

Special Report: Uninsurance in Nebraska

Introduction

In September 2003, the Nebraska Health and Human Services System contracted with the University of Nebraska Medical Center to examine the characteristics of the uninsured in Nebraska and to suggest strategies for providing them with access to affordable health insurance coverage. This one-year contract was issued as part of the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) State Planning Grants Program. For more information, see the HRSA Web site (www.hrsa.gov).

In order to examine the characteristics of the uninsured in Nebraska and to develop policy recommendations, researchers at the University of Nebraska Medical Center conducted a household telephone survey of 3,750 Nebraskans and held 13 focus groups across the state's six health planning regions. The purpose of the household survey was to determine the characteristics and location of the uninsured in the state. The purpose of the focus groups was to improve the research team's understanding of the experience of the uninsured in Nebraska and to understand the factors small employers consider when deciding whether to offer health insurance to their employees.

Highlights

- Approximately 9.9% of Nebraskans (145,000 persons) are uninsured (they are younger than 65 years and have no health insurance of any type—private insurance, Medicare, Medicaid, or military insurance). Statistically, 9.9% is a number that represents a range between 8.3% and 11.5% uninsurance. This range is consistent with other reports such as the U.S. Census Bureau's Current Population Survey, which describes Nebraska's uninsurance rate as 10.8%,¹ representing a range between 9.9% and 11.7%. Nebraska's uninsurance rate compares favorably to the nation's 15.6% uninsurance rate.²
- Nearly four out of five of uninsured Nebraskans reside in households with incomes at or below 200% of the Federal Poverty Level (FPL). (See Table 1 for incomes corresponding with FPLs.)
- Among the uninsured, 21% are younger than 19 years, 34% are aged 19 to 34, and 40% are aged 35 to 64.
- Sixty-three percent of the uninsured live in households where the head of the household is employed.
- Nearly 68% of Nebraskans younger than 65 years obtain health insurance through their employer.

Continued on p. 224

- Of employed Nebraskans offered coverage by their employer, 20% were uninsured; of those not offered coverage through their employer, 39% were uninsured. Due to the high cost of premiums, small businesses that have fewer than ten employees are less likely to offer health insurance as an employee benefit than are larger employers.
- Sixty-five percent of the uninsured stated that cost was the reason they did not purchase private insurance.
- The uninsured were less likely than the insured to report “excellent/very good” health status (61.2% vs. 71.8%) and more likely than the insured to report “fair/poor” health status (11.9% vs. 6.3%).
- Approximately 57% of uninsured Nebraskans, compared to 86% of insured Nebraskans, visited a doctor in the last 12 months.
- When the uninsured seek health care, they are more likely to use public clinics than are the insured—50% of the uninsured relied on public clinics (such as services available through some public health departments or Federally Qualified Health Centers) as the source of their care compared to 23% of the insured. In areas where public clinics did not exist, the uninsured reported more difficulty obtaining treatment and that they had used home remedies and medications prescribed for someone else. The uninsured without access to public clinics reported fearing the debt they would incur by seeking treatment and thus chose to delay care as long as possible.
- Fourteen percent of the uninsured reported that there was a time in the last 12 months when they needed care but could not get it, compared to 3% of the insured.
- Thirty-three percent of uninsured Nebraskans and 27% of insured Nebraskans were concerned that insurance would not cover the cost of their health care.

Report Profile

How Many Nebraskans Are Uninsured and Who Are They?

	United States	Nebraska
Uninsurance Rate Total Population Younger than 65 Years, 2004	15.6%	9.9%
Non-metropolitan Areas (rural) in Nebraska		11.1%
Metropolitan Areas (urban) in Nebraska		8.7%

Uninsurance Rate of Nebraskans (Younger than 65 Years) by Race/Ethnicity, 2004

	United States	Nebraska
White/Caucasian	13%	9.1%
Black/African American	21%	6.5%
Hispanic	34%	26.9%
Non-Hispanic	–	8.7%

Uninsurance Rate by Age Group, Nebraska 2004

Under 19 years of age	6.7%
19 to 34 years	16.0%
35 to 54 years	9.1%
55 to 64 years	7.9%

Uninsurance Rate by Income (According to Federal Poverty Level), 2004

	United States	Nebraska
0 to 100% FPL	37%	24.7%
101 to 200% FPL	29%	21.4%
201 to 300% FPL		7.3%
More than 300% FPL	(>200% FPL) 10%	3.7%

Distribution of Uninsured (Aged 19-64 Years) by Employment Status, Nebraska 2004

Employed	49.5%
Self-Employed	13.7%
Unemployed	29.2%
Other	7.7%

Nebraska Businesses Offering Health Insurance by Business Size

	United States	Nebraska
All Businesses	56.2%	66%
1-3 employees		49%
4-9 employees		65%
10-18 employees		80%
20-49 employees		88%
50-99 employees		95%
100 or more employees		98%

What Difference Does Health Insurance Make?

Doctor Visits in the Past 12 Months, Nebraska 2004	Insured	Uninsured
0 visits	14.0%	42.8%
1 to 2 visits	35.9%	30.4%
3 to 4 visits	23.6%	13.6%
5 to 10 visits	18.3%	6.5%
More than 10 visits	8.1%	6.7%

What Difference Does Health Insurance Make? (continued)

Self-reported Health Status, Nebraska 2004	Insured	Uninsured
Excellent/Very Good	75.8%	61.2%
Good	17.8%	26.9%
Fair/Poor	6.3%	11.9%

Why Nebraskans Lack Health Insurance, 2004

Why Uninsured Nebraskans (Younger than 65 Years) Do Not have Private Insurance		
Too Expensive		65.4%
Not Eligible		11.4%
Don't Need/Want		5.7%
Expect to be Eligible Soon		4.5%
Rarely Sick		2.0%
Don't Know Where to Begin		1.4%
Too Much Hassle		0.7%
Other		9.0%

Where Nebraskans Go for Health Care, 2004

Usual Source of Care by Insurance Status	Insured	Uninsured
Emergency Room	1%	4%
Clinic	34%	51%
Doctor's Office	62%	13%
Other	2%	1%

What are the Consequences of Uninsurance?

Forgo Needed Care by Insurance Status, 2004	Insured	Uninsured
Percent of Nebraskans who needed care in the last 12 months but could not get it	3%	14%

Underinsurance Among Nebraskans, 2004

Insured who say worrying that insurance will not cover care is a problem		27%
Insured who say worrying whether they will pay more than expected for care is a problem		36%

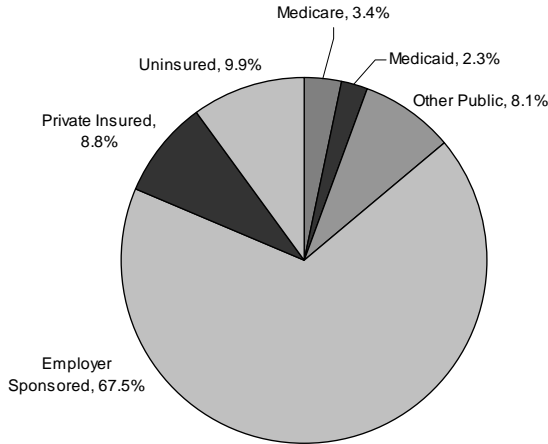
Source for U.S. data: Kaiser Family Foundation State Health Facts: Health coverage and the uninsured. <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Nebraska&welcome=1&category=Health+Coverage+%26+Uninsured> (retrieved December 2005).

Note: All U.S. data was collected for 2004, except data for percent of businesses providing health coverage, which was collected for 2003.

Section 1: How Many Nebraskans Are Uninsured and Who Are They?

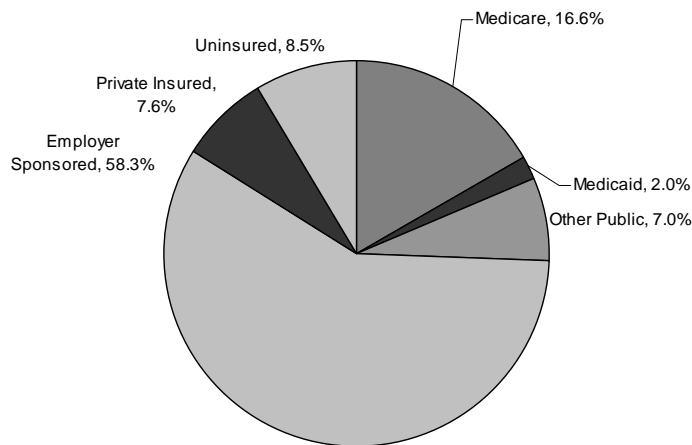
Although almost 68% of Nebraskans younger than 65 years received health insurance coverage through their employers, and nearly all Nebraskans aged 65 and older were covered through Medicare, approximately 145,000 non-elderly Nebraskans (10%) lacked health insurance in 2004 (Figures 1 and 2).

Figure 1 - Types of Coverage of Insured Nebraskans Younger Than 65 Years, 2004



Note: Other public insurance includes Railroad Retirement Plan, TRICARE/CHAMPUS, Indian Health Service, and SCHIP.

Figure 2 - Types of Coverage of Insured Nebraskans of All Ages, 2004



Note: Other public insurance includes Railroad Retirement Plan, TRICARE/CHAMPUS, Indian Health Service, and SCHIP.

The uninsured have lower incomes.

Seventy-nine percent of the uninsured in Nebraska made 300% or less of the FPL (Figure 3). Income categories used in this report are based upon the 2003 FPL income guidelines (Table 1). A family of three at 300% of the FPL would have an annual household income of \$45,780 before taxes.

Figure 3 - Distribution of Uninsured by Income According to Federal Poverty Level, 2004

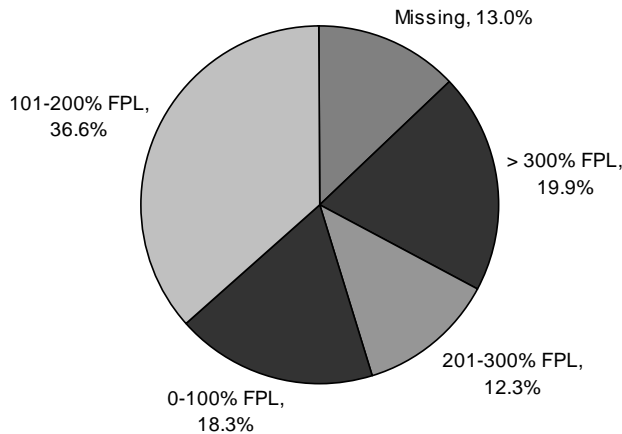


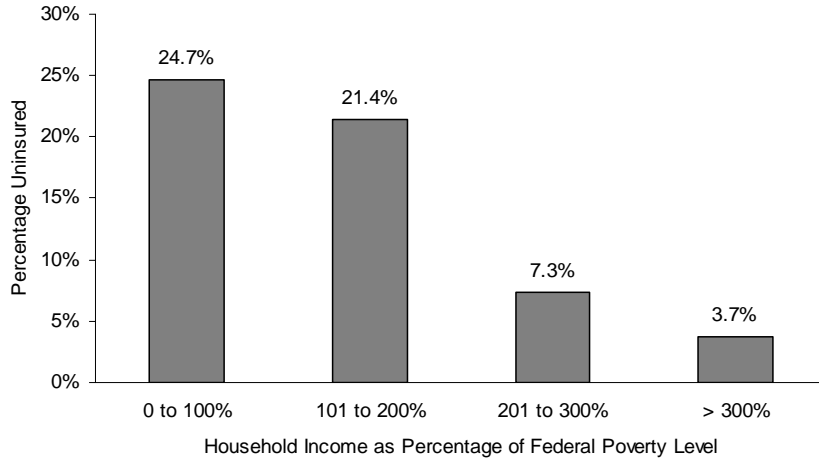
Table 1 - 2003 Federal Poverty Level (FPL) Income Guidelines

Family Size	100% FPL	200% FPL	300% FPL
1	\$8,980	\$17,960	\$26,940
2	\$12,120	\$24,240	\$36,360
3	\$15,260	\$30,520	\$45,780
4	\$18,400	\$36,800	\$55,200
5	\$21,540	\$43,080	\$64,620
6	\$24,680	\$49,360	\$74,040
7	\$27,820	\$55,640	\$83,460
8	\$30,960	\$61,920	\$92,880

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, The 2003 HHS Poverty Guidelines.

Nebraskans younger than 65 years at 200% of the FPL or below are more likely to be uninsured than are Nebraskans of the same age group earning at or above 201% of the FPL. According to the telephone survey, approximately one-fifth of those earning between 101% and 200% of the FPL and one-fourth of those at 100% of the FPL or below were without health insurance (Figure 4).

Figure 4 - Percentage of Uninsurance for Nebraskans Younger Than 65 by Poverty Level, 2004



The cost of health insurance is the primary barrier to purchasing private health insurance. More than 65% of the uninsured younger than 65 years reported that they could not afford private health insurance (Figure 14).

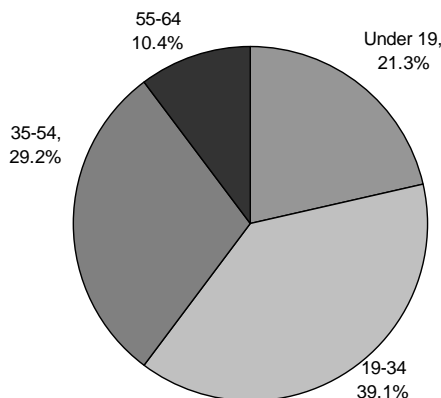
What we heard:

“Well, what if you are not even making enough to cover all your stuff? I mean your expenses exceed your income. You’re on a tight budget because you have to pay for food and all your personal needs each month.” –Urban Native American

The uninsured are working-age adults.

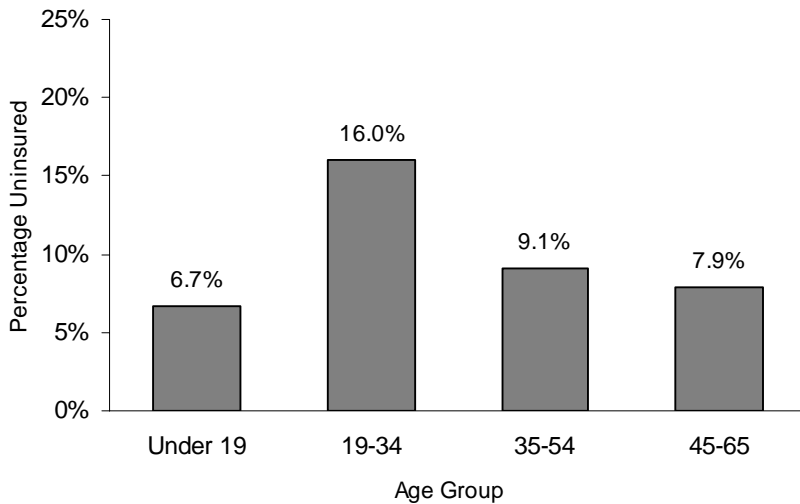
Approximately 21% of uninsured Nebraskans were children, and the remainder were working age adults. More than 68% of the uninsured younger than 65 who are without health insurance were between 19 and 54 years of age (Figure 5).

Figure 5 - Age Groups as Percentages of All Uninsured Nebraskans Younger Than 65, 2004



Young adults are more likely to be uninsured than any other age group (Figure 6). Sixteen percent of adults aged 19-34 years were uninsured—an amount almost twice that of the next highest uninsured age group (9.1% of adults aged 35-54 years). Sixty-eight percent of young adults aged 19-24 and 49% of young adults aged 25-34 lived in households with a total income that is less than 300% of the FPL. In other words, young adults are overrepresented among the uninsured because they are overrepresented among the low-income population.

Figure 6 - Percentage Uninsured Nebraskans Younger Than 65 by Age Group, 2004



What we heard:

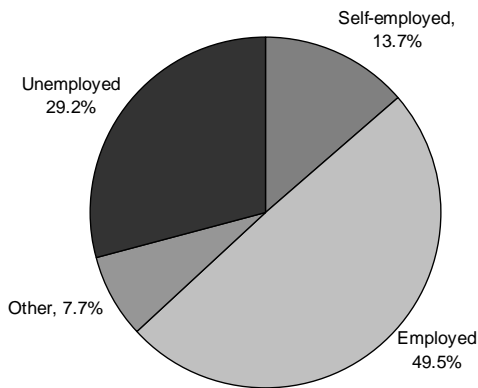
“People I know . . . are still paying off doctor bills they got when they were in their twenties, and they are in their thirties and forties now. Because it was so expensive, and they didn’t have insurance when they got sick or whatever.”

—Low-income White male

The majority of the uninsured are employed.

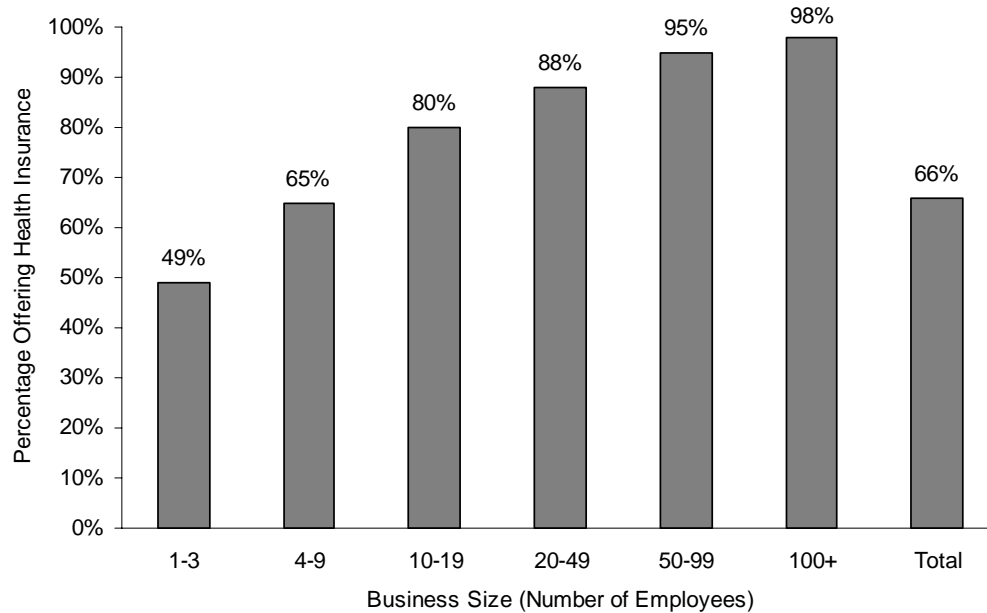
Over 63% of uninsured Nebraskans aged 19-64 were employed. However, only two-thirds of those who were employed were offered health insurance by their employer. Those offered coverage by their employer were less likely to be uninsured. Specifically, of those offered coverage by their employer, 20% were uninsured; of those not offered coverage through their employer, 39% were uninsured.

Figure 7 - Percentage Uninsured Nebraskans Aged 19 to 64 by Employment Status



Employees of small businesses are at a greater risk of being uninsured. According to data from the Nebraska Department of Labor, employers with fewer than 10 employees were least likely to offer health insurance (Figure 8).

Figure 8 - Percentage of Nebraska Businesses Offering Health Insurance by Number of Employees, 2004



Source: Nebraska Workforce Development, Department of Labor, 2004.

Note: The Nebraska Workforce Development Department of Labor Survey, from which these data are taken, was conducted as part of the Nebraska State Planning Grant to identify which types of industries and business sizes were most likely to offer benefits to their full- and part-time employees.

What we heard:

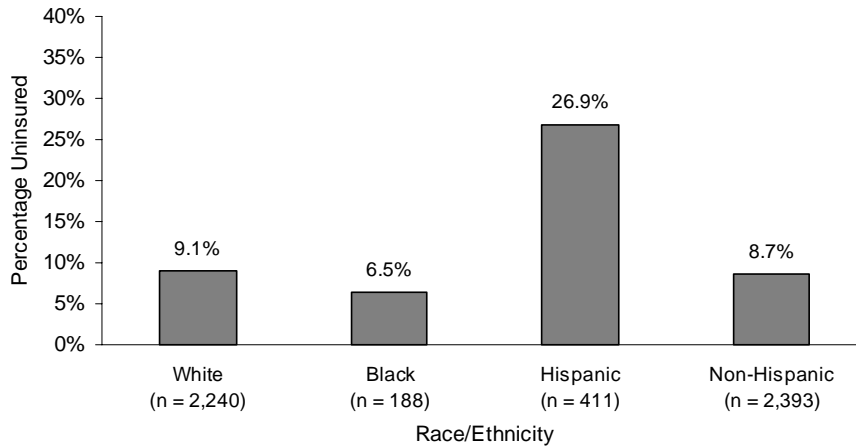
“My employer offers insurance, but it is ridiculous. There’s no way you can afford it unless you have somebody else working in your household. It’s almost half a paycheck” (every two weeks). –Low-income White female

“I don’t qualify for any coverage. . . . You have to be management.” –Low-income White female

The uninsured are from all racial and ethnic groups, but Hispanics are most likely to be uninsured.

Uninsurance rates are similar for White and Black Nebraskans. However, Hispanics are nearly three times as likely to be uninsured as are non-Hispanic whites (Figure 9). In addition to the common barriers of cost and eligibility, Hispanic focus group participants reported that barriers to obtaining health insurance included lack of information about the role of health insurance in the U.S. health care system, lack of information about how to obtain health insurance, legal status, and language barriers.

Figure 9 - Percentage Uninsured Nebraskans Younger Than 65 by Race/Ethnicity, 2004



Note: The percentages for Blacks and Whites are statistically in the same range. Blacks are undercounted because of issues pertaining to telephone ownership and response rate.

What we heard:

“And when they don’t get covered the first time [because of the deductible], a lot of people I know cancel it because they think it doesn’t work. And they tell their coworkers that they tried to use it but it didn’t work and so other people also cancel it. There is misinformation, a need for more education about health insurance, deductible, coverage, the time that has to pass so you’re covered, doctor visits, copay, etc. A lot of people don’t know the difference between the deductible and the co-pay.” –Rural Hispanic female

“If your children are not born here, they can’t get insurance. Even if the mother and father are both working, [children] don’t get coverage because they don’t have social security numbers.” –Rural Hispanic male

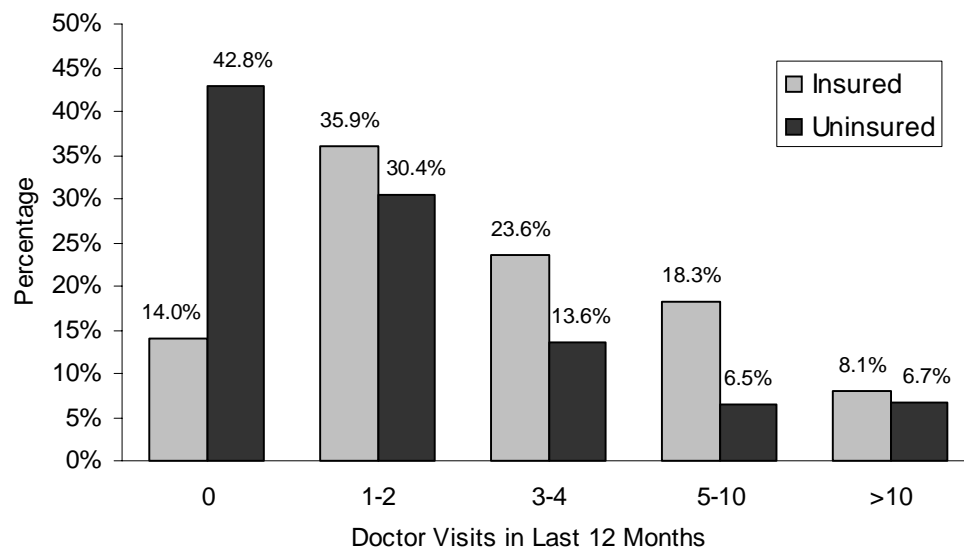
Section 2: What Difference Does Health Insurance Make?

Having health insurance affects an individual's access to health care.

Uninsured focus group participants reported having less access to health care because providers prefer to see insured patients and because the focus group participants feared that they would not be able to pay the bills for treatment. Lacking insurance reportedly limited the use of all levels of care including preventive, primary, and acute care. The uninsured did not report increased use of hospital emergency departments for fear of the charges incurred.

- Health insurance status affects access to primary and preventive health care. Approximately 27% of uninsured Nebraskans younger than 65 did not have a regular source for medical care, compared to 6% of insured Nebraskans. About 57% of uninsured Nebraskans, compared to 86% of insured Nebraskans, visited a doctor in the last 12 months (Figure 10).
- Health insurance status affects access to acute care. Approximately 14% of uninsured Nebraskans, compared to 3% of insured Nebraskans, reported not getting needed care in the past 12 months.

Figure 10 - Number of Doctor Visits in Past 12 Months by Insurance Status, 2004



What we heard:

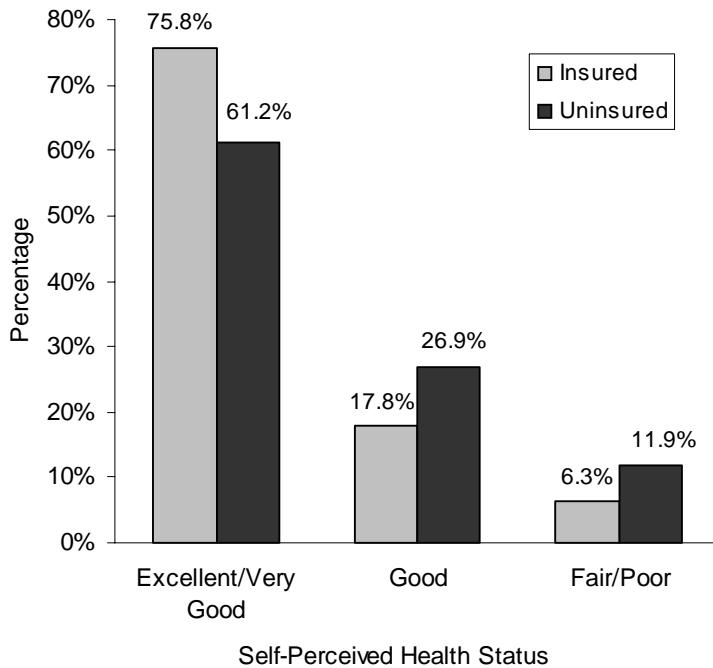
“Last year I was pregnant and I lost my twin babies. But I went to the clinic and they asked me if I had insurance, and because I didn’t have it they couldn’t take care of me. They said I had to wait until it was an emergency. I waited for two days, holding in the pain. When I went to Kearney [for care], it was too late. I had already lost my babies. If I had had medical assistance when I needed it, I would not have lost my babies.” –Rural Hispanic female

Having health insurance affects an individual’s health status.

Insured Nebraskans younger than 65 years reported being in better health than those without health insurance. Health insurance status impacts whether or not an individual can receive care when it is needed, whether or not an individual can obtain preventive care or be seen by a specialist, and reportedly affects how an individual is treated in the health care setting. People without health insurance are more likely to delay seeking treatment for an illness, with the wait often resulting in increased anxiety, poorer health outcomes, and higher bills than would have resulted had they received treatment earlier. These factors affect overall quality of life, including an individual’s ability to provide for his or her family and contribute to his or her community.

- About twice as many uninsured as insured reported being in “Fair/Poor” health. (Figure 11).
- Uninsured focus group participants reported receiving poorer quality health care and being treated with less respect than the insured.

Figure 11 - Health Status of Insured and Uninsured Nebraskans Younger Than 65, 2004



What we heard:

“My mother didn’t see a doctor for an infection because she was afraid of how much it would cost. A bladder infection turned into a blood infection, and that is what essentially killed her.” –White Female urban employer

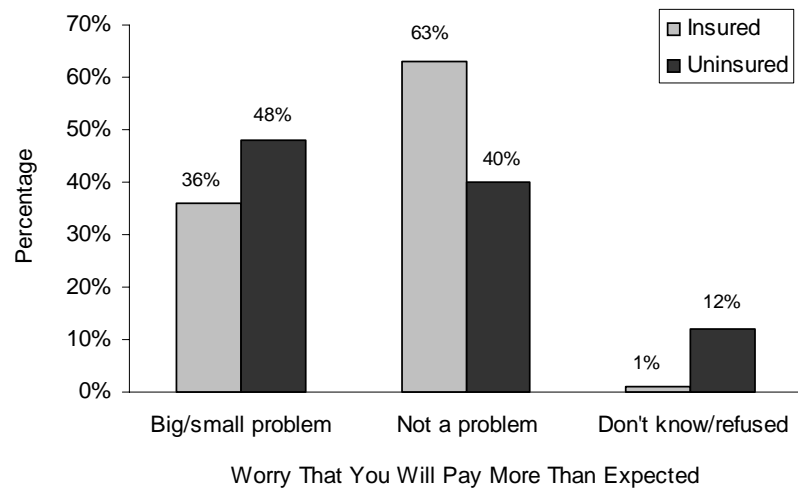
“They [the people that provide health services] ask you, ‘Why didn’t you get here before you were so ill?’ But you think, ‘I don’t have insurance or money.’ And if you have to get hospitalized and can’t go to work, then your family can’t eat. That’s why you hold on [and don’t seek care] until the last minute.” –Rural Hispanic female

But some of the insured also worry about costs.

Both the insured and uninsured worry that care will cost more than they expect. Many of the insured have policies with high deductibles and copays, or preexisting conditions that are not covered. Those insured who face such uncovered expenses are considered to be underinsured. Farley (as cited in Comer and Mueller)³ defines the underinsured as those whose out-of-pocket expenses exceed 10% of their income, while Taylor et al.⁴ define the underinsured as those who have high deductibles relative to their income. Adequate health insurance provides peace of mind by protecting assets and avoiding debt.

- The cost of health care concerns both the insured and the uninsured (Figure 12).
- Both insured and uninsured Nebraskans worried that they do not have sufficient health coverage (Figure 13).

Figure 12 - Level of Worry Among Insured and Uninsured Nebraskans That They Will Have to Pay More Than Expected for Care, 2004

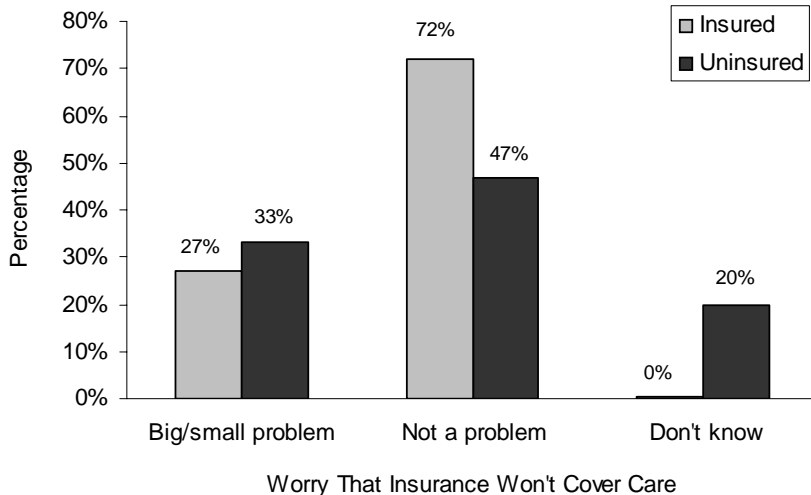


What we heard:

“We don’t have any preventive coverage, no annual checkups, no well-baby exams, no immunizations. . . . I would get something beyond just the major medical if I could afford it.” –Rural White employer

“I would possibly be more proactive about my health needs if I had [better] health insurance. . . . I have major medical that has a \$5,000 deductible, and it doesn’t do anything unless something really catastrophic happens, and so I pretty much have to circumvent the AMA [preventive care guidelines] for things like Pap smears, mammograms. I sometimes can find a place that will do them; I have to ask, ‘But what does it cost?’ ” –Self-employed White female

Figure 13 - Level of Worry Among Insured and Uninsured Nebraskans That Insurance Won’t Cover Care, 2004



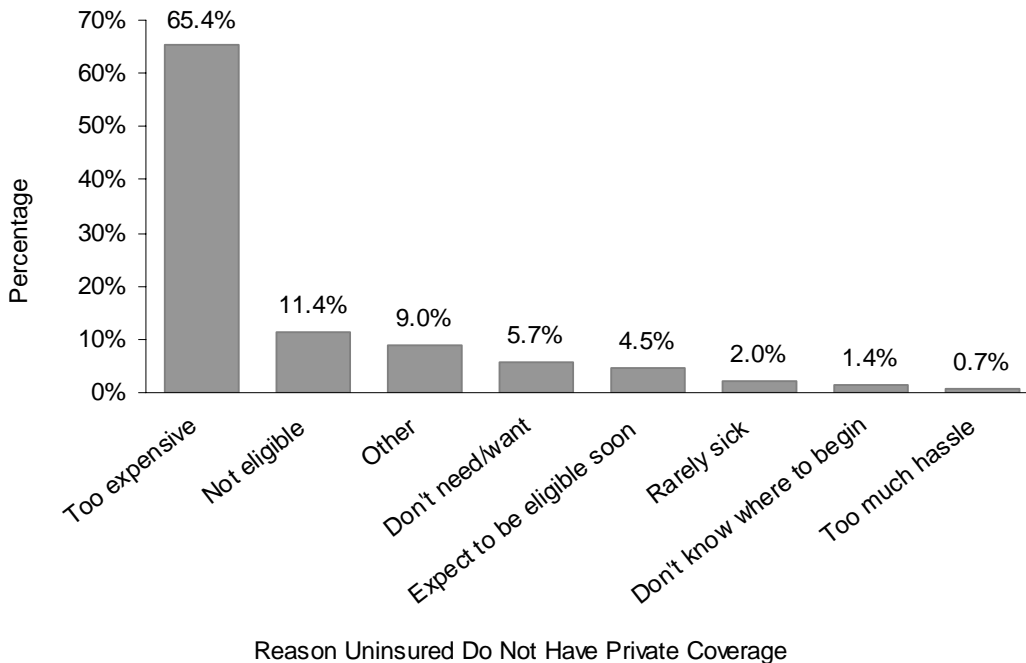
Section 3: Why Do Nebraskans Lack Health Insurance?

Nebraskans lack health insurance because of the high cost of private premiums and employee contributions for employer-sponsored coverage. Uninsured focus group participants spoke of having to decide between meeting basic needs and purchasing health insurance. Low-income working families are especially vulnerable to this dilemma because they do not earn enough to afford health insurance but earn too much to qualify for public programs. Many uninsured Nebraskans also said that employer-sponsored insurance was not a viable option either because employee contributions were too high or because they were ineligible.

Health insurance is not affordable.

Uninsured Nebraskans feel that health insurance is too expensive (Figure 14).

Figure 14 - Reasons Uninsured Nebraskans Younger Than 65 Do Not Have Private Insurance Coverage, 2004



The uninsured make a calculated risk when choosing not to purchase health insurance. Uninsured focus group participants reported valuing health insurance and finding it difficult to make the decision to be without it. Many of the uninsured understand the risk they are taking in choosing not to purchase health insurance. They choose to take that risk rather than forgo meeting basic needs such as feeding their families and paying rent.

Consumers want health insurance to provide value. When deciding whether or not to purchase health insurance, uninsured focus group participants considered the value provided by the insurance. If a significant portion of a paycheck is sacrificed to pay for health insurance, purchasers want the insurance to cover primary and preventive care without incurring significant debt for deductibles, office copays, and medications.

What we heard:

“Uninsurance is a crisis in rural America. The majority of people who are without health insurance are without it because of the cost.” –Rural White employer

“We cut it [our health insurance] two weeks ago because it [went up and now it is] too expensive. We don’t have the money. It’s not enough to pay for other bills and food. . . . And we have three kids, you know. What are we going to feed them if we give them the whole check? It’s difficult.” –Female refugee

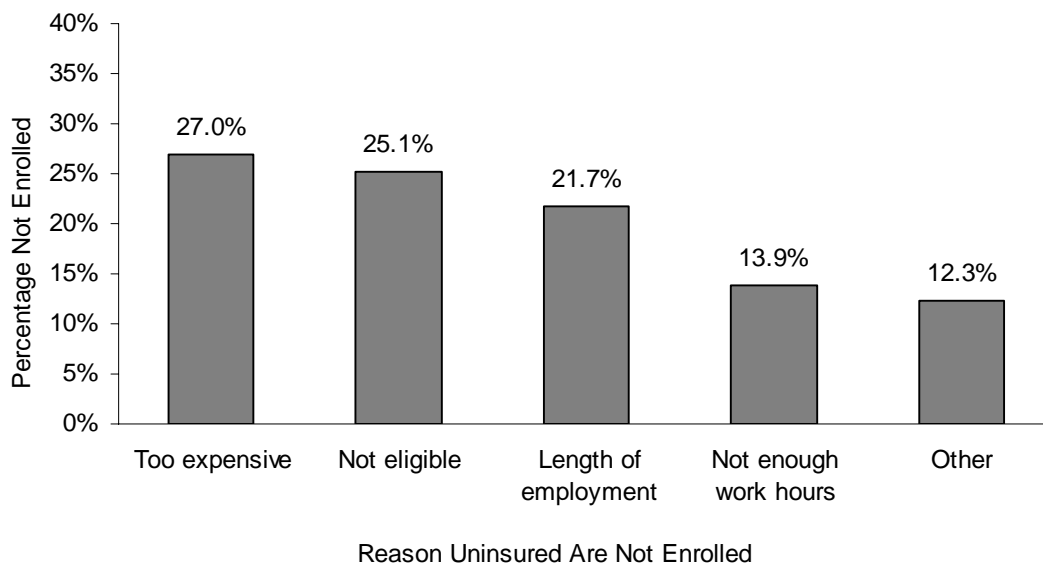
“[People don’t have insurance] because of the high price of health insurance and the low salaries.” –Rural Hispanic female

“There are a lot of companies that sell health insurance, but you either have it or you eat.” –Rural Hispanic male

Barriers exist to employer-sponsored coverage.

- Fewer employers are offering the benefit of health insurance. Approximately 48% of Nebraska’s uninsured said that their employer did not offer health insurance.
- Many of the uninsured cannot afford the cost of the employee contribution for employer-sponsored coverage or they are ineligible for coverage (Figure 15).
- Focus group data show that employees often felt they had to decide between spending money on basic needs such as food and rent or buying health insurance.

Figure 15 - Reasons Uninsured Nebraskans Aged 19 to 64 Were Not Enrolled in Employer-Sponsored Health Insurance, 2004



- Small businesses are less likely than larger businesses to offer health benefits. The high cost of health insurance premiums for small businesses is passed on to employees.
- Employers find it difficult to afford benefits that keep up with rising health insurance costs. Approximately 57% of employers said the reason they did not offer health insurance was because it was too expensive. Approximately 16% said they did not offer it because employees can't afford the contribution, and 14% said an inability to control costs precluded the provision of employee coverage.*+

What we heard:

“But times have changed, because every place I ever worked had insurance until my last two jobs. . . . The place that I work at full-time did have insurance until five years ago, but they can't afford it anymore. So it's not just the employees that are uninsured, it's the bosses that are uninsured, too. It's got so expensive.” –Low-income White female

“We come here with no English. We can't get the good jobs at \$9 an hour; we get \$6 an hour. Two hundred dollars [per paycheck every two weeks] is too expensive for insurance. We have three kids and we have to feed them.” –Female refugee

If [the employers] charge you \$40 a week, like company X [a large local employer], that's all right, but the smaller companies charge you a lot, as much as \$300. If you get work in a smaller company, you end up paying too much.” –Rural Hispanic female

It is difficult to qualify for public programs.

Many uninsured Nebraskans are among the “working poor” and do not qualify for public programs. Focus group participants relayed the message that despite interest in participating in public programs, their income levels were too high to qualify. Some participants also said that lack of citizenship made them ineligible for public programs.

What we heard:

“I was just diagnosed on May 9 with Stage III B terminal lung cancer, and knowing that I was going to have humongous hospital bills, medical bills, I basically went in and quit my jobs [neither of which offered health insurance] and took medical leave, because I knew I had to try to get zero income so I could get Medicaid.” –Low-income White female

*Source: Nebraska Workforce Development, Department of Labor, 2004.

+Note: The Nebraska Workforce Development Department of Labor Survey, from which these data are taken, was conducted as part of the Nebraska State Planning Grant to identify which types of industries and business sizes were most likely to offer benefits to their full- and part-time employees.

What we heard:

“They took it [Medicaid] away, straight up. . . . I didn’t make any more money and any less; they just took it away. And I even went as far as telling my [social] worker . . . ‘you know, just let my son stay on it,’ you know what I’m saying? I don’t care about me too much. I’m concerned about my son, you know, with that asthma.” –African American female

“Also, at Kids Connection, if the children don’t have social security numbers they can’t be part of it. That’s because it’s part of the state. It’s different because for that you have to be a citizen.” –Rural Hispanic female

Section 4: Where Do the Uninsured Go for Health Care?

The uninsured often delay or go without needed medical care. Home remedies and leftover medications previously prescribed for a different person or condition are substituted for medical treatment for fear of incurring high costs and debt in the formal health care system. When the uninsured do seek care, their needs are sometimes met through formal safety-net providers, such as Federally Qualified Health Centers (FQHCs), and the informal safety net, which consists of private providers who have agreed to provide charity or low-cost care. Public clinics, such as FQHCs, are not available in most Nebraska communities. Focus group participants often described care provided by both the formal and informal safety nets as limited in scope and uncoordinated. The uninsured considered seeking care in the emergency room an option of last resort for fear of the high cost incurred.

The uninsured are more likely to seek care in a clinic than in a doctor’s office.

The usual source of medical care differs for the insured and the uninsured. The uninsured rely on public clinics, where available, for their health care (Figure 16). The type of clinic used also differs among the insured and uninsured (Figure 17).

Figure 16 - Usual Source of Care by Insurance Status, 2004

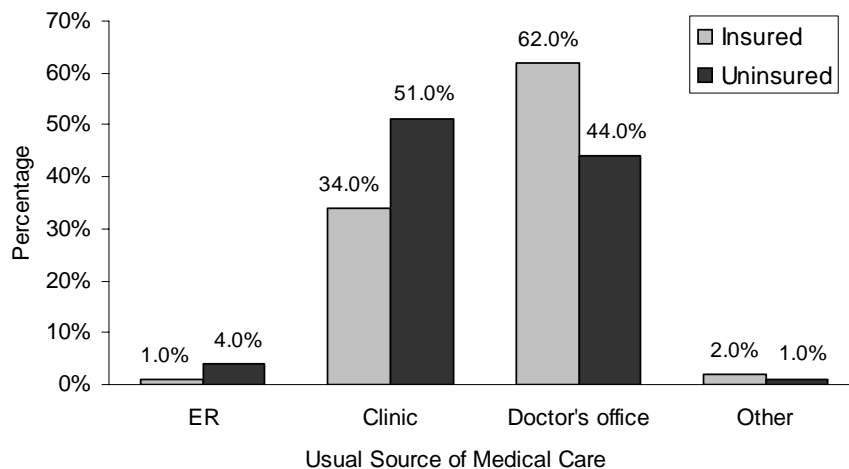
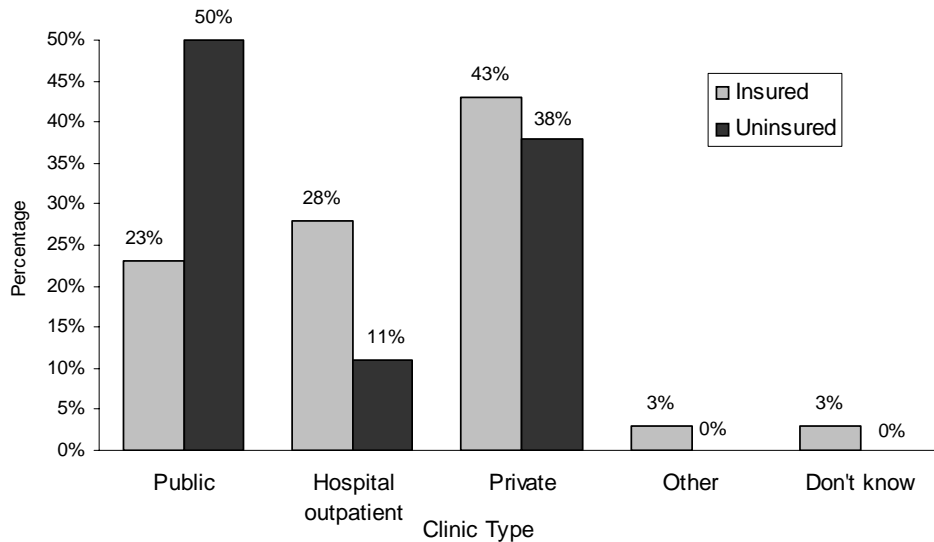


Figure 17 - Type of Clinic in Which Care is Obtained, by Insurance Status, 2004



What we heard from those with access to a formal safety-net clinic:

“They [FQHC in east central Nebraska] don’t throw you out the door if you say you don’t have the money. If you can’t afford to give them nothing, they still treat you just like you had a \$100 bill in your pocket.” –Low-income White male

“[This place means] being healthy so you can live a happy life. . . . Being healthy just makes me feel like a better person, like I’m more productive. My attitude is, if I can’t go to work, I feel kind of worthless.” –Low-income White male

“You really do have hope when you come here and you know that you’ve got a safe place to come, where they will take care of you.” –Low-income White female

“But that clinic [One World] has no more capacity, as well as Hope [Medical Outreach Coalition]; they are both saturated.” –Urban Hispanic male

What we heard from those without access to a formal safety-net clinic:

“I’m being sued by a doctor’s office here. . . . They want \$318 a month, and the house payment is \$200 a month.” –Low-income White female

“It costs \$79 to walk into a doctor’s office in my town . . . just to go in and say real quick, ‘this is what’s going on.’ ” –Low-income White female

“But if you don’t have money, they don’t take care of you. . . . You go to the people that sell medicine from the country you come from. We know that it’s illegal to buy those cheap medications, but we don’t have too many options.” –Rural Hispanic male

Section 5: What Are the Consequences of Uninsurance?

Lacking health insurance affects individuals' and families' quality of life. Nebraskans without adequate health insurance reported that they were likely to delay needed medical care; make decisions between spending income on health care or basic needs; and experience adverse psychological consequences, often as a result of the financial stress of being uninsured.

Being uninsured affects quality of life.

People without insurance tend to delay obtaining health care. Fourteen percent of the uninsured reported that there was a time in the last 12 months when they needed care but could not get it, compared to 3% of the insured.

The uninsured worry about paying for health care. Forty-eight percent of the uninsured compared to 36% of the insured worried that they would have to pay more than expected for health care.

Uninsured Nebraskans often must choose between meeting basic needs and obtaining medical care. Uninsured focus group participants reported facing the dilemma of deciding between meeting basic needs for their families, such as food and rent, or using money to obtain health care for themselves or a family member.

What we heard

Without adequate health insurance, participants reported feeling “Stuck” “Depressed” “Frustrated” “Worried” “Mad” “Hopeless” “Suicidal.”

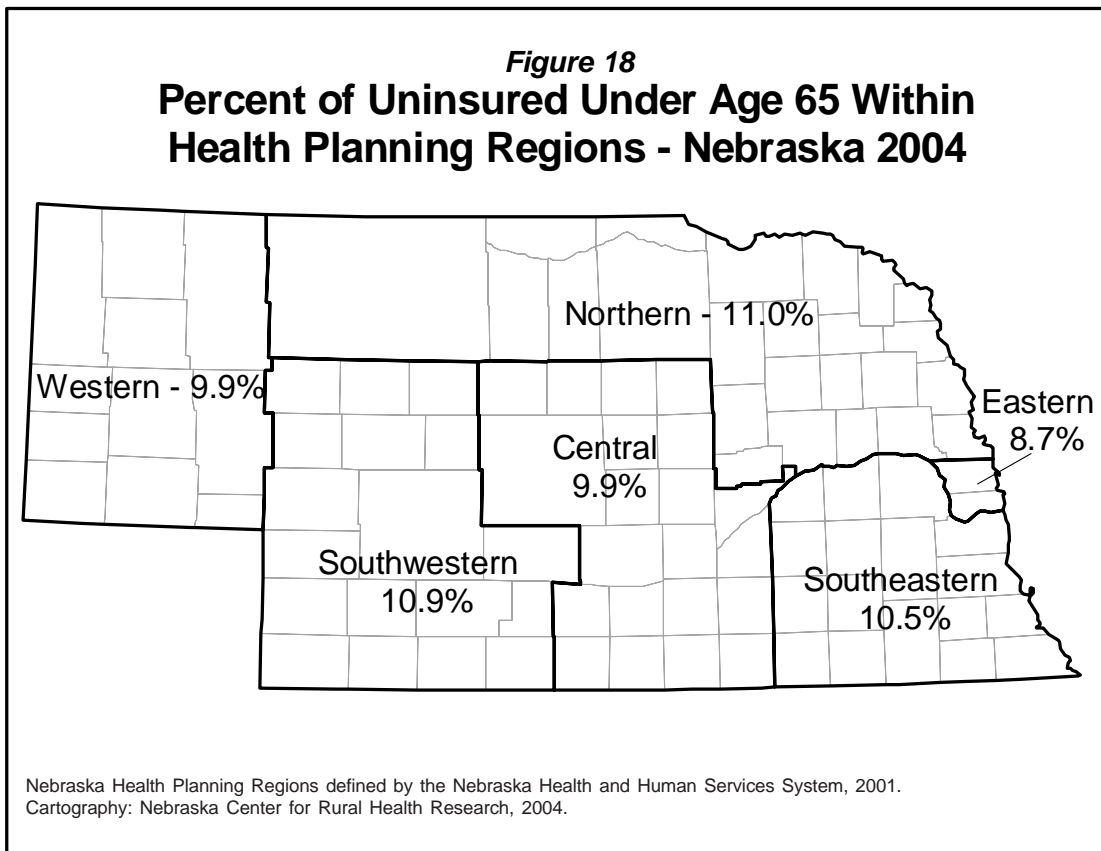
*“When you’re surviving paycheck to paycheck, when you’re sick, there’s no paycheck.”
–Low-income White female*

“We have a friend who had an aneurysm. . . . Now they are in the situation where what they owe is worth more than their ranch.” –White rural employer

High rates of uninsurance affect economic development in rural communities.

Health care facilities and providers in rural areas contribute jobs, income, and tax revenue to local economies. The presence of hospitals and physicians in a rural area positively affects the economic viability of the community. Employment impact is an example of this: health-related jobs comprise between 10% and 20% of local employment opportunities in rural counties.⁵ High uninsurance rates and the related burden of uncompensated care are a major factor in the closure of rural hospitals.¹ Hospital loss and high rates of uninsurance also lead to physician loss.¹ When local rural communities lose facilities and providers due to increasing rates of uninsurance, economic viability is placed at risk.

In addition to the effect of uninsurance on a community’s economic viability due to burdens placed on the health system, uninsurance may affect a community’s development in other ways. Rural small employers who participated in focus groups perceived three effects of high costs of health insurance on rural economic development. First, the high cost of insurance prevents small employers from offering it and thus discourages young families from taking jobs in rural areas. Second, the high cost of insurance and health care was perceived as diverting resources from other economic activities that would improve rural development. Third, the high cost of health insurance causes rural families to be uninsured and thus decreases access to health care. Furthermore, the rate of uninsurance is higher in rural areas of Nebraska than in urban areas. As supported by the telephone survey, among Nebraskans younger than 65 years, the uninsurance rate was 11.1% for individuals living in non-metropolitan counties and 8.7% for individuals living in metropolitan counties (Figure 18).



What we heard

“They are looking for a job where they can get decent insurance for their families, and that means moving to an urban area.” –Rural White female

“Spending all that money on insurance and health care impedes development. We don’t have the money to put into something else in the community when it is all going to health care costs.” –Rural White agricultural small employer

What we heard:

“It’s no longer going to be the community you grew up in; it’s just going to become a dust bowl or something. Everybody’s going to have to leave just to live life and be healthy.”

–White college-aged male

“The first thing we said when we came in, one of the very serious problems of living in central Nebraska, as well as southwest Nebraska, is poor wages and lack of health care. And if there were ways that employers could have some help with the health care, they might hire more employees or they might invent more jobs and come here and start them.” –Rural self-employed White male

Uninsurance hurts the productivity of Nebraska’s workers.

Uninsurance is also reportedly costly to both public and private sectors, resulting in more sick days and less-productive employees. According to the Institute of Medicine, there is significant economic value to be gained through better health outcomes by insuring all Americans. Assuming the uninsured would use health care as those do who currently have insurance, between \$65 billion and \$130 billion would be gained from higher worker productivity nationally as health outcomes would be better from improved health care.⁶

What we heard:

“Well, if an employer pays for your health insurance, they’re investing in themselves ’cause if you injure yourself at home and can’t show up for work, they’re losing productivity, but if they insure you, you can get treatment and you can get back to work a lot faster.” –White male community college student

Section 6: Why Should We Care About the Uninsured?

The costs of caring for the uninsured are transferred to the insured through higher health care costs and taxes.

About \$35 billion was spent on uncompensated health care for the uninsured in 2001, though people who were uninsured for an entire year averaged approximately half the amount of medical costs as those who were insured.⁷ Taxpayers are largely responsible for paying for the medical costs of the uninsured. Seventy-five to 80% of uncompensated care for the uninsured is publicly supported through federal, state, and local government programs.⁶

We have a moral obligation to the uninsured.

Providing health insurance is believed by some to be a moral obligation. Because the health of individuals determines the health of communities, many employers and uninsured focus group participants believed that providing health insurance to employees was a moral obligation. Both employers and the uninsured agreed that having adequate health insurance allows Nebraskans to enjoy a higher quality of life by helping them to maintain their health through prevention and early treatment and to minimize worry about incurring medical debt.

A moral obligation also may be said to arise from the fact that uninsured focus group participants consistently reported that they valued health insurance but were uninsured because they had to decide between meeting basic needs for their families, such as food and rent, or using money to purchase insurance. Though it was difficult to make the decision to be without insurance, they chose to take that risk rather than forgo meeting the basic needs of their families.

What we heard:

“Having health insurance allows you to fulfill your obligation to your family and maintain a quality life, a healthy life.” –Native American female

“I feel so sad and hurt and worried to hear about pre-existing conditions [that prevent people from getting insurance]; it just seems like society couldn’t tolerate that.” –Self-employed White female

“I look at what it is going to take for [my employees] to get insurance. If I have to, I will cut somewhere else, such as in advertising, to pay the cost. It is a social reason.” –Rural small employer

“You just want to be able to take care of your family. We all need to be healthy . . . to be able to function, you know, in society, in school.” –Rural Hispanic female

Section 7: Conclusion

Providing health insurance to all Nebraskans will support their contributions to Nebraska's economy and help all Nebraskans achieve "the good life." The cost of health care is a barrier to access for the uninsured and the underinsured that results in health disparities, burdens the health and social service providers in communities, and contributes to the inefficient use of the health care system. The consequences of uninsurance can be damaging to individuals, families, businesses, and communities and may be mitigated by implementing policies to provide coverage for low-income Nebraskans and to provide small employers with affordable health insurance options. Participants across all groups conveyed the message that the entire U.S. health care system is broken and that they would prefer to have access to health care and not health insurance.

What we heard:

"I think we need to separate health insurance versus health care here for your research. I don't believe in it [health insurance]. It's the only system we happen to have in this region, but I don't think it's the only one we hope for. There's other ways to get health care than paying for insurance that isn't going to pay for health care anyway." –Rural self-employed female

"I think the medical system in this country sucks. It's horrible. If you don't have money, you don't get health care and that's BS. That's not the way it's supposed to be." –White male community college student

"Poor people die a lot faster; that's the truth of the matter." –Low-income White female

"Listen to the little people." –Low-income Asian female

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Appendix A: Data Collection

Household Survey

Statistical information in this report is based on data collected from the Nebraska State Planning Grant random-digit-dialed household telephone survey. Random-digit dialing was used to minimize selection bias due to unlisted numbers. Based on the preferred language of the respondent, the survey was conducted in English or Spanish. To insure balanced geographic sampling, approximately 600 surveys were completed from within each of Nebraska's six health planning regions (Figure A.1). One person in each contacted household was randomly selected to complete the survey. To obtain more precise estimates of the uninsurance rates among minorities, Hispanics and African Americans were sampled with higher probability in certain areas of the state.

Between March 10 and May 8, 2004, 3,750 adults between the ages of 19 and 64 were surveyed; 2,625 surveys were completed, resulting in a response rate of 70%. The purpose of the survey was to identify the demographic characteristics of Nebraska's uninsured, their geographic location, their perceived health status, and the nature of the barriers they encountered in obtaining health insurance. The survey required approximately 20 minutes to complete. Each participant was asked up to 47 questions covering the following general topics: the types of health insurance available to the respondent, the amount of coverage the respondent had, a description of the respondent's health services utilization patterns, the respondent's perception of his/her health status, and the respondent's attitudes about health care and health insurance. Demographic questions about race, marital status, employment status, and age were also included.

Focus Groups

Data collected in the household survey were supplemented by information obtained from participants in 13 focus groups conducted between June 3 and July 27, 2004, across the six health planning regions of Nebraska (Figure A.1). Based on data collected in the household survey, the following demographic groups that are most likely to be uninsured or underinsured were targeted for inclusion in the focus groups: urban African Americans, urban Native Americans, rural Hispanics, urban Hispanics, students in technical college, those with low income, and refugees. Focus groups of small employers and self-employed Nebraskans were also conducted, as data indicates that these groups also struggle to offer/obtain health insurance.

Key contacts known and respected within each demographic group were used to recruit and host the focus groups. These key contacts were obtained by working with the State of Nebraska Health and Human Services System, the Nebraska State Health Insurance Policy Coalition, Area Health Education Centers, and members of civic organizations. Each key contact was asked to recruit 10 to 12 focus group participants. As required by the Institutional Review Board at the University of Nebraska Medical Center, an informed consent process was used to insure that all focus group participants were fully informed about measures taken to protect their privacy and about the risks and benefits of participating in the groups. The participants were offered a light meal and a \$40 stipend as compensation for the approximately four hours of their time required for travel and participation in the focus groups. Demographic information, income, and insurance status were obtained anonymously from each participant in order to interpret the findings of each group. Proceedings from each of the groups were audio-recorded and transcribed. All of the Hispanic groups were conducted in Spanish. Transcripts of the focus groups were analyzed to identify the frequency of participant comments categorized according to themes.

Figure A.1

