the lost productivity of uninsured Americans costs our economy from \$65 to \$130 billion.<sup>27</sup>

It is important to note that coverage is necessary but not sufficient for access. The quality of the coverage matters: if it fails to cover a pre-existing condition or critical service, financial barriers will persist. An adequate supply of high-quality doctors, nurses and other providers matters as well. The nation faces a primary care shortage. For example, between 1997 and 2005 the number of medical school graduates entering family practice residencies dropped by 50 percent.<sup>28</sup> This decline is occurring in a country that already has a mal-distribution of health care resources. And other non-financial barriers to access persist, from lack of information about when and how to access the system to subtle forms of discrimination that perpetuate racial disparities. A health reform plan designed to improve access should start with expanding coverage and improving efficiency, but cannot end there if it is to succeed in promoting access to valuable health care.

## Solutions

A wide range of visions and detailed plans have been developed to fix the broken health system. The 2008 election is likely to focus on some of them; others have been proposed in Congress and by Members of this Committee. With my colleagues at the Center for American Progress, I also have outlined a way to improve and expand health coverage.<sup>29</sup> But rather than discussing these ideas in depth, I would like to end by making three comments on approaches to reform.

The first is the importance of addressing the coverage and cost problems simultaneously. Coverage will continue to erode, even with expansions, if the cost of coverage continues its rapid increase. This is evident in the recent experience with children's health: some of the gains in kids' coverage have been lost due to the unrelenting cost increases that have eroded employer coverage as well as states' ability to Medicaid and SCHIP. The same is true in reverse: the unsustainable cost curve cannot be bent without ensuring coverage for all Americans. The United States spends nearly \$500 billion more than peer nations, adjusting for wealth, in part due to its complexity.<sup>30</sup> Not only do we pay seven times more per capita on administrative costs as a result, but we pay "hidden taxes" from cost shifting. Some fraction of uncollected bills for care for the uninsured gets added to the bills for the insured. One analysis estimated that this added \$922 to the premium for a privately insured family in 2005.<sup>31</sup> Moreover, gaps in coverage limit the potential of policies to bend the growth curve in health costs. There is widespread, bipartisan agreement that improved prevention, chronic disease management, health information technology, and similar policies could reduce the nation's health costs. However, the full potential of these policies to realize savings may be constrained or even reversed if one-third of the population cycles in and out of insurance over the course of two years.<sup>32</sup>

Second, solutions must be national in scope. States can and should help develop the framework and feasibility of solutions. This Committee's creation and support of state planning grants has made a real difference in both local health systems and the national knowledge of how to make systemic change. But, an effective and efficient U.S. health system cannot be constructed one state at a time. States face structural barriers such as balanced budget requirements and ERISA that are formidable. And, a state-by-state approach tolerates inequity in the system. Poor states have more uninsured and can't afford to do much about it. And 50 separate reform efforts complicate our already complicated system and inhibit efforts to simplify it.

Third, the perfect should not be the enemy of the good. It would be hard to create a more irrational health care system than the one we have. Plans for a well-functioning system are, by definition, radical and have a role in the debate. However, when advocates of market-based solutions and single-payer systems put purism ahead of pragmatism, we get gridlock. More of the same means that people die every day in the wealthiest nation on earth due to lack of financial access to care. The solution will, by necessity, be a hybrid: a mix of public and private coverage, and individual and employer responsibility. This is the framework we have seen from Republican governors and Democratic presidential candidates. It is what many Members of Congress have proposed. And, hopefully, it will be inherent in the legislation that you consider in the near future to address the health crisis in the United States.

## Notes:

---

- <sup>1</sup> P.R. Orszag, "Testimony: Growth in Health Care Costs," United States Senate Committee on the Budget, January 31, 2008.
- <sup>2</sup> H. Aaron, "Budget Crisis, Entitlement Crisis, Health Care Financing Problem – Which Is It?" *Health Affairs*, 26(6): 1622-33, November / December 2007.
- <sup>3</sup> National Center for Health Statistics, *Health, United States, 2007*. (Atlanta: Centers for Disease Control and Prevention, 2007).
- <sup>4</sup> Kaiser Family Foundation & Health Research and Educational Trust. *Employer Health Benefits 2007 Annual Survey*. (Menlo Park, CA: Kaiser Family Foundation, 2007).
- <sup>5</sup> Bureau of Labor Statistics, "Tomorrow's Jobs", in *Occupational Outlook Handbook (OOH), 2008-09 Edition*. (Washington, DC: U.S. Department of Commerce, 2007).
- <sup>6</sup> Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance*. (Menlo Park, CA: Kaiser Family Foundation, October 2007).
- <sup>7</sup> Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance*. (Menlo Park, CA: Kaiser Family Foundation, October 2007).
- <sup>8</sup> Kaiser Family Foundation & Health Research and Educational Trust. *Employer Health Benefits 2007 Annual Survey*. (Menlo Park, CA: Kaiser Family Foundation, 2007).
- <sup>9</sup> Kaiser Family Foundation, *How Non-Group Coverage Varies by Income*. (Menlo Park, CA: Kaiser Family Foundation, February 2008).
- <sup>10</sup> C. Schoen et al., "Insured but Not Protected: How Many Adults are Underinsured?" *Health Affairs*, W5-289-302, June 14, 2005.
- <sup>11</sup> D.U. Himmelstein et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs*, Web Exclusive, W5-63-W5-73, February 2, 2005.
- <sup>12</sup> L.J. Blumberg, L. Clemans-Cope, and F. Blavin, *Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs*. (Washington, DC: The Urban Institute, December 2005).
- <sup>13</sup> J. Holahan and A. Cook, "The U.S. Economy and Changes in Health Insurance Coverage, 2000-2006," *Health Affairs*, Web Exclusive, w135-144, February 20, 2008.
- <sup>14</sup> L. Clemans-Cope and B. Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation, 2001 to 2005*. (Menlo Park, CA: Kaiser Family Foundation, December 2006)
- <sup>15</sup> McKinsey. (September 2004). "Will Health Costs Eclipse Profits?" *McKinsey Quarterly* Chart Focus Newsletter.
- <sup>16</sup> P.R. Orszag, "Testimony: Growth in Health Care Costs," United States Senate Committee on the Budget, January 31, 2008.
- <sup>17</sup> Congressional Budget Office, *Geographic Variation in Health Care Spending*. (Washington, DC: CBO, 2008).
- <sup>18</sup> Kaiser Commission on Medicaid and the Uninsured, *Uninsured in Rural America*. (Menlo Park, CA: Kaiser Family Foundation, April 2003).
- <sup>19</sup> A.L. Kellerman, "Crisis in the Emergency Department," *New England Journal of Medicine* 355(13): 1300-1303, September 28, 2006.
- <sup>20</sup> Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance*. (Menlo Park, CA: Kaiser Family Foundation, October 2007).
- <sup>21</sup> Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. (Washington, DC: National Academies of Science, 2002).
- <sup>22</sup> Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance*. (Menlo Park, CA: Kaiser Family Foundation, October 2007).
- <sup>23</sup> J. Hadley, "Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintended Injury or the Onset of a Chronic Condition," *JAMA* 297(10): 1073-1084, March 14, 2007.
- <sup>24</sup> S. Dorn. *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*. (Washington, DC: The Urban Institute, January 2008).
- <sup>25</sup> Federal Bureau of Investigations, *Crime in the United States: 2006* (Washington, DC: U.S. Department of Justice, September 2007), available at: [http://www.fbi.gov/ucr/cius2006/offenses/violent\\_crime/murder\\_homicide.html](http://www.fbi.gov/ucr/cius2006/offenses/violent_crime/murder_homicide.html) (accessed January 21, 2008).
- <sup>26</sup> L. Blumberg et al., "Setting A Standard Of Affordability For Health Insurance Coverage," *Health Affairs* 26(4): w463-w473, 2007.
- <sup>27</sup> Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*. (Washington, DC: National Academies Press, June 2003).
- <sup>28</sup> T. Bodenheimer, "Primary Care: Will It Survive?" *New England Journal of Medicine* 355(9): 861-64, 2006.
- <sup>29</sup> J.M. Lambrew, J.D. Podesta, and T. Shaw, "Change in Challenging Times: A Plan for Extending and Improving Health Coverage," *Health Affairs*, Web Exclusive, W5-119-132, March 23, 2005.
- <sup>30</sup> McKinsey Global Institute, *Accounting for the Cost of Health Care in the United States* (Washington, DC: McKinsey Global Institute, January 2007).
- <sup>31</sup> Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured*. (Washington, DC: Families USA, June 2005).
- <sup>32</sup> C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, December 18, 2007).