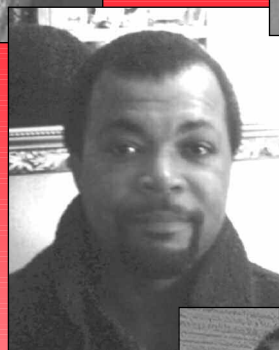


2005 Northwest

Health Gap Study



Oregon ■ Montana ■ Idaho ■ Washington



Northwest Federation of Community Organizations (NWFCO)

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Executive summary

Between high wage earners who have comprehensive employer-based health benefits, and the low-income people who are covered through public health programs, lies a rapidly growing population with no coverage or inadequate coverage. These people are in the health gap.

Increasing numbers of people are falling into this gap in health coverage, where they are underinsured or uninsured. Employer-based health coverage is declining. Cost sharing is rising for those with employer-based coverage and those who purchase health care on the individual market. More people are covered by minimal plans with high deductibles.

Some people are particularly at risk of falling into the health gap. Low wage earners, people who work for small businesses, and people with temporary jobs are far less likely to have access to employer-based coverage. Older people and people with serious health problems are charged higher premiums and have higher health care costs. People of color are more likely to be uninsured, as are people who live in rural areas.

Many people may not realize they are in the health gap until a health problem occurs and rising health care costs and high deductible plans drain any savings they have. Many more people are simply one health problem away from the health gap and health insecurity. A serious health problem can mean a loss in the ability to work, loss of a job, loss of employer-based coverage, impossibly high health insurance costs on the individual market, and a dangerous slide into the health gap.

Falling into the health gap has enormous health and financial consequences. The uninsured tend to be less healthy, are more likely to have health problems that arise from postponing care, and often cannot get the health care they need. Once minor health problems escalate into serious health conditions, paying the bills can be financially catastrophic.

Once someone has fallen into the health gap, it can be extremely difficult to climb back out. People in the health gap often face both health problems and medical debt. People in the health gap also often face higher prices for purchasing health care, and may face difficulties working. Many bankruptcies are caused by medical problems faced by the underinsured and uninsured.

This report builds on the 2004 Northwest Job Gap Study, which estimated a living wage for a number of family structures, estimated the number of job openings that pay a living wage, and estimated the gap between the number of living wage jobs being created in the Northwest and the number of people needing living wage jobs. This report takes a closer look at the health-related area of the living wage, and the many reasons people do not make a living wage due to health issues.

In short, the health gap highlights a serious crisis in the health care system, which is failing to provide quality, affordable coverage. People are pursuing innovative strategies for closing the health gap. These include long-term solutions focused on health care for all, as well as shorter term solutions that expand public programs, improve oversight over private insurance carriers, and address the trend in employers dropping health coverage.

Introduction

This report provides a close look at the health care system and who is and is not covered by that system.

It starts out by defining the health gap, and then covers the following issues:

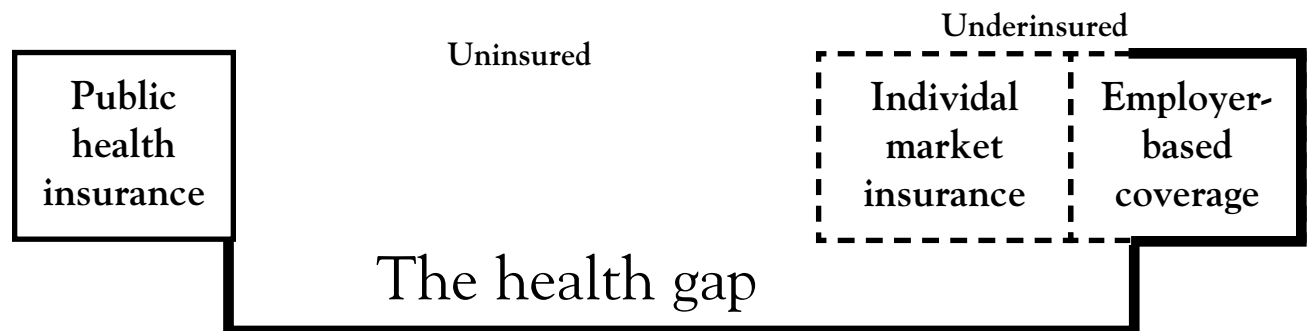
- Why the health gap is widening
- Who is most likely to be in the health gap
- The health and financial consequences of falling into the health gap
- How the health gap relates to a living wage
- The difficulties of getting out of the health gap
- Strategies for closing the health gap

As this report covers these areas, it also includes personal stories and quotes from many people who are in the health gap, or on the brink of it.

“I’m at risk every day – I can’t miss my dialysis and I can’t skip my prescriptions, but I really can’t afford either one.”

SAUL RIOS

What is the health gap?



The health gap is the large void in health care coverage between the comprehensive employer-based coverage available for some higher wage employees, and the comprehensive public health care programs available for some very low-income people, and some people with serious medical problems.

Anyone who is under or uninsured falls into the health gap, and many, many more are at risk of sliding into the gap. Many families are one illness or health problem away from serious financial difficulties. An illness can result in greatly increased health care costs, the inability to work, greatly reduced income, and loss of health insurance. Many families only find out in a crisis that what they thought was adequate health coverage does not cover their health care needs for the long term.

Why is the health gap widening?

Declines in employer-based coverage

Employer-based coverage is declining. Between 2000 and 2003, the rate of employer-based insurance coverage for adults fell from 68.9 percent to 65.1 percent, and the uninsured rate for adults increased by 2.4 percent.

Health insurance coverage for adults by income ¹

	Coverage distribution within income category		Change in percentage 2000-2003
	2000	2003	
All Incomes (millions of people)	168.8	175.1	
Employer	68.9%	65.1%	-3.8%
Medicaid and State	5.3%	6.1%	0.8%
Medicare	2.3%	2.7%	0.4%
Private Nongroup	5.6%	5.8%	0.2%
Uninsured	17.9%	20.3%	2.4%
Less than 200% of FPL	49.3	55.0	
Employer	33.9%	29.9%	-4.0%
Medicaid and State	16.1%	17.3%	1.2%
Medicare	4.4%	4.7%	0.3%
Private Nongroup	8.0%	7.3%	-0.7%
Uninsured	37.6%	40.8%	3.2%
200 to 399% of FPL	50.9	50.3	
Employer	75.9%	72.7%	-3.1%
Medicaid and State	1.5%	1.9%	0.4%
Medicare	1.9%	2.4%	0.5%
Private Nongroup	5.4%	5.6%	0.2%
Uninsured	15.3%	17.3%	2.1%
400% of FPL and above	68.6	69.8	
Employer	89.0%	87.4%	-1.6%
Medicaid and State	0.4%	0.4%	0.0%
Medicare	1.1%	1.3%	0.3%
Private Nongroup	4.0%	4.7%	0.7%
Uninsured	5.6%	6.2%	0.6%

The number of uninsured Americans under age 65 increased by 5.1 million between 2000 and 2003. Declines in employer-based coverage are responsible for most of this trend.²

People with low wages are less and less likely to have employer-based health insurance. Three quarters of the drop in employer-based coverage between 2000 and 2003 occurred for people making low wages (under 200 percent of the Federal Poverty Level (FPL)). The percentage of people with employer-based coverage increases dramatically with income. Only 30 percent of adults under 65 with incomes under 200 percent FPL had employer-based health insurance in 2003, while 87 percent of adult with incomes over 400 percent FPL had employer-based coverage.

Although employer-based coverage levels dropped for all types of employers, employment is shifting to industries and places of employment that are less likely to provide health coverage. Between 2000 and 2003, there was a large decrease in the number of workers in medium and large-sized places of



Claudia Perez

Owner, Wish Upon A Star Day Care, Burley, ID

My husband Ruben and I have three children and we're all uninsured. Ruben has been working at a farm for the last 18 years, but his job has no benefits. I recently started my own business — a day care center — where I employ three full-time employees, but I can't find affordable insurance for my employees or for my family. The rates I've been quoted have been two or three times those offered other businesses.

Fewer companies provide health coverage in this area these days. I had insurance through a previous employer, but when they laid off all their workers I couldn't afford to continue the insurance. I got a new job, but it was part-time with no benefits. That's why I decided to start my own business. I thought it would be an opportunity to get ahead. But with the way people running family businesses get punished with health care costs, it's really hard. My children were covered through Medicaid for a while, but since I started my business they can't qualify anymore, even though we still can't afford the costs of private coverage.

I truly would love to be able to offer insurance for my staff and maintain a strong workforce, but I can barely afford to keep the lights on during business hours. And this problem has impacted me personally, too. I've suffered from colon problems for some time,

"I recently started my own business — a day care center — where I employ three full-time employees, but I can't find affordable insurance for my employees or for my family. The rates I've been quoted have been two or three times those offered larger businesses."

CLAUDIA PEREZ

but without insurance I couldn't afford to get treated. As a result, I ended up in the hospital for an emergency surgery, a second surgery later, and a \$20,000 medical bill. Since the surgeries, the quotes I've been given for health insurance are unbelievable. People like me who need care the most are getting quoted the highest rates, so high we're priced out of the market and can't afford to get covered.

I want to go back to school to get my Masters degree so I can get a better job with benefits, but we would need more income, and I would need to have my health. Instead, it looks like I'm going to need another surgery soon, a major one to remove my gall bladder and appendix. That's going to sink us \$10,000 further in debt. I'm afraid of getting so ill that I won't be able to work and our family will have to survive on one income, which just isn't enough. As it is, we do our best, but even with my husband working two jobs and me working 60 hours a week, we struggle to keep up.

Notes on our budget: We pay \$400 a month for housing, \$100-200 for utilities (depending on the season), up to \$650 a month for transportation and about \$400 a month for food. The medical bills and health care costs can be \$500 to \$700 on top of that. That leaves us with no room to save for emergencies, and no way to deal with an unexpected bill or if my husband lost his job.

employment. Nearly one million fewer people worked for companies with 25 to 999 employees in 2003 than did in 2000. And over two million fewer people worked for companies with over 1,000 workers in 2003 than did in 2000. More people are self-employed or working for companies with fewer than 25 employees-both of which are less likely to provide health insurance. When considered by employer size, the largest decreases in employer-based health insurance occurred for people working for employers with less than 25 employees.

Because employer-based health coverage dropped for workers-rather than simply for people who lost their jobs-employer coverage may continue to decline, even as employment rates increase.³

Key reasons for the widening health gap

- Fewer employers are offering comprehensive health care
- Health insurance plans are charging higher premiums and copayments
- Employers are shifting cost sharing to employees
- Health insurance plans are adding new cost sharing requirements
- More people are working for small employers, who are less likely to provide health care

Premium and copayment increases

Premiums have been increasing, and much of this cost has been shifted to employees. When labor markets are slack, employers can more easily pass the costs of increasing health care premiums along to their employees.⁴ Since 2001, premiums have increased 59 percent, and employee contributions have increased 57 percent for single coverage and 49 percent for family coverage.⁵ Larger employers make significantly larger contributions to family coverage than do smaller employers.

Premium rates have seen double digit increases from 2000 to 2004. Premium rates increased nine percentage points faster than the economy-wide inflation rate and the rate of increase in worker's hourly earnings. Premium increases also grew faster than the estimated growth in medical claims expenses, suggesting increasing profit margins for insurers.



Saul and Mary Lou Rios

Rupert, ID

I am a proud family man — a husband of 27 years, a father of three, a grandfather of four. We've lived in Idaho for 25 years. I worked as an operator at a plant in Heyburn for 17 years. Mary Lou worked there too, and the wages were pretty good — with my \$11.44 an hour and her \$10 an hour, we made enough to support us and our two teenage kids. Things could still get tight in winter with the high heating bills, but we were able to put away about \$1,000 in the bank for security. I realize now that one of the reasons we could get by was that we had decent health insurance through our employer.

Since we lost health coverage, everything has changed.

When my kidneys stopped working in 2002, I had to leave my job. Then, in 2003, the plant closed and Mary Lou was laid off. We kept our health insurance through the plant as long as we could. It used to be affordable, only about \$30 a month out of pocket, though the coverage was limited and we had to pay out of pocket for prescriptions, glasses, and dental work. Before I got sick the premiums went up slowly each year. After, they started

rising \$100 at a time for each of us. By the fall of 2004, the premiums were over \$550 for Mary Lou alone, and another \$300 for me. At over \$800 a month, it was either pay the mortgage and eat, or pay the insurance. We couldn't keep paying.

"I realize now that one of the reasons we could get by was that we had decent health insurance through our employer. Since I got sick, we tried and tried to keep our health care coverage, but couldn't afford it. Now I can't get the kidney transplant I need."

SAUL AND MARY LOU RIOS

It took me two years to find a kidney donor. Just as my sister just taking the test to make sure she could donate to me, they cut my coverage, and I was taken off the transplant list. Now I'm at risk every day — I can't miss my dialysis and I can't skip my prescriptions, but I really can't afford either one. It makes me angry when I think about it too much. In 19 years of paying for insurance, I never got sick. All of a sudden, when I do get

sick, I lose my job and lose my insurance, and now I can't even get the kidney I need to get back on my feet.

Our regular bills keep piling up. Then we have all these out of pocket health expenses. Because I can't work and the plant closed, we're trying to scrape by on Mary Lou's unemployment and my small check from SSI. We're not making enough to keep up with the regular bills, let alone pay for health insurance or medications that can cost as much as \$200 for just one prescription. So we keep going deeper in debt.

The last two years have been very difficult for us. We do our best to manage the stress and depression, but it's not easy being \$80,000 in debt with no way to get healthy and get back to work. We need to declare bankruptcy, but right now we don't even have the money to pay a lawyer to do that. I feel like the deck is stacked against us — and other Idahoans in our situation — when it comes to the private insurance system. Our state turns a blind eye on its responsibility to address this crisis in the health insurance system that impacts so many of our people.

Notes on our budget: We pay \$485 a month in rent, about \$380 a month for all utilities, between \$250 and \$300 for food, and around \$150 a month for transportation with our two cars.

**Individual health insurance
premiums for single policies by age, 1996 and 2002⁶**

Age	1996	2002
<40	\$1,288	\$1,661
40-54	\$1,992	\$2,767
55-64	\$1,961	\$3,703

Copayments for office visits are increasing for all types of plans. Employees of companies with fewer than 200 employees generally have higher cost sharing requirements for employer-based coverage.

Premiums on the individual market, like those for employer-based coverage, have been rising. The average premium for an individual health insurance policy has increased by 44 percent from 1996 to 2002. Like employer-based coverage, cost sharing is increasing, and high deductible plans are more frequently available.

Benefit reductions and high deductible plans

New types of cost sharing are also arising in the employer-based health care market. In the 1990s separate hospital deductibles and cost sharing were very rare. By 2004, 53 percent of people with employer-based coverage faced separate cost sharing arrangements. Over 30 percent of employees with job-based coverage must now pay either a separate annual deductible, or a copayment for hospital care; the average payment required is \$222. Another 13 percent must pay a coinsurance when hospitalized, with the average coinsurance rate being 16 percent. And a further five percent must pay both a deductible or copayment, and coinsurance.⁷ Cost sharing for prescription drug coverage is also increasing.

“I had thought I had health insurance at the time. But the deductible was \$7,000 for each of us. That isn’t much health insurance. What’s worse, I was hurt in September and our plan year started October 1, so after a month I had starta paying all over again. It was like having a deductible of \$14,000.”

DARREL COX

More benefit reduction came from increases in cost sharing, rather than from decreases in specific types of coverage. But 15 percent of workers with employer-based coverage work for firms that reduced benefits.

More employers are offering high deductible plans to employees. Sometimes these plans are coupled with health care savings accounts. A survey of employers found increasing interest in offering this type of coverage to employees.⁸

As discussed above, there has also been a reduction in the number of employers who offer coverage at all, particularly for smaller employers. In a survey of reasons small employers did not offer health insurance, nearly 80 percent said the reason was cost. Most employers surveyed say

“After years of hard work saving and planning, medical debt drained all of our savings. Now we are left with no retirement savings and are struggling to get by.”

SAUL AND MARY LOU RIOS

they plan on increasing employee contributions in the next year.

Employers also provide incentives for employees to not take employer-based coverage. Over 17 percent of employers

provide additional compensation to employees who do not take health benefits. Almost 12 percent of employers vary the level of cost sharing required for family coverage depending on whether the spouse has access to health coverage elsewhere. Some companies also provide additional compensation if an employee chooses single rather than family coverage.

When employers do offer coverage, not all employees are eligible. Of employers offering health coverage, only 6 percent provide coverage to temporary employees, and 48 percent provide coverage to

“We’re both 61, with nothing to show but red ink for all our years of hard work. What good is insurance if rising deductibles and out-of-pocket costs are so high it wipes out your retirement before it ever kicks in? Why do we call it insurance if it doesn’t offer any real protection?”

DARREL AND SHIRLEY COX

part time employees. About 80 percent of employees in companies that offer health care are eligible for that health care. And only 82 percent of the eligible employees take the health care offered by their employer — usually because of cost. Consequently, one third of people who work for companies that provide health care are not covered by their employer’s health care either because they cannot afford it, or are not eligible for the coverage.⁹

Benefit reductions and increased cost sharing make it impossible for some families to purchase the health care offered by their employers, or to purchase plans on the individual market. With increases in high deductible plans, many more people are underinsured, and not getting needed health care. Research has shown that higher costs discourage the use of needed services, particularly among low-income individuals.¹⁰

Faces of the health gap



Tim Murphy

Rochester, Washington

I am 28 years old now and I live in Rochester, Washington. I have a rare disease called Crohn's disease, which is difficult to treat because doctors still don't know much about how to treat it. It's just something I have to live with until they find a cure, which basically means that I need surgery every few years. I am very lucky because right now I can keep working, and I have a job that provides health care. But that has not always been the case.

The first surgery was probably the hardest. I had just gotten out of school and was working as a mechanic. My insurance was about to kick in—I was two weeks away from getting coverage when I had to have surgery. The surgery cost me \$12,000 and because I was so young and just out of school, I had no savings. I maxed-out two credit cards trying to pay the bills and had to move back home. It's been six years since that surgery and I am still paying those credit card companies about \$200 a month because of the interest.

Things are a bit better now. I've been working for awhile, I moved out of my Mom's house, and I have health insurance, but my health still makes it difficult because it is unpredictable. For awhile I was working as a mechanic at a construction site, but the work was seasonal and the hours were really rough. I worked 12-hour days, 6-7 days a week. I would get pretty sick sometimes because of my weak immune system. Now I work the graveyard shift at a garage. I still sometimes have to work long hours, which is a big drain on my health. I make a decent wage so I can pay for rent and food, but medical expenses are still a struggle. Most of my monthly expenses go towards my health. Even with insurance, I still have to pay for a lot of hidden costs. It is very easy to reach the maximum out of pocket spending cap when

“Even with health insurance, it is a real struggle to pay for basic necessities and the high expenses of my chronic health condition.”

TIM MURPHY

I need IV treatments every 6 weeks that cost \$3,000 each. Insurance doesn't cover supplements, which are one of the only treatments that help. My special dietary needs produce high food bills, and I am still paying off my medical debt.

But I'm one of the lucky ones because for now, even with the disease, I can keep working and keep my insurance.

Notes on my budget: I make about \$3,000 per month. My rent has is usually \$650 per month and utilities and other regular bills are around \$300 per month. Because of my disease I spend approximately \$300 per month on food and another \$90 per month on two dietary supplements that I take daily. My car payment, car insurance and gas end up costing about \$700 per month. My insurance through work has a \$40 per month premium and a \$400 per year deductible. Once I meet that deductible, I pay 20 percent of medical bills. Because of my health care needs, I pay the maximum out of pocket for my insurance — \$3,500 — every year. So in addition to the \$200 per month that I'm paying the credit card companies for the costs of my surgery 6 years ago, I pay approximately \$250 every month in other medical bills.



Rheda Vargas

Small Business Owner
Canyon County, ID

I opened a restaurant about six months ago. I can't afford to get insurance for our employees — I can't even afford to get it for myself and my husband. He's been working for the same establishment for eight years, but we can't get health insurance through his job either. Right now, with him bringing home about \$1,200 a month and the business barely breaking even, we're in a squeeze to make ends meet.

It's almost impossible to find work with health insurance these days. The reason I decided to open the luncheonette was I applied for dozens and dozens of jobs and didn't get called for a single interview. Who's going to hire someone in their 60s when it's going to cost the business even more in insurance premiums?

I have some serious health concerns. I need to take prescriptions that retail for close to \$1,000 a month to avoid another 15 week stay in the state hospital. Two and a half years ago I had to go in for surgery for a polyp and ended up in the hospital for two months with a bill of over \$100,000. We had to declare bankruptcy. The county got the bill down to \$45,000, but they'll put a lien on anything I ever own, and I'll be paying on that bill for the rest of my life. I should be going back for more tests to make sure the cancer's not back, but there's nowhere I can go.

"I own a small business and wish I could provide care for myself and my family, but insurance companies have priced us out of the market."

RHEDA VARGAS

I try to keep looking on the sunny side, though. I need to for my business — that's what my customers appreciate about me. But we're working very hard behind the smiles just to keep afloat. We restore furniture on the side, work off part of our rent, whatever we can to pay the bills. We have to work our fingers to the bone, and hope we will be able to retire some day.

Notes on our budget: Our rent is \$500 a month, and \$250 more in utilities. Transportation costs \$250 a month for our car, \$100 for insurance, and gas and repairs on top of that. Food is around another \$300, and medical bills at least \$200.

Darrel and Shirley Cox

Grangeville, ID

I've been self-employed all my life, working in mining, logging and trucking projects. My dad had a sawmill when I was a kid, so I knew about trucking before I even went to school. In a good month I would net \$4,000-5,000, working twelve to fourteen hours a day. With my income and Shirley's — she worked over thirty years at First Security Bank — we got by pretty well, though I was never able to build up a reserve to protect against the financial risk of running my own business.

When I had six trucks and business took a turn for the worse, we landed in debt and it took me eight years working straight through to pay off all but one bill. If I'd made it back from Michigan safe and sound four years ago, every bill would have been paid. But I didn't. I fell off the top deck of the car carrier I was hauling and landed on my head. The impact cracked one vertebra, compacted my spine a full inch, and broke my skull right behind my neck. After the ambulance ride, ER intake, CAT scan, MRI, and overnight stay, we got a bill for \$8,500.

And there were lots of doctor and chiropractor visits after that.

“After years of hard work saving and planning, medical debt drained all of our savings.

Now we are left with no retirement savings and are struggling to get by.”

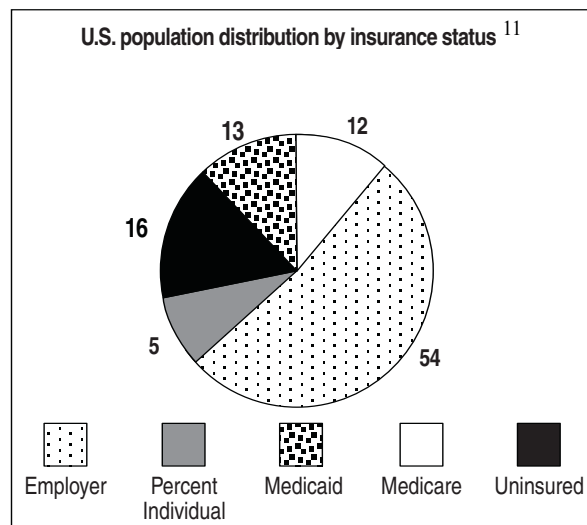
DARREL AND SHIRLEY COX

I had thought I had health insurance at the time. But the deductible was \$7,000 for each of us. That isn't much health insurance. What's worse, I was hurt in September and our plan year started October 1, so after a month I had start paying all over again. It was like having a deductible of \$14,000. We used to get insurance through Shirley's work, but her job was eliminated when Wells Fargo took over, so we were purchasing coverage on the individual market. In April we got a letter that our premiums were going up again, 25 percent, to over \$300 for both of us. By now, if we still had insurance, we'd be paying \$400 or \$500 a month — or who knows, maybe more? Anyway, we couldn't afford to pay the hospital, the ambulance, and the doctors' bills and keep paying more than \$300 a month in premiums, so we had to drop the insurance.

When I got hurt, the bills didn't stop coming. We have high mortgage payments because we refinanced our home to pay off the debt from my business. I had to cash in my 401(k) and drain my retirement savings to pay down the debts, and Shirley had to go back to work at Wells Fargo for \$10 an hour, with no health benefits. She's diabetic but we just can't afford to pay for the health coverage they offer. I can't work as long of hours and can't bring home money like I used to. We're both 61, with nothing to show but red ink for all our years of hard work. What good is insurance if the deductibles and out-of-pocket costs are so high they wipe out your retirement before it ever kicks in? Why do we call it insurance if it doesn't offer any real protection?

Notes on our budget: Our mortgage is \$1,600 a month, utilities \$250 a month, and \$400 a month for transportation in a rural area like ours with gas prices so high. We've grow and can as much food as we can, but we still pay \$50 a week for groceries. And then there's Shirley's health costs for her diabetes — \$99 for a two month supply of Lipitor, \$100 for a package of test strips, and more. We still owe over \$2,000 to our medical doctor and chiropractor. Shirley sets aside \$100 a month to pay on the doctor's bill, and we pay to the chiropractor when we can.

Sources of health care coverage



In 2003, 54 percent of people in the U.S. had employer-based health care, 16 percent were uninsured, 13 percent had Medicaid coverage, 12 percent had Medicare coverage, and 5 percent had health care from the individual market.

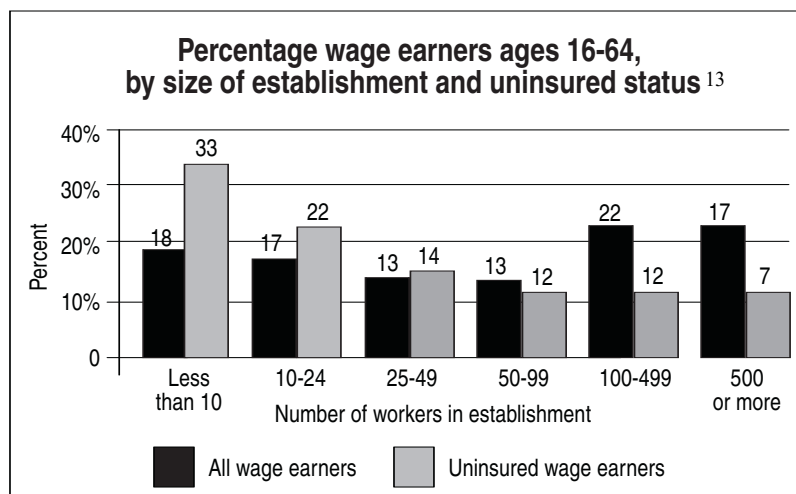
State data for 2002-2003 follows a similar trend:

- In Washington, 55 percent of the population had employer-based health insurance, 5 percent purchased private health insurance, and 15 percent were covered by Medicaid, 10 percent covered by Medicare, and 15 percent were uninsured.
- In Oregon, 53 percent of the population had employer-based health insurance, 5 percent purchased private health insurance, and 15 percent were covered by Medicaid, 10 percent covered by Medicare, and 16 percent were uninsured.
- In Idaho, 53 percent of the population had employer-based health insurance, 5 percent purchased private health insurance, and 13 percent were covered by Medicaid, 11 percent covered by Medicare, and 18 percent were uninsured.
- In Montana, 45 percent of the population had employer-based health insurance, 9 percent purchased private health insurance, and 14 percent were covered by Medicaid, 14 percent covered by Medicare, and 17 percent were uninsured.

Who is most likely to be in the health gap?

Who is most likely to be uninsured?

Many workers in the U.S. are uninsured. Around 19 percent of working Americans were uninsured in 2003. In fact, 54 percent of the uninsured are wage earners between the ages of 16 and 64.¹²



Low-income workers in general are over three-times more likely to be uninsured than those with incomes above 200 percent of the poverty level (42 percent vs. 11 percent).¹⁴

Eric Hanson

Rochester, Washington

I run a diner on the main street in town. The last few years have been pretty hard. People who used to come in twice a week now only come once a week. Some people don't come in at all because everyone is on a tight budget. Revenue for the restaurant dropped about \$17,000 dollars a year in 2002 and 2003. Before the drop in business I was struggling to get by and wasn't able to save any money, but I was making ends meet. When business slowed down, I lost my house and car because I could not afford the payments. I moved in with my mother so we could share the cost of rent and I could help take care of her. Last year, my health insurance had to go as well.

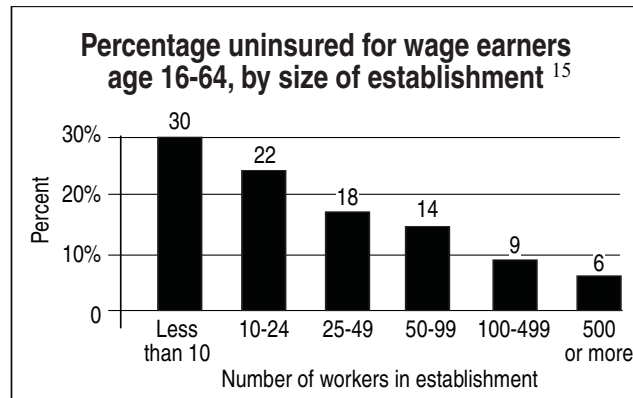
Unfortunately, I have high blood pressure and my doctor told me I need prescription medication. Since I lost my health insurance, I can't afford the doctor visits. I tried to talk to my mother's doctor to see if I could keep getting the prescriptions, but he said no — not without an appointment. I don't want to be dishonest about it, but I really need this prescription. The doctor said he needed to do lab tests to make sure the medication wasn't hurting my liver. I put off the tests as long as I could. I could either afford the medication to lower my blood pressure or the lab fees to see if the medication was hurting my liver, but not both. So I kept taking the medication until the doctor wouldn't prescribe it anymore. It seemed like the only choice I had. Now I can't afford any of it.

"I am self employed and can no longer afford health insurance.

Now I can't afford to treat my high blood pressure."

ERIC HANSON

Notes on my budget: Before things slowed down at the restaurant, I was making about \$22,000 a year. My house payment was about \$1,800 a month. I paid about \$500 a month for transportation, and \$300 a month for health insurance.



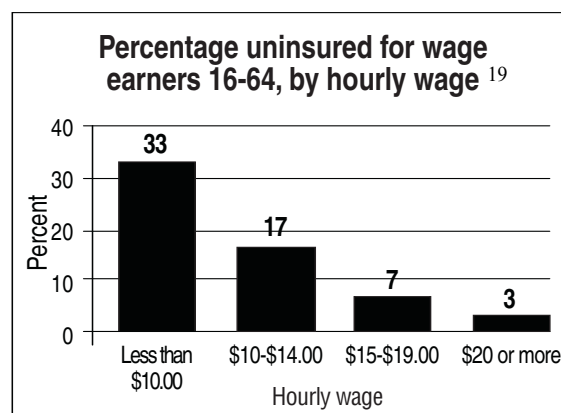
Wage earners who are self-employed, work in small businesses, earn low wages, and work part time are most likely to be uninsured.

Thirty percent of workers in establishments with fewer than 10 employees were uninsured, while only six percent of those in establishments with over 500 workers were uninsured.¹⁶ Workers in establishments with fewer than 10 employees represent 18 percent of workers, but 33 percent of uninsured wage earners. The self-employed are two times more likely to be uninsured than are other wage earners.

Workers who earn low hourly wages are at the greatest risk of being uninsured. Only 53 percent of workers earning less than \$10 per hour had job related health care coverage. About 33 percent of workers earning under \$10 per hour were uninsured, and 17 percent of those earning \$10-15 were uninsured.¹⁷

People working part time — fewer than 35 hours per week — were also more likely to be uninsured. Around 58 percent of part-time workers had job-related insurance, while 78 percent of full-time workers had job-related insurance.¹⁸

People of color are more likely to be uninsured than whites. While only 14.5 percent of whites are uninsured in the U.S., 35.7 percent of Hispanics, 20.8 percent of African Americans, and 19.5 percent



of people of other race/multiple races are uninsured. Hispanics are disproportionately represented among the uninsured. Although Hispanics are only 14.8 percent of the population, they account for 28.2 percent of all uninsured people in the U.S. Similarly, African Americans are 12.6 percent of the U.S. population, but 13.9 percent of the uninsured in the U.S. Whites account for 66 percent of the population, but only 51 percent of the uninsured.²⁰

However, the data on uninsured wage earners only looks at whether or not a person has health insurance. The data does not indicate whether the wage earner can provide coverage for their family. And the data provides no information on the level of health care these wage earners have. These health care plans could be high deductible plans or lack coverage in critical areas. Many more of these workers are likely underinsured.

Distribution of uninsured under age 65 by race / ethnicity ²¹

	White	Black	Hispanic	Other	Total Uninsured	White	Black	Hispanic	Other
United States	21,483,6	206,728,410	13,118,700	3,343,570	44,674,300	48	15	29	7
Idaho	175,470	NSD	54,520	12,130	242,540	72	NSD	22	5
Montana	124,590	NSD	NSD	26,170	157,650	79	NSD	NSD	17
Oregon	342,170	NSD	172,490	37,350	560,800	61	NSD	31	7
Washington	567,730	NSD	154,990	112,150	895,220	63	NSD	17	13

Population distribution by race / ethnicity ²²

	White	Black	Hispanic	Other	Total	White	Black	Hispanic	Other
United States	194,236,600	34,809,870	40,322,930	17,999,010	287,368,410	68	12	14	6
Idaho	1,152,350	3,590	123,280	48,410	1,327,640	87	NSD	9	4
Montana	801,690	3,210	26,060	73,940	904,900	89	NSD	3	8
Oregon	2,834,170	58,630	383,330	249,530	3,525,650	80	2	11	7
Washington	4,753,030	196,300	440,960	639,320	6,029,610	79	3	7	11

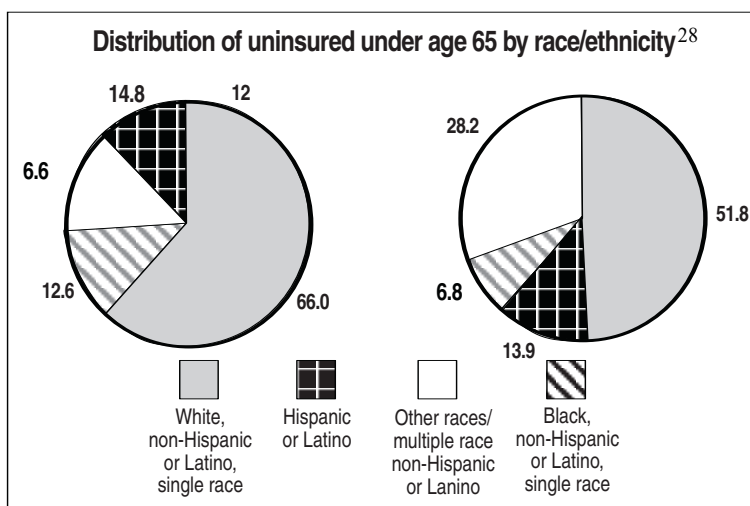
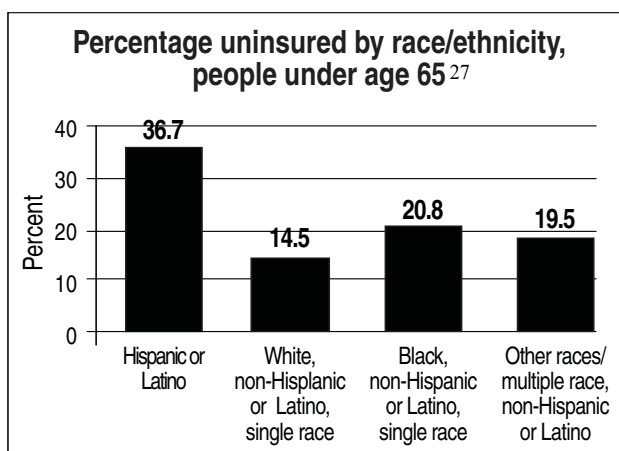
These disparities in health insurance rates can be largely explained by the segregation of people of color into low-wage occupations and job sectors where fewer employers insure their workers. For example, African Americans and Latinos are about as likely as whites to work full-time and year-round, but they are much more likely to be uninsured. Native Americans are in a similar situation. Thirty percent of American Indians with permanent, full-time employment are uninsured, compared to only eight percent of whites working the same amount.²³ This disconnect between work and insurance also holds true for immigrants.²⁴

Job segregation and employment discrimination, therefore, take their toll not only on the wages and financial security of people of color, but also on their access to health insurance coverage. Because people of color are denied access to coverage and care at much greater rates than are whites, they are more vulnerable to falling into the health gap.

People who live in rural areas are less likely to have access to health care. Compared to people who live in urban communities, rural residents tend to have lower incomes and less access to health care. Nearly 20 percent of the uninsured in the U.S. live in rural areas. Nearly 25 percent of residents of rural counties that are not adjacent to urban counties are uninsured. These non-adjacent rural counties are more remote, almost half of the residents of these rural non-adjacent counties have low incomes, and residents of these counties are more likely to work for small companies or be self-employed. Residents of rural non-adjacent counties have the lowest rate of private health insurance, because they are less likely to be offered health benefits through their employer.²⁵

Transportation can be a serious barrier for rural residents trying to obtain medical care. Often residents of rural communities must travel long distances and incur high transportation costs in order to find access to health care.

Adults aged 19-24 are at the greatest risk of being uninsured; 36.4 percent of this group does not have health insurance. This group is 9.5 percent of the total non-elderly population, but 18.4 percent of the uninsured. However, substantial percentages of all age groups are uninsured.²⁶



Who is most likely to be in the health gap?

- Lower wage workers
- People who work for small businesses
- People who are self employed
- People of color
- People who work part time jobs
- People who work temporary jobs
- People who live in rural areas
- People with poor health

During the summer of 2005 the U.S. Census Bureau will be releasing comprehensive data on the uninsured by county for the first time. The data will provide information on the total uninsured population, as well as information on the number of children age 0-17 who are uninsured.²⁹ After the data are released, the information will be posted at www.nwfco.org.

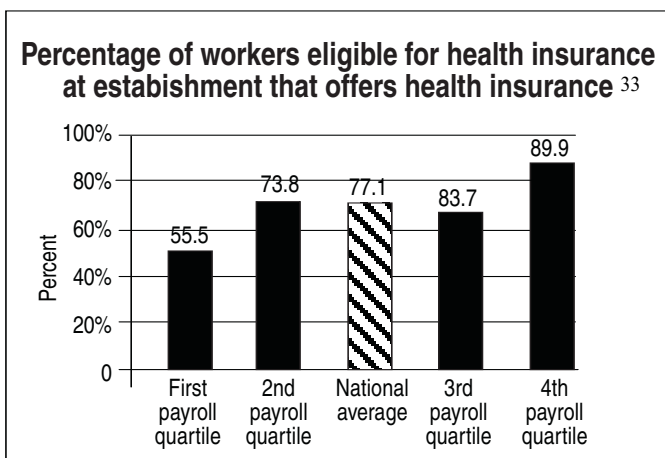
Who is least likely to have access to comprehensive employer-based coverage?

Many factors impact whether an employee has health care coverage through their employer. Certain types of employers are more likely to provide coverage, certain types of employees are more likely to be eligible, and the amount an employee must contribute plays a role in whether the employee can afford offered coverage.

Employees who make higher wages are more likely to work for employers who offer coverage, be eligible for that coverage, and to enroll in employer-based health care plans.

One way to measure this is to look at average payroll for employees (compensation excluding fringe benefits).³⁰ If you divide average payroll into four quartiles-ranging from the lowest to highest quartiles-you have a measure of the wage dependence of health care issues. For example, 72.4 percent of employees in the lowest 25 percent of wage earners work where health insurance is offered, while 97.4 percent of employees in the top 25 percent of wage earners work where health insurance is offered.³¹ But all of these employees are not necessarily eligible for health insurance. Of the employers that offer health insurance, the percentage of employees eligible for insurance again differs by wage. Just over 55 percent of the lowest 25 percent of wage earners are eligible for

health insurance, while nearly 90 percent of the top 25 percent of wage earners are eligible.³² But again, not all of these employees can afford to enroll in the health care they are eligible for.



“I am 22 and have no health insurance because I recently lost my job. I would love to have a job that offers me some sort of health insurance, but those jobs are few and far between.”

ZACK WARREN



Jennifer Maas
Billings, MT

I am a 21-year-old student at Montana State University-Billings and I am uninsured. I make almost \$10 an hour with tips at my two jobs, but neither one provides health insurance. In Montana that's pretty good money, but I still live paycheck to paycheck.

For several years while I was insured under my father's plan I took an expensive prescription drug for seizures. The condition started in high school; I would suddenly pass out. I was eventually diagnosed with a mild form of epilepsy. My Dad's health

insurance covered my care for a while, but now I am uninsured and have more than \$2,000 in medical debt. I have had to completely stop my treatment and can only afford to pay \$25 a month toward the hospital bills.

Recently, I have run up another hospital bill for a cyst under my arm. I continue to pay what I can every month and hope that the hospital doesn't turn me over to collections. I also saw a doctor for a serious stomach problem. That cost another \$200, and he referred me to a specialist. I cannot afford any more health care bills, so I have just been trying to deal with it by taking over the counter antacids.

I work two jobs and go to college, and there is no way I can afford health insurance. I have medical debt and can't treat my epilepsy.”

JENNIFER MAAS

I work two jobs, make a decent wage, I graduated third in my class, and receive tuition scholarships. I am trying to make something of myself and be a productive member of society, but cannot go to a doctor, and I cannot afford medical care.

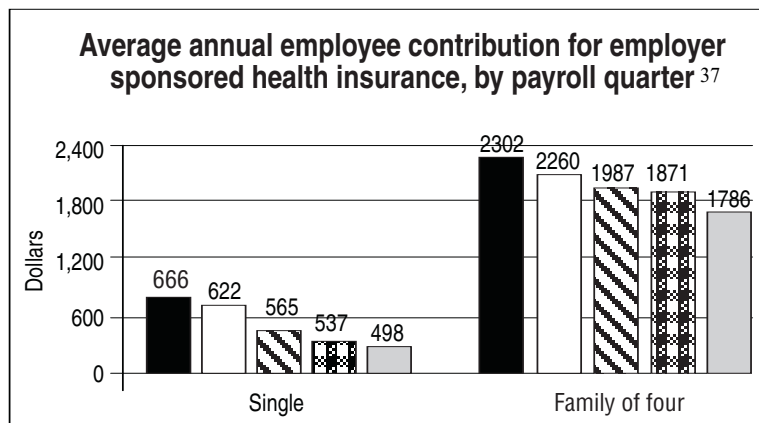
Notes on my budget: I live with roommates to lower my expenses. I pay \$200 in rent, \$200 for food, \$50 in utilities, my car, insurance, and gas cost about \$520 a month, and I pay at least \$25 toward my medical debt.

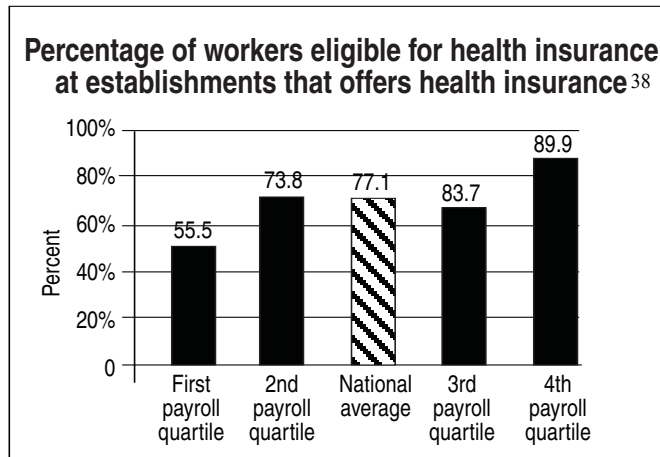
“I work for \$10 an hour; with no health benefits. I am diabetic, but we just can’t afford to pay for the health coverage my employer offers.”

SHIRLEY COX

Of employees eligible for health insurance through their employer, the percentage who enrolled differed by pay level. Just over 67 percent of the lowest 25 percent of wage earners enrolled in their employer’s health plan, while 88.8 percent of the highest 25 percent of wage earners enrolled.³⁴ This lower enrollment rate is likely because lower wage employees often can not afford the cost sharing requirements of the employer-based coverage for which they are eligible.

Employee contributions to employer-based coverage also differed by wage. Lower paid employees had to make higher contributions than did higher paid employees. The lowest 25 percent of wage earners contributed \$2,302 annually for family coverage, while the top 25 percent contributed \$1,786 annually.³⁵ This higher rate likely played a role in the fact that lower-wage employees were less likely to purchase family coverage. For the lowest 25 percent of wage earners, 55.2 percent of employees enrolled in single coverage, while in the highest 25 percent, 42.1 percent of employees enrolled in single coverage.³⁶





The likelihood of having employer-based health insurance rises with income. For many low-income people, employer-sponsored health insurance is either not available, or the employee share of the premium is not affordable.

There are no real options in the private market for individuals to avoid the health gap

For health care purchased on the individual market, there is a huge range in cost, depending on the comprehensiveness of coverage purchased and factors such as the age and health status of the person purchasing health insurance.

Distribution of individual health insurance premiums for single policies, 1996 and 2002³⁹

Percentile	1996 (median \$1,302)	2002 (median \$1,913)
90th	\$2,886	\$4,728
75th	\$2,006	\$3,261
50th	\$1,302	\$1,913
25th	\$665	\$990
10th	\$312	\$541

For example, in 2002 the median annual premium for single coverage was \$1,913, with highest cost (top 10 percent) plans at \$4,728 and the lowest cost (lowest 10 percent) at \$541. While there is some data on the costs of purchasing health care on the individual market, there is little information tying these costs to actual levels of health care coverage.⁴⁰

“Since I had a health emergency that required surgery, the quotes I’ve been given for health insurance are unbelievable. People like me who need care the most are getting quoted the highest rates, so high we’re priced out of the market and can’t afford to get covered.”

CLAUDIA PEREZ

The huge variation in cost is some measure of the great variation in benefit and cost sharing levels of the plans available on the individual market. Purchasers could buy a health care plan and consider themselves insured, but still have very high copayment requirements and very limited benefits. They might not realize this is a problem until they encounter health problems.

On the individual market, age is a particularly important factor. Premiums for individual plans vary with the age of the person purchasing health care. Older people may be less able to purchase on the individual market because of these higher costs.

One health problem can send people into the health gap

Most families are one illness away from the health gap and serious health care insecurity. This section looks at the gaps in the health care system that can lead to this health insecurity.

Loss of employer-based coverage

Increasing numbers of people fall into the health gap at some point in their lives. Families can seem to be making a living wage and saving for the future, but often this financial stability is dependent on employer-based health care coverage. If a family loses access to that coverage because of health problems, job loss, or rising health insurance costs, very few families can afford to continue to purchase health care coverage.

“In one month I will be uninsured, and every medical cost for me will be paid out of pocket. It is an extremely scary time for us and we are nervous with what the future may bring. We are honest people who have worked and saved our entire lives. Because of our medical debt, the fact that I can no longer work, and all the other changes in our lives after my stroke, we have nothing left.”

KIT

Families may only find out their employer-based coverage is inadequate after a medical emergency. Increasing numbers of employers offering high deductible plans and health savings accounts contribute to the widening health gap. These plans provide little coverage, and families can quickly find themselves with high medical bills.

Workers who have access to employer-sponsored insurance are vulnerable to losing their coverage when health problems arise, since the ability of these workers to continue their health coverage is tied to maintaining the capacity to work.⁴¹

Bill Smith

Olympia, Washington

I am 31 years old and live in Olympia, Washington with my wife and three kids who are eight, six, and two years old. I am a parts consultant for a car dealership. My wife and I both work full time and our combined monthly income is \$3,700. We are able to save a little money each month for emergencies. But we currently don't have enough savings to deal with a layoff or medical emergency.

"I have health insurance through my job. I have acute tendonitis in my right wrist, and my insurance doesn't cover the treatment I need. The tendonitis in my wrist has affected my ability to do my job."

BILL SMITH

I have health insurance through my job. My premium recently went up and I now have a higher deductible. The problem is I have acute tendonitis in my right wrist. My insurance doesn't cover the treatment I need. My insurance has a cap on the allocation of certain services. The only thing, short of surgery, that will help my wrist is physical therapy, but my insurance doesn't cover the frequency and amount of physical therapy I need. I only get eight visits a year. The tendonitis in my wrist has affected my ability to do my job. I had to recreate my job title to accommodate my disability. It has also affected my home life. I am less hands on with my kids, and I can't pick up the baby.

My biggest concern is that my wife and kids are uninsured. We can't afford to buy them insurance with our monthly income.

If the kids get sick we have to take them to the emergency room. Because that gets so expensive, we focus on preventative care, like eating healthy. The kids did have Medicaid, but they were dropped three months ago. They didn't get renewed because our monthly income was too much to qualify. But we still can't afford to buy health insurance.

Notes on our budget: Our combined monthly income is \$3,700. Our rent is \$900 per month, and we pay \$350 a month on utilities. We spend about \$160 every month on child care, and \$600 a month on transportation (car insurance, gas). Food for our family comes to about \$500 a month, and we spend approximately \$200 every month on miscellaneous expenses, like clothing for the kids. Depending on how healthy the kids are, we spend approximately \$350 every month in out of pocket health care expenses. If we have to pay an emergency room bill, then that goes up. I pay \$85 a month for my health care with a \$20 copay for every doctor visit. My insurance pays 80 percent of doctor visits.

“In 19 years of paying for insurance through my employer, I never got sick. All of a sudden, when I do get sick, I lose my job and lose my insurance, and now I can’t even get the kidney I need to get back on my feet.”

SAUL RIOS

Difficulties purchasing adequate coverage on the individual market

What happens to people without access to employer-sponsored health care? Public programs provide assistance to some low-income adults who meet income and family structure requirements. Others must purchase private non-group health insurance, or take the risk of going without any health insurance coverage.

Premiums for private coverage are usually determined by an applicant’s expected health care costs, which increase with age and poorer health.⁴² For some, health conditions make coverage extremely difficult to obtain if they do not have job-based coverage. As a result, workers may seek less expensive plan options, and may even choose not to accept health insurance coverage at all.⁴³

While employees often pay a relatively small portion of an employer-sponsored group premium, the entire cost of a private insurance premium must be paid for by the individual or family. So for older individuals or those with health problems who don’t have employer-based coverage, an even higher wage is required to purchase health care and attain a living wage.

Underinsured at risk of falling into the health gap

Individuals who cannot afford the level of benefits included in the average employer-sponsored plan often choose to pay for only the benefits they expect to use, which results in relatively lower premium costs for private insurance. Even when families opt for minimal health coverage, private non-group insurance usually ends up being more expensive than employer-sponsored insurance.

People with minimal plans are underinsured and at risk of incurring major health expenses.

“The gaps in our health care coverage affect our lives everyday. I have to wait before taking my kids to the doctor because coming up with the copays is tough. The braces my daughter needs to improve her speech are not covered. I am always behind in paying basic bills.”

TANEISHA WHITE

Health consequences of falling into the health gap

“I recently had two kidney stones. I was out for a solid week in excruciating pain. I knew I could not afford any more medical bills, so I managed the pain as best as I could with ibuprofen.”

ZACK WARREN

“I could either afford the medication to lower my blood pressure or the lab fees to see if the medication was hurting my liver, but not both. Now I can’t afford any of it.”

ERIC HANSON

Going without insurance can have severe consequences. The uninsured are up to three times more likely than those with insurance to report problems getting medical care, even for serious conditions.⁴⁴ Uninsured adults are more likely to be unable to receive urgent care when needed than are adults with insurance.⁴⁵

In addition to having trouble obtaining care, the uninsured are more likely to have health problems that arise from postponing care. Uninsured adults are far more likely than the insured to postpone or forgo health care altogether, and are less able to afford prescription drugs or follow through with recommended treatments.⁴⁶ Since they are less likely to receive timely preventive care, the uninsured are more likely to be hospitalized for avoidable health problems.⁴⁷

The uninsured are generally less healthy than people who have private health insurance. The uninsured are more likely to be in fair or poor general health, and more likely to have functional or activity limitations than those with private health insurance. The degree of discrepancy

in health is likely an underestimate: researchers have found the uninsured tend to underreport medical conditions because they use fewer medical services than the insured.⁴⁸

The underinsured face often cannot get coverage for the specific health care they need, and face the same challenges as the uninsured.

Financial consequences of falling into the health gap

Once minor health problem develops into a serious health condition, paying the bills out-of-pocket can be financially catastrophic for the uninsured.⁴⁹

Medical debt and bankruptcy are serious issues for people in the health gap. Of the 1.5 million people who filed for bankruptcy in 2001, over 50 percent did so because of medical causes. This means that over 2 million people, those declaring bankruptcy and their dependents, dealt with medical bankruptcy in 2001 alone. Of the people who declared bankruptcy because of illness, around 76 percent had insurance when they became sick. Many of the people who experience these financial problems are middle-class insured families.

“Back when we were both healthy, our income was around \$43,000 a year and we were saving and investing money for our retirement. We never could have imagined the state we’re in today. Now every penny that we’ve set aside for retirement has gone to cover our medical bills, and all of our hopes and plans for the future have been put on hold indefinitely.”

KIT

The uninsured and underinsured face job-related barriers to getting health care. Often employers who do not offer health care also do not offer sick leave, or offer very limited sick leave benefits. Low-wage workers may face serious difficulties even finding time to go to a doctor’s appointment, or may risk losing their job or critical wages while obtaining medical care.

The health gap and the living wage

What is a living wage?

A living wage is a wage that allows families to meet their basic needs without public assistance and provides them some ability to deal with emergencies and plan ahead. It is not a poverty wage.

The report, “Searching for Work that Pays: 2004 Northwest Job Gap Study,” estimated a living wage for families in the Northwest. This report looks more closely at the importance of health care to the living wage.

Trade-offs and tough times: What happens to families that don't make a living wage?

"With rising premiums, it was either pay the mortgage and eat, or pay the insurance. We couldn't keep paying."

SAUL AND MARY LOU RIOS

The living wage estimates the level of income sufficient to meet a family's basic needs and maintain a reasonable standard of living. When families are unable to earn living wages, many are forced to make difficult choices between adequate health care, balanced nutrition, and paying the bills. If full-time workers are making trade-offs between basic needs, their wages do not allow for economic self-sufficiency. Since living wage estimates are state-wide averages, the budget for each individual family will vary according to their particular circumstances.

Health care and the living wage

"I lost a week of looking for work while I was sick. What happens if I get a job and then I get sick? Any job I can get will likely not provide sick leave or health insurance. If I miss a week of work I am likely to lose my job. I don't think it should be this hard to be stable and healthy."

ZACK WARREN

Previous Northwest Job Gap Studies and many other living wage studies⁵⁰ assume that families have access to employer-based health care, but the number of employers who do not offer health insurance is increasing, particularly for low-wage workers.⁵¹ Even for families with employer-based coverage, the data available tracks only employee contributions to health care plans, not the extent of the health care coverage provided by the insurance that employees purchase.

The variable in any family's living wage calculation that has the most volatility is health care. This report is meant to complement the living wage study by deepening the analysis of the relationship

between access to health coverage and economic security. Many people in the Northwest cannot afford adequate health care, and are underinsured or entirely uninsured. These people fall into the health gap. Without health insurance, these families cannot make a living wage. While healthy uninsured families may get by without health insurance for years, when serious health problems arise, any small savings quickly vanish to cover health care costs. The uninsured are at risk of falling into deep medical debt, and missing out on vital health care.

The fine print: what is not included in many plans on the individual market?

Coverage for:

- Vision
- Dental care
- Mental health treatment
- Substance abuse treatment

The Northwest Job Gap study in 2004 estimated the cost of purchasing very basic private health insurance on the private market, for those families who did not have access to employer-based health insurance. Private plans vary from state to state, but most do not cover the costs of vision, dental, mental health, or substance abuse

treatment, which must be purchased for an additional fee. So the estimates of the cost of purchasing health care on the individual market are for the most minimum of health care plans, and the level of coverage is not comparable to the typical level of coverage provided by employer-based plans.

The Northwest Job Gap study provided the most comprehensive analysis of the living wage possible, given the available data. Because health care emergencies can carry such extreme financial consequences, access to stable, comprehensive care is a critical component of the living wage.

Kit

Yelm, Washington

Back when we were both healthy, our income was around \$43,000 a year and we were saving and investing money for our retirement. We had saved about \$12,000. We thought we were doing fine. We had everything we wanted. Even when my husband had to retire early for health reasons, we thought we could manage. We never could have imagined being in the state we're in today. Now, every penny that we've set aside for retirement has gone to cover our medical bills, and all of our hopes and plans for the future have been put on hold indefinitely.

“Even though we had health insurance, after I had an aneurism our medical bills emptied our retirement savings. Now I am at risk of being uninsured—just when I most need health care.”

KIT

I used to work as a kennel keeper at a local veterinary hospital and I loved my job. But at work one morning I had an aneurism that changed our lives.

My husband spent every day with me, but I did not recognize him for over three months. After 21 days in the hospital, four months of nursing home care, and four return trips to the hospital we had \$300,000 in medical debt.

We had health insurance. It was far too expensive for me to purchase at the veterinary hospital, but Al was still covered by his previous employer. This employer was in the process of switching insurance carriers. This is when all our problems with hospital bills began. There began a lengthy battle between the insurance companies as to who would cover my health costs, and we were lost somewhere in the middle. After exhausting negotiations, we were still left with a debt of almost \$25,000.

After my aneurysm, I was not able to work. I still miss my job everyday. Now Al and I are both on disability and receive \$2200 a month, and every penny of it is spent the moment we receive it.

In one month, Al will begin receiving Medicare. Then his coverage through his previous employer ends and I will be uninsured until I am eligible for Medicare in another year and a half. We will be responsible for all prescriptions at that point, and every medical cost for me will be paid out of pocket. It is an extremely scary time for us and we are nervous about what the future may bring. We are honest people who have worked and saved our entire lives. It is frustrating and painful to think that because of the debt and all the changes in our lives after my aneurism, we have nothing left.

Notes on our budget: For our health insurance we pay a premium of almost \$500 per month, \$300 for prescriptions, and often go without prescriptions that are not essential to our survival. Our house payment is \$512 a month and our additional living expenses, including utilities, gas, car insurance, home insurance, and food is approximately \$350. Any money that is left over is spent on doctor visits and paying our debts. We write checks to every debt collector until our checking account is empty.

Closing the health gap

Across the nation and the Northwest, people are pursuing innovative strategies for closing the health gap. Some are looking at large scale, system-wide solutions, while others are focusing on immediate incremental measures that can patch edges of the health gap.

A common theme is the end goal of health care coverage for all. For example, the National Coalition on Health Care—an organization of one hundred of America’s largest businesses, unions, health care providers, associations of religious congregations, pension and health funds, insurers, and groups representing patients and consumers—recently released their recommendations for comprehensive health care reform, and the first principle is: health care coverage for all,⁵² with one of the major strategies as the establishment of a universal publicly financed program.

With this as the big picture goal, there are many interim strategies that hold promise for halting the widening of the health gap. These strategies fall into three major categories: expanding public programs, and improving access to employer-based coverage and individual market coverage. Each of these strategies patch part of the health gap, providing more coverage to some people in the health gap. This report includes a few examples.



Taneisha White
Portland, Oregon

I am 32 years old and raising four children; Johnette, 14 years old, Emony, 12 years old, John-yell, 10 years old and John, 9 years old. I work full-time, making about \$2,400 a month, and have health insurance coverage from my employer. My daughter John-yell has chronic asthma and a heart problem. She was diagnosed when she was only 10 months old. I spend \$279 month on prescription drugs just for John-yell, and pay \$15 co-pays every time any family member goes to the see a doctor. I have to wait awhile before I take my kids to the doctor because coming up with a \$15 co-pay is tough. And our health care expenses keep rising.

John-yell also needs braces, as problems with her teeth are affecting her speaking skills. She is in fourth grade and her speech is categorized as first grade level. Her teacher keeps asking me when John-yell will get

braces to help with her speech development.

The insurance does not cover braces, so we are looking for other ways to help her with her speech. The gaps in our health care coverage affect our lives everyday.

I’m always behind on paying bills such as phone and electricity. I want to find an additional job in order to pay the rest of my bills, but who is

“Medicaid is the only thing that keeps my daughter out of the health gap.”

TANEISHA WHITE

going to watch my kids after school? I can only afford to see a doctor myself about every four years. Last month, I finally made an appointment after worrying for months about pains in my back. I worry a lot about what would happen if I really got sick. Just this month, John-yell has access to Medicaid — care that she very much needs.

“The kids did have Medicaid, but they were dropped three months ago. They didn’t get renewed because our monthly income was too much to qualify. But we still can’t afford to buy health insurance.”

BILL SMITH

The importance of public health care programs

Public health care programs such as Medicaid and Medicare provide one of the only safeguards against the serious shortfalls in the private health insurance market. These programs play a critical role in health care coverage. But they are available only to certain groups. While Medicaid does an excellent job of covering low-income children and many families with serious health problems and low incomes, not all low-income people are eligible for Medicaid. For example, even very low-income adults without children are often ineligible for coverage. And at the wage level where Medicaid cover-

age ends, there is a large gap in income before families are likely to be able to afford individually purchased health care or have access to employer-based health care.

One strategy for filling the health care gap is to expand public health care coverage to more people, while maintaining comprehensive coverage for those enrolled.

Examples of strategies for patching the health gap

Require employers to provide coverage for their employees or pay a fair contribution to public programs that will provide coverage for their employees.

The decision by a number of large, profitable employers to cut health coverage has sparked a health



David Johnson

I am 43 years old and the father of a thirteen-year-old named David Jr. I am self-employed and make about \$2,000 a month. I am not eligible for Medicaid, but luckily my son has coverage. I

don't know what we would do without it. Being a single Dad and trying to make a living on my own is tough. I can't afford to buy my own health insurance coverage. It is way too expensive. All I can do is to stay healthy in order to work and pay for the very basic necessities — rent, food, gas for my car. If I get sick we will be in big trouble. I worry about what will happen to David Jr. and me if any unexpected expenses come up — I simply can't afford to set aside savings.

“I worry about what will happen to David Jr. and me if any unexpected expenses come up.”

DAVID JOHNSON

coverage race to the bottom. Requiring employers to contribute to employees' health care can both increase access to employer-based coverage and strengthen public health care programs, as employers have the choice to provide coverage directly or contribute to public programs. This strategy recognizes that investing in workers' health is a reasonable condition of doing business.

Improve oversight of the private health insurance system. This could be achieved through changes such as:

- Requiring prior approval of rate increases
- Increasing the transparency of the health insurance market and policies
- Protecting public participation in rate setting
- Placing tighter limits on the range of rates insurers may charge for the same coverage

This strategy focuses on the private health insurance market's failure to provide affordable, comprehensive coverage to individuals and small businesses. With better oversight and greater transparency, health insurance carriers would be encouraged to improve the quality and affordability of their policies. If costs were lower and less volatile, more people could afford to purchase these plans. Clear, concise information on plans allows purchasers to have a better understanding of their plan options and what they are purchasing.

Provide the underinsured and uninsured access to state-negotiated discounts on prescription drugs by allowing them to join purchasing pools.

Many states are able to negotiate substantial savings on prescription drugs because they purchase on a large-scale or pool with other purchasers. Many underinsured and uninsured have particular difficulties obtaining prescription drug coverage and paying for prescriptions. When the underinsured and uninsured have access to negotiated discounts, they can afford to purchase more of the prescription drugs they need, and states can also increase the size of their purchasing pool and the savings for participants.

Develop incentive programs for businesses that provide health care and living wage jobs.

This strategy uses economic incentives to encourage and attract businesses that pay higher wage jobs and provide health care. Not all economic incentive programs have this requirement. If businesses are not required to provide health care and living wage jobs, incentive programs may end up using tax dollars to encourage the creation of low-wage jobs that do not provide health care.

While these examples are not comprehensive solutions to the health gap, each one works to patch part of the health gap, providing more coverage and shrinking the numbers of underinsured and uninsured.

Conclusion

More and more people are falling into the health gap, where they are uninsured or underinsured. Between high wage earners who have comprehensive employer health benefits, and the very low-income and sick who are covered through public health programs, lies a rapidly growing population with no coverage or inadequate coverage. The health gap is growing as employers cut benefits and private insurance premiums skyrocket.

The health gap exists because health insurance system is in crisis. People in the health gap do not have access to adequate health insurance through their employer, by purchasing on the individual market, or through eligibility for public health care programs. And many people are simply one illness or health problem away from falling into the health gap.

The current patchwork of coverage is not meeting people's needs. We need health care reforms that close the health gap. Business leaders, health care advocates, elected officials, health care providers, and many others all stand behind a long-term goal of a comprehensive system of health coverage for all. In the meantime, strategies to fill holes in the health gap include the expansion of public programs, and improved access to individual market plans and employer-based coverage. In lieu of universal coverage, these short term solutions can decrease the number of people at risk of falling into the health gap.

Endnotes

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About the organizations releasing this report



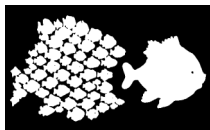
Northwest Federation of Community Organizations (NWFCO) is a regional federation of four statewide, community-based social and economic justice organizations located in the states of Idaho, Montana, Oregon, and Washington: Idaho Community Action Network (ICAN), Montana People's Action (MPA), Oregon Action (OA), and Washington Citizen Action (WCA). Collectively, these organizations engage in community organizing and coalition building in 14 rural and major metropolitan areas, including the Northwest's largest cities (Seattle and Portland) and the largest cities in Montana and Oregon. 1265 South Main Street Suite #305, Seattle, WA 98144, Voice: (206) 568-5400, Fax: (206) 568-5444, Web: <http://www.nwfc.org>

Idaho Community Action Network

The Idaho Community Action Network (ICAN) serves as a powerful, consolidated voice for low- and moderate-income Idahoans, with chapters and membership clusters in fourteen Idaho communities, including the state's three largest cities and numerous rural areas. Through ICAN, low-income Idaho families have a voice in the decisions that impact their lives. In addition to its direct action work, ICAN runs a statewide, volunteer-driven food program that helps low-income families supplement their monthly budgets. ICAN's community organizing model integrates the provision of food with training, leadership development, and action on issues to win concrete changes in people's lives and advance the cause of social, racial and economic justice for all Idahoans.



Oregon Action (OA) is a statewide, non-partisan network of people and organizations dedicated to economic justice for all through individual and group empowerment. Oregon Action was founded in 1997 to build on the history and values of Oregon Fair Share, which for twenty years organized low and moderate income people to win consumer and community reforms.



Founded in 1982, **Montana People's Action (MPA)** is a statewide economic justice organization with over 6,000 member families in Billings, Bozeman, and Missoula. For over two decades MPA has been the primary voice for low- and working-income Montanans around the issues of housing, access to credit and banking services, access to health care, economic development policy, and income security.

Washington Citizen Action

Washington Citizen Action (WCA) is a statewide, grassroots organization. With over 50,000 members, we are the largest consumer advocacy group in the state. We work on a range of issues with the broad aim of bringing about greater economic justice in our state and the country. Our board represents a coalition of groups, including labor, senior, faith, and community organizations. Our field and telephone canvasses do education, activation, and fundraising with our members. Our strength as an organization depends on our members' involvement. 3530 Bagley Avenue North, Seattle, WA 98103, Voice: (206) 389.0050, Fax: (206) 568.5444, Web: <http://www.wacitizenaction.org>.