THE KAISER COMMISSION ON
Medicaid and the Uninsured

HEALTH CARE: SQUEEZING THE MIDDLE CLASS

WITH MORE COSTS AND LESS COVERAGE

Testimony of Diane Rowland, Sc.D.
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Ways and Means Committee
"Economic Challenges Facing Middle Class Families"
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Introduction

Mr. Chairman and members of the committee, thank you for the opportunity to testify today on the growing problems of rising health care costs and increasing gaps in health coverage as they affect middle class Americans. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

Health insurance coverage provides a valuable key to gain access to preventive and primary health care services, and peace of mind and financial security for those facing serious health care problems. Yet, a growing number of Americans—46 million in 2005 and increasing each year—lack health insurance to help them address their health care needs. Our growing uninsured population gets care later, if at all, and ends up sicker than those with coverage. The Institute of Medicine reports that lack of health insurance causes 18,000 unnecessary deaths each year. Leaving 46 million Americans without health coverage not only compromises their health but also puts a growing burden on our health care system and adds additional strain to our economy.

And, even for those with health coverage, rising premium costs, the increasing out-of-pocket costs from more limited coverage, and decreasing availability of employer-based coverage make obtaining and paying for health care an increasing financial burden. For many, health insurance coverage through the workplace now has higher deductibles and more cost-sharing as well as higher premiums. Access to health insurance and medical care that is affordable is becoming out of reach for more and more middle class families and contributing to our growing uninsured population.

My testimony today will focus on health care coverage, the growing burden of health care costs for America's families, and the challenge of making affordable coverage a reality for all Americans.

Health Coverage for Working Americans

While the elderly rely on Medicare for their health insurance coverage, most non-elderly Americans receive their health insurance protection through the workplace. Of the 257 million non-elderly Americans, 156 million (61% of the non-elderly population), are covered by employer-sponsored health insurance (Figure 1). Public coverage through Medicaid and SCHIP provide an important adjunct to employer-based coverage for low-income families, especially children, covering 16 percent of the non-elderly population.

The availability and affordability of employer based coverage varies widely by income, with higher-income families more likely to be covered by employer-based coverage than moderate or low-income families. Nearly 3 out of 4 (71%) of the 74 million middle-class non-elderly individuals—who I will define today as having incomes between 200 and 400 percent of the federal poverty level (about $41,000 to $82,000 for a family of 4 in 2007)—have employer sponsored coverage. Lower-income families (with incomes 100-199% of poverty, some of whom might actually consider themselves part of the middle class) have much lower levels of private coverage—only 39 percent have employer-based coverage—resulting in higher levels of uninsurance (30%) and greater reliance on public coverage (26%).

Lack of employer-based coverage and limited access to public coverage leaves nearly 11 million (14%) middle-income Americans uninsured. They account for nearly a

quarter (23%) of the nation's 46 million uninsured although the majority of the uninsured have even lower incomes (Figure 2). In addition, like most of the nation's uninsured, the middle-class uninsured come from working families. In fact, 9 in 10 (91%) come from families with at least one full-time worker, but many of these workers are in jobs that do not offer health insurance coverage or where such coverage is unaffordable.

Availability and Affordability of Coverage

Over time, the availability of employer-sponsored coverage has been declining. From 2000 to 2006, the percentage of firms offering health coverage fell from 69 percent to 61 percent (Figure 3). The size and type of firm where an individual works and the nature of the job make a difference in whether or not health coverage is offered. Sixty percent (60%) of firms with fewer than 200 workers offer health insurance, while almost all large firms (98%) offer health coverage (Figure 4). Between 2000 and 2006, small firms accounted for a substantial share of the decrease in offer rates.

Firms with a high percentage of low-wage and part-time workers are less likely than higher-wage firms to offer health benefits, with only 4 in 10 such firms offering coverage. In addition, the presence of unionized workers increases the likelihood that a business will offer health insurance—87 percent of firms where there are at least some union workers offer coverage, compared to 60 percent of firms where there are no union workers. Certain industries such as agriculture, construction, and the service industry have higher than average rates of uninsured workers, even among the "white-collar" professionals and managers in the industry. For example, about 20% of management workers in the construction and service industries are uninsured.

When insurance is offered, it is becoming increasingly unaffordable for many. From 2000 - 2006, the cumulative increase in premiums for employer-sponsored insurance was 87 percent compared to a 20 percent increase in wages and 18 percent increase in overall inflation (Figure 5). Since 2000, the cumulative increase in premiums is over 4 times the increase in wages for non-supervisory employees. The average annual family premium reached $11,480 in 2006, and the average family contribution was $2,973 (Figure 6). This means a family earning $40,000 in 2006 would have to pay 7% of their pre-tax income for their share of health insurance premiums. At $11,480 per year, the full cost of family coverage now exceeds the full-year income of a minimum wage worker. In 2006, premiums grew twice as fast as wages and inflation. Even when premium increases have moderated over the last decade, the rise in health care costs and premiums has outpaced the growth in wage earnings, creating a growing gap between worker's income and the cost of health insurance (Figure 7).

Stability of Coverage

The combination of declining employer coverage and rising health costs has placed more and more middle-income families at risk of being uninsured and additional financial burden for health care on those with coverage. In the absence of employer-offered coverage both low- and middle-income workers are at risk of being uninsured, but they have few coverage options given the high cost and limitations in the non-group market and limited access to public coverage.[1] While Medicaid and SCHIP have helped to offset declines in employer-based coverage for low-income children, middle-income adults have not been able to avail themselves of this safety-net. Medicaid and SCHIP

[1] Yu-Chu Shen and Sharon K. Long, "What's Driving the Downward Trend in Employer-Sponsored Insurance?" *Health Services Research* 41(6):2074-2096, December 2006

do not cover adults without dependent children, and the income levels for eligibility for parents in most states are far below the levels for children. In 24 states, a parent working full-time at minimum wage has an income too high to qualify for Medicaid (Figure 8).

Because public coverage offset employer coverage declines for children, all of the growth in the uninsured between 2000 and 2004 was among adults. Adults under 100 percent of poverty accounted for almost half of the growth in uninsured adults between 2000 and 2004, and over 20 percent of the growth was among near-poor adults (100-199% FPL), who some might classify as the lower middle class. However, middle-income adults contributed about a quarter (24%) of the growth, raising concern that loss of coverage is increasingly becoming a problem for the middle class (Figure 9). From 2004 to 2005, there was no significant change in the number or percentage of uninsured among those with incomes between 2-4 times the poverty level, due in part to the improving economy, but the lower middle class accounted for over three-quarters of the growth in the number of uninsured—comprising 1.0 million of the 1.3 million growth in that year. Unfortunately, 2005 also saw an increase in uninsured children for the first time in a decade as public coverage was unable to offset fully the loss of employer-based dependent coverage.

Employer-based coverage for the middle class is increasingly threatened. Between 2001 and 2005, the share of middle-income employees in firms with employer-based coverage dropped from 82.4 percent to 78.5 percent and, in turn, their uninsured rate grew from 13.4 percent to 16 percent (Figure 10). The decline in employer sponsorship of health benefits explained a quarter (26%) of the drop in job-based

coverage; losses in eligibility accounted for 19 percent, and the loss of coverage as a dependent of another worker with job-based insurance explained another 25 percent (Figure 11). About a third (30%) of the decline in employer-sponsored coverage among middle-income employees was attributable to decreased participation by employees in the health plans offered to them. Other research indicates that cost is a large reason why employees decline health insurance – about half (52%) of uninsured employees eligible for their employment-based coverage reported they declined to take up the health benefits because it is too expensive.

The factors leading to decreased availability of employer-sponsored coverage—sponsorship, eligibility and take-up—noticeably affected the lowest-income employees, but are also more common among middle-income employees than those with the highest incomes. Lack of coverage in the workplace for a worker can be offset by a spouse's coverage. However, in 2005 about 13 percent of middle-income employees were not offered health benefits through their own or their spouse's employer, which is more than three times the rate (4%) among higher-income employees (Figure 12). The share of employees declining coverage decreases as income increases; a higher percentage of middle-income workers than higher-income workers declined health insurance benefits offered to them through an employer (8% vs. 4%).

Those without access to employer-sponsored health insurance or public coverage must look to the non-group insurance market for coverage, but unfortunately this market has not proven itself to be an attractive option for many uninsured people. Among those without an offer of coverage through an employer or public coverage, less than a quarter of the middle-income purchase non-group coverage (Figure 13). Some

potential purchasers are excluded or charged higher premiums because they have preexisting medical conditions. When available, lower-cost products generally have high deductibles and coverage limitations, especially for maternity care or mental health services. The low percentage of middle-income adults who purchase non-group coverage underscores the limitations of the non-group market.

Scope of Coverage

While the availability of employer-sponsored coverage is declining and the premium costs are rising, the scope of medical care costs covered by insurance is also contributing to growing stress on family budgets. Health insurance policies do not provide complete "100 percent" coverage for health care needs. Depending on their policies, individuals with insurance can have to pay deductibles for physician or hospital services, copayments or cost-sharing for physician visits and other medical services, and pay additional amounts for using providers that are outside a plan's network.

Thus, even people who have insurance can face significant out-of-pocket costs. For example, data from the Kaiser/HRET 2006 Employer Health Benefits Survey shows that 12 percent of workers in PPOs who have deductibles are in plans with a deductible for single coverage of $1,000 or more and that about half of all covered workers are in plans that have cost-sharing in addition to the general deductible for people who are hospitalized. A recent study by Dana Goldman and others at the Rand Corporation looking at health plan data from 15 large employers from 2003 and 2004 found that more than 10 percent of patients with cancer had out-of-pocket expenses over $18,500

and 5 percent had out-of-pocket costs over $35,660, despite having private health coverage through their work.[2]

People's out-of-pocket liability may increase if new consumer directed health care designs gain favor in the market. About 7 percent of employers offering health benefits offered a consumer directed health plan in 2006, covering about 4 percent of all workers with employer-sponsored health insurance (Figure 14). These plans have significantly higher deductibles than traditional insurance arrangements and are more likely to assess coinsurance rather than fixed-dollar copayments for office visits and prescription drugs. In some cases this higher out-of-pocket liability is partially or fully offset by employer-contributions to employee health care savings arrangements, although 37 percent of employers offering HSA-qualified plans do not make contributions to HSA accounts established by their workers.

The movement toward “consumer-driven” health plans restructures insurance toward catastrophic coverage. Consumers face higher deductibles, making them more directly responsible for the purchase of their care and more sensitive to the price of services. The implications of these changes on consumer costs, out-of-pocket spending and access to care are just beginning to be assessed as the participation in these plans is still relatively low.

Medical Debt and the Financial Burden of Health Care

As the availability, affordability, stability and scope of health insurance decrease, far more of the middle class—both insured and uninsured—are now dealing with

2 D.Goldman et al, “Benefit Design and Specialty Drug Use,” *Health Affairs* 25(5):1319-1331, Sept/Oct 2006

budget-consuming medical bills and debt. Researchers from AHRQ examined the financial burden of health care relative to family incomes over time. Financial burden was defined as having out-of-pocket expenses for health care services and insurance premiums that exceeded 10 percent of a family's disposable (or after-tax) income. They found that in 2003 almost 20 percent of the total nonelderly population had this level of health cost burden and that the financial burden for health care was heaviest for those with lower incomes (Figure 15). A third (33%) of the poor experienced such financial burden, compared to 10 percent of those in the highest income group (at or above 400% FPL). Nearly a quarter (23%) of middle-income Americans spent more than 10 percent of disposable income on health in 2003.

The prevalence of high out-of-pocket costs increased significantly from 1996 to 2003, but the increase was particularly steep among the poor and those with middle incomes. In 1996, about 16 percent of the middle class had out-of-pocket health expenses that consumed at least 10 percent of their family income. By 2003, however, 23 percent of middle-income families experienced a financial burden from health care costs that exceeded 10 percent of family income, and about 6 percent had health costs that consumed over one-fifth of the family's disposable income. Essentially, financial burden for the middle class rose, placing them at the same risk for high burden in 2003 as those in the lower-middle class with incomes just above poverty.

The researchers also found that financial burden varied considerably depending on the type of health insurance a person has. Among those covered either by employer-sponsored insurance or public programs, about 19% had out-of-pocket health expenses that consumed at least 10% of their family income. In contrast, 53% of those

with private non-group coverage were dealing with this high level of out-of-pocket health costs, and over 20% had even higher health care costs that consumed more than one-fifth of the family's disposable income (Figure 16). The authors note persons with non-group plans are nearly 3 times as likely to bear high total financial burdens for health care as individuals with public insurance or no coverage. Those with non-group coverage are at greater risk of financial burdens as a result of the combination of high premiums plus high out-of-pocket spending.

When the researchers assess how adequately the insurance coverage protects individuals from high out-of-pocket costs relative to income, the difference between employer-sponsored coverage and coverage in the non-group market is again striking. When premium costs are excluded to measure underinsurance, out-of-pocket expenses for medical services consume more than 10 percent of disposable income for 5.5 percent of those with employer-sponsored coverage compared to 12.9 percent of those with private non-group coverage.

Those who bear the greatest burden for health care are most likely to be those with serious illness or chronic conditions. The AHRQ researchers found that forty percent of persons with diabetes had out-of-pocket expenses that consumed more than 10% of their income in 2003, as did 56% of persons who experienced a stroke or other cerebral problem. Those with financial burdens incur high expenses largely due to hospital and prescription drug costs.

Likewise, cancer, the second leading cause of death in the United States, commonly poses financial burdens for families. A November 2006 USA Today/Kaiser/Harvard survey of households affected by cancer surveyed the financial

impacts of cancer on families. Even though most (95%) reported being covered by insurance during their cancer treatment, the survey found that nearly half (46%) of people affected by cancer said the costs of care were a burden on their family, including one in six (17%) who said costs were a major burden. A quarter (25%) of all respondents—including those with health insurance—say they used up all or most of their savings as a result of the financial cost of dealing with cancer, and 11 percent were unable to pay for basic necessities like food, heat and housing.

It is clear that for many, health insurance alone is no longer a guarantee of financial protection from the costs of health care and financial stress when illness strikes. Today's higher premiums, deductibles, and copayments can create substantial financial burden for families, and many learn only through an unexpected serious injury or illness that they are not well-protected financially. Based on analysis of the 2003 Kaiser Health Insurance Survey, we found that one in six adults who are privately insured—17.6 million adults—report having substantial problems paying their medical bills.[3] Privately insured adults with medical debt are largely from middle-class families. Two-thirds of the privately-insured who have medical debt have family incomes between $20,000 and $75,000.

An important difference between the privately insured with medical bill problems and those without debt is their health status. Those with medical debt are almost twice as likely to have an ongoing or serious health problem compared to others with private coverage. Unfortunately, the privately-insured who have medical debt are also as likely

[3] Meaning that in the past year, they reported having either great difficulty paying their health care costs, had problems paying their medical bills in the past year, had changed their life significantly in order to pay medical bills, or had been contacted by a collection agency about medical bills.

as the uninsured to postpone care, skip recommended tests and treatments, and not fill drug prescriptions (Figure 17). This can lead to more serious illnesses, which are often more costly to treat than earlier interventions and contribute to more disability and premature death.

Some families are turning to their credit cards to pay their medical bills and going into debt to pay for health care as a result. According to a newly released study by Demos and the Access Project, 29 percent of low- and middle-income households with credit card debt spanning at least three months reported that medical expenses contributed to their current level of credit card debt. One-fifth (20%) of those surveyed reported having a *major* medical expense in the past three years that contributed to their credit card debt. Households reporting that a recent major medical expense contributed to their debt had an average of $11,623 in unpaid credit card bills, which is almost $4,000 higher than the average amount for other indebted households. These mounting levels of personal indebtedness and the growing role of medical bills in bankruptcy proceedings point to the financial toll rising health care costs and limits on the scope of health insurance protection are taking on America's families.

The Public's Concern about Rising Health Care Costs

The research documents that health costs are becoming increasingly difficult for middle-class families to manage and eroding both health and financial security. Public opinion also bears out the research. Concern over rising health costs has mounted as many watch their health care premiums, deductibles, and copays rise. The increasing costs of health care—both premiums and out-of-pocket payments for health care—create financial insecurity for families. In a September 2006 public opinion poll, we

found that 60 percent of adults with health insurance were worried about being able to afford the cost of their health insurance over the next few years, and almost a third (27%) was very worried.

In the same poll, 66 percent of adults with health insurance reported that their health insurance premiums are going up, and nearly a third (31%) felt their premiums were going up a lot. In addition, about half (48%) of adults with health insurance saw their copays and deductibles increasing, adding to their out-of-pocket costs. These findings held true when a subset of middle-income respondents (those with income $30,000-$49,999) was analyzed.

In a recent Kaiser Family Foundation public opinion poll, concerns about health care costs dominated the list of 13 possible issues the public is worried about (Figure 18). Almost half of the public (47%) was very worried about having to pay more for health care or insurance, and 39 percent said they were very worried they would not be able to afford the health care services they needed.

The public is worried about the impact of rising health costs on their family budgets and their lives, and many are looking to Congress for action. Seventy percent (70%) of the public, and a slightly higher percentage of middle-income respondents (75%), felt that health insurance premiums were unreasonably priced and that Congress should *try* to do something about the unreasonable cost of health care. In fact, about two-thirds (64%) of the public believes that health care costs are something Congress not only should--but c*an*—do a lot about.

The Challenge Ahead

Health insurance provides families with an important source of financial security when illness strikes and helps to promote access to health care services that can often stave off more serious illness. Although the majority of non-elderly Americans receive health care coverage through their employer today, the availability and affordability of employer-based coverage is declining…putting more and more middle- and low-income working families at risk of being uninsured and without coverage for their health needs. For those with coverage, the value of that coverage has begun to erode as limits on the scope of coverage leave more and more insured Americans to face increased out-of-pocket costs when they seek care.

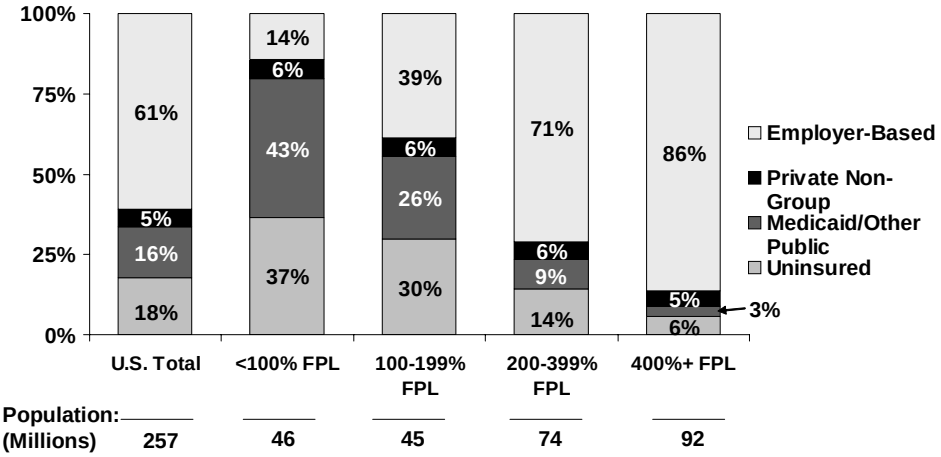
Rising costs for both health care services and insurance coverage are placing a heavy load on family budgets, businesses, and public programs. The financial burden resulting from these growing costs is already squeezing out good health practices, leading many to defer care due to costs and contributing to increases in the uninsured.

As Congress moves forward to address rising health care costs and their impact on America's families, it will be important to address not only the cost of health insurance but also the impact of any changes on reducing the uninsured population and promoting improved access to affordable care for all Americans. Shifting more costs onto consumers could further endanger access to care and financial security. The quality and scope of coverage and the availability of financial assistance to make coverage affordable for low- and middle-income families will determine whether the nation can provide affordable access to preventive and primary care as well as catastrophic health care for all Americans.

I appreciate the opportunity to testify before the committee today and welcome your questions. Thank you.

Figure 1

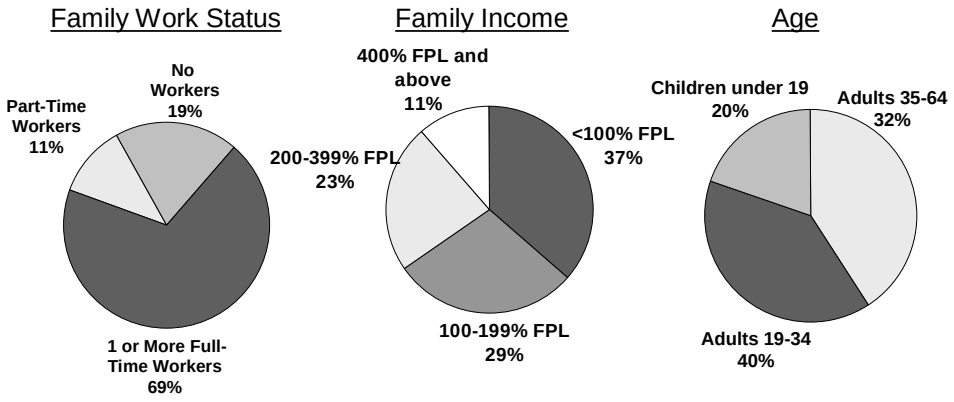
Health Insurance Coverage of the Nonelderly by Poverty Level, 2005



The federal poverty level was $19,971 for a family of four in 2005. Sums may not equal totals and data may not total 100% due to rounding.
SOURCE: KCMU and Urban Institute analysis of the March 2006 Current Population Survey.

Figure 2

Characteristics of the Uninsured, 2005

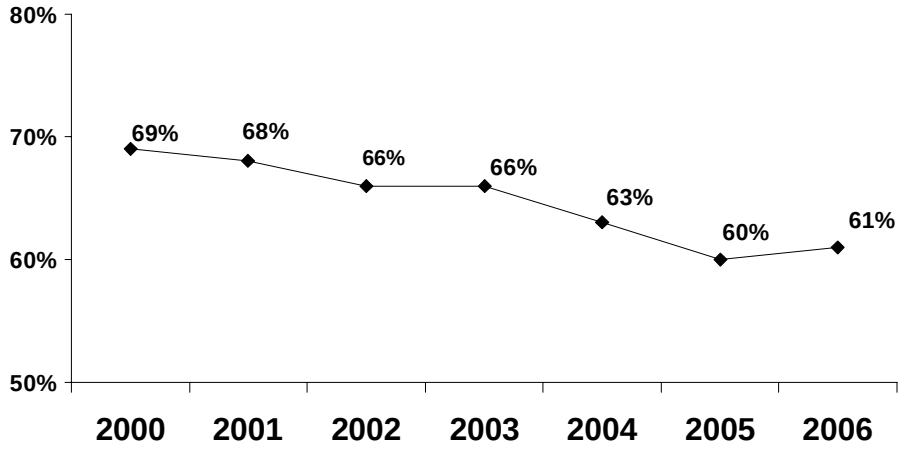


Total = 46.1 million uninsured

NOTE: The federal poverty level was $19,971 for a family of four in 2005.
Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of March 2006 CPS.

Figure 3

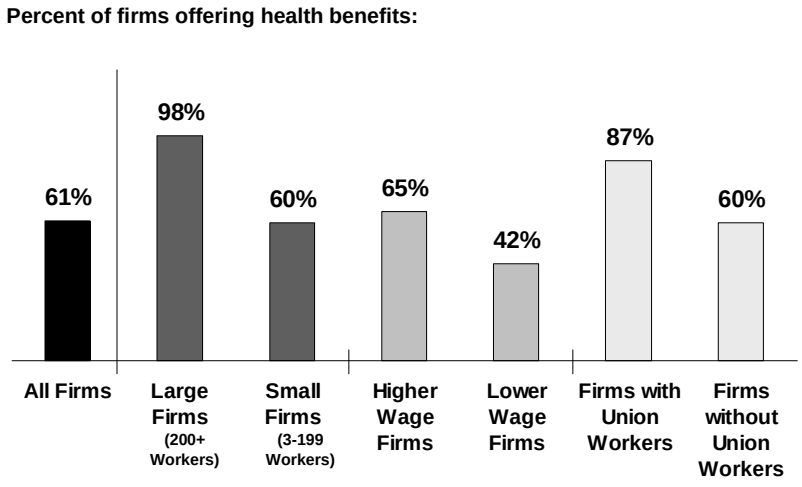
Percentage of Firms Offering Health Benefits, 2000 - 2006



Note: Difference is statistically significant over the 2000-2006 period.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2006.

Figure 4

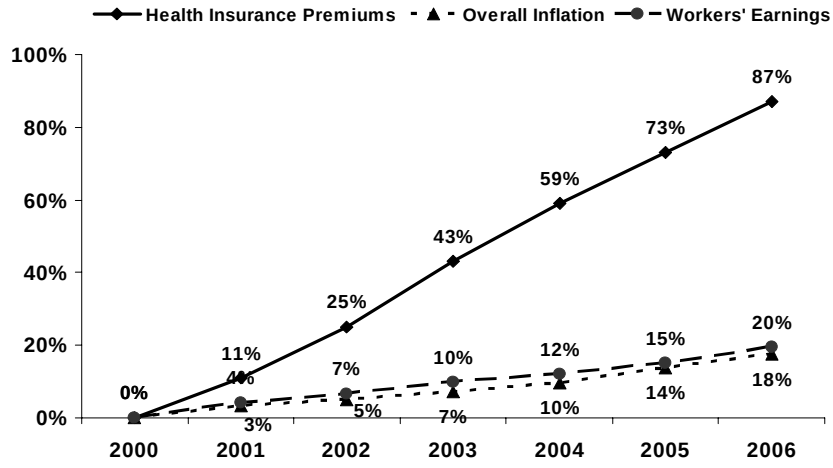
Health Insurance Offer Rates by Firm Characteristics, 2006



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006.

Figure 5

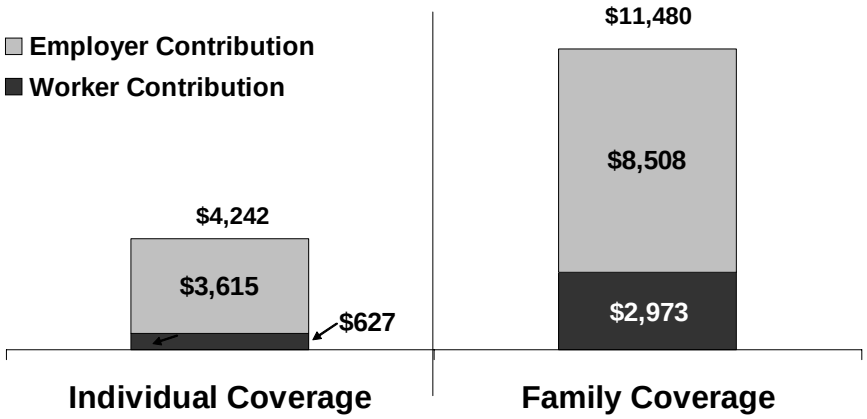
Cumulative Changes in Health Insurance Premiums, Overall Inflation, and Workers' Earnings, 2000-2006



Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.
SOURCE: *Employer Health Benefits, 2006 Annual Survey*, Kaiser Family Foundation and Health Research & Educational Trust, September 2006.

Figure 6

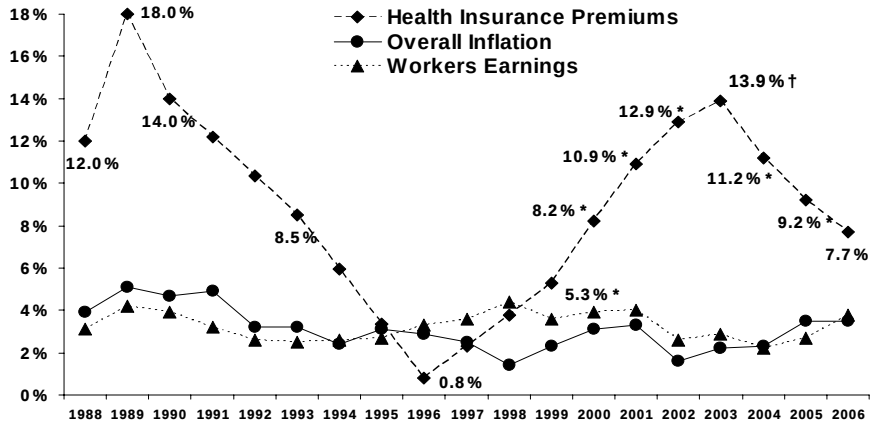
Average Annual Premium Costs for Covered Workers, 2006



Note: Family coverage is defined as health coverage for a family of four.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006.

Figure 7

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2006

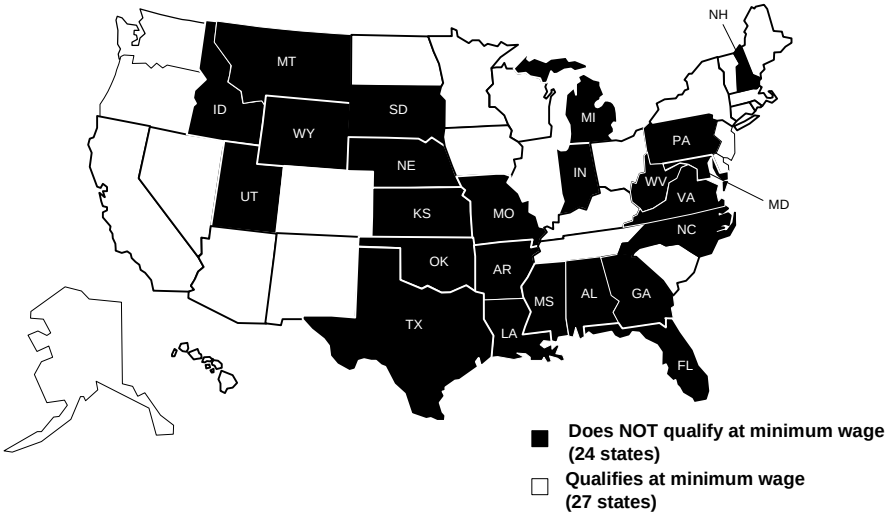


* Estimate is statistically different from the previous year shown at p<0.05. † Estimate is statistically different from the previous year shown at p<0.1. Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

SOURCE: KFF/HRET Survey of Employer-Sponsored Health Benefits, 1999-2006; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; HIAA, 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation, 1988-2005; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2005.

Figure 8

Medicaid Eligibility for Working Parents by Federal Minimum Wage, July 2006

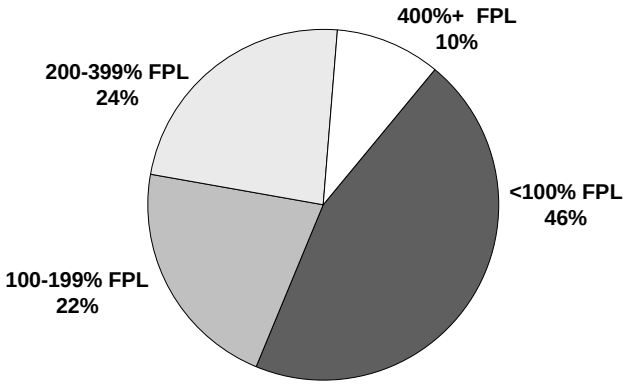


*A parent in a family of three working full time at federal minimum wage earns $893 per month

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

Figure 9

Growth in Nonelderly Uninsured Adults by Family Income, 2000 - 2004

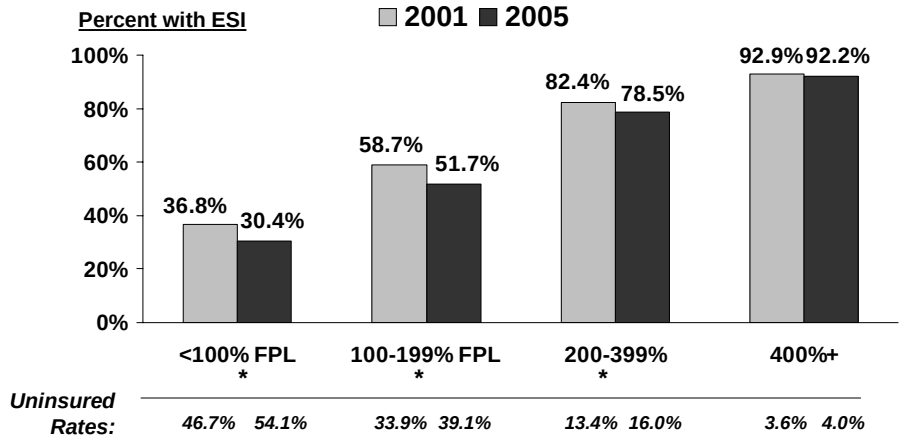


Total Growth in Uninsured Adults = 6.3 Million

The federal poverty level was $19,307 for a family of four in 2004. Note: Totals may not sum to 100% due to rounding.
Source: KCMU/Urban Institute 2005

Figure 10

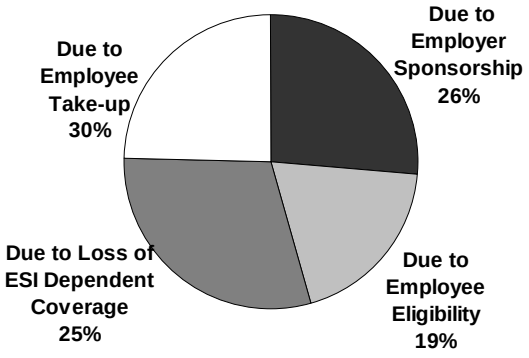
Changes in Employees' ESI Coverage and Uninsured Rates, by Family Income Levels, 2001-2005



* Statistically significant changes for both ESI and uninsured rates for these groups (p<.05).
Source: Urban Institute analysis of the February 2001 and 2005 Contingent Work Supplement of the Current Population Survey (CPS) and the March 2001 and 2005 Annual Social and Economic (ASEC) Supplement of the CPS.

Figure 11

Reasons for Decline in ESI among Middle-Income Employees, 2001- 2005

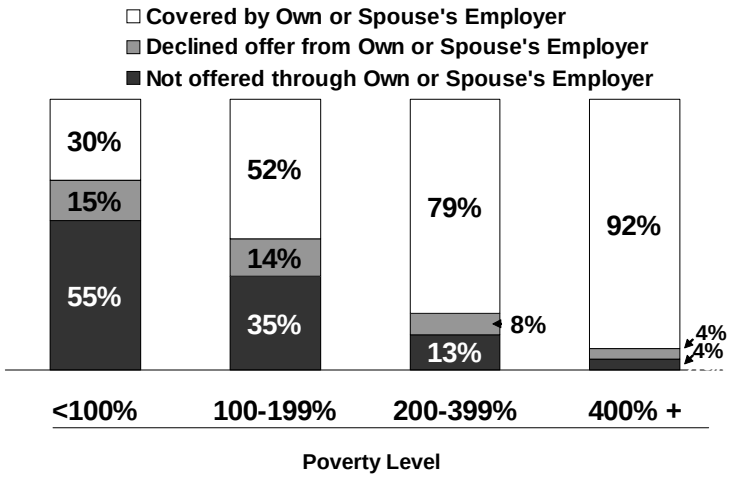


3.9% Decline in ESI among Middle-Income Employees (82.4% - 78.5%)

Source: Urban Institute analysis of the February 2001 and 2005 Contingent Work Supplement of the Current Population Survey (CPS) and the March 2001 and 2005 Annual Social and Economic (ASEC) Supplement of the CPS.

Figure 12

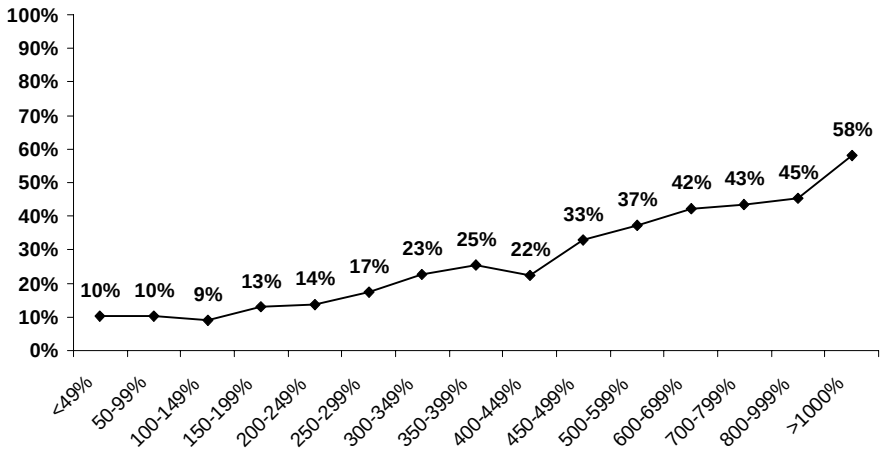
Employee Access to ESI within the Family by Family Income, 2005



Data may not total 100% due to rounding.
Source: Urban Institute analysis of the February 2005 Contingent Work Supplement of the Current Population Survey (CPS) and the March 2005 Annual Social and Economic (ASEC) Supplement of the CPS.

Figure 13

Percent of Nonelderly Adults without Public Coverage or an ESI Offer Who Have Private Non-Group Insurance, by Income Level, 2000-2003

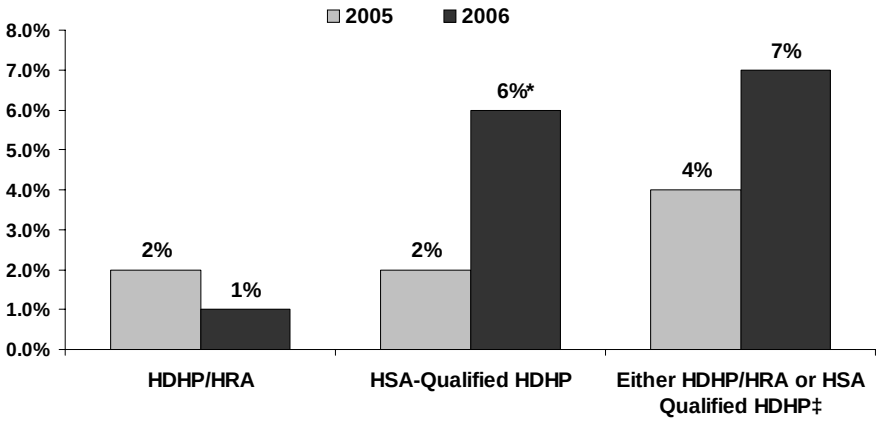


Note: The federal poverty level was $15,260 for a family of three in 2003.

Source: KFF analysis of pooled data from Medical Expenditure Panel Survey (2000-2003)

Figure 14

Percentage of Firms Offering Health Benefits That Offer an HDHP/HRA and/or an HSA Qualified HDHP, 2005-2006



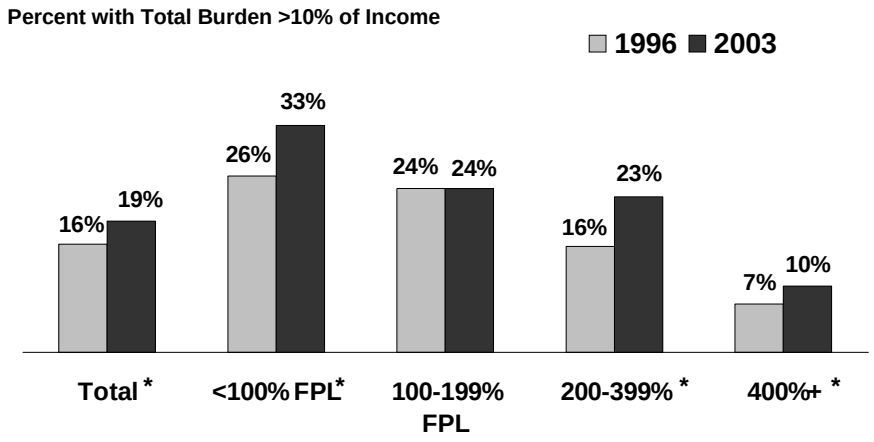
*Estimate is statistically different from estimate for the previous year shown at p<.05.

‡The 2006 estimate includes 0.4% of all firms offering health benefits that offer both an HDHP/HRA and an HSA qualified HDHP. The comparable percentage for 2005 is 0.3%.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2006.

Figure 15

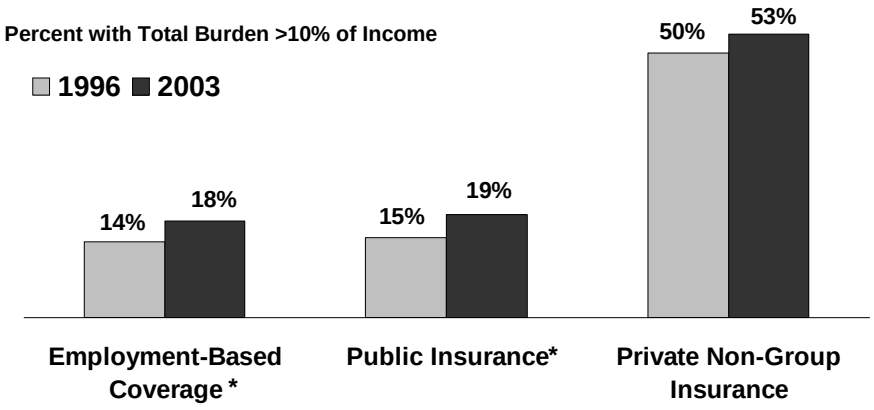
Prevalence of High Family Out-of-Pocket Burdens among the Nonelderly, By Poverty Level, 1996 vs. 2003



Total financial burden includes all out-of-pocket payments for health care, including premiums.
* Statistically significant change between 1996 and 2003 (p=.05).
Source: Banthin and Bernard, 2006.

Figure 16

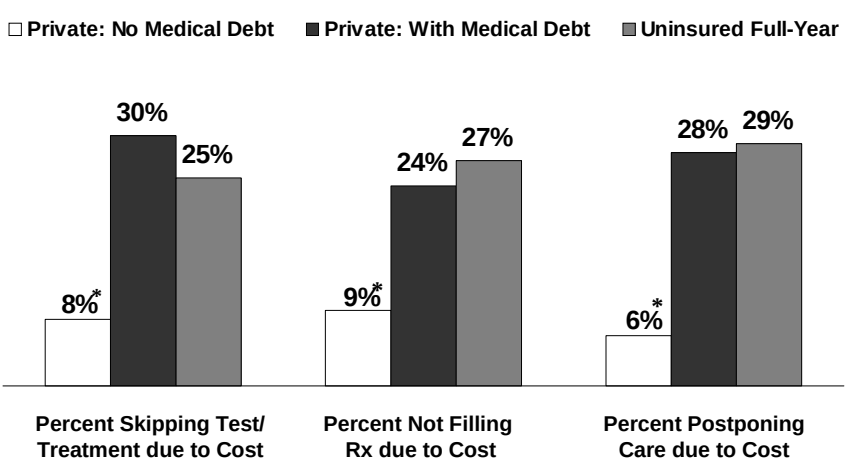
Prevalence of High Family Out-of-Pocket Burdens among the Nonelderly, By Source of Health Coverage, 1996 vs. 2003



Total financial burden includes all out-of-pocket payments for health care, including premiums.
* Statistically significant difference between 1996 and 2003 (p=.05).
Source: Banthin and Bernard, 2006.

Figure 17

Problems with Access to Care Among the Uninsured and Those with Medical Debt

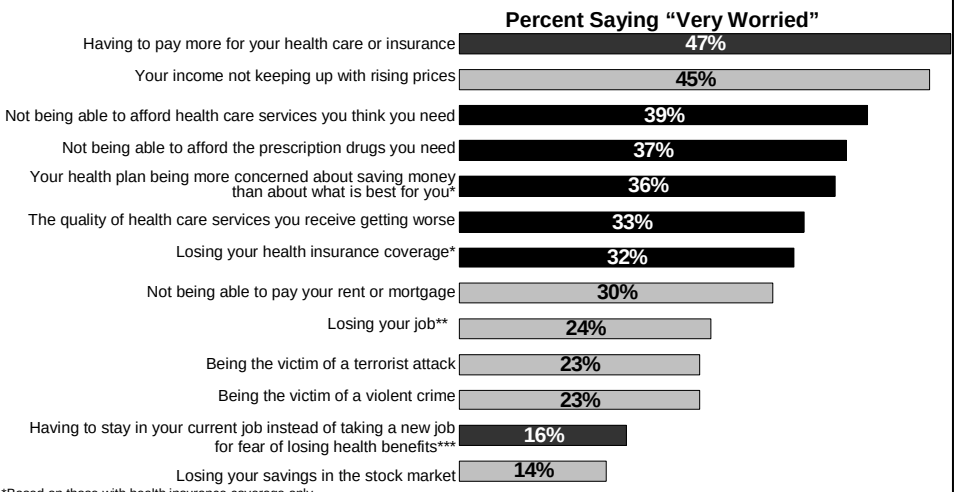


*Significant difference compared to those privately insured with medical debt (95% CI).
Rates adjusted for age, education, income, race, health status, and employment.
Source: C. Hoffman et al, "Medical Debt and Access to Health Care," KCMU pub # 7403, September 2005. Based upon data from the 2003 Kaiser Health Insurance Survey.

Figure 18

Health Care Worries in Context with Other Worries

I'm going to read you a list of things that some people worry about and others do not. How worried are you about each of the following things—are you very worried, somewhat worried, not too worried, or not at all worried?



*Based on those with health insurance coverage only.
**Based on employed only.
***Based on those who are employed with health insurance coverage only.
Source: Kaiser Family Foundation Health Poll Report Survey, October 2006

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