The Uninsured in Illinois and Chicago

Close to 2 Million Face Barriers to Health Care

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The Access Project is a national initiative of The Robert Wood Johnson Foundation, in partnership with Brandeis University's Heller Graduate School and the Collaborative for Community Health Development. It began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities in developing and sustaining efforts that improve healthcare access and promote universal coverage with a focus on people who are without health insurance.

If you have any additional questions, or would like to learn more about our work, please contact us.

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United Power for Action and Justice is an organization of 330 dues-paying member congregations, community organizations, unions, hospitals, and community health centers in Chicago and its suburbs. It is committed to citizen initiated democracy and action for justice on common good issues affecting metropolitan Chicago. United Power is currently asking the Cook County Board to include $20 million in next year's budget to create a pilot program to expand primary care in Cook County and has begun to advocate for the use of tobacco settlement moneys to be used to create health care coverage for the uninsured. This effort is called the "Gilead Campaign for the Uninsured."

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Close to 2 Million Face Barriers to Health Care

Executive Summary

Over 44 million persons are now without health insurance in the United States; over a million of them live in the Chicago Metropolitan Area. Despite a booming economy, the number of people without insurance has continued to rise in the past several years. The State of Illinois, historically below national levels of uninsurance, has seen its number of uninsured increase dramatically in the past year. The number of people without health insurance in Illinois jumped from 1.5 million to 1.8 million between 1997 and 1998. This one-year increase in the uninsured, from 12.4 percent to 15 percent of the population, gives Illinois one of the fastest growing uninsured populations in the country.

In the Chicago Metropolitan Area, an estimated 16.3 percent, or about 1.3 million persons, were uninsured in 1998. This also was a substantial increase over the previous year, when 13.8 percent of Chicagoland residents (just over a million people) were without health insurance. Lack of insurance coverage is a problem that persists not only in the city, but also in the suburbs. An estimated 550,000 suburban residents lack health care insurance, with another 742,000 uninsured in the City of Chicago.[1]

Who Are the Uninsured?

Health insurance, and the hazards of going without, is an issue that affects all races and classes, city and suburban residents, children and adults, the employed and unemployed. A survey by the Metro Chicago Information Center in 1995 showed that 43 percent of all greater Chicago residents were worried about losing their health insurance. Still, members of certain groups are more likely to be uninsured:

Income. The working poor are the most at risk for being uninsured. One-third of the uninsured in the Chicago area have annual incomes between one and two times the federal poverty line (between $16,600 and $33,200 for a family of four). Middle and high-income persons may also be uninsured, however. Nearly one in five of the uninsured is in a household with an income greater than $50,000 per year.

Employment. Among working-age adults in the Chicago area who are uninsured, three-quarters are employed, 44 percent on a full-time, year-round basis. Many of the working uninsured are employed by smaller businesses, which offer insurance to their employees less often than larger firms. In the Chicago area, over 60 percent of uninsured, employed adults work for businesses with fewer than 100 employees.

Ethnicity. The largest portion (37 percent) of the uninsured are white, mainly because they are the largest racial group in Chicago. Members of minority groups are uninsured at much higher percentages, however. Hispanics are more than three times as likely to be uninsured as non-Hispanic whites; fully one-third of the Hispanic population in the

[1] Estimates of the uninsured in the United States and in Chicago are based on a sample of residents and should not therefore be considered precise. For the Chicago estimates, there is a 90 percent likelihood that the true number of uninsured is between 680,000and 800,000 for the City of Chicago, and between 500,000 and 600,000 for the suburbs.

Chicago area has no health insurance. Twenty-one percent of African-Americans in the Chicago area are now uninsured, twice the rate of whites. Uninsurance among African-Americans has grown significantly in the past several years, from 16.6 percent in 1995/96 to 21.4 percent in 1997/98. Comparing the single year estimates for 1995 and 1998[2], lack of insurance among the African-American population grew from 15.8 percent to 23.5 percent, representing an increase of about 140,000 people.

Age. Nearly one in four Cook County children in families with incomes below 2½ times the federal poverty line ($41,500 for a family of four) is uninsured. Young adults age 19-29 are the most likely to be uninsured (27 percent) but 13 percent of near retirees (age 55-64) lack insurance at an age where they are at higher risk for many health problems.

What Difference Does Insurance Make?

People who lack health insurance have significantly less access to health care and are, in general, less healthy. The uninsured:

- are less likely to have a regular doctor and more likely to receive care from emergency departments or hospital outpatient clinics;
- receive fewer preventive health services;
- delay care, do not fill needed prescriptions, and come into the hospital more severely ill;
- are hospitalized more frequently for conditions that could have been treated on an ambulatory basis;
- have shorter hospital stays and often use fewer discretionary, high-cost procedures.

The restricted access to the healthcare system that uninsured individuals face imposes a high cost on that system. Many of the uninsured receive their care from "safety net" facilities, which in the Chicago area include three hospitals and 28 clinics in the Cook County system, plus 70 private "federally qualified" health centers. These facilities face the financial pressure of serving a large number of uninsured patients. The services are partly subsidized by shifting some of the costs to insured patients, creating a ripple effect through the system. In effect, the insured and their employers subsidize the care of the uninsured (and *their* employers, since most of the uninsured are employed).

There are also less tangible, though no less real, costs to society:

- The financial costs of lack of insurance – including bad debt and charity care, government subsidies to hospitals, clinics, and local health departments, and health facilities' cost shifting to private insurers – has been estimated at about $100 billion per year. The burden of uncompensated care also falls disproportionately on those hospitals located in lower income areas, weakening those providers most crucial to the safety net.
- Because those with less access to health care tend to be in worse health, there is a cost of lost workdays and reduced productivity.
- Because people without insurance must often pay large medical bills out of their own pockets, medical costs are a major factor in personal bankruptcies. Nationally, an estimated 150,000 people owe $50,000 or more in unpaid medical

[2] These single year estimates should be used with caution. They have less statistical accuracy than the two-year averages, meaning that the actual uninsurance rates for each year fall within a wider statistical confidence interval (as explained in footnote 1).

bills, and an estimated 20 percent of the 1.4 million personal bankruptcies each year are due at least in part to high medical expenses.

- There is also a cost to the inefficiency of the current patchwork system of care for the uninsured. A rational system that includes everyone and encourages appropriate use of care and early detection of illness will bring more equity, financial stability and efficiency to healthcare consumers and providers in Chicagoland.

Why a Local Solution?

Pursuing a local solution to the problem of the uninsured is not merely a last resort in the absence of national reform. The development of a local solution offers advantages not available with a "one size fits all" national program. Access to health care is not simply a matter of having insurance, but is also influenced by cultural and structural barriers – such as language differences, the unavailability of health care professionals in certain areas, and inadequate transportation – which are often uniquely local and require local responses. Local leadership is needed to organize the health care system to serve all segments of the community. A drawback to the current safety net for the uninsured is that it is often uncoordinated, unable to promote prevention and early intervention. Without doubt, adequate reform will require policy action and financial resources at the state and national levels. Addressing access to care at a local level, however, enables improvement of the delivery of care in addition to its financing.

Conclusion

Despite decades of debate and analysis, the number of uninsured continues to increase, and the evidence of adverse health and financial consequence mounts. The makeup of the Chicago-area uninsured is very consistent with national trends: the uninsured are mostly employed and above the poverty threshold, and are disproportionately young adults and non-white. The extent of the problem has not diminished with strong economic growth and low unemployment; an economic recession with job losses could bring an even sharper increase in the number of uninsured.

Many states – among them Minnesota, Oregon, Washington and Tennessee – have succeeded in covering a substantial portion of their uninsured, and an increasing number of counties and cities are finding that it is feasible for them to make an impact as well. Options include bolstering safety net providers, getting more eligible people enrolled in Medicaid and Kidcare, expanding Medicaid, subsidizing insurance premiums for lower income families, and a range of other creative solutions that have been tried across the country.

Inattention to eroding insurance coverage and the resulting restrictions to health care access will only lead to a worsening of the problem. Local leaders – from the health care industry, local and state government, the religious and business communities, and the neighborhoods – should come together to begin to formulate solutions that will best serve the people of the Chicago region.

Introduction

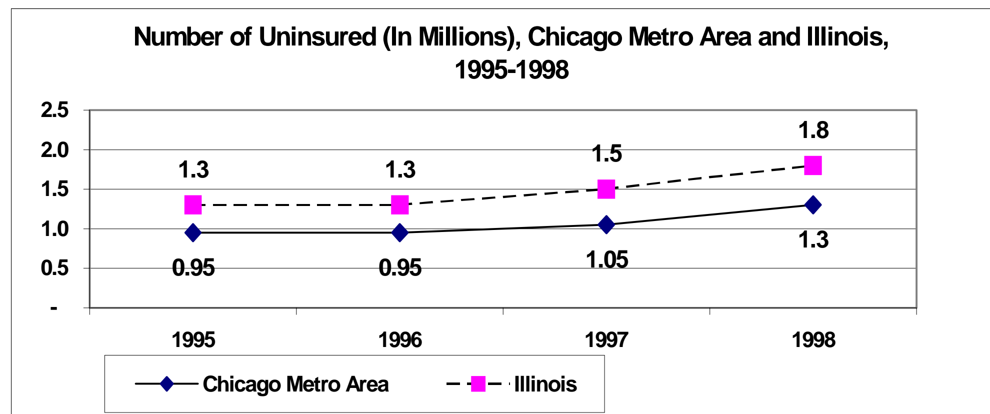
Despite a booming economy, more and more people are facing the health and financial risks of being without health insurance. Nationally, the steady rise in the number of uninsured continues, with an estimated 1 million more uninsured in 1998 than the year before. Over the past decade, the number of people without health insurance has increased about 30 percent to a current 44.3 million.

Fastest Growing Uninsured Rates by State, 1997-1998

	Percentage Point Increase	1998 Uninsured Rate
Hawaii	2.5	10.0%
Illinois	2.6	15.0
Indiana	3.0	14.4
Maryland	3.2	16.6
Nevada	3.7	21.2
South Dakota	2.5	14.3
Wisconsin	3.8	11.8

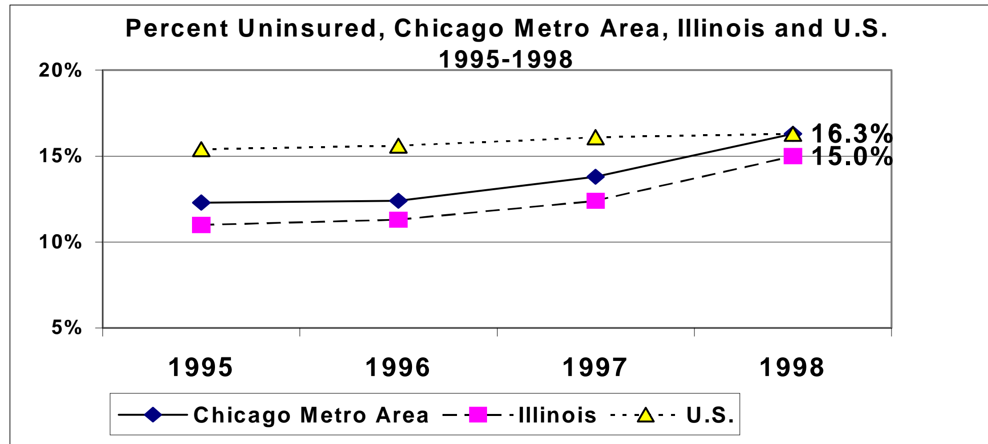
Source: Current Population Survey, U.S. Census Bureau.
Note: The percentage point changes among these states are statistically indistinguishable, and should not be used for ranking.

The number of uninsured in Illinois and Chicago has increased as dramatically over the past few years. Between 1995 and 1998, an estimated 350,000 more people became uninsured in the Chicago metropolitan area, rising from about 950,000 to 1.3 million. In Illinois, an estimated half million more people became uninsured over the same period, going from about 1.3 million to 1.8 million. The percentage of all Chicago area residents who are uninsured rose from an estimated 12.3 percent in 1995 to 16.3 percent in 1998. In all of Illinois, the proportion rose similarly, from an estimated 11.0 percent in 1995 to 15.0 percent in 1998. Lack of health insurance coverage is a problem that persists not only in the city, but also in the suburbs. An estimated 550,000 suburban residents in the Chicago metropolitan area lack health care insurance, with another 742,000 uninsured in the City of Chicago.[3]



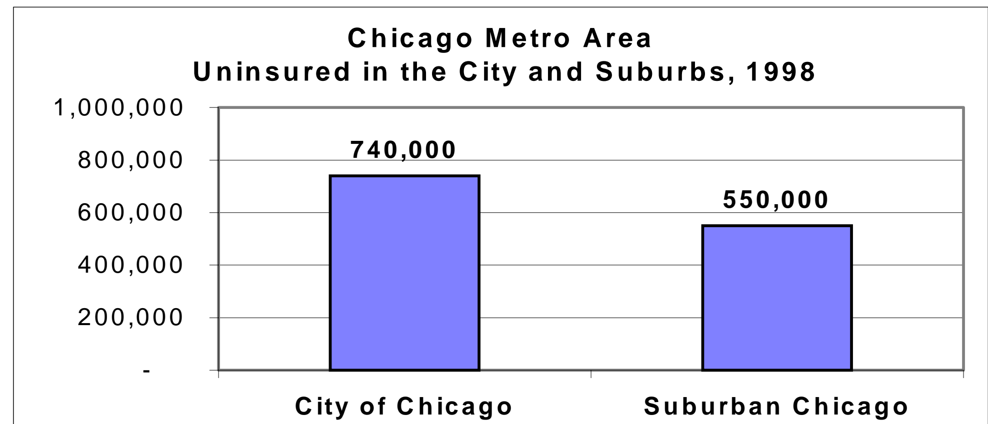
Source: Current Population Survey, U.S. Census Bureau

[3] Estimates of the uninsured in the United States and in Chicago are based on a sample of residents and should not therefore be considered precise. For the Chicago estimates, there is a 90 percent likelihood that the true number of uninsured is between 680,000 and 800,000 for the City of Chicago, and between 500,000 and 600,000 for the suburbs.



Source: Current Population Survey, U.S. Census Bureau

Information on the uninsured specific to Chicago and Illinois is scarce. While employers and insurers collect information on the privately insured population and federal and state agencies track the Medicare and Medicaid population, there is no public entity in Illinois that regularly tracks and publishes information on the state's uninsured population[4].



Source: Current Population Survey, U.S. Census Bureau

The above numbers calculated from the U.S. Census Bureau's Current Population Survey (CPS) indicate that a serious problem is growing worse. Using data from the CPS as well as other local and national sources, this report shows how lack of health insurance affects all segments of the population in the Chicago metropolitan area, and has serious adverse implications for both the physical health and economic well-being of individuals and the community.

[4] The Metro Chicago Information Council, a nonprofit survey organization, does regularly collect some statistics on insurance status in the Chicago area.

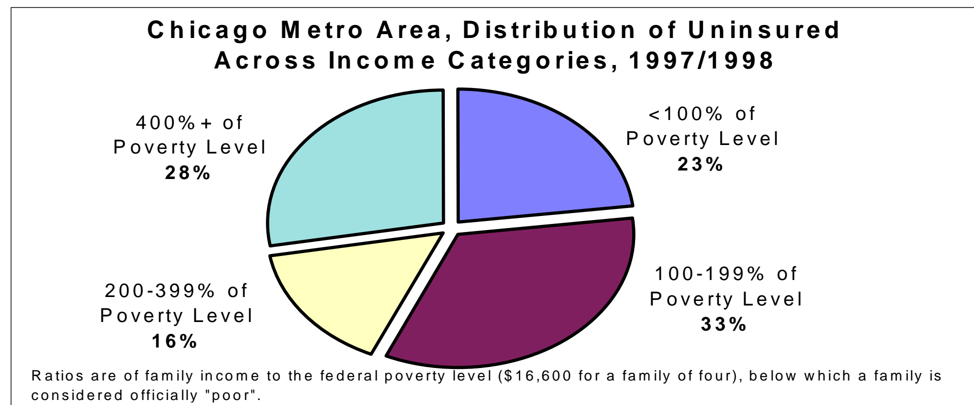
Who Are the Uninsured[3]?

With one in six Chicagoans uninsured, the problem cuts across income, age and ethnic categories, though certain groups are more affected than others. A survey by the Metro Chicago Information Center in 1995 showed that 43 percent of all greater Chicago residents were worried about losing their health insurance. The only group with coverage that is close to universal is those over 65, almost all of whom are eligible for the federal Medicare program, though the extent of that coverage is often inadequate. Going without insurance has clear and serious implications for an individual's access to health care and, ultimately, for his health.

Income and Health Coverage

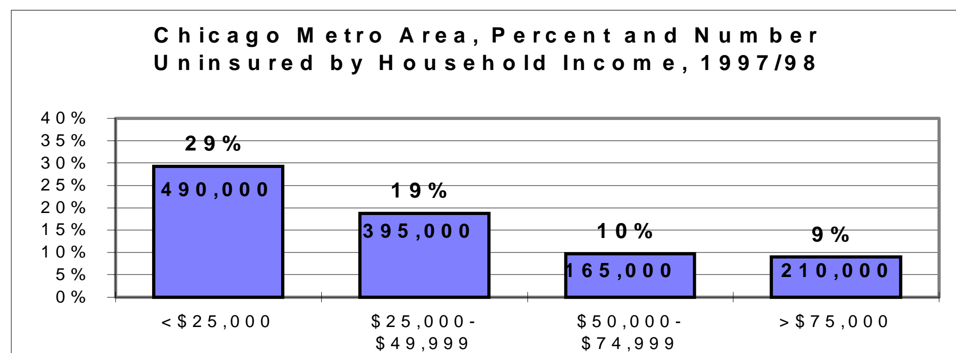
The uninsured are disproportionately concentrated in families with lower incomes. The middle class is by no means immune, however.

The "near poor" are most at risk for being uninsured. Over one-third of the uninsured in the Chicago area have annual incomes between one and two times the federal poverty line, or between about $16,600 and $33,200 for a family of four. (Those with lower incomes, with the exception of childless adults, are more likely than this group to have a public source of insurance, such as the state's Medicaid program.)



Source: Current Population Survey, U.S. Census Bureau

Middle-and high-income persons may also be uninsured, however. An estimated 10 percent of people with annual household incomes between $50,000 and $75,000 are uninsured, as well as 9 percent of people with family incomes above $75,000.



Source: Current Population Survey, U.S. Census Bureau

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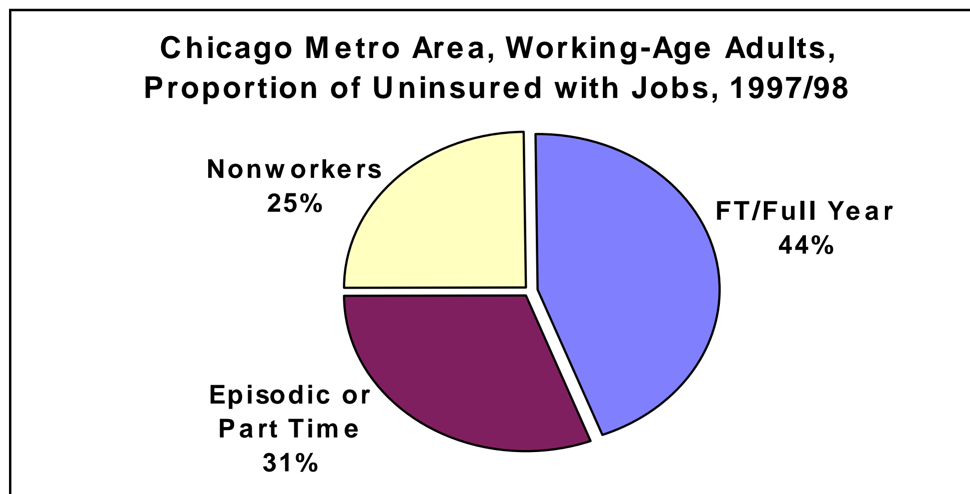
[5] In order to reduce the error margins of estimates for subgroups of the uninsured, 1997 and 1998 survey data were merged and averaged according to guidelines provided by the U.S. Census Bureau. Statistics for subgroups thus reflect 1997-98 averages.

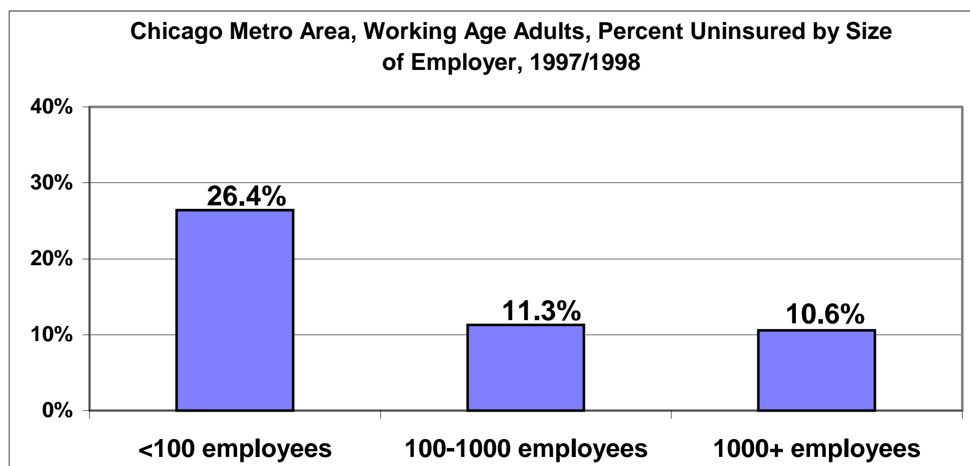
Employment and Health Coverage

It is perhaps startling to learn that most of the adult uninsured in Chicago, and across the nation, are employed. Among working-age adults in the Chicago area who are uninsured, three out of four are employed, more than half of those on a full-time, year-round basis. The number of full-time workers who are uninsured has increased over the past several years. An estimated 13.7 percent of full-time, year-around workers were uninsured in 1997/98, up from 10.3 percent in 1995/96. This represents an increase of about 100,000 uninsured persons.[6]



Source: Current Population Survey, U.S. Census Bureau

The reasons for being employed and uninsured are largely related to the cost of health insurance. Many of the working uninsured are employed by smaller businesses, which offer insurance to their employees less often than larger firms. In the Chicago region, one in four workers in companies with fewer than 100 employees were uninsured.



Source: Current Population Survey, U.S. Census Bureau

Many employees are uninsured not because their employers do not offer coverage, however, but because they cannot afford their share of the cost. A new study from the Center for Studying Health System Change estimates that there are 7 million uninsured

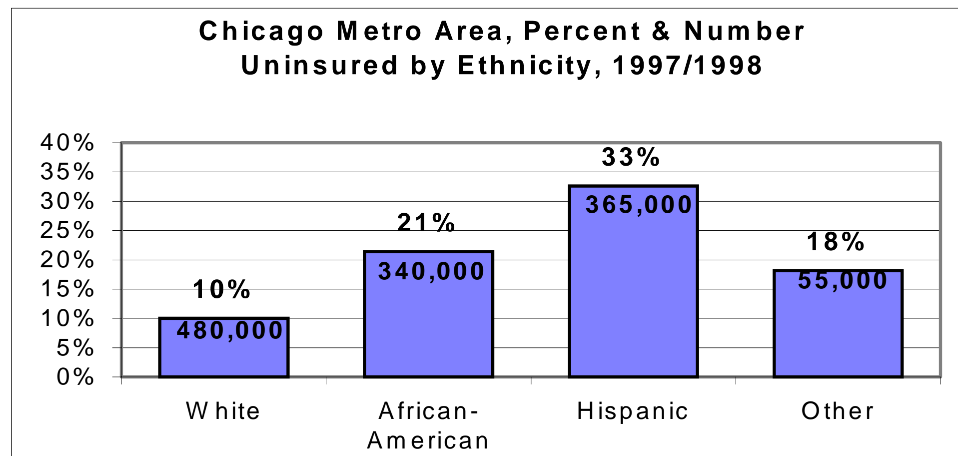
[6] Differences are statistically significant at the .05 confidence level.

persons nationally who have access to employer-sponsored health coverage, either through their own job or through a family member. Two-thirds of these working uninsured said they could not afford their share of the insurance premium. Low-income workers, Hispanic workers, young adults, and those with health problems were all more likely to decline employer-sponsored coverage and become uninsured [Cunningham et al, 1999].

Employment is still the primary source of health insurance in the United States. Employment-based coverage has been eroding, though, and most of the uninsured are employed. Ironically, among poor adults, those who work are twice as likely to lack health insurance as their unemployed counterparts [Guyer and Mann 1999].

Ethnicity and Health Coverage

The largest portion (37 percent) of the uninsured are white, mainly because they are the largest racial group in Chicago. Members of minority groups are at much greater risk of being without insurance, however. Hispanics are more than three times as likely to be uninsured as non-Hispanic whites; fully one-third of the Hispanic population in the Chicago area has no health insurance. Twenty-one percent of African-Americans in the Chicago area are now uninsured, twice the rate of whites. Uninsurance among African-Americans has grown significantly in the past several years, from 16.6 percent in 1995/96 to 21.4 percent in 1997/98[7]. Comparing the single year estimates for 1995 and 1998[8], lack of insurance among the African-American population grew from 15.8 percent to 23.5 percent, representing an increase of about 140,000 people. Further research should be done to verify the magnitude of this increase, and to examine why lack of coverage seems to increasing faster among African-Americans than in other ethnic groups.



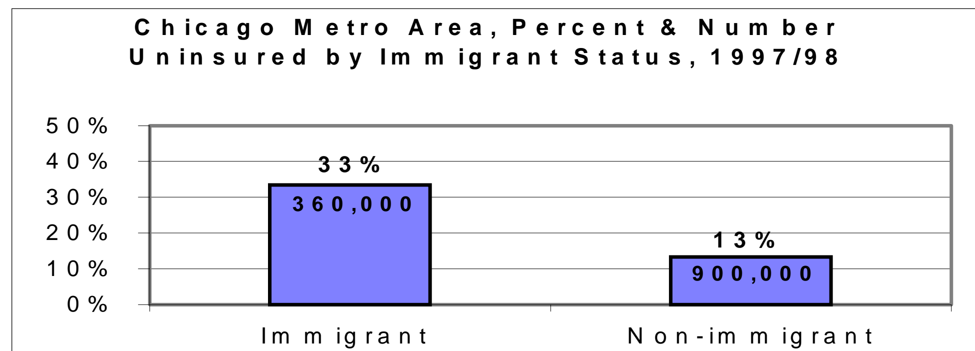
Source: Current Population Survey, U.S. Census Bureau

[7] Differences are statistically significant at the .05 level.

[8] These single year estimates should be used with caution. They have less statistical accuracy than the two-year averages, meaning that the actual uninsurance rates for each year fall within a wider statistical confidence interval (as explained in footnote 1).

Immigrants

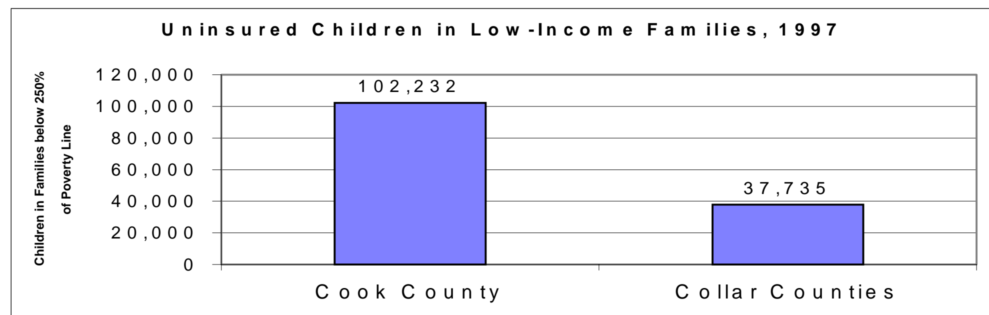
Across the United States, immigrants are much less likely to have health insurance. In the Chicago area, immigrants are 2 ½ times as likely to be uninsured than non-immigrants.



Source: Current Population Survey, U.S. Census Bureau

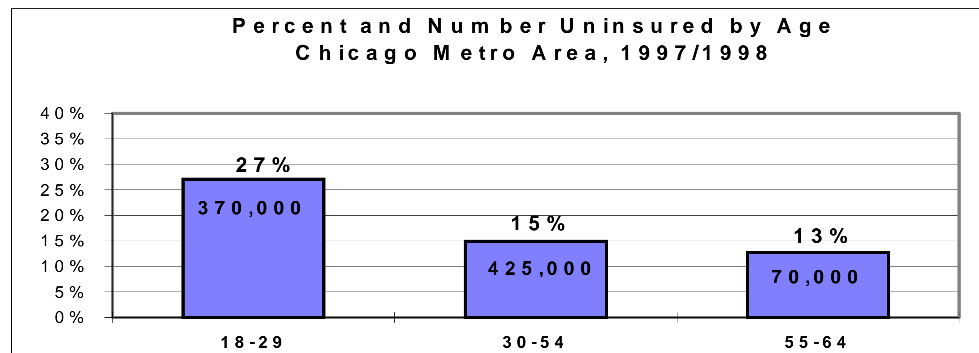
Children and Adults

According to a recent survey by the Illinois Department of Public Aid, nearly one in four Cook County children in families with incomes below 250 percent of the federal poverty line (about $41,000 for a family of four) is uninsured. Children are inexpensive to insure and have relatively few health care needs. Two state insurance programs – Medicaid and KidCare – target children, yet a large gap remains for children in Cook County. As of June 1999, barely 20 percent of the low-income children in Illinois who are eligible for KidCare were enrolled [Ryan, press release June 21, 1999].



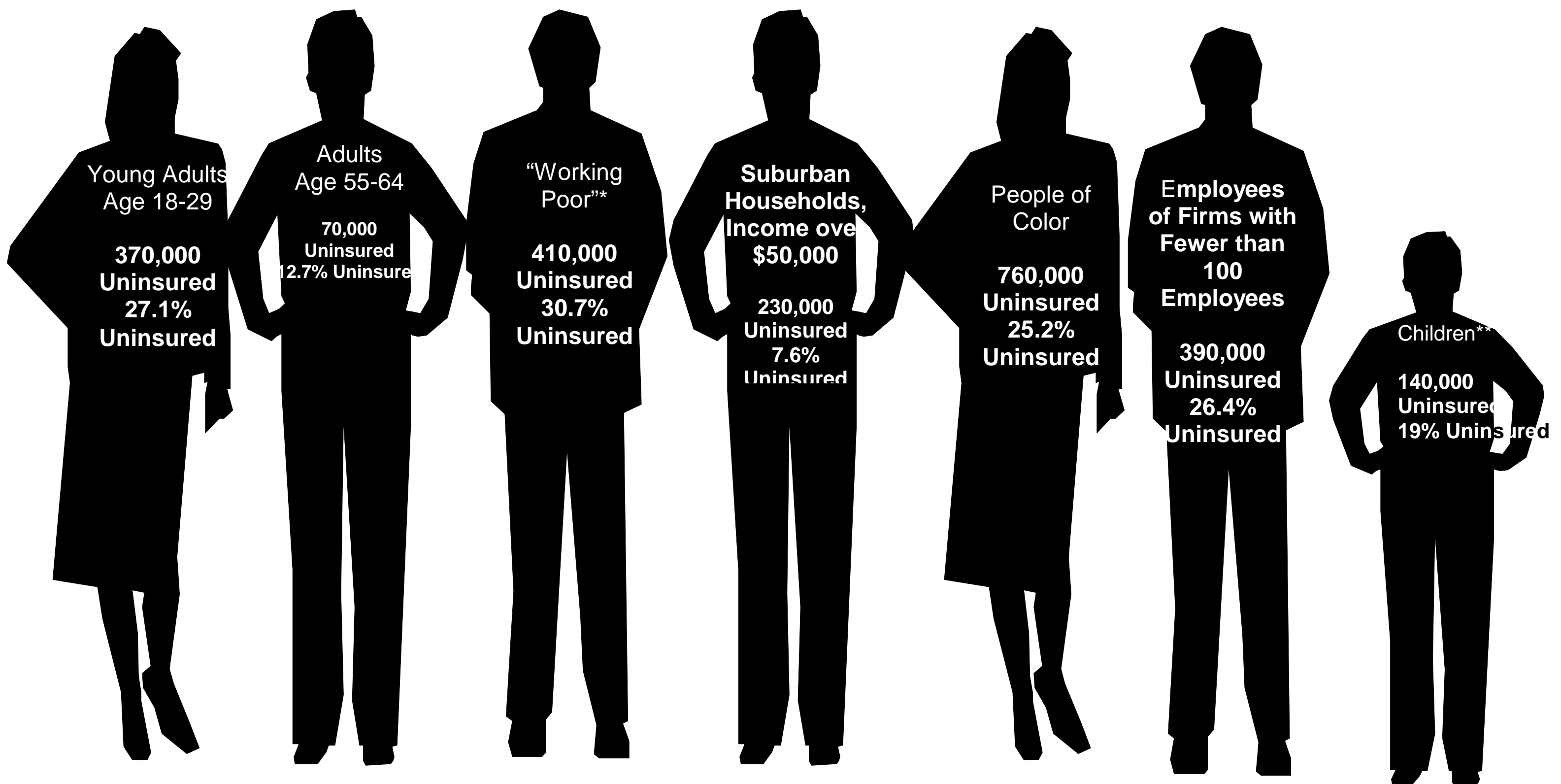
Source: Rucinski et al.

Among adults, young adults are the most likely to be uninsured, but 13 percent of near retirees (age 55-64) lack insurance at an age where they are at higher risk for many health problems.



Source: Current Population Survey, U.S. Census Bureau

Who is Uninsured in the Chicago Area?
Some Typical Groups



*People in families with income between 1 and 2 times the federal poverty line ($16,600 to $33,200 for a family of four).
** Children in families with income below 250 percent of federal poverty line ($41,500 for a family of four).
Sources: All except Children figures: Current Population Survey, U.S. Census Bureau; Children figures: Rucinski et al. 1999.

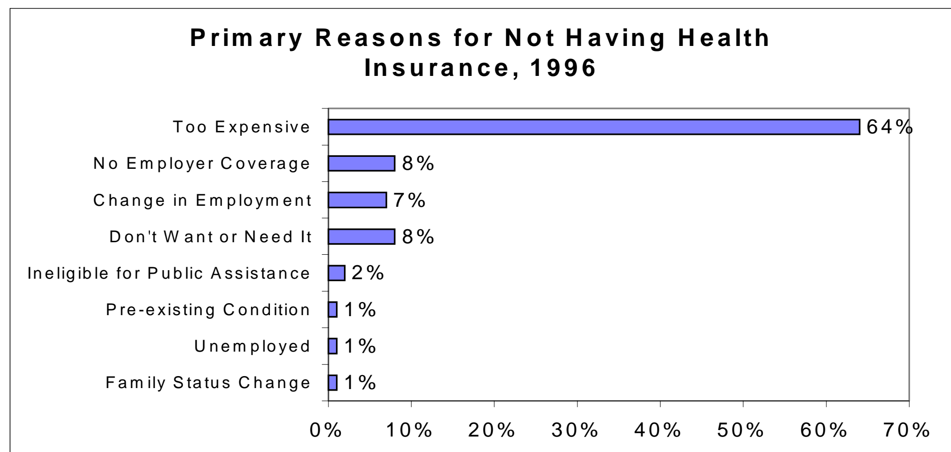
Reasons for Declining Coverage

Health insurance in the United States is not universal, as it is in other industrialized nations. In the U.S., a combination of public entitlement programs and the private insurance market comprise a decidedly non-comprehensive system. Many people are excluded. Major reasons for the increasing levels of uninsured include:

◊ *Declining employer-based coverage*. As health insurance premiums rise, many employers require employees to pay a greater share of the premium. Increased cost sharing leads fewer employees to sign up for their company's health plan. While the percentage of businesses nationally that *offer* coverage has not gone down, the portion of workers *accepting* that coverage on behalf of themselves and their families declined between 1987 and 1996. (Cooper and Schone 1997). Low-wage workers have borne the brunt of higher premium costs. A newly released survey found that premium costs were higher for low-wage workers than for high-wage workers. Workers making less than $7 an hour were asked to pay an average of $130 per month for family coverage, while workers earning more than $15 an hour were charged an average of $84 per month for family coverage [Cunningham et al, 1999]. Between 1987 and 1996, the percent of low-wage workers (less than $7/hr) with health coverage declined from 54 percent to 42 percent, while coverage for high-

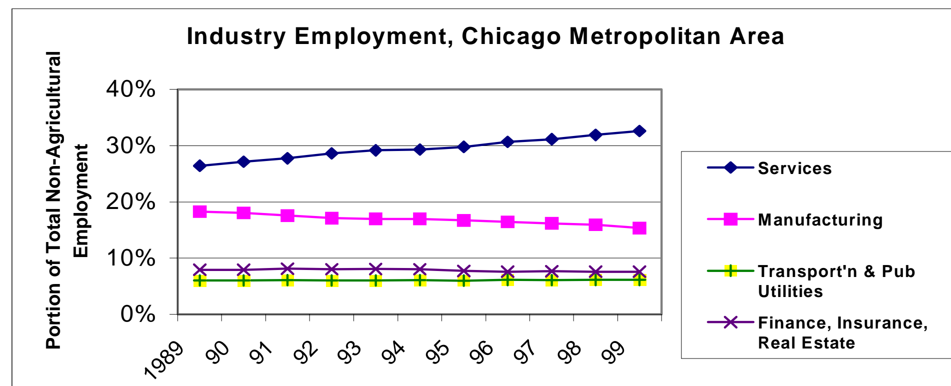
wage workers (more than $15/hr) increased from 87 percent to 90 percent [Cooper and Schone, 1997].

◊ *Cost to individuals.* Consistent with the dynamics of declining employer-based coverage, the main reason people report not having insurance is that it is too expensive. Nearly two-thirds of respondents in a national survey gave this reason. By contrast, only one in twelve surveyed said either that no employer coverage was available or that they did not want or need health insurance.



Source: Donelan et al. 1996, cited in Kaiser Commission on Medicaid and the Uninsured 1998

◊ *Structural changes in the American economy.* People are moving into jobs less likely to provide health care coverage, such as service sector jobs, part-time and temporary work. In the Chicago metropolitan area, the share of jobs in service industries has risen steadily over the last decade. The share of jobs in industries more likely to offer health coverage – such as manufacturing, transportation and finance – have remained steady or declined.



Source: Bureau of Labor Statistics

◊ *Decreasing Medicaid enrollment.* As the number of people on welfare has decreased, so has the number of families receiving health coverage through Medicaid. While families and children leaving welfare are still eligible for Medicaid during a transition period, many do not take advantage because they are not aware of their eligibility or it is inconvenient to enroll. Many of the jobs former welfare recipients accept do not offer coverage either. The number of Medicaid recipients in Illinois declined by

about 130,000 from 1994 to 1998, and a recent national study estimates that about half of those who lost Medicaid coverage from 1995 to 1997 became uninsured [Families USA 1999].

◊ *Slow enrollment in new programs.* The Urban Institute estimates that seven million children nationwide are eligible, but not enrolled, in Medicaid or the Children's Health Insurance Program. In Illinois, perhaps 150,000 out of 190,000 eligible for KidCare are not enrolled. Many of the parents of these children simply do not know about the program, or they might be reluctant to participate in a program that is perceived by some as public assistance.

◊ *Health status.* People with chronic health conditions often have a more difficult time finding affordable health coverage. A 1999 survey by the Metro Chicago Information Center found that 5 percent of Chicago area residents have been denied health coverage at some time because of a pre-existing medical condition.

What Difference Does Insurance Make?

There are many uninsured, with diverse characteristics, in Chicago and across the country. The question remains: so what? There are county hospitals, health clinics and emergency rooms that uninsured people can go to, right? Particularly in a metropolitan area the size of Chicago, getting health care should not be a problem for someone, whether they can pay for it or not.

It is true that care for the uninsured is available, in differing degrees, through a community's health care "safety net" – public hospitals, charity care from private hospitals and physicians, federally-chartered community health centers, county clinics, etc. The safety net is stronger, and enjoys more public support, in some parts of the country than in others. In the Chicago area, Cook County operates three hospitals and 28 clinics, which serve about one half of the county's indigent population. There are also 70 private "federally qualified" health centers in the county, and the metropolitan area's hospitals provide $1.2 billion in uncompensated care each year [Metropolitan Chicago Healthcare Council].

It is rarely the case, however, that a community's safety net providers can entirely meet the needs of that community's uninsured. As a rule, people who lack health insurance have significantly less access to health care, and are in worse health, than their insured counterparts. In a market-oriented health care system, those without the means to pay are not as well served, despite the best efforts of safety net facilities.

Insurance and Access to Care

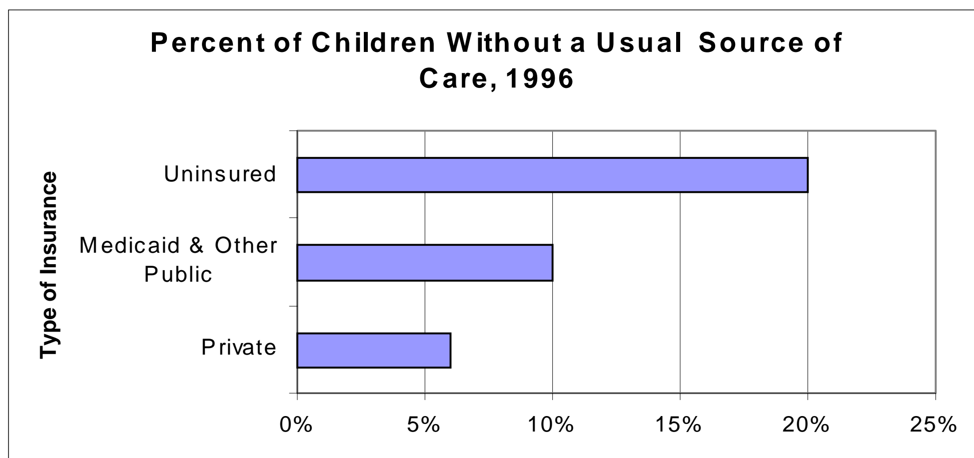
"Access" to health care can be evaluated in a number of different ways. Many of these measures deal with the *process* of health care. For example, surveys will ask whether someone has a usual source of health care and what that source is, relying on research that demonstrates the value to an individual's health of the continuity of a regular family doctor, as opposed to a hospital emergency room. Other process measures include the frequency of physician visits and whether a person has delayed or foregone needed care in the recent past.

Another way access is measured is in terms of the *outcome* of health care. One example is the concept of "avoidable hospitalizations" that identify illnesses for which hospitalization would not be necessary if treated early. A high level of avoidable

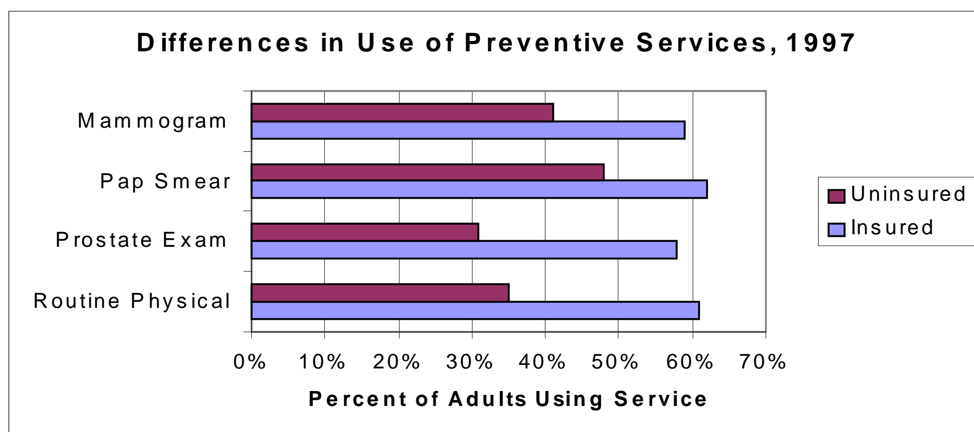
hospitalizations in a community is an indicator of inadequate access to primary care services.

With impressive consistency, research on the benefits of health insurance demonstrates a clear pattern: people without health insurance lack the access to health care services that their insured neighbors enjoy. The uninsured:

◊ are less likely to have a regular doctor and more likely to receive care from emergency departments or hospital outpatient clinics;
◊ receive fewer preventive health services;
◊ delay care, and do not fill needed prescriptions, come into the hospital more severely ill;
◊ are hospitalized more frequently for conditions that could have been treated on an ambulatory basis;
◊ have shorter hospital stays and often use fewer discretionary, high-cost procedures. [Weissman and Epstein 1994]



Source: Kaiser Commission on Medicaid and the Uninsured, 1998



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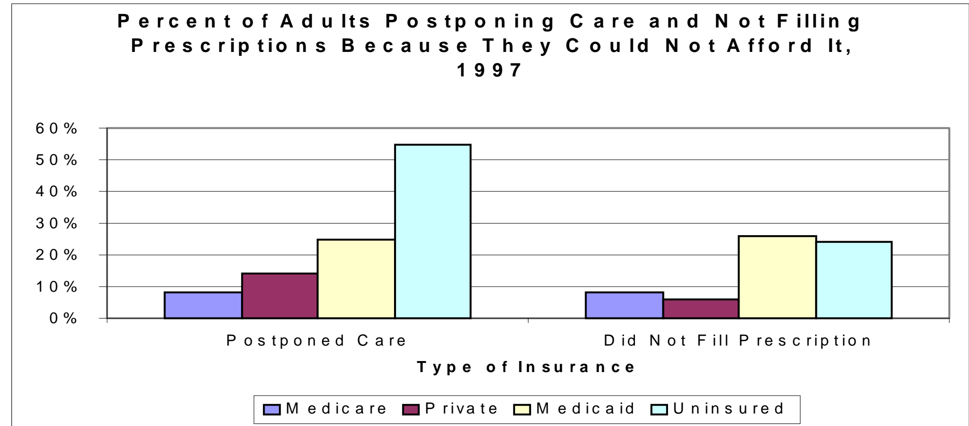
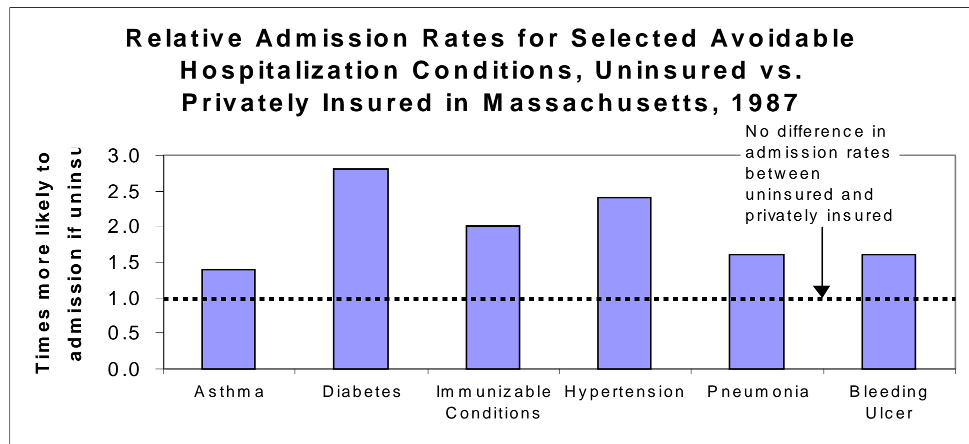
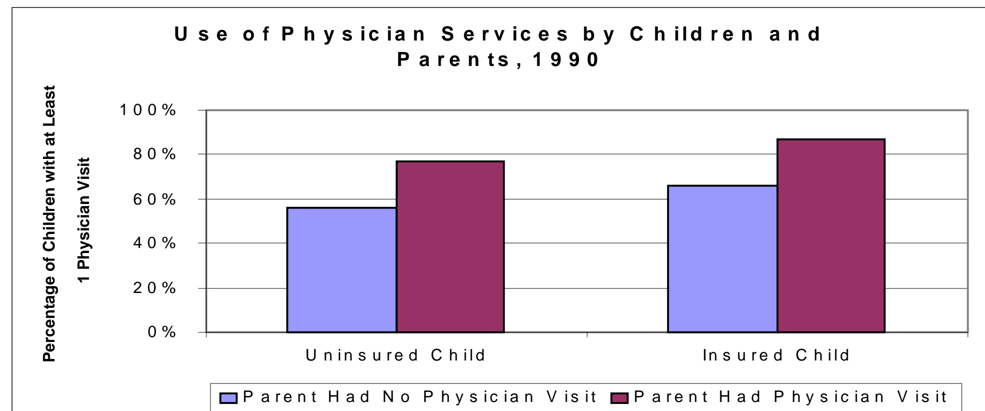


Source: Kaiser Commission, 1998



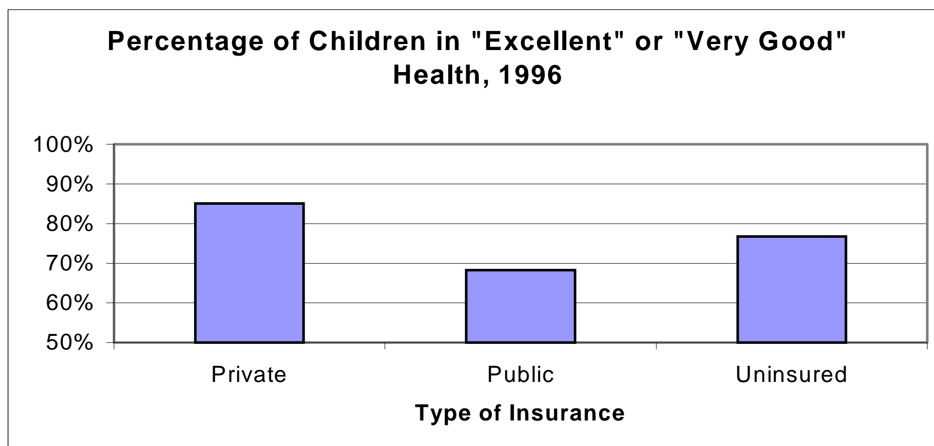
Source: Weissman et al., 1992

There is a more complex relationship of insurance and care as well, involving children and their parents. A recent study emphasizes the link between parents' and children's use of the health care system, and finds that even children who have insurance are less likely to access care if their parents do not regularly do so. Since parents who are not insured are less likely to seek care, the study concludes that "[n]eglecting financial access to care for adults may have the unintended effect of diminishing the impact of targeted health insurance programs for children." [Hanson 1998]

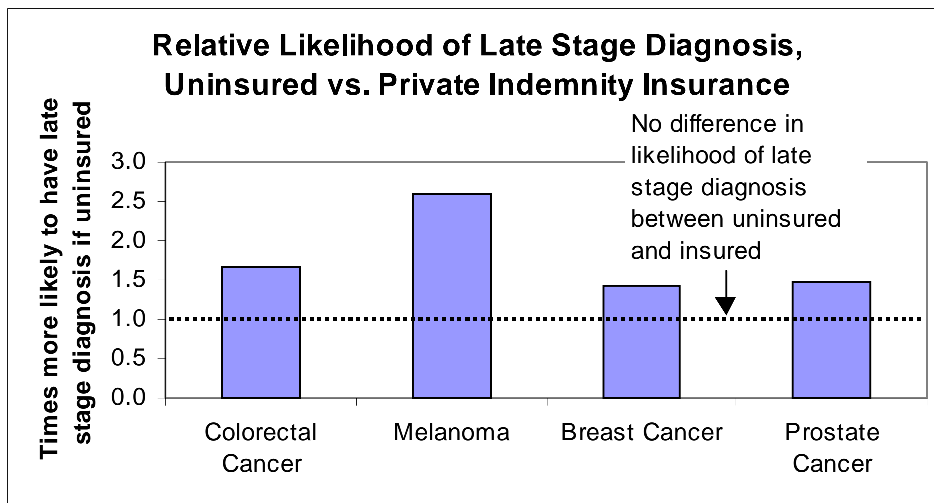


Source: Hanson 1998

The ultimate outcome measure of access is a person's health. Evidence suggests both that people with diminished access to care are generally less healthy, and that uninsured people (who also typically have worse access) are less healthy than the privately insured [Weinick et al. 1998; Andrulis 1998; Short and Lair 1994]. A new study shows that the uninsured are significantly more likely to being diagnosed at a later (and more serious) stage of four types of cancer than those with private insurance [Roetzheim et al. 1999].



Source: Weinick et al. 1998



Source: Roetzheim et al. 1999

The pattern is clear: lack of insurance is associated with diminished access to the health care system. Poor access leads to poor health, which imposes a cost both on individuals and on society. Expanding access to primary care and coverage – for children *and* adults – will begin to break this chain. Lack of insurance is a major financial barrier to health care. In today's health care system, in which over $1 *trillion* – an average of nearly $4,000 for every person in the country – is spent on health care every year, a financial barrier can be insurmountable. This is especially true when we realize that most of the uninsured, though employed, have relatively low incomes.

Broad Social Costs

Lacking insurance clearly has an impact on the health and well being of an individual and his or her family. There are wider, societal costs as well. The cost to society of

caring for the uninsured is difficult to quantify because so many expenses are indirect. The Lewin Group, a consulting firm, estimates that national societal costs are in the range of $100 billion annually [Baxter 1999]. This estimate includes bad debt and charity care, government subsidies to hospitals, clinics, and local health departments, and health facilities' cost shifting to private insurers. Chicago-area hospitals provide about $1.2 billion a year in uncompensated care. While health care providers used to be able to pass these costs to insurance carriers, managed care has diminished this financial cushion. The burden of uncompensated care also falls disproportionately on those hospitals located in lower income areas, weakening those providers most crucial to the safety net.

Not included in the $100 billion estimate are the out-of-pocket costs faced by the uninsured, which can lead to financial ruin for those facing catastrophic illness. Nationally, an estimated 150,000 people owe $50,000 or more in unpaid medical bills. A 1997 survey done by Visa on personal bankruptcy estimated that in the East Central Region, of which Illinois is a part, 13 percent said medical expenses were the "last straw" that drove them to file for bankruptcy. Applied to Illinois bankruptcy statistics, this would translate to an estimated 8,000 bankruptcies each year in Illinois due primarily to medical costs [Visa U.S.A. 1997]. While the total financial impact of these bankruptcies is unknown, it is another example of how the medical costs of the uninsured are indirectly borne by the community.

The current patchwork safety net for the uninsured, besides being inadequate, is often inefficient. Costs are increased when delayed care results in more severe illness, higher bills, and more lost workdays. Costs are also increased when the uninsured are unnecessarily treated in emergency rooms or as inpatients, because the incentives are not in place to the patient or provider to steer them earlier into less intensive outpatient care. A rational system that includes everyone and encourages appropriate use of care and early detection of illness will bring more equity, financial stability and efficiency to health care consumers and providers in Chicago.

Why Pursue a Local Solution?

✓ *Gridlock at the National Level*

Since the failure of the Clinton Administration's Health Security Act in 1994, national policy makers have been reluctant to pursue any comprehensive plan to cover the uninsured. Experts predict that, with the exceptions of some incremental reforms such as insurance for low-income children, this federal stalemate will continue for some time to come. If any substantial increase in coverage and access for the uninsured is to be achieved in the near future, it will have at the state and local levels.

✓ *Advantages to Local Solutions*

Pursuing a local solution is not merely a last resort, however, but offers unique advantages. Access to health care is not simply a matter of having insurance, but is also influenced by cultural and structural barriers – such as language differences, the unavailability of health care professionals in certain areas, and inadequate transportation – which are often uniquely local and require local responses. In addition, communities can shape responses around the specific characteristics of the local uninsured population – particular low-income ethnic groups, for example, or employees of certain industries. Local leadership is needed to organize the health care system to serve all segments of the community. A drawback to the current safety net for the uninsured is that it is often uncoordinated, unable to promote prevention and early intervention. Addressing access

to care at a local level enables improvement of the process of care in addition to its financing.

There is increasing interest across the country in community-based solutions to increasing health care access. One example of a successful local initiative is the Hillsborough County Health Care Plan in Tampa, Florida. In response to the increasing financial burden of care for the uninsured in the Tampa area, Hillsborough County used a half-cent sales tax increase to finance a comprehensive managed care plan for uninsured county residents. Starting in 1992, the integrated system of social services and medical case management has steered patients toward the most appropriate levels of care. Over 600 physicians are involved with the plan, and they now serve about 27,000 members per year. Emergency room spending has been reduced by more than $10 million annually, and hospital use has declined dramatically for health plan members. Overall, the county estimates that the plan has produced savings of $50 million per year while improving health care for its poor, uninsured residents.

Another local solution is in Buncombe County (Asheville), North Carolina. Project Access is a collaboration of the county government, the county medical society, hospitals, doctors, pharmacists, churches and various other not-for-profit organizations. The impetus for the program was a decision by the county in 1995 to divert half of its indigent care fund to the creation of a network of providers to serve the 15,000 uninsured in the county. About 500 percent of the county's physicians (85 percent) and all of its hospitals are now part of the network, which provides $3.5 million worth of coordinated preventive, primary and hospital care, free of charge, to the county's uninsured.

Conclusion

The facts and figures in this report tell a story that has become very familiar. Despite decades of debate and analysis, the number of uninsured continues to increase, and the evidence of adverse health and financial consequences mounts. The makeup of the Chicago-area uninsured is very consistent with national trends: the uninsured are mostly employed and above the poverty threshold, and are disproportionately young adults and non-white. While an expansive safety net system does exist, there are still clear disparities in access to care and health outcomes between the insured and uninsured.

What is surprising is that the extent of the problem has not diminished with strong economic growth and low unemployment. The shift towards service sector, part-time, and temporary jobs, as well as employers shifting more of the rising costs of coverage to employees, have helped offset any gains made in the strong economy. Research has indicated that the number of uninsured is strongly associated with the level of unemployment [Weissman and Epstein 1994]. An economic recession with job losses could bring a sharp increase in the number of uninsured.

It is therefore important to act on this problem during a time of relative prosperity. But what is to be done? One of the greatest obstacles to overcome may be the sense of resignation over a problem that has persisted for so long. However, many states – among them Minnesota, Oregon, Washington and Tennessee – have succeeded in covering a substantial portion of their uninsured, and an increasing number of counties and cities are finding that it is feasible for them to make an impact as well. Options include bolstering safety net providers, getting more eligible people enrolled in Medicaid and Kidcare, expanding Medicaid, subsidizing insurance premiums for lower income families, and a range of other creative solutions that have been tried across the country.

Inattention to eroding insurance coverage and the resulting restrictions to health care access will only lead to a worsening of the problem. Local leaders – from the health care industry, local and state government, the religious and business communities, and the neighborhoods – should come together to begin to formulate solutions that will best serve the people of the Chicago region.

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Source of Estimates

Estimates of the number and percent uninsured in Metro Chicago and Illinois were calculated using the U.S. Census Bureau Current Population Survey (CPS) – March Supplement. The CPS consists of a monthly sample of 50,000 households drawn to be representative at the national and state level. While the CPS is designed primarily to collect labor statistics, each March a supplemental set of questions are added which include items on health insurance. 2500 additional Hispanic households are added to the CPS - March Supplement to improve the reliability of estimates for this population. Sample sizes for Illinois vary slightly each year, but during the period referenced in this report ranged from 5500-6000 persons for Illinois, and 3500-4000 persons for Metro Chicago. The overall response rate for the 1999 CPS-March Supplement was 83.9%.

The CPS employs ratio estimation, whereby sample estimates are adjusted to independent estimates of the national population by age, race, sex, and Hispanic origin. This weighting partially corrects for bias due to undercoverage, but how it affects different variables in the survey is not precisely known. Moreover, biases may also be present when people who are missed in the survey differ from those interviewed in ways other than the categories used in weighting (age, race, sex, and Hispanic origin). All of these considerations affect comparisons across different surveys or data sources.

Reliability Statistics of Estimates of Uninsured

Total City and State Estimates	Year(s)	Percent Uninsured	1-p	Standard error	90% Confidence Interval	
Chicago Metro Area	1995	12.3	87.7	0.54	11.4	13.2
Chicago Metro Area	1996	12.4	87.6	0.55	11.5	13.3
Chicago Metro Area	1997	13.8	86.2	0.57	12.9	14.7
Chicago Metro Area	1998	16.3	83.7	0.60	15.3	17.3
City of Chicago	1998	23.5	76.5	1.12	21.7	25.3
Chicago Suburbs	1998	11.5	88.5	0.68	10.4	12.6
Illinois	1995	11.0	89.0	0.42	10.3	11.7
Illinois	1996	11.3	88.7	0.43	10.6	12.0
Illinois	1997	12.4	87.6	0.44	11.7	13.1
Illinois	1998	15.0	85.0	0.47	14.2	15.8

Total City and State Estimates	Year(s)	Est. Number Uninsured		90% C.I. Of # Uninsured	
Chicago Metro Area	1995	968,308		898,423	1,038,192
Chicago Metro Area	1996	954,195		884,862	1,023,529
Chicago Metro Area	1997	1,062,147		989,583	1,134,711
Chicago Metro Area	1998	1,293,621		1,214,709	1,372,532
City of Chicago	1998	742,123		684,106	800,140
Chicago Suburbs	1998	549,511		495,814	603,207
Illinois	1995	1,297,753		1,215,415	1,380,090
Illinois	1996	1,338,872		1,255,382	1,422,362
Illinois	1997	1,500,104		1,412,279	1,587,929
Illinois	1998	1,844,229		1,748,306	1,940,152

Metro Chicago, Subgroup Estimates	Year(s)	Percent Uninsured	1-p	Standard error	90% Confidence Interval	
Ethnicity						
White	1997/1998 ave.	10.0	90.0	0.53	9.1	10.9
African-American	1997/1998 ave.	21.4	78.6	1.38	19.1	23.7
Hispanic	1997/1998 ave.	32.6	67.4	1.53	30.1	35.1

Other	1997/1998 ave.	18.0	82.0	1.32	15.8	20.2
Immigration Status						
Immigrants	1997/1998 ave.	33.4	66.6	1.70	30.6	36.2
Non-immigrants	1997/1998 ave.	13.3	86.7	0.50	12.5	14.1
Age Groups						
18-29 years old	1997/1998 ave.	27.1	72.9	1.40	24.8	29.4
30-54 years old	1997/1998 ave.	14.9	85.1	0.82	13.5	16.3
55-64 years old	1997/1998 ave.	12.7	87.3	1.76	9.8	15.6
65+ years old	1997/1998 ave.	1.8	98.2	0.59	0.8	2.8
Family Income as Percent of Federal Poverty Line						
< 100% of Poverty	1997/1998 ave.	35.3	64.7	2.02	32.0	38.6
100%-199% of Poverty	1997/1998 ave.	30.7	69.3	1.51	28.2	33.2
200%-399% of Poverty	1997/1998 ave.	15.8	84.2	1.24	13.8	17.8
400%+ of Poverty	1997/1998 ave.	8.1	91.9	0.50	7.3	8.9

Metro Chicago, Subgroup Estimates	Year(s)	Percent Uninsured	1-p	Standard error	90% Confidence Interval	
Household Income						
Below $25,000	1997/1998 ave.	29.3	70.7	1.35	27.1	31.5
$25,000-$49,999	1997/1998 ave.	18.7	81.3	1.02	17.0	20.4
$50,000 - $74,999	1997/1998 ave.	9.7	90.3	0.86	8.3	11.1
$75,000 or greater	1997/1998 ave.	9.0	91.0	0.73	7.8	10.2
Size of Employer						
<100 employees	1997/1998 ave.	26.4	73.6	1.40	24.1	28.7
100-1000 employees	1997/1998 ave.	11.3	88.7	1.25	9.2	13.4
1000+ employees	1997/1998 ave.	10.6	89.4	0.95	9.0	12.2
Work Schedule						
Full Time/Full Year	1997/1998 ave.	13.7	86.3	0.78	12.4	15.0
Part-Time/Full Year	1997/1998 ave.	21.1	78.9	2.36	17.2	25.0
Full Time/Some unemployment	1997/1998 ave.	31.8	68.2	3.38	26.2	37.4
Part Year	1997/1998 ave.	23.0	77.0	2.63	18.7	27.3
Nonworkers	1997/1998 ave.	27.1	72.9	1.88	24.0	30.2

Estimated Increases in Uninsured African-Americans	Year(s)	Percent Uninsured	1-p	Standard error	90 % Confidence Interval	
African-American	1997/1998 ave.	21.4	78.6	1.38	19.1	23.7
African-American	1996/1997 ave.	17.1	82.9	1.23	15.1	19.1
African-American	1995/1996 ave.	16.6	83.4	1.47	14.2	19.0

Estimated Increases in Uninsured African-Americans	Year(s)	Est. Number Uninsured		90% C.I. Of Number Uninsured	
African-American	1997/1998 ave.	341,022		304,872	377,173
African-American	1996/1997 ave.	261,207		230,241	292,172
frican-American	1995/1996 ave.	258,903		221,227	296,579

Estimated Increases in Uninsured Full Year/Full-Time Workers	Year(s)	Percent Uninsured	1-p	Standard error	90% Confidence Interval	
Employed Full Time/Full Year	1997/1998 ave.	13.7	86.3	0.78	12.4	15.0
Employed Full Time/Full Year	1996/1997 ave.	11.6	88.4	0.74	10.4	12.8
Employed Full Time/Full Year	1995/1996 ave.	10.3	89.7	0.77	9.0	11.6

Estimated Increases in Uninsured Full Year/Full-Time Workers	Year(s)	Est. Number Uninsured		90% C.I. Of Number Uninsured	
Employed Full Time/Full Year	1997/1998 ave.	404,167		357,343	431,267
Employed Full Time/Full Year	1996/1997 ave.	333,864		306,439	377,990
Employed Full Time/Full Year	1995/1996 ave.	302,794		265,679	339,908

	Standard Error of the Difference				
	Uninsured African-Americans	Significance Level		Uninsured FT/FY Workers	Significance Level
Standard error of the difference between 1997/1998 and 1996/1997 estimates	1.85	0.05		1.07	0.10
Standard error of the difference between 1996/1997 and 1995/1996 estimates	1.92	Not significant		1.06	Not significant
Standard error of the difference between 1997/1998 and 1995/1996 estimates	2.01	0.05		1.09	0.05