- Linda*, a 17-year breast cancer survivor, had a catastrophic health insurance policy. Linda wanted a plan that was more comprehensive to cover her cancer screenings and regular check-ups. She applied for a policy in the individual market, but was denied because of her previous cancer diagnosis. With a pre-existing condition, it is unlikely Linda will find a comprehensive insurance policy in a market that allows medical underwriting and she is not eligible for any public programs.

While the HIAS can suggest options for dealing with the costs of cancer treatment to many callers, unfortunately, there are no options to address the needs of about 30% of people who seek help. Of those callers who had options suggested, 7 out of 10 found the options either unaffordable or inadequate. Lack of health insurance is an important barrier to cancer prevention and early detection; some of the patients who are struggling to pay for their cancer treatment could have prevented their cancers altogether or been diagnosed at an earlier stage had they had better access to health care.

measure that will be needed to address these disparities,

beneficiaries, with a sliding scale up to $238.40 for those with high incomes. Care at skilled nursing facilities is not covered by Medicare for the first 20 days; in days 21-100, Medicare will cover $256 per day. Medicare beneficiaries must also pay 20% of the Medicare allowable costs for services covered under Part B, which can be considerable in the case of a major illness such as cancer.[8]

Medicaid (Title XIX): Medicaid is a federally aided, state-operated and administered program that provides

childless adults were eligible for Medicaid or Medicare assistance.[12]

In most states, people who develop serious illnesses, including cancer, can qualify for Medicaid if, after medical expenses, their income falls below the state-established medically needy limit, which is typically well below the federal poverty level. To qualify for Medicaid

Figure 4. Percentage of Persons Younger than 65 Without Health Insurance Coverage at the Time of Interview by Age Group and Sex, January-March, 2007

Reference: Cohen RA, Martinez ME. Health insura

Islanders, and American Indians/Alaska Natives are much more likely to be uninsured than non-Hispanic whites (Figure 6). The most common reason that working individuals are uninsured is that their employers do not offer health insurance benefits.[19] Lack of employer-based health insurance is common for workers in small companies, low-wage workers, and part-time workers, as well as the self-employed.[19] When employees are offered employer-sponsored health insurance, uptake rates are generally more than 80%.[19]

There are numerous ways in which individuals or families can lose their health insurance. For example, an individual may lose or leave a job where insurance was offered; lose Medicaid eligibility when they or their children grow up; lose insurance through their spouse due to separation, divorce, or death; or be priced out of the market when the cost of premiums becomes unaffordable.[4] Parental health insurance coverage of children who are not students ends at age 18, as does coverage for many children

insured under Medicaid/SCHIP. Employer-based coverage sometimes fails to protect families from large medical expenses because illness may lead to job loss and the consequent loss of coverage.[20]

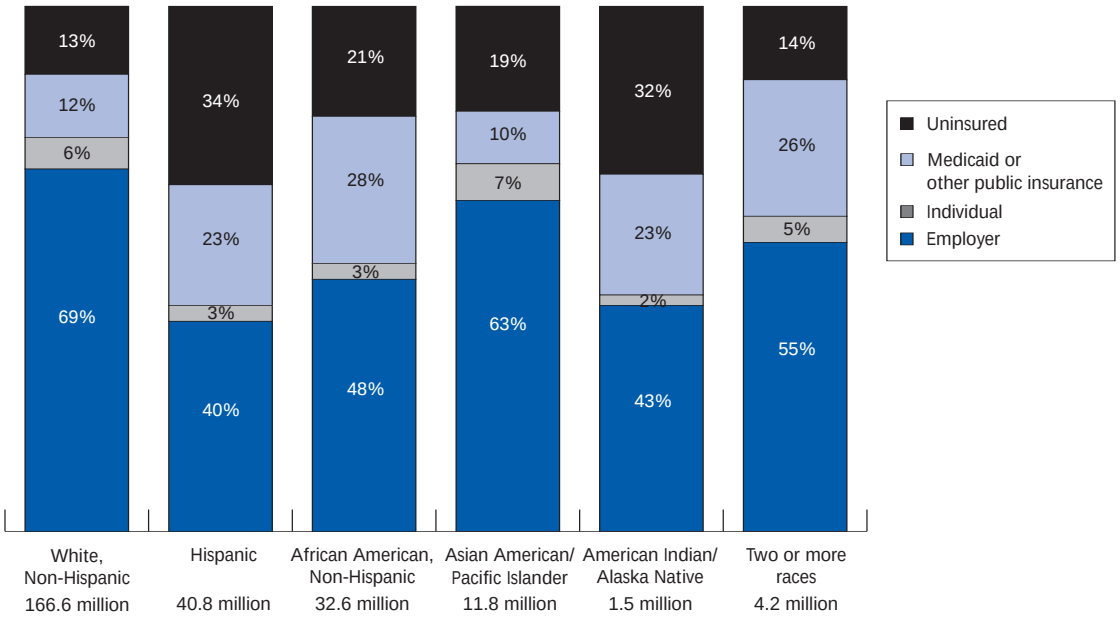
Who Is at Risk of Being Underinsured?

Health insurance generally does not provide total dollar coverage of health care costs. Covered services, deductibles, co-pays, and yearly or lifetime caps can vary considerably among the types of insurance that are available. Caps on total lifetime coverage or disease-specific coverage (e.g. $1,000,000) may be exceeded if prolonged, expensive medical care is needed. Almost everyone is at risk of being underinsured in the event of a major illness, but many individuals and families are underinsured even without experiencing a major illness. The term underinsured refers to people who have some form of health insurance, but who lack coverage for certain procedures or cannot afford the cost sharing associated with covered benefits, or both.[21] One common definition is that a person or family is underinsured if they would have to spend more than 10% of family income on out-of-pocket medical expenses in the event of a catastrophic illness.[22]

A recent study analyzed data from the Medical Expenditure Panel Surveys (MEPS), sponsored by the Agency for Health Care Research and Quality (AHRQ) for 1996 and 2003.[22] The MEPS household survey collects detailed information on health insurance coverage, health care utilization, and expenditures by sources of payment and additional data on health status, medical conditions, and other sociodemographic household characteristics.[22] According to this study, the percentage of non-elderly families who had out-of-pocket heath care expenditures (not including their insurance premiums) greater than 10% of after-tax family income increased from 6.7% in 1996 to 8.5% in 2003. When the cost of insurance premiums was included in calculating total expenses, the percent spending over 10% of after-tax income on health care rose from 15.8% in 1996 to 19.2% in 2003. Nearly one-quarter (24%) of the poor (family income <100% of federal poverty line) and 10% of the near-poor (family income 100% to <200% of the federal poverty line) reported total health care expenses exceeding 20% of family income. At all income levels, the burden was greatest for people with serious illness. Among people with cancer, 28.8% had total burdens exceeding 10% of family income, and 11.4% had total burdens exceeding 20% of family income.[22]

Even among the elderly population who have Medicare insurance, out-of-pocket health care costs can be considerable. In 2003, about 29.3% of all elderly persons had out-of-pocket spending on medical care in excess of

Figure 6. Health Insurance Coverage of the Nonelderly by Race/Ethnicity, 2005



Note: Nonelderly includes individuals up to age 65. "Other public insurance" includes Medicare and military-related coverage; SCHIP is included in Medicaid.
Reference: James C, Thomas M, Lillie-Blanton M, Garfield R. Key Facts: Race, Ethnicity & Medical Care. The Henry J. Kaiser Family Foundation, January 2007.
Source: Current Population Survey, March 2005.

$5,000, and 7.3% of all elderly persons had out-of-pocket spending on medical care in excess of $10,000.[23]

Medical debt is an important cause of bankruptcy filing in the US. A study of causes of bankruptcy among 931 people who filed for bankruptcy in the US in 2001 found that about half cited medical causes as an important reason for bankruptcy. Three-fourths of those with medical debt were insured at the onset of the bankrupting illness; 60.1% had private coverage, 5.7% had Medicare, 8.4% Medicaid, and 1.6% veterans/military coverage. About one-third of individuals who had private insurance at the onset of their illness lost coverage during the course of their illness. On average, the mean out-of-pocket expenditure for all debtors citing medical expenses for bankruptcy was $11,854. For debtors citing cancer as the medical condition associated with the bankruptcy, it was $35,878.[20] Compounding the financial consequences for individuals and families without health insurance are pricing policies in which uninsured patients are charged more for services. In 2004, a survey found that the rates charged to uninsured and other "self-pay" patients for hospital services were often 2.5 times what most health insurers actually paid and more than three times the hospital's Medicare-allowable costs.[24]

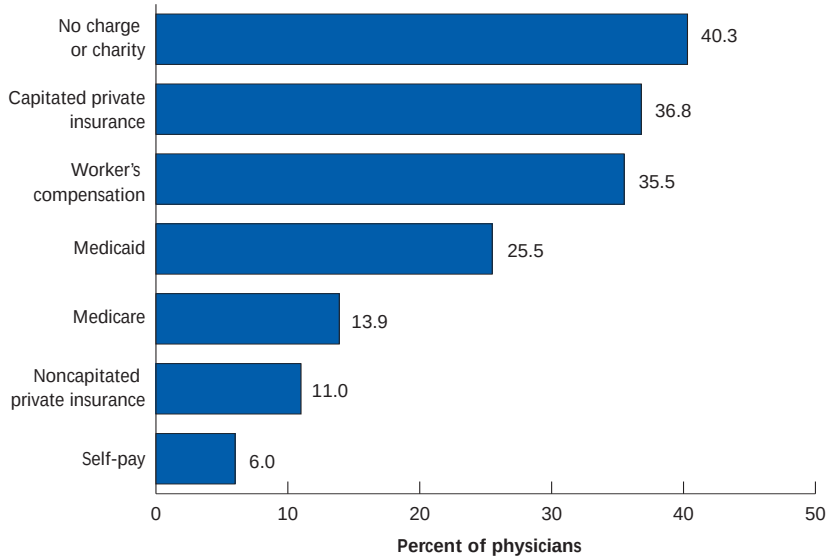
Even the very poor are at risk of medical debt and aggressive debt recovery practices. A cross-sectional study of patients being seen at 10 safety net provider sites in Baltimore, Maryland, found that 42% reported that they currently had a medical debt (average $3,409), and 39.4% reported ever having been referred to a collection agency for a medical debt. The mean annual income in the patients interviewed was $7,864, and 47.2% reported that they were homeless. Among individuals who had current medical debt or who had been referred to a collection agency in the past, 24.5% no longer went to that site for care, 18.6% delayed seeking care when needed, and 10.4 % reported "only going to emergency rooms now."[25]

How Does Health Insurance Impact Access to Health Care?

Individuals who are uninsured, underinsured, or insured by government programs may face significant barriers to obtaining health care. Some private physicians do not accept new patients unless they have private insurance or are able to pay the full cost at the time of the visit. For example, a recent national survey of office-based physicians found that, although 96% were accepting new patients, 40.3% did not accept "no charge" or charity patients, 25.5% did not accept Medicaid patients, and 13.9% did not accept patients covered by Medicare (Figure 7).[26] Patients who are unable to afford outpatient care in private practice settings often seek care in hospital emergency departments, which are required by law only to examine patients to determine if a medical emergency exists.[27] Consequently, many patients initially seen in emergency departments are referred to outpatient providers for follow-up care, but uninsured or Medicaid-insured patients may be excluded from care by the system.

A recent study employed scripted interviewers to contact clinics stating that they had been seen in a community emergency room the previous night and were seeking a follow-up appointment for a serious medical condition such as pneumonia or suspected ectopic pregnancy.[28] Callers claiming to have private insurance were almost twice as likely to receive prompt appointments as those stating that they had Medicaid insurance (63.6% versus 34.2%). Uninsured callers who said that they could pay cash for the entire charge at the time of the visit were equally likely to receive an appointment as those with private insurance, while only 25.1% of

Figure 7. Percentage of Office-based Physicians Not Accepting New Patients by Payment Method, 2003-2004



Source: Hing E, Burt CW. Characteristics of office-based physicians and their practices: United States, 2003-04. Series 13, No. 164. Hyattsville, MD: National Center for Health Statistics, 2007.

uninsured individuals who offered to pay $20 at the time of the visit were offered appointments.

As more Americans go without health insurance and as access to affordable health care decreases, millions of Americans turn to the health care “safety net” for their health care needs. At the core of the safety net are health

be advised to quit smoking or to lose weight (Table 1). An analysis of data from an earlier (2000) NHIS survey found that individuals with no insurance or with Medicaid insurance were less likely to use tobacco cessation aids in a quit attempt during the past year.[30]

Early detection and screening: Analyses of the NHIS and the Behavioral Risk Factor Surveillance Survey (BRFSS) have consistently found that individuals without health insurance have lower rates of cervical, breast, and colorectal cancer screening than individuals with health insurance.[31-34] A few studies reported screening rates for Medicaid insured patients that were lower than those for privately insured patients, but higher than for uninsured patients.[35,36] Studies of individuals aged 65 and older, using other suveys and data sources, found that individuals who were dually insured by Medicare and Medicaid or uninsured were less likely to receive cancer screening tests than comparison groups (those with Medicare alone or those with Medicare plus supplemental private insurance, depending on the study).[36-38]

Analyses of the NHIS 2005 survey also found that the likelihood of receiving recommended cancer screening te

were not Medicaid-enrolled. Although survival was somewhat poorer in the late-enrolled compared to the pre-enrolled group, this difference was not statistically significant.[41] A study of stage at diagnosis for cervical cancer patients diagnosed in California in 1996-1999 found that women insured by Medicaid were significantly more likely than women without Medicaid coverage (including uninsured and privately insured) to be diagnosed at late stage.[42] However, when risks were analyzed by duration of Medicaid enrollment, increased risk of late stage diagnosis was confined to those enrolled at the time of, or less than 12 months before, diagnosis, and

insurance survived for 5 years after diagnosis, compared with 66% of those with Medicaid insurance and 65% of those who were uninsured at the time of diagnosis. More detailed analyses were done for breast and colorectal cancers, two important cancers for which both early detection and quality of treatment are known to influence survival.

Figure 11 shows the stage distribution of breast cancer cases diagnosed among white, black, and Hispanic women in 1999-2000. In each racial/ethnic group, patients with private insurance were more likely to be diagnosed with stage I breast cancer and less likely to be diagnosed with stage III and IV cancer than those who were uninsured or who had Medicaid insurance. Breast cancer survival for all stages comb

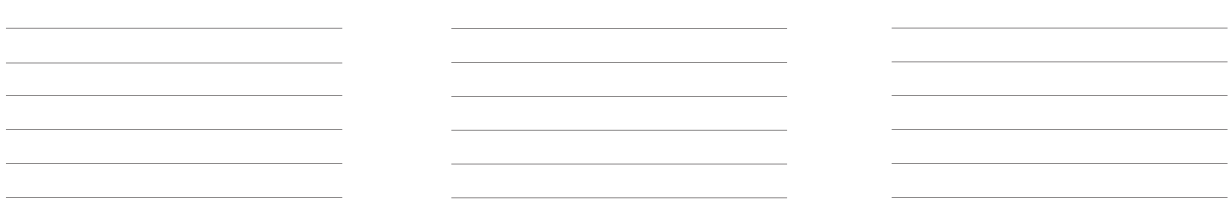
patients and 63% of Medicaid-insured patients (data not shown). When data were analyzed within each stage, survival was consistently lower for women who were uninsured or who had Medicaid insurance, compared to those who were privately insured (Figure 13).

Figure 14 shows the stage distribution of colorectal cancer cases diagnosed among white, black, and Hispanic patients in 1999-2000. In each racial/ethnic group, patients with private insurance were more likely to be diagnosed with stage I and less likely to be diagnosed with stage IV colorectal cancer than those who were uninsured or who had Medicaid insurance. Survival for all stages combined was also associated with insurance status (Figure 15). Among patients with private insurance, 65% survived 5 years, compared with 50% of patients who were uninsured and 46% of those with Medicaid insurance; the difference in survival between uninsured patients and those with Medicaid insurance was not statistically significant. Patterns of survival by insurance type were similar for white, black, and Hispanic men and women, although black men and women had lower survival rates than whites or all races/ethnicities combined; among black patients, 60% of those with private insurance survived 5 years, compared with 41% of uninsured patients and Medicaid-insured patients. When data were analyzed within each stage, survival was consistently lower for men and women who were uninsured or who had Medicaid insurance, compared to those who were privately insured (Figure 16). In fact, patients who were diagnosed with stage I cancer who were uninsured or Medicaid-insured were more likely to die within the first 5 years than privately insured patients diagnosed with stage II cancer, and privately insured patients with stage III disease had similar survival to Medicaid-insured or uninsured patients with stage II disease.

The results of the analysis of breast and colorectal cancer survival by insurance status among patients diagnosed in 1999 and 2000 and reported to the NCDB were similar to those of a previous study that examined 3-year cancer survival by insurance status among patients diagnosed in Kentucky in 1995-1998 and followed through 1999.[48] The latter study found that 3-year relative survival among breast cancer patients was 90.6% for privately insured patients, 75.5% for patients with Medicaid insurance, and 77.7% among the uninsured. For colorectal cancer patients, 3-year survival was 70.9% for those with private insurance, 53.0% for those with Medicaid insurance, and 52.8% for those who were uninsured.

Although neither the NCDB analyses nor the Kentucky Registry study was able to control for sociodemographic factors other than race/ethnicity, sex, and age, or for the presence of other health conditions that might impact survival, both studies were able to control for stage, and the NCDB analysis controlled for zip code level of income. In addition, when survival by insurance status was examined using the NCDB for a cancer with very high survival (stage I and II thyroid cancer), the largest

Figure 14. Colorectal Cancer Stage Distr



difference in predicted 5-year survival based on differences in insurance status was only 2%. Thus it does not appear likely that the large differences in survival between insurance groups are accounted for by factors other than those related to diagnosis and treatment of their cancer.

How Does Insurance Type Influence Stage at Diagnosis and Survival?

Later stage at diagnosis for cervical, breast, colorectal, and prostate cancer among patients who are uninsured or who have Medicaid insurance can be explained in part by lower access to and/or use of cancer screening services. Analyses of NHIS 2005 data presented in this report, as well as prior studies, found that screening rates were substantially lower among uninsured than among privately insured individuals, and that Medicaid-insured patients consistently had screening rates that were lower than those for the privately insured but substantially higher than those for the uninsured. Later stage at diagnosis may also be associated with lack of follow up or delay in follow up of abnormal screening test results. A review of studies evaluating follow-up care for an abnormal cancer screening result found that less than 75% of patients received such care, and identified barriers to follow up at the provider, patient, and health care system levels.[49] Appropriate follow up of an

abnormal screening test requires a number of critical steps where the process can break down. The primary care provider and/or patient must be informed of the abnormal result, the appropriate follow-up diagnostic evaluation must be recommended, a provider and site for the diagnostic evaluation must be identified, and the patient must make and keep the appointment. Patients without health insurance and those whose health insurance is not widely accepted face additional cost and administrative and access barriers that may be insurmountable for many.

The finding that patients with Medicaid coverage

contribute to poorer access to preventive services and treatment for Medicaid-insured compared to privately insured individuals. Medicaid reimbursements are generally less than reimbursements for Medicare or private insurance. In many states, payment rates below the cost of the care delivery result in low provider participation. When this occurs, Medicaid enrollees may find themselves limited to the same set of overtaxed safety-net providers as uninsured adults, with related delays in getting appointments and referrals to specialists. Medicaid's limited coverage periods also weaken the positive effects of insurance. One study based on a federal survey found that the median length of time that adults younger than 65 maintained Medicaid enrollment was just five months;[55] Medicaid requires eligibility certifications as frequently as monthly, and some people lose coverage simply because they did not meet administrative requirements. As a consequence of the intermittency of Medicaid coverage, adults identified as covered by Medicaid at one point in time may not achieve the benefits that continuous health coverage can provide such as repeated screenings and a regular source of medical care.

He

Although there is substantial evidence that insurance status is an important factor in access to and use of cancer care, there is little information on how economic issues impact treatment choices at the level of the individual patient. For example, to what extent do individuals forego treatment or select less than optimal treatment because they are unable to find a health care provider who is willing to provide it, or because they are afraid of the level of medical debt that they would incur? As the cost of some new cancer therapies can exceed $100,000 a year, to what extent will availability and type of insurance coverage, as well as individual financial resources, determine who has access to the most effective therapies?

There are many ways to fund proposals and at this time, the American Cancer Society does not endorse one over another. However, the funding must be realistically achievable.

In addition to addressing the issues surrounding insurance, the American Cancer Society is expanding and enhancing its commitment to quality health care with several crucial efforts that are already under way.

- Offering up-to-date cancer information that helps patients easily understand their disease and enables them to effectively work with their health care provider to make treatment decisions
- Helping those diagnosed with cancer find hope and inspiration by connecting them with others who have "been there"
- Making trained patient navigators available to help people get the care they need
- Offering a Health Insurance Assistance Service to cal

- Hope Lodge®, which provides free lodging to patients and caregivers who must travel away from home to obtain cancer treatment
- The Personal Health Manager, which provides newly-

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