

Why Health Insurance Is Important

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Having health insurance is important because coverage helps people get timely medical care and improves their lives and health. Some may believe that people always have access to medical care because they can always go to an emergency room. But even areas with well supported safety-net care do not remove barriers to access to the same extent as does having health insurance. “Coverage matters,” concluded the Institute of Medicine (IOM) during a recent multiyear appraisal.¹ Indeed, the prestigious IOM estimated that lack of coverage was associated with about 18,000 extra deaths per year among uninsured adults.² Several points deserve emphasis.

1. Uninsured people receive less medical care and less timely care.

Overall, uninsured people get about half as much care as the privately insured, as measured in dollars spent on their care—even taking into account free care received from providers. This discrepancy holds true even when spending is adjusted for age, income, health status, and other factors.³ (This finding and most information presented here do not come directly from District sources, for which data are often lacking. But most patterns are believed to be generally true of all locations.)

Uninsured adults get fewer preventive and screening services and on a less timely basis. Shortfalls are documented for many types of illness or condition, including screening for cervical and breast cancer as well as testing for high blood pressure or cholesterol. Cancers, for example, are more likely to be diagnosed at a later stage of illness, when treatment is less successful. Uninsured pregnant women use fewer prenatal services, and uninsured children and adults are less likely than their uninsured counterparts to report having a regular source of care, to see medical providers, or to receive all recommended treatment.

Shortfalls are particularly notable for chronic conditions. For instance, uninsured adults with heart conditions are less likely to stay on drug therapy for high blood pressure.⁴

Having health coverage is associated with better health-related outcomes.

Some uninsured people may decide not to obtain insurance precisely because they expect not to need medical care, so simple comparisons of the insured and uninsured can be misleading.⁵ However, many studies adjust for factors like age and health status that affect need for care. One recent study examined people who experienced an unintentional injury or a new chronic condition—times when care is more clearly needed. Uninsured individuals were less likely to obtain any medical care, and if they did receive some initial care, they were more likely to get none of the recommended follow-up care.⁶

2. Uninsured people have worse health outcomes.

The “bottom line” for uninsured people is that they are sicker and more apt to die prematurely than their insured counterparts. Conversely, having health coverage is associated with better health-related outcomes. Evidence comes from many studies using a variety of data sources and different methods of analysis.⁷ Death risk appears to be 25 percent or higher for people with certain chronic conditions, which led to the IOM estimate of some 18,000 extra deaths per year.

Some complain that low health status may be a cause of uninsured status, rather than the other way around. (Note that this objection is the opposite of the complaint noted above that good health may promote uninsurance.) Again, however, as the IOM noted, several studies use statistical methods to adjust for this “reverse causation,” and still find that lack of health insurance results in poorer health outcomes. The study of unexpected accidents and new chronic conditions also addressed this issue; its short-term follow-up showed that uninsured accident victims were more likely to have ended treatment without being fully recovered, and that those with chronic conditions still reported worse health status.⁸

3. Lack of insurance is a fiscal burden for uninsured people and their families.

Uninsured people do not benefit from the discounted medical prices that are routinely negotiated by

private health plans or imposed by public programs. Until recently, those without coverage were billed full hospital charges, for example. The low incomes of some patients qualify them for charity care, but others have often been dunned for unpaid bills. Uninsured families report medical bill problems at double or triple the rate of insured families, and medical bills have been found a contributing factor in a sixth or more of bankruptcies, according to various surveys.⁹

A recent movement to reduce charges for the uninsured has gained strength among public officials and from hospitals, and it may have alleviated this problem. On the other hand, affordability problems have increased along with rapid growth in the costs of care.

The IOM noted that low levels of insurance in an area can also burden medical providers because of higher demand for free or reduced-cost care.

4. The benefits of expanding coverage outweigh the costs for added services.

Expanding coverage would improve health, lengthen lives, reduce disability, help control communicable diseases, and raise productivity. Newly insured people would get more services, above what they currently pay out of pocket or receive from medical providers in the form of uncompensated care. This can be expected to raise medical spending, but by less than the value of longevity and other benefits achieved.¹⁰ Such estimates are complex to make and do not address political issues concerning the sources for financing increases in spending, especially the likelihood that expansions would shift some spending from the private to the public sector.

5. Safety-net care from hospitals and clinics improves access to care but does not fully substitute for health insurance.

Proximity to safety-net hospitals or clinics increases access to care, according to studies using various methodologies.¹¹ Better access presumably improves health outcomes, although this effect appears less well documented, and safety-net access may provide less continuity of care than insurance. Comparison across

states shows that access to care is better where governments and private payors better support the safety net, but that the improvement is less than that insurance achieves.¹² Similarly, communities that have high capacity of community health clinics have better access to care than communities with low capacity, but the effect on access of higher insurance coverage rates is even greater.¹³ Insurance likely costs more as well, however, and it can be argued that public budgeting can control public safety-net subsidies, whereas an insurance entitlement like Medicaid is a more open-ended commitment of public resources.

Support for safety-net care can be seen as complementary to insurance expansion. Some people will always remain uninsured, and community clinics add capacity to otherwise underserved geographic areas. Clinics may also be better for addressing access problems attributable to cultural and language barriers.

6. Cautions are appropriate in using these findings.

Most benefits of insurance coverage are estimated for coverage in general, not for every type of insurance. Medicaid has sometimes been separately analyzed and achieves less on some measures than does private coverage.¹⁴ One possible reason is that enrollees more often go on and off coverage; another is that Medicaid programs often pay lower rates to participating providers.

Private insurance coverage that differs from traditional patterns—for instance, limited-benefit coverages or plans with very high deductibles—might also achieve lesser health improvements. Conversely, adding additional benefits to existing conventional coverage will not necessarily achieve improvements of proportionate magnitude. Insurance and access to safety-net services are far from the only influences on health and longevity. Environmental and public health measures can have major impacts as well, including promotion of vaccinations, smoking cessation, and maintenance of healthy weight.¹⁵

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Endnotes

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² IOM. 2002. *Care without Coverage: Too Little, Too Late*.

³ This section relies upon the IOM reports just cited; Hadley, Jack. 2003. "Sicker and Poorer: The Consequences of Being Uninsured," *Medical Care Research and Review* 60(2, suppl):3S-75S; and "Consequences of Uninsurance," a series of factsheets accessible from <http://covertheuninsured.org/factsheets/>.

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- ⁷ See sources cited in note 3 and the literature that they review.
- ⁸ Hadley. 2007. *JAMA*, cited in note 6.
- ⁹ May, Jessica H. & Peter J. Cunningham. 2004. "Tough Trade-Offs: Medical Bills, Family Finances and Access to Care," Center for Studying Health System Change, Issue Brief 85 <http://www.hschange.org/CONTENT/689/689.pdf>; USA Today/Kaiser Family Foundation/Harvard School of Public Health. 2005. "Health Care Costs Survey, Summary and Chartpack" <http://www.kff.org/newsmedia/upload/7371.pdf>; Dranove, David and Michael L. Millenson 2006. "Medical Bankruptcy: Myth Versus Fact," *Health Affairs* 25(2), web exclusive, w74–w83.
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