[Chapter Three]

Consequences of the Uninsured and Underinsured

Living without health insurance greatly impacts the life of an individual. The uninsured are less likely to receive adequate care and often when they do, it comes later, with serious consequences such as increased mortality and lower quality of life. Furthermore, the uninsured and underinsured are less likely to receive the preventive care they need.

In addition to affecting the individual, the uninsured dramatically impact the communities in which they live:

- The uninsured are often unable to pay for medical services they receive.
- These expenses are passed on to others through higher medical fees and insurance premiums.
- Since many uninsured and underinsured individuals obtain primary care at emergency rooms, they risk overburdening of the local trauma system.
- This impacts the finances and ability of emergency rooms to handle trauma.
- The overuse of an emergency department can even lead to increased local taxes.

Many individuals without health insurance still seek care, but often not in the most cost-effective manner. Since emergency rooms are obligated to evaluate every patient who comes seeking care and offer immediate services if needed, they are often seen as a reliable source of care. Unfortunately, this is an expensive and inefficient way to receive care. A more cost-effective setting for the uninsured to seek care is through Federally Qualified Health Centers (FQHCs). These are local non-profit community health providers that provide affordable primary care and prevention services. Unfortunately, less than 10 percent of the uninsured population in Texas is served by FQHCs (Camacho, 2004).

In this chapter, we will review the individual and societal consequences of being uninsured and underinsured. We will begin by reviewing the impact on the health of the individual. We will also look at the effect that the large number of uninsured has on local hospitals, local economies, and the Texas economy as well as on large and small businesses.

Consequences for Health Status

Poorer Health and Shorter Lives

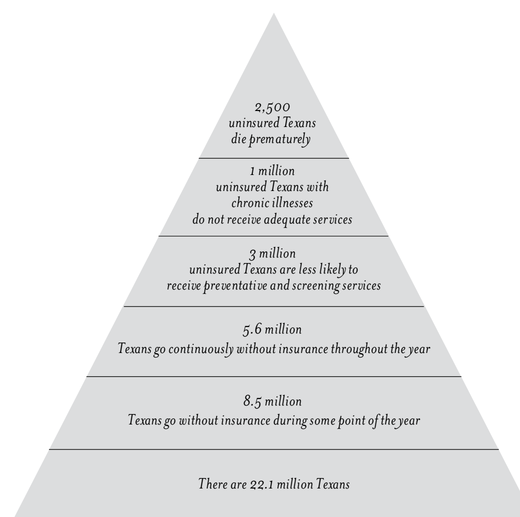
Texas leads the nation, at 25.1 percent, in the percentage of people who lack health insurance (U.S. Census Bureau, 2005). The tragedy of this is that the uninsured are more likely to be hospitalized for problems that could have been prevented had they received appropriate and timely outpatient care. Screening and subsequent referral is a critical component of the detection of disease in its early stages.

People who lack health insurance have reduced access to preventive care and are less likely to receive timely diagnosis of screenable conditions such as cancer and high blood pressure (IOM, 2002). This is true in both the young and the elderly. Uninsured children are much less likely to have received a well-child checkup within the past year, regardless of age, race, ethnicity, income or health status. A recent study shows that over 50 percent of

uninsured children did not receive a checkup in 2003, almost twice the rate (26 percent) for insured children (Kenney, *et al.*, 2003). Additionally, the insurance gap in Texas is especially high among Hispanics, of whom 60 percent are without health insurance (Families USA, 2003). These findings are particularly worrisome given the aforementioned shifting demographic trends in Texas (see Chapter Two – Uninsured in Texas).

For those that have access, screening for cancer can be particularly effective. Cancers that can be detected early by screening account for about half of all new cancer cases and include cancers of the breast, colon, rectum, cervix, prostate, oral cavity and skin (ACS, 2005). In 2005, an estimated 1.3 million people in the United States will be diagnosed with cancer, and over half a million will die of the disease that year. Estimates of the premature deaths that could have been avoided through screening vary depending on a variety of assumptions, but may be as high as 35 percent (ACS, 2005). Beyond the potential for avoiding death, screening may reduce cancer morbidity since treatment for earlier-stage cancer is often less aggressive than for the more advanced cancers. Increasing age is one of the primary risk factors, and screening at recommended ages has been shown to reduce mortality from these cancers. According to the American Cancer Society, the five-year survival rate is about 85 percent (ACS, 2005).

Figure 1: Consequences of the Uninsured and Underinsured in Texas



The uninsured are more likely to suffer adverse consequences of chronic diseases such as diabetes. More than 1.3 million Texans have been diagnosed with diabetes, and an additional 300,000 are estimated to be undiagnosed, but living with the condition. Conservative estimates rank diabetes as the sixth leading cause of death in Texas (Texas Diabetes Council, 2005) and uninsured adults with diabetes are less likely to receive recommended services (IOM, 2002). Lacking health insurance for longer periods increases the risk of inadequate care for this condition and can lead to uncontrolled blood sugar levels, which, over time, put diabetics at risk for additional chronic disease and disability such as end-stage renal disease and blindness from diabetic retinopathy. Diabetes accounts for the greatest number of new cases of end-stage renal disease. As might be expected, uninsured patients with end-stage renal disease begin dialysis with more severe disease than do those who had insurance before beginning dialysis (IOM, 2002).

Overall, the uninsured receive less preventive care, are diagnosed at more advanced stages of disease, and once diagnosed, receive less therapeutic care than do the insured. Thus, lack of adequate insurance leads to premature death. The case of cancer, the second leading cause of death in Texas, is illustrative of this point. Individuals who are poor, lack health insurance, or otherwise have inadequate access to quality cancer treatment experience higher cancer incidence, higher mortality rates and poorer survival rates (IOM, 2002).

The situation is similar with HIV. Texas reported 4,802 cases of HIV (not AIDS) in 2003, for an overall rate of 22 cases per 100,000 people. This represented a 3 percent increase over the 4,666 cases reported in 2002. Uninsured adults with HIV infection are less likely to receive highly effective medications that have been shown to improve survival, and consequently, they die sooner than those with coverage (IOM, 2002). Having health insurance has been found to reduce mortality in HIV-infected adults by 71 percent to 85 percent over six months (IOM, 2002).

Even those for whom disease may not be fatal may experience diminished quality of life. Interest in health-related quality of life (HRQOL) is soaring, because Americans are living longer and wanting to stay active and independent for as long as possible. Great strides have been made in combating fatality from many illnesses, such as cardiovascular diseases. Although cardiovascular diseases are the leading cause of death in the United States, their impact on disability is also dramatic. Two-thirds of heart attack patients fail to recover fully and 20 percent of stroke survivors require institutional care (CDCP, 2004). Many survivors of these cardiovascular events cannot perform daily tasks. It is estimated that 10 million Americans are disabled by cardiovascular disease (CDCP, 2004).

Health-related quality of life is far worse for people with diabetes than for those without the disease. According to the Behavioral Risk Surveillance System, on average, older adults with diabetes reported nearly twice as many unhealthy days (physical or mental) compared to those without the condition (Brown, 2004). People with diabetes report having more disabilities, poorer health status, less income and less access to care. For these people, quality of life is impacted by depression, heart disease, stroke, blindness and limb amputations.

Cancer is another disease for which there are many more long-term survivors today than in the past. In addition to the side effects of treatment, other factors, including the cost of treatment, the need for increased medical care, and limited access to quality care, significantly impact the quality of life of these survivors.

Altogether, the lack of health insurance adversely affects access to screening procedures for cancer and high blood pressure as well as other potentially treatable diseases. It also contributes to diminished quality of life due to lack of preventive and therapeutic care. Increasing the number of insured children and adults would increase accessibility to preventive and standard health services, and thus offer more complete and beneficial care to all.

Consequences in Access to Care

Access to care implies that people have a place to go and the financial and other means of obtaining health care services (Aday, 1993). In this section we discuss the impact of the large number of

uninsured Texans on higher medical insurance costs, and higher costs of health services, emergency rooms and physician services.

Higher Health Insurance Costs

Nationally, nearly 48 million Americans were without health insurance for 2005, including 5.6 million Texans (Families USA, 2005; U.S. Census Bureau, 2005). A recent national study reports that more than one-third (35 percent) of the total $65 billion cost of health care services provided to people without health insurance is paid out-of-pocket by the uninsured themselves (Families USA, 2005). The remaining $43 billion is primarily paid from two sources: about one-third is from a number of government programs, and two-thirds is paid by people with health insurance through higher premiums.

In 2005, Texas ranks eighth among states in the highest amount of added premiums due to unreimbursed costs of health care for the uninsured, behind New Mexico, Oklahoma, West Virginia, Montana, Alaska, Arkansas and Idaho (Families USA, 2005). Assuming no major policy changes by 2010, Texas will rank fourth nationally. In Texas, the 2005 health insurance premiums for a family with private, employer-sponsored coverage are $1,551 higher annually due to the cost of the uninsured (Families USA, 2005). Premiums for individual health insurance coverage are $550 higher for privately insured Texans in 2005. By 2010, these hidden costs will increase to $2,786 for premiums for families and $922 for premiums for individuals.

Higher Cost of Health Services

The Kaiser Commission on Medicaid and the Uninsured estimated the 2004 medical cost for the uninsured nationally at $125 billion (Hadley, 2002). The cost borne by health care providers nationally is estimated to be $41 billion or 33 percent.

Non-citizens are almost three times as likely to be uninsured as are U.S. citizens. Nearly 60 percent of non-citizens went without insurance in 2002, compared to 21 percent of U.S. native-born citizens and 33 percent of naturalized citizens. In Texas, most of the uninsured are legal residents; of the state's uninsured, more than 4 million (72.8 percent) are U.S. citizens (HCHTF, 2004). The highest concentration of the Texas uninsured is in the larger urban areas, with 80 percent residing in just 35 of the state's 254 counties (for more details, see Chapter Two – Uninsured in Texas) (TDI, 2004).

The cost of uncompensated care to hospitals in the United States was estimated to be $22 billion, or 5.4 percent of total expenses in 2002 (Miller & Assoc., 2005). The Texas health care infrastructure is heavily strained by the large number of uninsured. The burden of uncompensated care falls on a system already struggling to meet increases in the demand for services resulting from demographic and reimbursement changes. From 1992 to 2003, the number of patients admitted to Texas hospitals increased by 32 percent, to 2.6 million from 1.9 million, while the population change during the 1990s was only 23 percent (Perryman, 2005). During the same period the number of outpatient visits more than doubled, from 16 million to an estimated 35 million.

There are many structural issues that limit Texas counties' capacity and availability of health services. Almost 25 percent of all counties (63 out of 254) do not have an acute care hospital (Perryman, 2005). Another 50 percent, 123 counties, have only one

facility. As the number of uninsured Texans continues to grow, the impact is being felt in the rise of bad debt and charity care as well as increased use of hospital emergency rooms.

Public policy trends in Texas, as in the nation, have resulted in a shift of responsibility for paying for health care services for the uninsured from the states to the local communities. Texas hospitals treated more than 134,000 charity inpatients in 2003 (Perryman, 2005). This care was provided by a variety of hospital organizations. Of the 532 hospitals in Texas, 137 (26 percent) are government-controlled. The largest proportion of these (20 percent) are run by hospital districts or authorities.

Impact on Counties with Hospital Districts

Hospitals within hospital districts in urban counties bear most of the burden for uncompensated care in Texas (Miller & Assoc., 2005). Of the 10 Texas counties with the largest number of uninsured residents, seven are counties that support hospital districts with local *ad valorem* taxes (Harris, Dallas, Bexar, Tarrant, El Paso, Travis and Nueces).

In Texas hospitals, uncompensated care (defined as bad debt plus charity care) increased from $3 billion in 1993 to more than $7.7 billion in 2003 (CHS, 2004). In 2003, Texas hospitals reported $3.5 billion in bad debt and $4.2 billion in charity care (CHS, 2004). Charity care is provided to patients who meet the hospital's own criteria for inability to pay. Only a portion of a patient's account that meets the hospital's charity care definition is recognized as charity.

An analysis of charity and other uncompensated care and community benefits underscores the heavy burden placed on hospitals and community clinics by uninsured Texans (CHS, 2004):

Emergency Care	*$369 Million*
Trauma Care	*$82 Million*
Neonatal Intensive Care	*$6 Million*
Freestanding Community Clinics	*$72 Million*
Collaborative Efforts With Local Governments	*$9 Million*

Impact on Emergency Rooms

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to screen emergency patients to determine whether an emergency medical condition exists, and if so, to stabilize the patient regardless of ability to pay. While the act assures access to emergency services, the payments for these services are largely below costs or unfunded (Miller & Assoc., 2005). Between 1992 and 2003, Texas hospitals reported a 55 percent increase in the number of emergency room visits from 5.5 million to 8.6 million. Texas hospitals were reimbursed 34 cents for every dollar in charges for emergency services. An estimated 31 percent of trauma patients are either Medicaid or uninsured patients (Texas Hospital Association, 2005). These trends in the utilization of emergency medical care services are not financially sustainable in the long run.

Emergency department utilization is on the rise nationwide (Seton Healthcare Network, 2002). Findings from the National Hospital Ambulatory Medical Care Survey indicate that there was an increase in use, in terms of annual visits per one-hundred persons, from 36 visits in 1992 to 37.8

visits (McGraig, 2001). Nationwide, the number of emergency departments grew only 1 percent in that time period, from 5,707 in 1992 to 5,769 in 1999 (McGraig, 2001).

While the number of emergency room visits increased in Texas, the capacity to care for emergency patients diminished. In 2002 there were 5 percent fewer emergency departments than in 1999. Also, the increase in limited-service hospitals has resulted in a decrease in emergency room patient capacity. Texas leads the nation in the number of physician-owned limited-service hospitals with 50 such facilities; 28 more limited-service hospitals under development. Between 2000 and 2004, the number of physician-owned limited-service hospitals in Texas doubled from 25 to 50 (Association, 2005b). Limited-service providers serve relatively fewer uninsured patients and deliver significantly less emergency care. Full-service hospitals had an average of 14,760 emergency room visits per year or 40.4 visits per day, compared to an average of 480 emergency room visits per year or 1.3 visits per day for physician-owned limited-service hospitals. In addition, many of the visits to emergency rooms are for primary care and non-emergencies. More detailed discussion on trauma centers and emergency rooms can be found in Chapter Eight – Trauma Care in Texas.

Impact on Emergency Room Diversion

Trauma care in Texas is regionalized. Most of the uninsured Texans live in urban counties where hospital district hospitals both provide most of the indigent care and are the primary source of Level I (most intensive level of care) trauma centers. The growing number of uninsured places these safety net health systems in double jeopardy.

In July 2002, the Texas Hospital Association published a study showing the impact of increasing demand on the state's emergency departments. Statewide, 66 percent of the hospitals reported that their emergency departments were at or above capacity, including 100 percent of the Level I and Level II trauma centers and 84 percent of the Level III trauma centers. Based on patient charges, 14 percent of patients seen in Texas emergency departments are trauma patients; a total of 20 percent of these patients reside in a county outside the one providing trauma care; and another 17 percent of the medical patients treated are in hospitals outside of their counties of origin (THA, 2005a).

All of the major hospital district hospitals and academic teaching hospitals that provide a large proportion of the care to the uninsured also serve as their community's Level I or II trauma centers. When a hospital's emergency room cannot handle additional patients, it may go on diversion. This is when the hospitals are unable to provide appropriate care to all trauma patients; therefore, they send new patients to another hospital in the area. In many areas, especially urban areas with trauma centers, emergency rooms are going on diversion more and more. The Texas Hospital Association reports that emergency room diversions are a significant health policy challenge (THA, 2005a). In 2003, 75 Texas hospitals diverted ambulances due to overcrowding and lack of staffed beds. All Texas Level I and Level II trauma centers diverted ground or air ambulances at some time during the year.

In 2004, the 234 Texas hospitals eligible to obtain state-designated trauma funding received only $18 million to help offset more than $222 million reported in uncompensated trauma care provided the previous year. In March 2005, another

$18 million in state trauma funds was distributed to the 221 eligible and applying hospitals to offset more than $208 million reported in uncompensated trauma care (TDSHS, 2005).

Impact on Physician Services

Pagán and Pauly (2006) studied the relation between community-level uninsurance rates and the unmet medical needs of insured and uninsured adults. They found that the proportion of the local population without health insurance coverage was positively associated with having reported unmet medical needs, but only for insured adults. On average, a five percentage point increment in the local uninsured population is associated with a 10.5 percent increase in the likelihood that an insured adult will report having unmet medical needs. They conclude that local health care delivery systems are negatively affected by high uninsurance rates.

Other studies have shown that access to health care for both the insured and the uninsured is impacted by high community-level uninsurance rates (Andersen et al., 2002; Cunningham and Kemper, 1998; IOM, 2003).

There is little empirical evidence documenting a direct relationship between the large number of uninsured patients and the lack of access to or availability of physician services in Texas. However, there are emerging trends that would indicate that access to physician services, especially for patients covered by Medicaid, is becoming increasingly difficult.

The Texas Medical Association conducts a survey of Texas physicians every two years to track changes in physician practice behaviors. The 2004 survey found that only a small percentage, 6 percent, of Texas physicians in active practice reported that they are not accepting any new patients, regardless of insurance status (THA, 2004).

The following statistics represent those with open practices, currently accepting new patients:

- *Uninsured Patients* – In spite of their difficulties in financing costly medical services, uninsured patients had relatively better access to basic physician services, as 68 percent of physicians with open practices continue to see new uninsured patients and only 2 percent of physicians reported refusing to take new uninsured patients.

- *PPO Insured Patients* – Eighty percent of Texas physicians with open practices reported accepting these privately insured patients.

- *Medicaid Patients* – Access for Medicaid patients continues to decline. Only a minority of Texas physicians (45 percent) report unlimited acceptance of new Medicaid patients, a decrease from 49 percent reported in 2002 and 67 percent reported in 2000. A majority (62 percent of physicians) report that they accept no Medicaid patients, because of low reimbursement.

- *Medicare Patients* – In 2004, access for Medicare patients significantly decreased. Two-thirds (68 percent) of physicians with open practices continue to accept all new Medicare patients, but that number has declined from 74 percent in 2002 and 78 percent in 2000. Access to new Medicare patients varied by physician specialty: psychiatrists (46 percent), internists (59 percent) and family practitioners (60 percent) were less likely to accept new Medicare patients. Regionally, acceptance of new Medicare patients varied: The urban areas of Dallas and Fort Worth reported the lowest

acceptance (63 percent) and (62 percent) respectively, with Lubbock (86 percent), Brownsville (80 percent) and El Paso (76 percent) reporting the highest acceptance proportions.

Clues to physician practice behavior can be gleaned from a better understanding of the costs of providing medical services. According to the Medical Group Management Association (MGMA) data compiled by the Texas Medical Association, the average cost per medical service, measured in relative value units or RVUs, was $58 or about 28 percent less than billed charges of $81 per RVU. Medicare fees (2004) in Texas are only $37, or 36 percent below the average cost; and Medicaid fees of $27 were almost half the cost.

While many Texans remain uninsured, costs of insurance, emergency rooms, and health and physician services are increasing. To compensate for care of the uninsured, local communities are taking on health care costs and insurance premiums are increasing. The uninsured are resorting to crisis care in emergency departments, which leads to emergency room diversion and inadequate care. Further, erosion of the private and public reimbursement over time has diminished physicians' ability to continue to provide medical services below cost, especially to Medicaid patients. These are areas of increasing concern in maintaining or improving access to care in terms of cost and location.

Effects of Uninsured to Texas and Local Economies

As noted previously in this chapter, the costs of providing health care to the uninsured are substantial. Data from the Texas Department of State Health Services (TDSHS) survey in 2003 showed that 466 hospitals (two hospitals were not included) had $7.5 billion in total uncompensated care, both bad debt and charity charges. Hadley and Holahan reported in Health Affairs (February 2003) that uncompensated care by hospitals comprises approximately 63 percent of overall charges for care of the uninsured. Clinics and direct care programs account for approximately 19 percent and physicians 18 percent of uncompensated care, respectively. It is difficult to extrapolate directly from charges to incremental costs of care, but even if costs are conservatively estimated at 50 percent of charges, this indicates real costs to the state approximating $6 billion.

In the face of health care inflation, costs have significantly increased between 2003 and 2005. Texas does receive some federal assistance to offset these costs in the form of disproportionate share hospital (DSH) payments, which were approximately $900 million in 2004 ($1.3 billion including the state portion) (THHSC, 2004). This still leaves in excess of $5 billion in real costs which are borne through a variety of state and local programs and by the institutions and providers themselves (for more details on DSH and Medicaid, see Chapter Four – Medicaid and SCHIP in Texas).

While clinics and hospitals may receive some philanthropic support, and physicians may donate some time to provide uncompensated care, these costs are largely borne by local and state taxes and by cross-subsidy from paying patients. In other words, income from private insurance, Medicare, Medicaid and direct patient payments must provide enough operating income so that these institutions can provide uncompensated services, or they would be bankrupted.

Although health care costs continue to rise, Medicare reimbursement does not rise at the same rate as health care inflation, thereby decreasing the capacity for cross-subsidy from Medicare sources. Vigorous negotiations by managed care organizations and insurance companies continue to put pressure on hospital income and limit the cross-subsidy. As a result, pressures are growing to increase local community support of public hospitals, and public clinics continue to grow, particularly in large metropolitan areas.

Consequences to Business

Rising health care costs, coupled with uncertain economic conditions and declining profits, have created new pressure for companies and the people who help manage company health care programs – with no obvious short-term solution. Even companies with rising profits are unhappy with the current situation. In fact, nearly 66 percent of companies indicated that they have experienced significantly more pressure to manage internal costs than in the past (TDI, 2004). The confluence of these factors makes the challenge of providing health care coverage a highly visible and business-affecting issue.

Impact on Employee Wages

At double-digit increases, health care costs are growing faster than employer production and employee wages (TBGH). Costs for most employers are dangerously close to surpassing earnings. This rising cost trend is unsustainable in a market-based economy that is increasingly challenged to compete in a global marketplace; therefore many employers are passing on the high cost to employees through increased co-payments/co-insurance or premiums. Many employers are also looking at high-deductible health plans as a way out of their health care benefit cost and financing dilemma. In addition to higher deductibles, employees' share of their prescription costs have increased 25 percent to 30 percent over the last two years (TBGH). As a result, employees are now bearing 35 percent to 50 percent of the cost of health care through reduced wages, co-payments/co-insurance or higher premiums. If employers do offer "rich" benefits, the impact on wages is viewed by employees as a "pay cut." A 2004 study by Watson Wyatt Worldwide found that employers offering "richer" health care benefits have higher turnover rates.

At the other end of the spectrum, some employers have had to reduce hours or staff to eliminate the cost of providing health care. As a result, the uninsured percentage has jumped to 25.1 percent and the cost to continue coverage through COBRA or individual policies is just not attainable for many. COBRA is a requirement for most employers with group health plans to offer employees the opportunity to temporarily pay for their group health care coverage under their employer's plan if their coverage ceases due to termination, layoff or other change in employment status (referred to as "qualifying events"). Of the 45 million uninsured in America, 46 percent have shopped for health coverage, but only 2 out of 10 have been able to afford to purchase it (TBGH). Children and adults are less likely to receive necessary treatment without insurance, which means the uninsured may be sicker than the rest of us – they cannot get better jobs, and because they cannot get better jobs they cannot afford health insurance, and because they cannot afford health insurance they get even sicker.

Impact on Productivity

Although Americans are now living longer than ever before and population health has increased dramatically over the last century, there are

some areas of concern. For example, obesity has increased 61 percent in a 10-year period and accounts for 27 percent of growth in overall health care spending (TBGH). The prevalence of diabetes has increased 49 percent between 1990 and 2000. As the incidence of disease increases, employer costs are greatly impacted, because illness affects both the quantity of work (people might work more slowly than usual, for instance, or have to repeat tasks) and the quality (they might make more – or more serious – mistakes).

Brown, et. al. (2005) estimate the economic and productivity losses associated with diabetes in the Rio Grande Valley of South Texas to be $228 million per year. Bastida and Pagán (2002) estimated that women with diabetes earn $3,584 less annually than women without diabetes, whereas men with diabetes earn $1,585 less annually than men without diabetes. Brown, Pagán and Bastida (2005) show that men with diabetes were 10.5 percentage points less likely to work than men without diabetes, whereas there were no diabetes-related differences for women.

Because of the increasing need for health care, increased utilization is one of the factors continually driving up costs. Another factor is technology and new drug and treatment development. Pharmaceutical development alone drives increased costs and significantly increased utilization rates. Stress, less exercise and poor eating habits are contributors to the deteriorating health status, but instead of changing behavior, patients rely heavily on the new drugs that treat stress, high cholesterol and blood pressure. In the U.S., increased prescription utilization accounts for 51 percent of the trend (TBGH).

Impact on Absenteeism and Presenteeism

As companies struggle to rein in health care costs, most overlook what may be a $150 billion problem: the nearly invisible drain on worker productivity caused by such common ailments as hay fever, headaches and even heartburn (TBGH). Researchers say that *presenteeism* – the problem of workers' being on the job, but, because of illness or other medical conditions, not fully functioning – can cut individual productivity by one-third or more. In fact, presenteeism appears to be a much costlier problem than its productivity-reducing counterpart, absenteeism. Unlike absenteeism, presenteeism is not always apparent. It is possible to know when someone does not show up for work, but one often cannot tell when – or how much – illness or a medical condition is hindering an employee's performance.

Many of the medical problems that result in presenteeism are, by their nature, relatively benign. Research on presenteeism focuses on chronic conditions such as headaches, back pain, arthritis, gastrointestinal disorders and depression. Progressive conditions such as heart disease or cancer, which require expensive treatments and tend to strike people later in life, generate the majority of companies' direct health-related costs. But the illnesses people take with them to work, even though they incur far lower direct costs, usually account for a greater loss in productivity. This is because they are so prevalent, often go untreated and typically occur during peak working years. Those indirect costs have long been invisible to employers.

Lockheed Martin commissioned a pilot study in 2002 to assess the impact of 28 medical conditions – some serious, some relatively benign – on workers' productivity. Researchers from Tufts-New England Medical Center in Boston found that even employees with less severe conditions had impaired

on-the-job performance, or presenteeism. Table I lists several of the ailments studied; for each one, it includes estimates of prevalence, productivity loss and annual cost to the company in lost productivity (this figure was based on the average Lockheed salary, of roughly $45,000). Together the 28 conditions set the company back approximately $34 million a year. Researchers have found that less time is lost from people staying at home than from them showing up but not performing at full capacity.

While detailed information about the relative roles of insurance coverage or its absence upon these issues is not available, it is clear that the uninsured have a higher prevalence of unmanaged chronic illness than those who have insurance.

Impact on Other Businesses

Employers who do not provide health insurance coverage increase the cost to other employers in the community by steering their employees to take coverage as a spouse under another employer's health plan. Some employers are countering those efforts, as well as the high cost of providing spouse coverage, by implementing spousal surcharges for covering spouses that have the ability to be covered under their own employer's plan. About 8 percent to 10 percent of companies levy spousal surcharges. In general, workers pay $40 to $200 a month more for health coverage if their working spouse takes their insurance and declines their own (NBGH).

A recent survey by the Kaiser Family Foundation says 12 percent of U.S. employers vary in what they pay for family coverage if an employee's spouse is eligible for benefits elsewhere. An additional 11 percent were "very" or "somewhat" likely to do so this year and next (Hadley, 2002). A 2003 Hewitt survey of 640 large companies said 7 percent required working spouses to enroll in their employer's health insurance program and 32 percent were considering doing so. The survey also found 8 percent required employees to pay more if a working spouse declined their own coverage; 27 percent considered doing so in the future.

Table I — A Presenteeism Report Card

Condition	Prevalence	Average Productivity Loss	Aggregate Annual Loss
Migraine	12.0%	4.9%	$ 434,385
Arthritis	19.7%	5.9%	$ 865,530
Chronic Lower-back Pain (Without Leg Pain)	21.3%	5.5%	$ 885,825
Allergies Or Sinus Trouble	59.8%	4.1%	$ 1,809,945
Asthma	6.8%	5.2%	$ 259,740
GERD (Acid Reflux Disease)	15.2%	5.2%	$ 582,660
Dermatitis Or Other Skin Condition	16.1%	5.2%	$ 610,740
Flu in the past two weeks	17.5%	4.7%	$ 607,005
Depression	13.9%	7.6%	$ 786,600

Source: Debra Lerner, Williams H. Rogers and Hong Chang, at Tufts-New England Medical Center

In the absence of government or private-sector intervention, the erosion of employer-based health insurance coverage will be significant. Steps need to be taken immediately to ensure that the number of uninsured not only does not increase but also is reduced over time. Those steps should be part of a plan to move toward a health system in which everyone has health insurance coverage and should be consistent with the need to restrain the growth in health care costs and improve the quality of care.

Consequences for Mental Health

The Problem

Recent changes in Texas mental health care eligibility requirements and funding have resulted in reduced numbers of treated patients, decreased efficacy of treatment and diminished efficiency of funds allocated for treatment. One in 20 Texans or their family members with a diagnosable mental disorder want and need access to treatment and medications (MHA Houston, 2005a), but approximately 14,000 Texans with mental illness (besides bipolar disorder, schizophrenia, or clinically severe depression) have recently become ineligible for most public mental health services due to changes in eligibility (MHA Texas, 2005). Additionally, Texas is only serving one-fourth of those currently eligible for these reduced mental health services (MHA Texas, 2005). With 3.1 million adults and 1.2 million children at risk for developing some form of mental illness in Texas alone, these provisions are proving highly inadequate.

Texas needs to supply accessible mental health system services to the many mentally ill adults and children who are uninsured and thus cannot find adequate care. In Harris County in 2003, 13,400 of the 25,000 adults who received services from the public mental health system were uninsured. Furthermore, 140,000 of the 500,000 adults with mental illness in Harris County have severe mental illness and 84,000 of these 140,000 have no public or private health insurance and depend only on the public mental health service system for treatment (MHA Houston, 2005b). In Texas, approximately 76,000 adults with severe mental illness were unable to access treatment from the public or private mental health systems. Overall, uninsured, indigent children and adults have the greatest need for publicly funded, state-supported mental health services, but have less access to care (MHNC, 2004).

Unfortunately, lack of accessible effective public mental health services has caused an increase in crisis care for mental health patients. Children and adults without insurance receive little or no service, forcing them to move from crisis to crisis where immediate but not long-term needs are met. Therefore, problems are not being fully resolved, while an increasing amount of money is being spent (MHNC, 2004).

Medicaid/SCHIP Coverage

Publicly funded adult mental health services now only cover bipolar disorder, schizophrenia, or clinically severe depression (with very few exceptions.) Additionally, new eligibility requirements have reduced the effectiveness of the Texas Recommended Authorization Guidelines (TRAG), which assess the mental health service needs of an individual (MHA Texas, 2005).

Because of such restrictive eligibility requirements, Texas can state that 25 percent of its "priority population" is being served. In reality, however, Texas serves only about 12 percent of adult Texans with

diagnosable mental illness and 6 percent of its children with emotional disturbance. The eliminated mental health services from the SCHIP benefit package have left 57,000 children without mental health coverage, and have caused the families of about 250 children per year to give up parental responsibilities in order to ensure that their children can receive the appropriate mental health care from the state (MHA Texas, 2005).

Mental health services that are covered by Medicaid include medications, physician services, psychiatrist-only counseling, rehabilitation services, targeted case management and inpatient psychiatric care (for children younger than 21 and adults over 65.) Additionally, Texans with mental illness who are enrolled in the state's Medicaid program may obtain care from Community Mental Health and Mental Retardation Centers (CMHMRCs) or other Medicaid providers (MHA Texas, 2005).

However, state payments are newly limited to the preferred drug list (PDL) for Medicaid recipients. To receive a drug (which could possibly be the most effective treatment) not included on the list, the patient must first "fail" treatment with a listed drug. Not only is each drug different and therefore non-interchangeable, but neurological damage can result from delays in proper medication, thus suggesting that a preferred drug list could be, in fact, detrimental (MHA Texas, 2005). Further, limiting access to appropriate psychotropic drugs actually increases overall costs 17-fold. This is due to increased hospitalization costs and results in increasingly harming the patient and state by prolonged ineffective treatment.

Health Consequences

Current mental health service practices have negatively impacted the health of those being treated, as well as other patients, families, and children. Minorities are less likely to receive quality care for mental illness-related problems, and children now have a 90-day waiting period for SCHIP services. In addition, when children turn 19, they can find their benefits are gone, because they no longer qualify for federal programs. And, as mentioned above, inadequate drug prescription slows and/or reduces the effectiveness of treatment. Moreover, those patients who are forced to go to emergency rooms have negative effects on other patients, according to physicians (MHA Texas, 2005).

Overall consequences of untreated mental illness manifest themselves in poor school performance, juvenile/criminal justice involvement, unemployment, homelessness and suicide (MHNC, 2004). Specifically, homelessness accounts for 3,900 individuals with mental health problems at any time in Houston, 2,000-2,500 of whom suffer from severe and persistent mental illness (HCHTF, 2004). Those who become unemployed and sometimes consequently become homeless due to mental illness find themselves trapped and distanced from sources and means of help.

Economic Consequences

Cutting mental health care dollars can increase the overall medical costs, because rather than treating the underlying problem, "quick fixes" are being used to treat side-effects (NMHA, 1993). In general, mental illness incurs direct and indirect costs to the state. Direct costs include the operation of public health facilities and the criminal justice system, while indirect costs include employment and earnings, productivity, health care costs and costs to families (MHA Texas, 2005). Overall, the National Advisory Mental Health Council estimates that providing

mental health coverage equal to other health coverage would save $2.2 billion annually in savings for general medical services and reduction in indirect costs such as absenteeism (MHA Houston, 2005a). In 2002, Texas spent $38.36 per capita on mental health, or 44 percent of the national average. This was only 1.5 percent of all state spending, and 75 percent of the national average of 2 percent (MHA Texas, 2005).

In general, there is a loss of productivity from depression and mental illness, resulting from absenteeism and presenteeism, which adds on to the losses due to disability costs, lost earnings and social costs (NMHA, 1993; MIT, 2002; Whitmer, 1999). Employees of six large employers showed that those with depression had medical claims 70 percent higher than the average expenditures for medical problems (such as smoking, high cholesterol and high blood pressure) (Whitmer, 1999). Additionally, medical costs declined by $882 per employee per year when workers with depression were treated with prescription medicines (Coalition for Fairness, 2003).

Another study has shown that employees with depression lose four or more hours per week in productive time than those without depression. In a company of 1,000 employees, this equates to about 19,300 hours of lost productivity per year. Overall, Americans lose 200 million work days to depression each year, costing employers $44 billion in direct treatment, absenteeism, lost productivity and mortality. For depression treatment alone, the savings realized by equalizing mental health benefits could offset the incremental medical plan cost of equalizing mental health benefits for all diagnoses. On average, it costs six times more to treat someone in an inpatient setting than in the community (MHA Texas, 2005).

Criminal Justice Consequences

Inadequate treatment and chronic under-funding of mentally ill patients leads to public costs related to crime and criminal justice, homelessness and uncompensated health care (MHA Texas, 2005). Among these, criminal justice spending included $1.2 billion to $1.8 billion for the mentally ill during 1993-1994 (MHA Texas, 2005). In Harris County, the average cost of a day in jail is $56, or $20,440 per year, and the thousands of inmates with mental health needs cost the taxpayers millions of dollars per year, financed primarily by county property tax. Recently, there has been a 25 percent increase in the budget for anti-depressant and psychotropic medication for the jail system (MHA Houston, 2005).

Because jails and juvenile facilities have become a primary source of treatment for many people with mental illnesses, partnerships between criminal justice and mental health organizations and officials are studying possible forms of community-based treatment. It has been shown to be cost-effective to keep offenders with mental illnesses out of the criminal justice system and provide them with such treatment, partially because they tend to be disruptive in jail and require special housing and more medical treatment. Congress recently authorized $50 million to fund the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, promoting the diversion of non-violent offenders with mental illness from jail (MHA Texas, 2005).

Not only is Texas' mental health care insufficient and undersupplied, but it is also leading to a progressively worse mental health status overall in Texas. New eligibility requirements have further limited access to care, and new practices have led to increased acute inpatient care and restricted prescription drug lists, among other setbacks. Such

constraints have contributed to a high turnover rate in patients, decreased productivity in the workplace, increased spending for recurrent visits to emergency departments, and untreated criminal offenders. This suggests the need for community-based programs that offer housing options and long-term support for gradual treatment and recovery. Only when public mental health care is more accessible and effective and the state is more committed to funding it will patients be treated in a manner beneficial to themselves and the state.

Summary

Altogether, lacking health insurance adversely affects many aspects of a person's life as well as aspects of their communities. An individual without health insurance has reduced access to care, which keeps him or her from receiving adequate check-ups and preventive care. The uninsured are more likely to have diminished quality of life and increased mortality than their insured counterparts. In addition, uninsured people who are mentally ill must rely solely on government programs to receive medications and treatments. As a result, many receive inconsistent care, leading to reduced efficiency of treatments.

The increasing uninsured population in Texas is also negatively impacting the state and local governments. Emergency rooms are overburdened with the increased admissions, and the uninsured constitute a disproportional share of these admissions. This is leading to increases in the costs of health insurance and the overall delivery of health care services. In addition, local taxes must be used, raising rates for individuals and businesses. Health insurance has become a major expense for businesses, which impacts wages as well as the number of employees.

The uninsured rate in Texas has become an increasing problem which requires cooperation and shared responsibility on the state and local levels for resolution. Without changing the current system, the problem of the uninsured will impact not only those directly involved such as hospitals and medical professionals, but also the community at large with increased taxes and reduced businesses and therefore the Texas economy as a whole.

References

Aday, L. A. 1993, At Risk in America: The Health and Health Care Needs of Vulnerable Populations in the United States: San Francisco, Jossey-Bass Publishers.

American Cancer Society, 2005. *Cancer Facts and Figures* 2005. American Cancer Society: Atlanta, GA.

Bastida E, Pagán, JA.. The impact of diabetes on adult employment and earnings of Mexican Americans: findings from a community based study. Health Econ. 2002 Jul;11(5):403-13

Brown D.W., Balluz L.S., Giles W.H., Beckles G.L., Moriarty D.G., Ford E.S., and Mokdad A.H., 2004. Diabetes mellitus and health-related quality of life among older adults. Findings from the behavioral risk factor surveillance system (BRFSS). Diabetes Res Clin Pract., v. 65, p. 105-115.

Brown HS 3rd, Estrada JK, Hazarika G, Bastida E. Diabetes and the labor market: the community-wide economic cost in the Lower Rio Grande Valley. Diabetes Care. 2005 Dec;28(12):2945-7.

Brown HS 3rd, Pagán JA, Bastida E. The impact of diabetes on employment: genetic IVs in a bivariate probit. Health Econ. 2005 May;14(5):537-44.

Camacho, J. (2004). FQHCs and the Uninsured. *Presentation to the Task Force on December 14, 2005*.

Center for Health Statistics. (2004). 2003 Annual Survey of Hospitals. in Texas Department of State Health Services. Website: http://www.tdh.state.tx.us/chs/hospsurv/OnlineReports/char2003.pdf.

Centers for Disease Control and Prevention. (2004). Chronic Disease Notes and Reports. Special Focus: Heart Disease and Stoke. *Department of Health and Human Services, At A Glance: Centers for Disease Control and Prevention*. Website: http://www.cdc.gov/nccdphp/cdnr/CDNRfall04.pdf.

Coalition for Fairness in Mental Illness, 2003. *Employers Should Support Mental Health Parity*. http://www.mhlg.org/business_3-03.pdf.

Families USA, 2003. Who's Uninsured in Texas and Why? Website: Washington, D.C., http://www.familiesusa.org/site/DocServer/Texas_uninsured.pdf?docID=2404.

Families USA. (2005). Paying a Premium: The Added Cost of Care for the Uninsured. Website: http://www.familiesusa.org/site/DocServer/Paying_a_Premium.pdf?docID=9241.

Hadley, J. (2002). Sicker and poorer: The consequences of being uninsured. A review of the research on the relationship between health insurance, health, work, income, and education. *Kaiser Commission on Medicaid and the Uninsured*: Washington, DC.

Hadley, J. and Holahan. J. (2003). How Much Medical Care Do the Uninsured Use, and who Pays for it? Web exclusive in *Health Affairs*. Website: http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.66v1/DC1.

Harris County Housing Task Force (HCHTF). (2004). Finding a Home: Houston Report on Housing for Adults with Mental Illness. Website: http://www.mhahouston.org/uploads/housingreport36.pdf.

Hewitt Associates. (2003). Creating New Health Care Behaviors Among Employees. Executive Summary of Hewitt Teleconference.

Institute of Medicine. (2002). Health Insurance is a Family Matter. *National Academies Press*: Washington, D.C. Website: www.nap.edu.

Kenney, G., Haley, J., Tebay, A. (2003). Children's Insurance Coverage and Service Use Improve. *Snapshots of America's Families III, The Urban Institute*: Washington, D.C. Website: http://www.urban.org/UploadedPDF/310816_snapshots3_no1.pdf.

McGraig, L. F. and Burt C. W. (2001). National Hospital Ambulatory Medical Care Survey: 1999 Emergency Department Summary. in Department of Health and Human Services, *Advance Data from Vital and Health Statistics: National Center for Health Statistics*. Website: http://www.cdc.gov/nchs/data/ad/ad320.pdf.

MIT Sloan School of Management, 2002. Coalition for Fairness in Mental Illness: Pass Mental Health Parity Now! End Discriminatory Mental Health Coverage. Website: http://www.mhlg.org/parity.pdf

Mental Health Association in Texas. (2005). Turning the Corner: Toward Balance and Reform in Texas Mental Health Services. Website: http://www.mhatexas.org/TurningtheCorner.pdf.

Mental Health Association of Greater Houston. (2005a). Comprehensive Mental Health Parity for Texas. Houston, Texas.

Mental Health Association of Greater Houston. (2005b). Untreated Mental Illness in Harris County: A Steep Price to Pay. Houston, Texas.

Mental Health Association of Greater Houston. Mental Health Issues Hit Your Bottom Line Hard. Houston, Texas.

Mental Health Needs Council. (2004). Mental Illness in Harris County: Prevalence, Issues of Concern, Recommendations.

R. K. Miller & Associates. (2005). The 2005 Healthcare Business: Market Research Handbook, 9th Ed.: Loganville, GA

The National Business Group on Health. Website http://www.businessgrouphealth.org/

National Mental Health Association. (1993). Why Mental Health Parity Makes Economic Sense., National Advisory Mental Health Council.

Pagán, JA. (2006). Personal communication.

Perryman, R.M. (2005). "Critical Condition!" The Perryman Report: Special Report: An Assessment of the Impact of the Health Care Sector on the Texas Economy, with Emphasis on the Situation Confronting Hospitals and the Effects of Medicaid and Children's Health Insurance Program (CHIP) Funding Reductions. The Perryman Group: Waco, TX, Website: http://www.thaonline.org/Advocacy/Perryman/THAStudy-020405.pdf.

Seton Healthcare Network. (2002). Out of the Emergency Room: Communicating Healthcare Options to Low Income Texans: Austin, Texas.

Stoll, K. and Jones, K. (2004). One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003. Families USA: Washington, D.C. Website: http://www.familiesusa.org/site/DocServer/82million_uninsured_report.pdf?docID=3641.

Texas Business Group of Health. Website: http://www.tbgh.org/

Texas Department of State Health Services. (2005). August 26, 2005 DSHS Uncompensated Trauma Care Distribution to Hospitals Website: http://www.tdh.state.tx.us/hcqs/ems/2005DSHS UncompensatedTraumaCareDistrtoHosp.htm

Texas Department of Insurance. (2003). Working Together for a Healthy Texas Final Report: Texas State Planning Grant. *Texas Department of Insurance – State Planning Grant Division*. Website: http://www.tdi.state.tx.us/general/pdf/spgfinalreport.pdf.

Texas Diabetes Council, 2005. The Changing Face of Diabetes: A Plan to Prevent and Control Diabetes in Texas 2006-2007. http://www.tdh.state.tx.us/diabetes/PDF/splan05.pdf

Texas Health and Human Services Commission (THHSC). (2004). Texas Medicaid in Perspective, 5th ed. June 2004. Website: http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html.

Texas Hospital Association. (2005a). Hospitals: Keeping the Promise.

Texas Hospital Association. (2005b). Report on Limited Service Providers.

Texas Hospital Association. (2005c). Texas Hospital Association Legislative Action Alert. Austin, Texas.

Texas Medical Association. (2004). Texas Medical Survey, "Medicare and Medicaid Access: Special Report-2004 Survey of Texas Physicians."

U.S. Census Bureau. (2005). DeNavas-Walt, C., Proctor, B.D. and Lee, C.H. Income, Poverty, and Health Insurance Coverage in the United States: 2004. in U.S. Census Bureau, and Current Population Reports, Washington, D.C.: U.S. Government Printing Office. Website: http://www.census.gov/prod/2005pubs/p60-229.pdf.

Watson Wyatt Worldwide. (2004). WorkUSA 2004/2005: Effective Employees Drive Financial Results.

Whitmer, W., Goetzel, R. and Anderson, D. (1999). The HERO Study on Risks and Costs: Research Findings.