Kansas Health Institute's Underinsured in Kansas Project: Final Technical Report

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Sharon T. Barfield, M.S.W., LSCSW
Andrew Ward, Ph.D., M.P.H., Ph.D.

KANSAS HEALTH INSTITUTE

212 SW Eighth Avenue, Suite 300
Topeka, Kansas 66603-3936
(785) 233-5443
www.khi.org

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

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INTRODUCTION

As noted by Blewett, Ward and Beebe (2006), there is no single agreed upon set of criteria that identify what it means to be underinsured, and using different criteria may result in different estimates of the number of people who are underinsured (Also, see Bartlett, III, 2000; Comer, Mueller, & Blankenau, 1996). In the late 1980s, Salmon (1988) wrote that studies "have indicated that 8 to 26 percent of persons under 65 with private health insurance may be underinsured." More recently, Weinstock (2007) wrote that by "various estimates, anywhere from 12 percent to 29 percent of Americans fall into the underinsured category." For example, using out-of-pocket medical expenses equal to 10 percent or more of family income, medical expenses equaling 5 percent or more of income if low-income, or deductible equaling 5 percent or more of income as indicators of underinsurance, Schoen, et al. (2008) calculated that 12.3 percent of adults ages 19−64 insured all year were underinsured in 2003. By 2007, that percentage had jumped to 19.8 percent.

Defining the underinsured exclusively as people who spent more than 10 percent of family income on health care Banthin and Bernard (2006) found that in 2003, 19.2 percent (48.8 million people) were underinsured, an increase of 11.7 million people since 1996. Using data from the 1999 Commonwealth Fund Survey of Workers' Health Insurance, Donelan et al. (2000) reported that nearly 20 percent of insured adults were underinsured according to the experiential criteria of there being a time in the past year when the respondent did not have enough money to pay for medical bills, prescription drugs, or health care costs.

Regardless of what criteria are used to define underinsurance, people who are underinsured often find themselves facing a myriad of challenges (Silverman, 2008). For example, one recent study (Collins, Kriss, Doty, & Rustgi, 2008) demonstrated that underinsured persons frequently postpone or forgo recommended health care or cut back on needed prescription medications because of costs, while another study (Lee et al., 2007) showed that underinsured children tend to forego needed vaccinations. Many underinsured people incur substantial medical debt (Evans, 2008) that, in extreme cases, can force them into bankruptcy (Himmelstein, Warren, Thorne, & Woolhandler, 2005; Raiz, 2006). These kinds of financial burdens disproportionately affect low-income people (Banthin, Cunningham, & Bernard, 2008). In addition, groups such as children

with special health care needs (Hill, Freeman, Yuce, & Kuhlthau, 2008; Kogan, Newacheck, Honberg, & Strickland, 2005; Oswald, Bodurtha, Willis, & Moore, 2007) and the chronically ill (Stroupe, Kinney, & Kniesner, 2000), who typically are in the greatest need of the benefits provided by health insurance, often face the greatest health challenges associated with being underinsured (e.g., lack of access to needed care).

While considerable effort in Kansas has been devoted to addressing problems associated with being uninsured, much less attention has been directed to understanding the challenges faced by underinsured Kansans (Fox & Haas, 2006). To help remedy this situation, the Kansas Health Institute's (KHI's) *Underinsured in Kansas* project has, since its 2008 inception, had two principal goals:

1. Quantify, to the extent possible, who the underinsured Kansans are and the challenges they face because they are underinsured; and

2. Complement this quantitative analysis with qualitative research that puts the issues of the underinsured and health care in the broader contexts of individual, family and social well-being.

This technical report presents the quantitative and qualitative research methods used to investigate the experiences faced by underinsured Kansans. The report also summarizes the findings of the project, which offer the most extensive Kansas-specific look to date at how being underinsured can affect, in a variety of different ways, Kansas individuals, families and communities. The report supplements the following documents available on the KHI website (www.khi.org/underinsurance):

When Health Insurance is Not Enough: Kansas and Underinsurance
The Growing Health and Financial Costs of Inadequate Health Insurance
Voices of the Underinsured: Kansans Tell Their Stories

Federal health reform, more formally called the Patient Protection and Affordable Care Act, may address some of the issues raised in this research. Health reform has many provisions that are intended to increase access and decrease the cost of health insurance. These include, but are not limited to: guaranteeing access to insurance, eliminating pre-existing condition restrictions, providing premium credits, giving free choice vouchers and developing insurance exchanges. Other provisions limit out-of-pocket expenses, provide subsidies, eliminate lifetime maximums and provide comprehensive benefit requirements for plans in the exchanges as well as non-grandfathered plans offered outside of the exchanges.

In terms of price transparency, because health reform requires that greater health insurance consumer information be provided at the state level, insurers will have to provide this information in a standardized manner. In addition, hospitals will be required to publish their standard charge rates.

While federal health reform seems to address many of the components of underinsurance, it has some limitations. For example, several provisions only apply to the exchanges, new plans or the individual and small group markets. Others, like premium credits and cost-sharing subsidies, only apply to individuals within a certain income range.

Although the new law will limit out-of-pocket expenses for some, these expenses still can be as high as $11,900 for a family. Some provisions in health reform address the challenges highlighted by these findings but the Kansans surveyed and interviewed may not see immediate relief. Although the provision of eliminating lifetime maximums goes into effect immediately, other provisions won't be effective until 2014. Federal health reform also doesn't provide relief for medical debt already accumulated. These known limitations suggest that health reform will not comprehensively resolve the problem of underinsurance, leaving the subject an ongoing challenge for policymakers at both the state and national levels.

SURVEY METHODS

1. Purpose

The *Underinsured in Kansas* project included an exploratory study (Henry, 1998; Sim & Wright, 2002) to determine who in Kansas the underinsured are, and the challenges they face because they are underinsured. In this context, three of the principal exploratory goals of the project were:

A. Investigate the demographic characteristics of a randomly generated sample of underinsured Kansans;
B. Characterize the different dimensions of underinsurance among a randomly generated sample of underinsured Kansans; and
C. Determine the kinds of effects underinsurance has on a randomly generated sample of underinsured Kansans.

To accomplish these goals, KHI created a phone survey that was administered by the Survey Research Center (SRC) of the University of Kansas' Institute for Policy and Social Research. Questions for the survey were based on wording found in surveys such as the American Community Survey (U.S. Census Bureau, 2007) and the Current Population Survey (U.S. Census Bureau, 2009), while the content areas of the questions were based on a survey of peer-reviewed academic literature dealing with underinsurance. KHI piloted (Bowden, Fox-Rushby, & Wanjau, 2002) the survey before giving it to the SRC for administration.

2. Methodology

Based on criteria provided by KHI, the SRC used a series of screening questions to determine eligibility for the survey.

Although there continue to be debates about the sufficient conditions for a person to be underinsured (Blewett, Ward, & Beebe, 2006; Voorhees et al., 2008; Ward, 2006), there is consensus that a necessary condition is that the person is insured (Vernaglia, 2005). In some

families, one person might be insured and another uninsured (e.g., when one spouse has employment-based insurance and the other has no insurance because the couple cannot afford family coverage). To avoid confounding the effects of underinsurance with those of uninsurance, the SRC administered the survey only to families in which all members had been insured continuously since the beginning of 2009. Thus, the first question asked was:

1. Are you at least 18 years of age, and a member of a family all of whose members have had health insurance coverage continuously since the start of 2009?

The phone interview continued only for people who answered this question affirmatively. Respondents decided for themselves who was included/counted as members of their family. The survey did not impose limits on the relationships that could be included in the concept of "family." In this sense, each respondent self-defined their own family.

Because there are multiple dimensions of underinsurance, the SRC, under the direction of KHI, created screening questions with the intent of capturing as wide a meaning of "underinsured" as possible consistent with the peer-reviewed literature. For example, as noted by Donelan et al. (2000), experiential measures of underinsurance use "access to care and actual problems paying medical bills" as criteria for being underinsured. With this in mind, if the respondent answered "yes" to question one, then the person conducting the survey asked the respondent three other questions:

2. During 2009, did you or a family member pay an excessive amount for health insurance or health/medical care?
3. During 2009, did you or a family member have any problem about coverage (e.g., needed care not covered) or the ability to access covered benefits that led to a significant hardship?
4. During 2009, did you or a family member have a significant life change (e.g., divorce, took an additional job, depression) because of health insurance problems?

To be eligible for the survey required an affirmative answer to question 1 and to at least one of questions 2−4. Respondents could answer "yes" to more than one of the three questions. If a respondent was uncertain of what a question meant, the SRC administrants of the survey repeated the question but did not elaborate. Telephone surveys began on July 6 and ended on September 3, 2009. One hundred surveys were completed.

Table 1. **Screening Questions**

Question	Percent of "Yes" Answers	Percent of "no" Answers
During 2009, did you or a family member pay an excessive amount for health insurance or health/medical care?	81	19
During 2009, did you or a family member have any problem about coverage (e.g., needed care not covered) or the ability to access covered benefits that led to a significant hardship?	30	70
During 2009, did you or a family member have a significant life change (e.g., divorce, took an additional job, depression) because of health insurance problems?	17	83

As noted above, respondents could answer "Yes" to more than one of screening questions 2−4 and, in some cases, did so. For example, a person who answered "Yes" to the question about paying an excessive amount for health insurance or health/medical care might have also answered "yes" to the question about a significant life change because the excessive cost was a direct cause of that significant life change.

The survey activity of the SRC continued until they reached the goal of 100 completed surveys. The sample from which the 100 completed surveys came consisted of 2,461 telephone numbers, randomly selected by the SRC from the state of Kansas. The SRC called each number up to ten times (i.e., if the first call was not answered, the SRC would call again up to a maximum of ten times before the telephone number was considered to be an "unusable" number). In the sample, 533 potential respondents refused to complete the survey, 129 potential respondents were ineligible because they failed to satisfy at least one of the criteria, 944 potential respondents were associated with unusable telephone numbers, and 100 interviews were

completed. Thus, the connect rate (calculated as ([100 completed surveys] + [533 refusals] + [129 ineligible]) / ([2,461 randomly selected Kansas telephone numbers] – [753 disconnected numbers] – [61 fax/modem numbers] – [130 non-residential numbers])) for the survey was 50.2 percent. The response rate (Aday, 1996; Kviz, 1977) (calculated as ([100 completed surveys])/ ([1,706 distinct randomly selected Kansas telephone numbers called] – [753 disconnected numbers] – [61 fax/modem numbers] – [130 non-residential numbers] – [129 ineligible numbers])) for the survey was 15.8 percent.

The survey has a 95 percent confidence with a margin of error of +/- 1.9 percentage points. The margin of error reflects the interval in which the data collected in this survey would be within +/- 1.9 percent of the distributions reported in 95 out of 100 surveys conducted amongst adults in Kansas, selected using the same random digit dialing methodology, who satisfied the same screening questions.

3. Limitations

One of the limitations of the phone survey is that the 100 completed surveys are not sufficient to make statistically significant inferences about all Kansans or subpopulations of Kansas. For example, data from the survey are not sufficient to make statistically significant estimates about the number of underinsured Kansans. Similarly, the data do not warrant statistically significant estimates about the number of Kansans who experience the challenges identified in the study (e.g., postponing needed health/medical care because of costs). However, this limitation is consistent with the exploratory nature of the project.

A second limitation is that only landline phones were called. The randomly selected telephone numbers from the state of Kansas did not include any cell phone numbers (Keeter, Kennedy, Clark, Tompson, & Mokrzycki, 2007; Kempf & Remington, 2007).

A third limitation is that all interviews were conducted in English (Berkanovic, 1980); the SRC did not have the capacity to conduct the surveys in languages other than English (e.g., Spanish).

A fourth limitation is that the response rate of 15.8 percent is relatively low. Without further information about why people refused to complete the survey (information not gathered during administration of the survey), this means that it is possible that the resulting sample of 100 Kansans is not representative of all underinsured Kansans. If, for example, a disproportionate number of people of a particular subpopulation refused to complete the survey, it is possible that the summary statistics will not reflect the experiences of these underinsured Kansans.

As noted above, KHI's phone survey was part of an exploratory study aiming to provide a more complete picture of who the underinsured in Kansas are, and the challenges they face because they are underinsured, and to help focus future descriptive and explanatory research on important concepts and variables (Henry, 1998; Sim & Wright, 2002). Such studies are, as Henry (1998) writes, "quite reasonably limited by resource and time constraints" since their goals are conceptual clarification, guidance for future research, and policy orientation rather than statistically accurate descriptions of a target population (e.g., prevalence estimates of characteristics of the target population) or explanations of causal pathways. For these reasons, the limitations of the phone survey do not undermine its role in contributing to the overall *Underinsured in Kansas* project goals of providing a more complete picture that has hitherto been available of who the underinsured in Kansas are, and the challenges they face because they are underinsured.

SURVEY FINDINGS

In all reported survey percentages, missing, "refused", and "don't know" answers are excluded from the denominator.

DIMENSIONS OF UNDERINSURANCE

As established by peer-reviewed, published research, there are at least two dimensions of underinsurance: structural and economic (Bashshur, Smith, & Stiles, 1993; Blewett et al., 2006; Kuttner, 1999; Oswald et al., 2005; Ward, 2006). Health insurance is structurally inadequate when the insurance fails to cover one or more needed health goods or services, or the insurance fails to cover one or more recommended health goods or services (Bashshur et al., 1993; Ward, 2006). Health insurance is economically inadequate when the person or family incurs health care

costs that result in economic consequences such as medical debt or bankruptcy, or delays a needed or recommended health good or service because of cost (Abraham, DeLeire, & Royalty, 2010; Farley, 1985; Short & Banthin, 1995). The KHI survey asked questions intended to collect information about both dimensions of underinsurance for Kansans.

A. Structural Dimension: Needed Care Delayed Because of Lack of Health Insurance Coverage

As noted above, one of the ways in which a person can be underinsured is if their health insurance does not cover needed (sometimes referred to as "essential care") health/medical care (Stone, 2000; Weiner, 2001). To capture this dimension of underinsurance, survey respondents were asked the following question:

> "Was there any time during the first 5 months of 2009 that you or another family member needed health/medical care, but delayed or could not get it because it was not covered by that person's health insurance?"

The majority of respondents, 90.1 percent, answered "No" to this question. Respondents who answered affirmatively mentioned dental work, laboratory work and surgery as needed services not covered, and prescriptions and medical equipment as needed health goods not covered by their health insurance plan.

Of those who answered the question "Yes," over half indicated that the delay of needed care resulted in a worsening of a health condition, increased anxiousness, or a lack of sleep. Slightly less than half who responded affirmatively to the question reported that the delay of needed care resulted in feelings of helplessness or changes in appetite.

B. Structural Dimension: Physician Recommended Care Delayed Because of Lack of Health Insurance Coverage

A second way in which a person can be underinsured is that their health insurance does not cover recommended health/medical care. To capture this dimension of underinsurance, survey respondents were asked the following question:

> "Was there any time during the first 5 months of 2009 that you or another family member delayed or could not get recommended health/medical care because it was not covered by that person's health insurance?"

As in the case of the question about needed care, the majority, 90.8 percent, answered "No" to the question. Respondents who answered the question affirmatively mentioned alcohol and drug treatments, dental work and laboratory work as recommended services not covered.

C. Economic Dimension: Money Spent on Health Insurance Premiums During the First Five Months of 2009

The cost of having insurance is paid through monthly premiums. If an individual participates in an employer-sponsored insurance plan, the employer may pay a percentage of the employee's premium costs. However, as health care costs increase, many employers have decided to pass on a larger share of the premium costs to their employees. For low- and middle-income workers, the responsibility of paying that larger share may pose a substantial financial burden.

To capture information about how much families spent on health insurance premiums during the first five months of 2009, respondents were asked the following question (modeled on standard survey questions that ask about annual expenditures):

> "As I read the following choices, please indicate by "Yes" or "No" whether you would estimate that your **family** spent that amount on health insurance premiums during the first 5 months of 2009. [Health insurance premiums are the payments for having the health insurance coverage, as opposed to deductibles or co-payments that you have to pay in addition to the cost of having the health insurance.]"

The following table presents the percentages in the dollar range choices for those 79 respondents (out of 100 completing the survey) who gave an estimate:

Table 2. **Amount Families Spent on Health Insurance Premiums During the First Five Months of 2009**

Dollars	Percent of Respondents
$0–$249	20.2
$250–$499	13.9
$500–$999	16.5
$1,000–$1,999	17.7
$2,000–$4,999	24.1
$5,000 or more	7.6

D. Economic Dimension: Money Spent on Health Insurance Deductibles During the First Five Months of 2009

Besides paying for some or all of their insurance premiums, policyholders typically must also pay some of the costs for the health care services they receive. Deductibles are fixed dollar amounts that an insured person must pay before the insurer begins to make payments for covered benefits.

To capture information about how much families spent on health insurance deductibles during the first five months of 2009, respondents were asked the following question:

> "As I read the following choices, please indicate by "Yes" or "No" whether you would estimate that your **family** spent that amount on health insurance deductibles during the first 5 months of 2009? [A deductible is the amount that you have to spend before your insurance begins to make payments.]"

The following table presents the percentages in the dollar range choices for those 76 respondents (out of 100 completing the survey) who gave an estimate:

Table 3. **Amount Families Spent on Health Insurance Deductibles During the First Five Months of 2009**

Dollars	Percent of Respondents
$0–$249	40.8
$250–$499	10.5
$500–$999	18.4
$1,000–$1,999	11.9
$2,000–$4,999	17.1
$5,000 or more	1.3

E. Economic Dimension: Money Spent on Health Insurance Co-Payments During the First Five Months of 2009

A co-payment is the amount that an insured person must pay each time a health care service is received (e.g., $10 for a prescription, $25 for a doctor's office visit).

To capture information about how much families spent on health insurance co-payments during the first five months of 2009, respondents were asked the following question:

> "As I read the following choices, please indicate by "Yes" or "No" whether you would estimate that your **family** spent that amount during the first 5 months of 2009 on health/medical care that was **not paid for** by your health insurance. This does NOT include health insurance premiums or deductibles."

The following table presents the percentages in the dollar range choices for those 80 respondents (out of 100 completing the survey) who gave an estimate:

Table 4. **Amount Families Spent on Co-Payments During the First Five Months of 2009**

Dollars	Percent of Respondents
$0–$249	46.2
$250–$499	12.5
$500–$999	13.7
$1,000–$1,999	8.8
$2,000–$4,999	13.8
$5,000 or more	5.0

F. Economic Dimension: Needed Health Care Postponed Due to Cost

When needed health/medical care is postponed because of cost, the person or family is underinsured (Karsten, 1995). To capture this dimension of underinsurance, survey respondents were asked the following question:

> "Was there any time during the first 5 months of 2009 that you or another family member needed health/medical care, but delayed or could not get it because of the cost?"

The majority of respondents, 90.0 percent, answered "No" to the question. Of those who answered the question affirmatively, 10.0 percent, the types of needed health/medical care postponed included surgery, laboratory work and prescriptions. Among those who postponed needed care because of cost, 90.0 percent reported increased anxiousness, 80.0 percent a worsening health or medical condition, and 80.0 percent feelings of helplessness. A much smaller percentage, 20.0 percent, reported that postponing needed care resulted in trouble at work or at home.

G. Economic Dimension: Recommended Health Care Postponed Due to Cost

When recommended health/medical care is postponed because of cost, the person or family is underinsured. To capture this dimension of underinsurance, survey respondents were asked the following question:

"Was there any time during the first 5 months of 2009 that you or another family member delayed or could not get recommended health/medical care because of the cost?"

The majority, 92.8 percent, answered "No" to the question. Of the 7.2 percent who answered "Yes" to the question, the types of recommended health/medical care postponed included physician visits, laboratory work, and surgery.

H. Economic Dimension: Consequences of Health Care/Medical Bills

Although most Kansans have health insurance (87.6 percent according to 2007−2008 Current Population Survey data), for many that is not enough to protect them from the financial strain of paying for the health care they may need. A number of different factors may cause this strain, and the KHI survey asked several questions to better identify those factors.

One question asked respondents whether a collection agency contacted them about unpaid health care/medical bills:

"Was there any time during the first 5 months of 2009 that a collection agency contacted you or another family member because of an unpaid health care/medical bill?"

Although a majority of respondents answered "No" to this question, approximately 12.2 percent reported that they had been contacted by a collection agency regarding unpaid health care/medical bills.

Respondents were also asked a series of questions about difficulties they or family members encountered due to owing money for health care/medical expenses. Nine percent reported difficulties paying utility bills, 7.0 percent reported difficulties qualifying for credit, and 5.0 percent reported difficulties paying their mortgage or rent, or being unable to retire.

In addition to the kinds of difficulties mentioned above, owing money for health care/medical expenses also contributed to a variety of personal, family and social problems. For example, regarding personal problems, 12.0 percent reported increased anxiousness, 10.0 percent reported changes in sleep, and 8.0 percent reported feelings of helplessness. In addition, 6.0 percent reported trouble at home, while 3.0 percent reported trouble at work.

INTERVIEW METHODS

DESIGN

Each underinsurance situation is the result of a unique set of circumstances that cannot be explained by quantitative findings alone. So, members of the KHI project team traveled the state to conduct 10 in-depth interviews with underinsured Kansans to develop a more comprehensive understanding of how having inadequate health insurance affects families.

The Kansas Health Institute supports the practice of protection for human subjects participating in research. Therefore, to conduct the interviews in a manner that ensured this security (e.g., confidentiality), we requested and received approval from the Human Subjects Committee of the University of Kansas School of Medicine in Wichita, Kansas.

Then, to select people for the interviews, we used the sampling criteria described for selecting the survey respondents. We also worked on a case-by-case basis with the two cooperating organizations — the Kansas Health Consumer Coalition and the Kansas Association for the Medically Underserved — that assisted with sampling, to render a sample of 10 underinsured Kansans.

Before being interviewed, each person signed an approved informed consent and authorization form, indicating their willingness to take part in the interview as a research participant. During the face-to-face conversations, inquirers used an interview guide with standard-format questions. We asked participants about their experiences with inadequate health insurance, if those experiences had impacted their lives, and if so, how. These interviews, which lasted about 45 minutes, took place between September and November 2009. With the

respondents' consent, we digitally recorded each one. We also took field notes of verbal communication and body language.

Limitations

While findings from the interviews, such as postponing health care, are congruent with other studies of underinsurance, the results are representative only of the 10 people interviewed. They are not representative of all underinsured Kansans. And, as with other qualitative research, while we had no reason to doubt the information that persons interviewed relayed, that information was not independently verified.

DATA ANALYSES

The KHI analyst used grounded theory (Glaser, 2009) to analyze the qualitative data and identify emergent themes. Study team members undertook this process immediately following the interviews. Pursuant to each, inquirers debriefed and compared identified content to start the data coding process and inter-coder agreement while the heard, observed and written data were fresh.

Thereafter, staff transcribed the recorded interviews rendering more than 400 pages of transcripts. We utilized memoing to notate words or meaning when reading transcripts, which we reviewed multiple times before unitizing, coding and analyzing the transcribed information for emergent themes (Rodwell, 1998; Lincoln & Guba, 1985). This means that we reduced the transcript data to minimal units of meaning and placed content in coded segments. An inquirer then reviewed these sections for similarities and differences in words and ideas, making constant comparisons and juxtaposing the axial-coded data into themes and subthemes that lent an overall understanding of the study.

Finally, the author conducted member checks by drafting personal accounts from each transcript and sending them to available interviewees for review to ascertain the contents' trustworthiness and authenticity. The persons interviewed corroborated the credibility and accuracy of the author's interpretations of their experiences. These processes formed the framework for the interview findings in this report.

INTERVIEW FINDINGS

SAMPLE

The interview participants were all underinsured Kansans who ranged in age from 25 to 78. Five were female and five were male. All were non-Hispanic, nine were white and one was black. They came from different walks of life such as farming, teaching, coaching, social services and business and were living in geographically diverse areas including the southeastern, western, eastern, rural and urban parts of Kansas. Their unique, individual stories, including their health conditions, are described in the *Voices of the Underinsured: Kansans Tell Their Stories* report.

THE ILLUSION OF COVERAGE

Eight of the 10 underinsured Kansans interviewed didn't realize they were underinsured until they had trouble paying medical bills or were denied coverage.

While this sometimes occurred suddenly, more often it was cumulative. A few people had medical events (e.g., hospitalization) while others needed ongoing care for chronic conditions or a combination of both. Whatever the situation, after their insurance carriers paid claims and consumers received bills for uncovered care or unpaid portions of covered health care services, they discovered that their benefit structures were not adequate to protect them from the financial strain of paying for the health care services they needed and received.

At that point, the respondents' insurance and the sense of security it had afforded — sometimes for decades — appeared to be an illusion. One recounted how it seemed to just disappear:

> I had no clue. I really had no idea how much it [health care] would cost. When I first started to get bills and they were in the hundreds of dollars, I thought, "What do people do that have absolutely no insurance coverage?" because for 35 years I thought I had good insurance. I thought it would pay [for my health care] but it was gone almost instantaneously.

REASONS UNDERINSURED

The 10 Kansans we talked with were underinsured because in one way or another their health insurance coverage was not adequate, resulting in negative consequences.

Four of the 10 persons said their benefits were inadequate and gave the following reasons for their opinions: one policy didn't cover the knee component of a prosthetic leg that made it functional; one excluded care and supplies for a pre-existing condition; one afforded catastrophic coverage and paid for only three physician office visits per year per family member, leading them to ration care; and one stopped covering treatments for degenerative disc disease — although providers deemed the services medically necessary, the insurance company considered the degenerative disease one continuing incident that no longer warranted care.

Six of the 10 interviewees described their coverage as "pretty good," "good," "very good" or "really good." They initially thought it would adequately cover their health care expenses, but the reality turned out to be very different. However, even after realizing they were underinsured, participants still described their plans the same way — variations of "good." And, based on the descriptors given, the researcher agreed with the respondents' assessments of their insurance. So how could they be underinsured?

These individuals' insurance failed to protect them from financial distress when their health care needs were high or their incomes were low to moderate. In some instances, plans were not adequate in proportion to health care needs. In others, individuals' benefits were insufficient in relation to their income.

One person, whose coverage was inadequate relative to her health care needs, described her insurance as "really good." But what she was paying to treat her multiple, chronic conditions was more than she could afford: "It is really good coverage. It's just that I have many conditions and when you go [to the doctor] constantly, it really starts adding up."

One couple's policy was not adequate in relation to their budget. Living on a fixed retirement income, the pair struggled with small, unexpected increases in their share of premiums and cost-

sharing requirements: “We’re both on Social Security. I work two part-time jobs to help and pay premiums and co-pays and we get by but when the brakes go out on your car and all of a sudden the furnace goes out that puts you in a real bind.” If their income had been higher, their insurance would likely have been adequate since their health needs were not great.

Whatever the reason participants were underinsured, the limits of their insurance posed difficulties for them and their families.

REAL PROBLEMS

> ***“The anxiety and stress [related to medical debt] causes problems for real people. This is real. This is life. This is me, not some guy on a television commercial.”***

Others interviewed echoed the words of one respondent quoted above. They were all facing problems resulting from inadequate health insurance coverage such as financial and emotional distress. Therefore, many of the themes identified through data analyses pertained to these setbacks. The theme of *Psychological Challenges* emerged most often. Next came *Financial* and *Physical Challenges,* followed by *Work, Health Care, Family, Health Care System* and *Community Challenges* per Figure 1.

In this report, we relay what participants told us by using their quotes to represent these themes and subthemes that include some of the attempts they made to meet their challenges. We also provide findings under two additional themes: *Concern for Others* and *Experiences with Health Care Providers.*

Figure 1. **Challenges**

FINANCIAL CHALLENGES

"Medical debt has ruined our ability to function financially."

Eight of the 10 underinsured Kansans interviewed were dealing with *Financial Challenges*, the second most commonly occurring theme. Nine subthemes emerged under *Financial Challenges*, including *Problems Paying Bills, Medical Debt, Medical Debt as Credit Card Debt, Lifestyle Changes, Disrupted Retirement, Paying Medical Debt, Other Attempts to Meet Challenges, Collections* and *Bankruptcy*, as depicted in Figure 2. The respondents' quotes given below represent these themes.

Figure 2. **Financial Challenges Subthemes**

1. ***Problems Paying Bills***
2. ***Medical Debt***
3. ***Medical Debt as Credit Card Debt***
4. ***Lifestyle Changes***
5. ***Disrupted Retirement***
6. ***Paying Medical Debt***
7. ***Other Attempts to Meet Challenges***
8. ***Collections***
9. ***Bankruptcy***

Problems Paying Bills: Eight persons interviewed said they had trouble paying the cost of premiums, deductibles, co-payments and coinsurance associated with their health care. Because their incomes didn't stretch far enough to pay everything, participants had to make difficult choices: "I have to make choices. Every month I pay the health insurance premium and buy groceries, and then whatever's left gets split up between everyone." Decisions involving health care services for loved ones were especially difficult.

> You are juggling between, "Okay, are we going to pay our mortgage this month or are we going to buy medicine?" You're pitted between those things and that's a hard place to be in because a person's health is priceless. Of course, we want to take care of that first but we need a place to live and we need electricity. So juggling what we are going to give up this month is hard. How are you going to tell someone who's sick [husband with Muscular Dystrophy], who needs medicine, "sorry."

Medical Debt: People said they couldn't pay for both their health care and living expenses. So, they accumulated medical debt. Individuals owed for treatment from physicians, hospitals

and chiropractors as well as prescriptions, physical therapy and diabetes testing supplies. Several interviewees said diagnostic testing had significantly contributed to their debt.

> He [my husband] went to doctor after doctor that ran tests after test after test. And by the time we got all the bills we realized there was no way we could pay the premium and the deductibles and the coinsurance. We felt comfortable taking care of his health [needs] because we thought we were covered. Then we realized that what you think is not such a big deal adds up quickly. It becomes astronomical. When you pay radiologists, doctors, technicians and different hospitals you owe a lot of different people a lot of money. We were absolutely overwhelmed with medical debt. All the premiums, deductibles, and co-pays piled on top of us.

> I've just been through test after test, MRI's and bone scans and it has taken tons of tests to rule out this and rule out that before they said, "You have fibromyalgia."

Medical Debt as Credit Card Debt: Concerned about being denied health care, one person elected to charge services with credit cards.

> I've chosen to put it [out-patient medical expense] on credit cards. I don't like the feeling of owing medical providers money because I fear that they would deny treatment. I don't want to get where I was [in severe pain]. So, I keep them paid. I continue to put medical care on credit cards because I fear they will deny me treatment. I want to keep them paid. I have $20,000 in credit card debt. Everything I have on credit cards is medical debt only.

Lifestyle Changes: To pay for medical services and/or debt, eight participants tightened their budgets, cutting back on living expenses where they could.

> We've learned to be very frugal. I spend a lot of my time when I go grocery shopping. I try to stick to a really small budget and use coupons.

> We've done without. You don't get new shoes. You don't get new clothes. You don't get new glasses.

One family decided they would have to go without many of the amenities that other families take for granted. They also limited activities that connected them with social support that can be very helpful during hard times. This family and others decided to limit their recreational opportunities.

> We shut off the phones, shut off the cable service, shut off the internet. Everything we could cut out, we cut out. We stopped eating out completely, stopped going to the zoo and things where [daughter] could have fun. There are a few free places to go for her but not when gas is $3.00 a gallon. We stopped going to see family and friends because we can't afford to drive.

The inability to travel to visit their grandchildren hit two couples particularly hard.

> It hurts that our son, his wife and our granddaughter are where we used to live in [another state]. We miss them terribly. My granddaughter just started first grade. She's the light of my life. It's tough being away from them but we can't afford to travel.

Food was another issue. Families' needs to stretch their grocery dollars as far as possible sometimes made it difficult to make healthy choices.

> You buy cheap groceries…We want to be healthy and eat healthy food but you buy cheap food because you're trying to go the cheapest route possible. I like healthy whole foods and I enjoy cooking but eating cheap macaroni with spaghetti sauce is not our idea of a healthy meal…You look at food as medicine. You have to have food to function…but it's no longer enjoyable.

> We want to get the right kind of food. You can buy a lot of cheap pastas and things

> but it's not good for you. It certainly isn't good for someone with type 1 diabetes because pastas are full of carbohydrates. I eat pasta for supper and my blood sugar is high in the middle of the night. I would have to wake up every two hours checking my blood sugar and taking shots. We can't afford vitamins and what we need, whole grain and whole foods. The healthiest food is expensive.
>
> We have to be very, very careful about what we spend on everything, including food, and unhealthy calories are the cheapest. We've been eating a very unhealthy diet.

In addition to other cut-backs, people delayed home and automobile repairs, as illustrated in three quotes below.

> You're spending money on medical bills that you can't spend fixing your house.
> We had to delay putting a roof on our house. It should have been done four years ago when it started leaking but we paid medical bills.
>
> I have to have a new roof. I thought about doing it myself but can't. When I do a lot of physical labor, I get really low blood sugar fast. If I'm on a roof and get low blood sugar, there's like a 90 percent chance that I'm going to fall off that roof.
>
> Work around our house needs to be done but we can't afford to get it done. So you have an asset that you can't take care of that will no longer be an asset.

Disrupted Retirement: Three individuals disrupted or delayed their retirements. One said: "My concern was that we had made our retirement plans and they just weren't working out the way we had hoped."

Two of these three participants said they had used their retirement funds and savings to pay for health care or medical debt.

> I was absolutely exhausted, which was their goal, to wear me out until I just gave up. Finally, when I realized my health was in the balance, for my own health and to protect my mental and physical well-being, I bought the prosthesis myself [using retirement funds], which was a significant expense [$30,000].

One respondent was planning to postpone retirement.

> We're very frugal and plan and save for the future. We made a lot of choices, like no new clothes and no new car. We did the things we were supposed to do a long time ago so that we would have money for retirement**.** This [using retirement funds] dipped into our future… I'm going to postpone retirement.

One additional person said because he had been unable to save for it, he would never be able to retire.

> As far as retirement goes, we have the same amount of retirement [savings] right now that we had seven years ago. I am never going to be able to retire. I will work until I die because there's just not an option.

Two participants had returned to work after retirement.

> I had no cushion [after spending retirement pay out and life savings on medical bills]. So, as soon I got to feeling better I had to go back to work [after retirement]. I accumulated a bunch of part-time jobs resulting in my working more than 40 hours a week, often 60 hours to try to keep up with medical bills. I have to work more than I wanted. I had planned to work one part-time job in retirement.

Paying Medical Debt: All individuals said they expected and wanted to pay for the medical care they received and tried to do so. They attempted to manage their obligations in other ways besides cutting back on living expenses.

One couple sought financial counseling and two tried to consolidate their medical bills.

> We got financial counseling for help to develop a functioning budget. We've sought a lot of help from a lot of different places.
>
> We tried to do a consolidation and no one was willing to reduce the amount [we owed them] even if we could pay them in full by taking out a separate loan. People [providers and collectors] were completely unwilling to help us. They were completely unwilling to bend even in the slightest.
>
> Before we filed bankruptcy we went through a company to consolidate all our bills. You put everything together and make one monthly payment. That failed. They were taking out so much that I couldn't pay other bills.

Parents and grandparents stepped in to assist families with budgets strained by health care expenses.

> They [parents and grandparents] actually are the reason we've been able to make it because they give us money. They come down and buy us dinner or lunch because we can never go out. It's nice to have a little time away from the house because most of the time we're stuck in the house. We go to the thrift shop if we can. If we can't, grandparents buy clothes for [daughter]. My wife's mom and dad bought my shoes I've got on today and my jeans. I got two pairs of jeans from them and I only own two pairs of jeans. The rest are full of holes because I just wore them out.

Like the parents and grandparents who supported their adult children and grandchildren, adult children helped their parents.

> The brakes went out on the car. I really didn't have the funds to do it but over a period of time you know, four or five weeks, I could have gotten the brakes done. But I couldn't drive with those brakes in the condition they were in. Something happened to the brake

> line and it leaked. It went into the drum and soaked the pad until the whole thing, the guts, had to be taken out and replaced. My son said, "Hey, don't worry about it. Here's the money." But I won't let him do it without repaying him.

To manage their debt, the primary measure people took was trying to negotiate monthly payment plans with providers, some of whom were willing. One person took pride in the way her community seemed to coalesce around this issue.

> For the most part people have worked with us and they have done a really good job. We have had nothing but positive and respectful outcomes from the doctors and the medical offices that we've worked with… So I have to be proud about that, knowing that our local community understands the issues and is willing to work with families.

However, most medical professionals were not willing to arrange payment plans.

> We called everybody asking them to work with us and set up reasonable payment plans. They were completely unwilling to bend even in the slightest.

> We want to pay everyone off but when people aren't willing to work with you at all it makes it pretty hard to want to bend over to make them happy.

Collections: Despite patients' efforts to pay their bills, providers eventually turned unpaid balances over to collection agencies, stressing consumers both financially and emotionally. In two instances, medical professionals submitted accounts for collection when people had arranged plans and were making payments as agreed. Then the bills kept coming and so did the phone calls from collectors.

> We received several nasty phone calls a day from hospitals, doctors' offices or people representing them. They act like I'm skirting my responsibilities but they don't understand that I have to make choices. Every month I pay the health insurance premium

> and buy groceries, and then whatever's left gets split up between everyone. They don't understand that we're trying. Some get really nasty.
>
> It [collections] was just miserable. It's one of the most miserable things. Nobody should have to go through this. If we just were not paying our bills I could understand.

Interviewees said having their accounts turned over for collection had ruined their credit rating and dampened their hopes for the future.

> Because we owe so many different people from different procedures we have a hard time making satisfactory payments by the time we live for the month. Everybody wants a $60 or $70 payment and we can't do that and a lot of them have taken us to collections. We've been filed on in small claims court and our credit is ruined because of medical debt. It just adds up so fast that by the time you pay that huge premium every month there's not a whole lot left over to make those payments.
>
> All of these people [providers and collectors] have filed with credit agencies. That's the only debt we have. We don't have a single credit card. It's just medical debt and it's ruined our credit. We can't get anything like a car because our credit is shot.

For one couple, this meant delaying their plans to take over the family farm.

> We farm with my husband's parents who want to retire but they can't until we are financially stable. So they have to keep working until we get this medical debt paid off and are in a place where a bank will fund us to farm. Our credit is ruined, absolutely ruined. It will take us 10 to 15 years to rebuild what has happened.

Bankruptcy: Consumers tried to pay their obligations. They postponed health care, took extra jobs, tightened their budgets, disrupted their retirement, negotiated payment plans and sought financial counseling and bill consolidation. Some even allowed family members to assist

them financially. Still, ultimately four families had to file for bankruptcy because of medical debt.

> Payments are not much help if you owe $5,000 to $10,000 [in medical debt]. You're making payments and it's never going to go away if you can only pay a small amount a month. That wasn't good enough for the collectors. This is how I ended up in bankruptcy.

PSYCHOLOGICAL CHALLENGES

> ***"Probably the biggest thing is sitting there worrying about all the bills, the impact it has on your whole life."***

All 10 underinsured Kansans reported *Psychological Challenges* stemming from financial distress and inadequate insurance. Twelve subthemes emerged under *Psychological Challenges.* By far, *Worry* and *Stress* appeared most often, followed by *Anxiety* and *Depression*. Next came *Fear, Humiliation, Loss of Dignity, Loss of Control, Anger, Resentment, Frustration* and *Inadequate Mental Health Coverage.* Large amounts of worry and stress were reported; both words occurred multiple times in almost all transcripts. While these emotions appear linearly in Figure 3, they sometimes clustered together, as illustrated by the representative quotes below.

Figure 3. **Psychological Challenges Subthemes**

1. ***Worry***
2. ***Stress***
3. ***Anxiety***
4. ***Depression***
5. ***Fear***
6. ***Humiliation***
7. ***Loss of Dignity***
8. ***Loss of Control***
9. ***Anger***
10. ***Resentment***
11. ***Frustration***
12. ***Inadequate Mental Health Coverage***

Worry, one of the two most common emergent subthemes, took different forms. People worried about paying bills and medical debt, being improperly insured and the future.

> Probably the biggest thing is sitting there worrying about all the bills, the impact it has on your whole life. If you have a conscience you want to pay your bills. I've always paid my bills and when you can't pay them, it causes you just a tremendous amount of worry.

> The medical debt, knowing I'm not insured properly, I worried about it constantly.

> You just get so tired of worrying about it [medical debt and the future]. You get to a point where you just want to throw your hands up and say, "I'm done worrying about it," but you can't ever, you can't ever quit worrying about it.

Stress, the other most frequent emotional reaction, appeared alone and with others such as worry. Individuals were stressed about finances and insurance.

> It's kind of the irony. I feel like my family is healthy yet I think one of the stressors that people who are underinsured probably have is wondering, "I'm healthy but yet I don't feel like my coverage is adequate. What happens if I'm unhealthy?"

> I am constantly stressed out because of the financial thing. I worry if we're going to be able to get enough food and pay my medical bills. If I could somehow work out the financial aspect of being able to cover everything that needs to be covered [medical bills and living expenses] then that would go away.

> In my job, one of the things I look at is psychological stress and I could feel it taking a toll. I had to see a cardiologist because my heart rate was chronically high. Then, I realized that the stress of this issue [payment approval] was wearing me down.

Stress and Depression: Mounting stressors took a toll on respondents' mental health and some sunk into depression.

> At the worst, I got to the point where I didn't do anything but lay on the floor in a fetal position. It's mind boggling what depression and stress does.

> As finances have been in a death spiral, I have grown more and more depressed. At times, I despair that I have no future.

Anxiety: Family members were anxious about their insurance and finances.

> This whole thing, not being able to get adequate insurance, definitely has increased the anxiety in our family.

Fear: Several persons were fearful about their health care coverage, financial matters and the future.

> I think the biggest challenge is the fear. It's debilitating because you're afraid if you use your insurance, the premiums will go up. You're afraid if something happens, you won't be able to pay the deductibles.
>
> You know everybody is going through a rough hallway in this economy. The lack of adequate insurance is scary. It's awful and I just thank God that nothing worse has happened.

Stress, Anxiety, Fear and Depression: Some families reacted to growing pressures with multiple emotions.

> My husband and I were raised to take our responsibilities very seriously. When you walk around knowing that you owe people money and you can't pay them, that's a really angst-causing situation. The depression, the anxiety and tension in our house we have to deal with in addition to the fear is horrible. I'm constantly afraid that something is going to happen on the farm and one of us is going to end up in the hospital. If that happens, we are going to be set back farther. We can't go to the hospital because we just can't afford it. We can't dig ourselves deeper into that hole.

Humiliation, Loss of Dignity and Depression: Participants also felt humiliation and loss of dignity, in one instance mixed with depression.

> No one should ever have to be made to feel like less of a human being because they don't have enough money to keep themselves healthy.
>
> I had to beg for prescriptions from some of the insurance companies.
>
> I walked with a horrible gait because my leg was falling off and it was embarrassing to interact with my colleagues. It [dealing with insurance] also took a mental toll — depression, humiliation, loss of dignity while I gimp around, this pathetic creature out begging for a leg with a tin cup."

Anger: Only two respondents expressed anger about their situations, one of whom noted: "Paying for all of my medical care and insulin really makes me angry."

Resentment: A few were resentful.

> Every time I get a call at work from my wife saying our son is sick, I have to think about if he should go in [to the doctor] or not because we only have a few of these [office visits]. So, we can't or shouldn't expend them all. I resent going through that process. Every time someone gets sick, I have to ask, "Does this warrant a doctor's visit?"

Loss of Control and Resentment: Some of the people who felt powerless were also resentful.

> Then there's the body image and dealing with the loss of a limb, physical limitations and resentment toward people that I perceive to be controlling my destiny and health.

Loss of Control and Frustration: And, those who felt a loss of control over their lives were sometimes frustrated.

> I really wish insurance companies understood that while they're dealing with the bottom dollar, we're dealing with daily life. I have an 18-month-old and I have to carry him around. I have to cook and clean and work on the farm. When I'm in so much pain that I can't get out of bed, that makes life tough. I really wish that someone could make them [insurance company] understand that they are dealing with our daily lives. They're playing God and that frustrates me so.

> My concern if I were to describe it in a nutshell is the ever-tightening noose and not having some semblance of control. They [former employer] say, "We're cutting you off in three months. Here's a letter. In three months go fend for yourself." They say, "We're going to give you this coverage this year but we're going to cut it next year and we'll cut it some more the following year. So look forward to that." What are they really trying to say? When's the next shoe going to drop? That's my point of frustration.

Inadequate Mental Health Coverage: Some individuals were dealing with psychological issues serious enough to warrant professional mental health services. A few people got prescriptions for antidepressants from their medical doctors; however because of limited mental health coverage, they had trouble accessing counseling from a licensed provider.

> I was receiving therapy for my depression but again I fell behind on my payments and so I discontinued therapy. I hope to have my therapist paid off by the end of the year and start again in January. I have mental health coverage but the deductibles and out-of-pocket expenses have been heavy.

> The [mental health] coverage is very limited and counseling was going to cost a great deal out-of-pocket. We sought sources of free or low-expense counseling like our pastor. There are resources but you have to be careful about where you go when you have to pay for everything.

HEALTH CARE CHALLENGES

Health Care posed *Challenges* for six of the underinsured Kansans. Under this theme, the subthemes of *Postponing or Forgoing Needed Health Care* and *Postponing Dental Care* emerged most often, followed by *Not Filling Prescriptions* and *Other Attempts to Meet Health Care Challenges*, as shown in Figure 4 and highlighted in representative quotes.

Figure 4. **Health Care Challenges Subthemes**

1. ***Postponing or Forgoing Needed Health Care***
2. ***Postponing Dental Care***
3. ***Not Filling Prescriptions***
4. ***Other Attempts to Meet Health Care Challenges***

Postponing or Forgoing Needed Health Care: The prospect of incurring additional health care costs and the need to cut back on expenses led six individuals to make the difficult decision to postpone or forgo medically necessary health care. For example, in one family, a three-year-

old was not receiving "well-child visits" done at recommended intervals to ensure that a child is growing and developing normally.

Even though one person had chronic heart problems and a family history of cardiovascular disease, he went without care for it.

> We've had to triage my care just to focus on those things that are most immediately dangerous and more long term [diabetes] trying not to do anything at all for my cardiovascular system because I see that as less of an immediate threat. There's a lot of heart disease in my family, so that worries me.

Another reported that her husband delayed services until his blood pressure became "dangerously high."

> We delay care as long as we can. My husband's blood pressure was dangerously high when we caught it and got it under control. He didn't know it was high because he had not gone to have it checked. We were at a store that had one of those blood pressure stations. He checked it and it was way high. He checked it two or three times and we finally made the decision that he needed to go see someone because he had a serious problem. That's pretty sad that he had to wait.

Yet another said he had gone without physical examinations for many years to ensure that his wife received the services and medications she needed.

> I have placed my emphasis on her [wife]. You know how that works, the big strong guy is sacrificing for her.

Postponing Dental Care: Respondents indicated that they had postponed dental care. Some said the annual capped amounts their insurance paid deterred their access.

> I have postponed dental care because my back, shoulder, and neck problems are where I spend my money and you can only put so much on a credit card.

Not Filling Prescriptions: Like many who are underinsured, participants made decisions based on costs rather than what was good for their health. Because they couldn't afford to fill all their prescriptions, even individuals with serious health conditions had to decide which ones to do without.

> I would say, "OK, this month I'll get this prescription but I can't refill this one. It's going to have to wait to the next check." I would think, "OK, what is the most important?" I would go without my high blood pressure medication and I would start swelling. You could push on my ankles and legs and see the water. So, I'm thinking, "OK, this is not good. I can't skip my high blood pressure medication." Then you go to the next one and think, "Maybe I can go without this." I ended up hurting my health.

When people didn't fill prescriptions, it was often at risk to their health. When one person skipped her high blood pressure prescription, she said she experienced serious swelling that required an additional prescription taken on a continuing basis. When another person stopped taking medication to save money, her depression regressed to its state previous to starting treatment.

> I took myself off antidepressants before I changed to a less expensive one because we just didn't have the money and that was detrimental. It set me back to the beginning before I started to see improvement.

Other Attempts to Meet Health Care Challenges: Interviewees tried to manage their health care challenges by changing to different medications or generic drugs, which they believed didn't work as well as the original medications or brand name products.

> They changed some [of my wife's] medications to generics, which causes me some concern because they don't work as well. If these [generics] will do the job as well, how

> do you get from $40 a prescription down to $10 a prescription? If they work as well, why weren't we doing that before?
>
> The doctor moved him [husband] to one of the generic prescriptions [for high blood pressure]. It doesn't work quite as well but we can afford it.

One couple responded to their health care challenges by taking preventive measures to improve their health and avoid future medical care. They exercised, ate healthy, took yoga, lost weight and educated themselves.

> We're trying to get healthy, to be proactive in exercising and eating healthy to make sure that we don't have any incidences of health problems that we can prevent because we just can't financially afford to end up in the hospital. We just can't.
>
> I've been doing yoga and losing weight. I have checked out books from the library on treating my husband's high blood pressure and we've had to be our own doctors because seeing a nurse practitioner is $25 and they may want to see you two or three times before they figure out what's going on.

One individual's concerned adult children stepped in to make sure he received needed health care when he was sick.

> I became concerned when our three children started placing themselves in positions to intervene. Our children, God bless them, said, "This is what's going to happen." When I got the flu, I was self medicating. My daughter grabbed me by the ear one day at about 4:00 in the afternoon and took me to a clinic under false pretenses. We were going to go out to have a little father-daughter talk you know and we wound up in front of a physician's office.

PHYSICAL CHALLENGES

Eight of the 10 underinsured Kansans faced *Physical Challenges*. The most frequently appearing subthemes were *Lack of Sleep* and *Weight Gain* followed by *Multiple Physical Problems* and *Muscle Atrophy*. See Figure 5.

Figure 5. **Physical Challenges Subthemes**

1. ***Lack of Sleep***
2. ***Weight Gain***
3. ***Multiple Physical Problems***
4. ***Muscle Atrophy***

Lack of Sleep: Due to growing financial and psychological distress, seven participants said they had trouble sleeping, one of whom recalled the racing thoughts about bankruptcy that kept her up at night.

> You lay there and are up all night long thinking, "What am I going to do? How am I going to do it? Are we going to file bankruptcy? I never thought I'd be filing bankruptcy. I can't believe we're filing bankruptcy. What does this mean? What are we going to lose and how is this going to affect our future because everything is based upon a credit score… So does that mean you're never going to have anything?"

Weight Gain: To cope with stress and depression, people overate and gained weight, which worsened their existing health conditions and added new ones (e.g., high cholesterol and blood sugar). One said the inability to purchase healthy food had contributed to his weight gain. Stressors led to both weight gain and sleeplessness for many and to multiple physical issues for some.

> My husband didn't eat and I ate myself into oblivion. That's how we deal with stress. Learning to deal with those things has been a challenge in itself, just learning

to deal with the byproducts of all the stress that being underinsured caused us. The depression caused me to eat and put on a lot of weight.

Multiple Physical Problems: Some persons reported multiple problems, "I experienced weight loss, lack of sleep, headaches, worry and a cardiac visit [office visit for chronically high heart rate]."

Muscle Atrophy: Due to immobility while awaiting insurance approval for payment of a prosthetic leg, one person's muscles atrophied: "While I waited, my leg atrophied. And I was absolutely exhausted, which was their [insurance company's] goal, to wear me out until I just gave up."

WORK CHALLENGES

Seven underinsured Kansans said finances and dealing with insurance companies created *Work Challenges* them. Five subthemes emerged under this theme including *Difficult Choices, Taking Extra Jobs, Bill Collector Calls at Work, Work Hazard and Falls* as well as *Inability to Perform Work Functions and Employer Setbacks.*

Figure 6. **Work Challenges Subthemes**

1. ***Difficult Choices***
2. ***Taking Extra Jobs***
3. ***Bill Collector Calls at Work***
4. ***Work Hazard and Falls***
5. ***Inability to Perform Work Functions and Employer Setbacks***

Difficult Choices: Pondering how to pay their health care obligations, some people had to make difficult employment decisions. One had considered leaving her chosen career field in order to work in one that paid more: "I work for a nonprofit organization. I know that's by choice. That is my passion. So I'm faced with finding alternative employment or a second job."

Another participant considered taking a second job, but didn't think she was physically up to it.

> I probably would be working a second job but with my health [problems] I just can't because of the pain. It has come into my head many times… but there's just no way… By the time I'm done with my eight-hour job that's it for me.

Taking Extra Jobs: One couple took second jobs while continuing to work on the farm. Much of their extra income was going to pay medical debt and insurance premiums.

> We farm and that's a full time job for both of us… After looking at our budget, we decided there's no way we're ever going to be able to survive and pay medical bills. So I went back to teaching and he [husband] took a full-time job. We both work a lot of hours. It's not uncommon for us to do chores in the morning and go to work. We come home and eat supper the minute we get home. Then we'll load him [child] up in the car seat and milk cows or whatever needs to be done. My income goes to paying medical expenses and one week of his pay goes to pay the insurance premium.

Bill Collector Calls at Work: One interviewee told us about how bill collectors had called her at work.

> There was one terrible man. He was really mean and called and hounded me at work constantly… I was in my cubicle where everyone could hear my entire conversation. Some of them try to work with you but they want the same thing. They want those payments. They want you to say you're going to pay this amount and you're going to get it paid off in a certain amount of time.

Work Hazard and Falls: Since part of one interviewee's work involved working with infants, the instability of a temporary prosthetic leg she used while waiting for insurance payment approval of a permanent prosthesis became a work hazard.

> I needed to be able to walk, stand, hold and handle infants and not be worried about falling down. I am a risk to other people if I fall and I fell multiple times with the hydraulic prosthesis because it doesn't work in a way that is safe.

The falls this individual took while using a temporary prosthesis had lingering effects even a year after she paid out-of-pocket for a leg that met industry standards and was no longer falling.

> I fell twice in one week. Because of the falls, it takes you a long time to recover and get your confidence back. It's been pushing a year now and I'm just starting to stop thinking about an incline or "I have to lift my leg a little higher. This is uneven ground."

Inability to Perform Work Functions and Employer Setbacks: The same participant had to deal with other extreme employment difficulties that set back her employer's progress.

> I had to ask other people to do the physical part of my job. When the person who was filling in for me left on vacation, I was faced with having to test infants with a useless prosthesis strapped to me. I knew I couldn't test infants on crutches, or from a wheelchair, so I kind of hopped around. I could see that the parents were uncomfortable with my staggering around the room. I walked with a horrible gait because my leg was falling off and it was embarrassing to interact with my colleagues. I didn't know what to do or where to go next.

> It definitely affected my work. I couldn't travel. I couldn't even get up to the library. I could go to work and sit in my office but I could not work with infants, lift and carry objects or go to meetings. The entire miserable period cost me and the university about a year. It delayed grant submissions and other projects.

HEALTH CARE SYSTEM

The health care system itself presented challenges for some. In fact, five of the 10 underinsured Kansans identified it as the biggest one they had faced. Five subthemes emerged under the *Health Care System Challenge* theme. *Insurance Companies and Paperwork* appeared

most often, followed by *Dealing with Insurance Plan, Billing and Multiple Unknown Providers, Confusing Communication* and *Other Attempts to Meet Health-Care-System Challenges* per Figure 7. The representative quotes below illustrate these.

Figure 7. **Health Care System Challenges Subthemes**

1. ***Insurance Companies and Paperwork***
2. ***Dealing with Insurance Plan***
3. ***Billing and Multiple Unknown Providers***
4. ***Confusing Communication***
5. ***Other Attempts to Meet Health-Care-System Challenges***

Insurance Companies and Paperwork

> My wife has to constantly stay on the insurance companies. You are constantly watching. Keeping track and paying all the different bills. Just trying to keep it all straight and the payments up is unbelievably mind boggling, especially for somebody that's sick. There's no way I could have managed if I had been single. It's impossible. My wife is a wonderful person. She stuck with it and fought and kept going and that's the only way we were able to survive. The insurance company comes back and says something isn't covered. You have to argue with them and eventually it is. You have to stand your ground. They're out to make money. They're not worried about John Smith. They're worried about profit, the bottom line.

Dealing with Insurance Plan

> The biggest challenges were fighting with them [insurance company] and the mobility issues. I thought they would eventually pay for it [prosthesis]. My prosthetist tried to keep me mobile by using a test socket until approval came through. I ended up getting stuck in the test socket for months instead of days or weeks. While I waited, my leg atrophied.

Billing and Multiple Unknown Providers

> All they [the hospital] had to do was change one little box [to correct a coding error] and insurance would have paid it. I told them, "All you have to do is fix the mistake." They just said, "You owe us $250." It is crazy frustrating.

> Every month, I end up with stacks of bills. Every hospital uses a different radiologist and many other people I didn't know would be involved [in one procedure] and they all bill differently. It doesn't take long to end up owing 20 or more people. It's hard to keep track of all the bills and how much insurance paid. We're making payments but I have to make a payment to everybody else too. They [providers] don't understand why I can't just pay them in full, that I owe them and the doctor and the facility. It's ridiculous how many people have their hand in things. I don't understand why we can't move to a more simplified system. I don't claim to have the answers to the world's problems but it's not hard to see that something is out of whack with the health care system.

Confusing Communication

> One of my strengths is the English language. I could read you a paragraph of their [former employer's] communication and you would say, "What did they say?" I almost had to have an attorney and an English major, as an interpreter, for all of the language about these changes. So I became very concerned.

Other Attempts to Meet Health-Care-System Challenges: Families tried to resolve their concerns with the health care system in different ways such as staying on top of claim statements and bills, described above. In addition, one person researched benefit changes, networking with others affected by them. Another launched a letter-writing campaign and undertook other activities to publicize difficulties with her insurance carrier.

FAMILY CHALLENGES

"The financial stress makes us more stressed at home."

Six underinsured Kansans reported *Family Challenges* both within their immediate family and with extended family members. Three subthemes emerged under this theme including *Marital Relationships, Parent and Child Relationships* and *Adult Child and Parent Relationships* per Figure 8.

Figure 8. **Family Challenges Subthemes**

1. ***Marital Relationships***
2. ***Parent and Child Relationships***
3. ***Adult Child and Parent Relationships***

Marital Relationships: People said financial hardships strained their marriages. One couple sought marriage counseling, another considered divorce and a third person marveled that she and her husband were still married.

> We have a great relationship but it seems like money is the one thing that can strain it to the core. You take the first two years of a marriage which are supposed to be so happy and add in all that stress. It has made our lives, to be quite frank, a living hell.

> We both love each other but there were times we were thinking very seriously about divorce. It's not easy. It's just not easy.

> We're lucky to be married right now. It's been very difficult.

Parent and Child Relationships: One participant said worry and stress about being able to provide for his family's basic needs had negatively impacted his relationship with his daughter.

> The financial stress makes us more stressed at home. I have a daughter and I know that I get mad a lot easier than I should. I'm sure that is related to just being stressed out about whether I'm going to be able to buy groceries. We always have been able to [buy groceries] but it doesn't help when you're down [to small amounts of money].

Adult Child and Parent Relationships: As with immediate family members, economic distress strained extended-family relationships. In one case, parents had to postpone retirement because of their son and daughter-in-law's medical debt.

> This has really frustrated his parents as well because it's disrupting their lives too. They have [to keep farming] to deal with the byproducts of a situation that my husband and I [created]. They would like us to fast forward through this and get on with life, so that makes it hard.

COMMUNITY CHALLENGES

Two people experienced tensions with friends or other community members, indirect outcomes of being underinsured and another emergent theme. One couple living in a small town dreaded running into people to whom they owed money.

> We've done business with people. You hate to run into them in town when you know they made repairs on our house and it took us way longer to pay them than it should have because we have to make medical bill payments.

CONCERN FOR OTHERS

In the midst of their personal struggles, some of the underinsured Kansans we interviewed voluntarily expressed concern for others.

> I hope we can figure out something. I hope that there are no other families that have to continually go through this. No one should ever have to be made to feel like less of a human being because they don't have enough money to keep themselves healthy. I hate that anyone would have to work a whole week to pay an insurance premium that does them no good and that's where we are right now. I hope no one else has to experience this.

> My understanding is more than 50 percent of individuals my age are apt to experience these kinds of problems. Does everybody have to make these choices about treatment? Is

everybody experiencing these kinds of bills with co-pays and deductibles even with good insurance? When somebody is running upwards of a thousand dollars a month in credit card bills in order to pay for their out-of-pocket expenses for health care, that person needs assistance.

Experiences with Health Care Providers

We also asked people about their experiences with their health care providers. Six subthemes themes emerged under this theme. These included *Lack of Price Transparency, Questioning Necessity of Care, Refused Access to Care, Provider Problem Solving, Positive Attitudes Toward Providers* and *Preferred Practices.*

Figure 9. **Experiences with Health Care Providers Subthemes**

1. ***Lack of Price Transparency***
2. ***Questioning Necessity of Care***
3. ***Refused Access to Care***
4. ***Provider Problem Solving***
5. ***Positive Attitudes Toward Providers***
6. ***Preferred Practices***

Lack of Price Transparency: No person interviewed knew how much their health care would cost before receiving it. In need of care, patients didn't ask.

> When you get the bills, you're going, "You have be kidding me." You know the equipment is expensive but what they charge is unbelievable. No one told me what a test was going to cost or what they were going to charge me [for office visit]. They should tell you up front.

> When they said, "you need bypass surgery today" you don't stop and ask how much it is. You just say "fix me."

Questioning Necessity of Care: In addition, one consumer, uncertain about whether all the tests her doctors ordered were necessary, tried to balance this uncertainly with financial and health concerns.

> By the time you pay six or seven different people [for one procedure], you owe a lot of money. I understand that they were trying to figure out what's going on but I wish they would be more thoughtful about expenses the patient incurs before they order things (e.g., tests). When a doctor tells you that you need something it's hard to know for sure if you do. I have no medical training. So you do it and then three to four weeks later the bills start rolling in and you had no idea about the amount. Then the test turned out to be inconclusive or weren't helpful and they order other tests. That makes it really hard to not only trust that your providers are looking out for your best interests but also to trust yourself in knowing when something's wrong enough to justify seeking care.

Refused Access to Care: Some health care providers denied care to people who had outstanding balances and could not pay them.

> I've had several refuse to provide me additional care until I've paid up. For example, I had a very expensive series of tests with a group and I've not been able to get the results of those tests because I've not been able to pay [out of pocket amount] for those tests.

Provider Problem Solving: Respondents tried to overcome barriers blocking their access to health services. When one individual was refused care because of unpaid bills, she went past a medical practice office manager to talk directly with her physician.

> I am really pleased with the people that provide care. I think the real problem lies in the people that run their offices. If people running the business offices had half the compassion of the doctors, the health care industry would be way better. I went above the business office manager because of her insistence on the clinic's policy of requiring payment of balances. I finally got so frustrated that I talked to the doctor who had no idea

> what was going on. So we worked something out. I thought the health industry would be about trying to help people get healthy.

When one family was refused care due to unpaid balances, they sought needed services from a different provider to whom they didn't owe money.

> We had to change providers to get care because we owe one place too much money. We made paying them a priority so we can continue to receive care if we need it, which sounds terrible but you have to have a place to go if you have to have care.

Positive Attitudes Toward Providers: Whatever their experiences with medical professionals, even when they refused them care or turned their accounts over to collection agencies, participants maintained positive attitudes toward their providers: "I've had wonderful doctors, wonderful."

> With regards to the physicians and the testing facilities, everybody's been very nice very and reasonable. No one has been nasty. It's just that I've not been able to afford even small payments to several of the providers and have been turned over to collection agencies. I understand why they've done what they've done yet they don't understand why I can't pay even the smallest amounts.

One person said their family's practitioner went above and beyond in caring for their family members whose insurance paid for a limited numbers of office visits annually.

> We feel very comfortable with our family practice. We can always call and at least talk to a nurse which is nice. They do a lot of over-the-phone counseling as much as they can. They do a good job of taking care of us. So, I think the health industry has adapted to the current climate.

Preferred Provider Practices: Although interviewees maintained positive attitudes toward their providers, they did identify things they would have liked them to have done differently. The

main practice consumers would have preferred was to have been informed about the cost of their health care. One wished her physician would have been more thoughtful about the expenses she incurred.

> I would have appreciated knowing up front what some of these procedures were going to cost. I was just floored at how much out-of-pocket expense can come from something like a colonoscopy or a CAT scan. You may only have a co-pay for an office visit but then you pay a radiologist and the lab and others.

Both providers and consumers found themselves in difficult positions like those described above. Many medical professionals were likely torn between compassionately providing care and responsibly maintaining a profitable practice. They had staff salaries and living expenses to pay. The office manager was probably following practice policies approved by the physician. Such situations seem inherent in the existing health care system structure, even when individuals have good intentions, as one participant expressed.

> There are a lot of good people in both the provider side and the insurance side. It's just that we've got a gawd-awful, dysfunctional system that's chewing up lots and lots of people, including me.

DISCUSSION

The quantitative survey results and qualitative interview findings complement each other, as evidenced by selected themes that include:

1) Illusion of Coverage
2) Underinsurance Related to Health Care Needs and Income
3) Out-of-Pocket Expenses
4) Challenges of Underinsurance

ILLUSION OF COVERAGE

KHI's research found that most persons interviewed did not know their health insurance was not adequate until they couldn't pay their medical bills or were denied coverage. At that point, the respondents' policies and the sense of security they had afforded seemed to be an illusion.

Four of the 10 participants identified ways in which they believed their coverage was insufficient. The other six described their plans in varying degrees of "good." Even after realizing they were underinsured, interviewees described their plans the same way.

UNDERINSURANCE RELATED TO HEALTH CARE NEEDS AND INCOME

People's insurance often failed to protect them from financial distress when their health care needs were high or their incomes were low to moderate. In some instances, interview participants' plans were inadequate in proportion to their health care needs. In others, their benefits were insufficient in relation to their income.

OUT-OF-POCKET EXPENSES

Interview participants said their health care expenditures ranged from roughly $420 to $1,500 monthly. These amounts were consistent with the slightly more than one-third of survey respondents who reported spending at least $400 per month on out-of-pockets health care expenses. Nearly one in 10 survey respondent spent at least $1,000 monthly. These expenses are considerable since the average gross family income of survey respondents was about $45,700.

The out-of-pocket health care costs survey respondents reported included premiums, deductibles and co-payments. Among survey respondents reporting monthly costs, nearly one-third spent $400 or more in premiums monthly. Another third spent $100 or less. In addition, approximately one-third paid $200 or more in deductibles monthly and almost half paid $100 or less. Moreover, nearly one-fifth paid at least $100 in co-payments each month and almost six in 10 paid less than $100. Both survey respondents and interview participants reported the consequences of paying these expenses and those interviewed described them in detail.

CHALLENGES

Most of the Kansans interviewed talked about financial strains due to underinsurance. For some, out-of-pocket expenses or costly treatments for unexpected illness or injury resulted in medical debt and ruined credit ratings. To manage this debt, these individuals transferred it to credit cards, tightened their budgets, developed payment plans, withdrew funds from retirement or took second jobs to pay the bills. Even with these efforts, four out of the 10 people interviewed filed bankruptcy due to medical debt.

Survey respondents also identified economic challenges resulting from inadequate coverage. They reported that owing money for health care/medical expenses led to difficulties paying their mortgage or rent, utility bills and food. They also had trouble qualifying for credit and retiring.

The financial impact of underinsurance affected individuals interviewed in other ways as well. For example, many explained that they cut back on social activities, ignored needed home repairs, purchased cheaper but less healthy foods, delayed needed medical care and didn't fill prescriptions. Survey respondents reported similar experiences. Ten of 100 survey respondents said they, or another family member, had postponed at least one needed health care service such as surgery, physician office visits, laboratory work or prescriptions.

In addition, most of the Kansans interviewed reported social, emotional and medical consequences of being underinsured. Some revealed that the stress caused by medical debt negatively affected their marriage and relationships with other family members. Others talked about experiencing sleeplessness, overeating, depression, increased blood pressure or how stress or lack of treatment aggravated their illness. Similarly, survey respondents reported negative effects resulting from stress such as feelings of helplessness and changes in sleep patterns.

The impact of underinsurance can reach beyond the individual to places of employment. Some people interviewed experienced decreased productivity at work due to untreated medical conditions, stress, or having to deal with collection agency calls. Others had to quit work because of their untreated medical conditions. Survey respondents also reported experiencing work difficulties.

Together, the survey and interview finding illustrate the multiple dimensions of underinsurance and the underlying impact insurance limitations have on individuals, families and communities.

The challenges of underinsurance, such as work, stress, deferred care and bankruptcy, can have a much larger ripple effect through the economy. Stress and/or deferred care can create new or worsening health care conditions resulting in increased health care costs paid throughout the system. Loss of productivity affects employers' profits. Bankruptcy often results in uncompensated care.

NEXT STEPS

KHI's survey and interviews of underinsured Kansans constitute an exploratory study aiming to provide a more complete picture than has hitherto been available of who the underinsured in Kansas are and the challenges they face because they are underinsured, and to help focus future descriptive and explanatory research on important concepts and variables (Henry, 1998; Sim & Wright, 2002). Thus, the next research questions, which expand the exploratory research into descriptive and explanatory research, include the following:

Question 1: What is the prevalence of underinsurance in Kansas?

Question 2: What is the prevalence of demographic characteristics of underinsured Kansans?

Question 3: What is the prevalence of different dimensions of underinsurance amongst underinsured Kansans?

Question 4: What are the kinds and prevalence of effects of underinsurance amongst underinsured Kansans?

Question 5: To what degree and how do the provisions of health care reform address the challenges faced by underinsured Kansans?

Answers to these questions are important for policymakers interested in effectively addressing the challenges faced by underinsured Kansans, and will require creating a representative sample of underinsured Kansans from which it is possible to make the statistically significant estimates.

APPENDIX

DEMOGRAPHICS

A. Counties Represented

The one hundred respondents represented 38 out of 105 counties in Kansas.

Figure A-1. **Respondents by County**

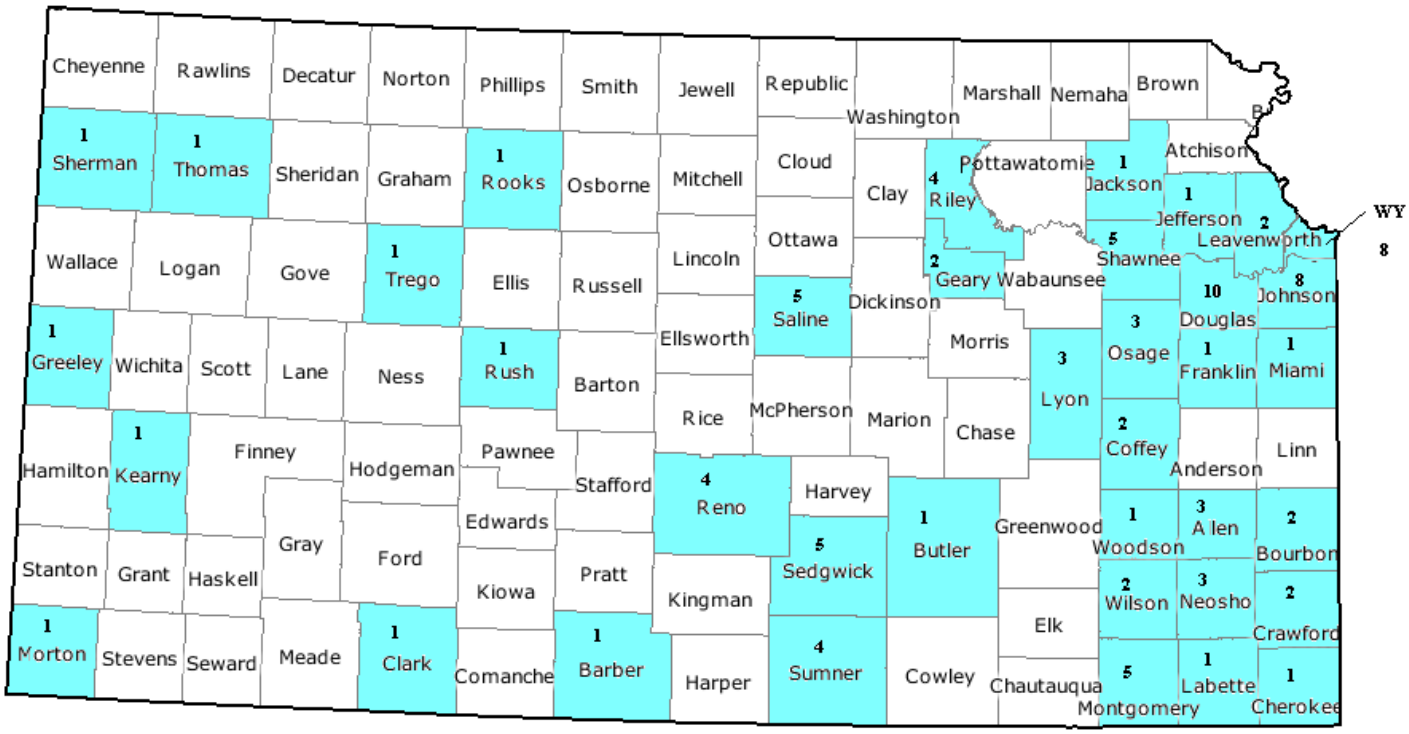

Table A-1. **Respondents by County**

County	Number of Survey Respondents
Allen	3
Barber	1
Bourbon	2
Butler	1
Cherokee	1
Clark	1
Coffey	2
Crawford	2
Douglas	10
Franklin	1
Geary	2
Greely	1
Jackson	1
Jefferson	1
Johnson	8
Kearny	1
Labette	1
Leavenworth	2
Lyon	3
Miami	1
Montgomery	5
Morton	1
Neosho	3
Osage	3
Reno	4
Riley	4
Rooks	1
Rush	1
Saline	5
Sedgwick	5
Shawnee	5
Sherman	1
Sumner	4
Thomas	1
Trego	1
Wilson	2
Woodson	1
Wyandotte	8

B. HOUSEHOLD AND FAMILY

In the survey, 'household' was defined for the respondents as the place in which they resided — e.g., a house, apartment, mobile home, trailer — during the first five months of 2009. Respondents were asked four questions relating to household characteristics:

1. **Household Size:** "What is your best estimate of the number of people who lived in your household (the place in which you reside — e.g., a house, apartment, mobile home, trailer) during the first 5 months of 2009?"

   Of those who answered the question, 20.9 percent reported a household size of one person, 44.8 percent a family size of two persons, 10.4 percent a family size of three persons, 16.7 percent a family size of four persons, and 7.2 percent a family size of five or more persons.

2. **Number of Children in Household:** "What is your best estimate of the number of children (persons 18 years of age or younger) who lived in your household during the first 5 months of 2009?"

   Of those who answered the question, 55.3 percent reported no children in the household, 11.8 reported one child in the household, 22.4 percent reported two children, 7.9 percent reported three children, and 2.6 percent reported four children.

3. **Number of Families in Household:** "What is your best estimate of the number of families who lived in your household during the first 5 months of 2009? (For example: If your married child and his/her children lived with you and your spouse or partner, then there were two families in your household; If your elderly parents live with you and your spouse or partner, then there were two families in your household)."

   Of those who answered the question, 90.8 percent reported one family living in the household, 5.7 percent reported two families, and 3.5 percent reported four families. None of the respondents reported three families.

4. **Family Size:** "How many people are in your family? (Include all persons in your family living with you as well as those who may not now be living with you but would consider your residence as their permanent residence — e.g., students away at school, people in the military.)"

   Of those who answered the question, 21.6 percent reported a family size of one, 38.1 percent a family size of two, 8.2 percent a family size of three, 15.5 percent a family size

of four, 7.3 percent a family size of five, and 9.3 percent a family size of six or more persons.

C. Age, Gender, Race and Ethnicity

The following two tables present the age ranges and gender for all respondents who self-indentified their ages and gender, and for those respondents who identified the age and gender of a spouse or partner with whom they lived:

Table A-2. **Self-Reported Age Ranges of Respondents**

Age Range	Percent of Respondents	Percent of Spouses or Partners
18–29 years	4.0	0.0
30–39 years	10.0	16.7
40–49 years	19.0	21.2
50–59 years	24.0	13.6
60–64 years	13.0	19.7
65 years or older	30.0	28.8

Table A-3. **Self-Reported Gender of Respondents**

Gender	Percent of Respondents	Percent of Spouses or Partners
Male	31.3	66.2
Female	68.7	33.8

The following table presents the age ranges, by gender, for all respondents who self-identified both their age and their gender (the sum of all the percentages is 100):

Table A-4. **Self-Reported Age Ranges of Respondents by Gender**

Age Range	Percent Male	Percent Female
18–29 years	0.0	4.0
30–39 years	4.0	5.1
40–49 years	4.0	15.2
50–59 years	7.1	17.2
60–64 years	4.0	9.1
65 years or older	12.1	18.2

The following two tables present the race and ethnicity for all respondents who self-indentified their race and ethnicity, and for those respondents who identified the race and ethnicity of a spouse or partner with whom they lived:

Table A-5. **Self-Reported Race of Respondents**

Race	Percent of Respondents	Percent of Spouses or Partners
American Indian or Alaskan Native	2.0	1.4
Black or African American	2.0	2.7
Native Hawaiian or Other Pacific Islander	0.0	1.4
White	93.0	91.9
Other (Including Multiple Races)	3.0	2.7

Table A-6. **Self-Reported Ethnicity of Respondents**

Ethnicity	Percent of Respondents	Percent of Spouses or Partners
Hispanic or Latino	3.2	5.9
Neither Hispanic nor Latino	96.8	94.1

D. Self-Reported Health Status and Marital Status

Respondents were asked to rank their own current (at the time of the survey) overall, general health, using a five point Likert scale ranging from excellent (scored as 1) to poor (scored as 5). Respondents were also asked how, in their best judgment, their spouse or partner would, if asked, rank his or her own current overall, general health using the same scale.

Table A-7. **Self-Reported Health Status of Respondents**

Health Status	Percent of Respondents	Percent of Spouses or Partners
Excellent	20.6	12.7
Very Good	32.0	40.8
Good	34.0	23.9
Fair	11.3	18.4
Poor	2.1	4.2

In addition, respondents were asked about their marital status during the first five months of 2009.

Of those who answered the question, 74.2 percent reported being married, 12.4 percent widowed, 8.2 percent divorced, and 5.2 percent never married and single. No respondent identified him or herself as unmarried and living with a partner.

The following table presents a summary of the information in (B) – (D):

Table A-8. **Self-Reported Demographic Categories of Respondents**

Demographic Categories	Percent of Respondents
Household Size	
1 person	20.9
2 persons	44.8
3 persons	10.4
4 persons	16.7
5 or more persons	7.2
Number of Children in Household	
0 children	55.3
1 child	11.8
2 children	22.4
3 children	7.9
4 children	2.6
Number of Families in Household	
1 family	90.8
2 families	5.7
3 families	0.0
4 families	3.5
Number of People in Family	
1 person	21.6
2 people	38.1
3 people	8.2
4 people	15.5
5 people	7.3
6 or more people	9.3

Table A-8 (continued). **Self-Reported Demographic Categories of Respondents**

Age Range	
18–29 years	4.0
30–39 years	10.0
40–49 years	19.0
50–59 years	24.0
60–64 years	13.0
65 years or older	30.0
Gender	
Male	31.3
Female	68.7
Race	
American Indian or Alaskan Native	2.0
Black or African American	2.0
White	93.0
Other (Including Multiple Races)	3.0
Ethnicity	
Hispanic or Latino	3.2
Neither Hispanic nor Latino	96.8
Health Assessment	
Excellent	20.6
Very Good	32.0
Good	34.0
Fair	11.3
Poor	2.1
Marital Status	
Married	74.2
Widowed	12.4
Divorced	8.2
Never married and single	5.2

E. Employment and Family Income

The survey contained several questions about the employment experiences of the respondents and members of their families.

1. **Number of Full-Time, Single Employer (i.e. having only one job) Family Members:** "During the first 5 months of 2009, how many members of your family (including

yourself) were employed full-time by a single employer (35 or more hours per week) or self-employed full time (35 or more hours per week)?"

Of those who answered the question, 31.5 percent reported no family members employed full-time by a single employer, 37.0 percent reported one family member, 27.2 percent reported two family members, and 4.3 percent reported three or more family members.

2. **Number of Family Members with More than One Job:** "During the first 5 months of 2009, how many members of your family (including yourself) had more than 1 paid job (e.g., a full-time job and, and the same time, a part-time job; 2 or more part-time jobs)?"

   In those families whose principal breadwinner (the person who, during the first five months of 2009, brought in the greatest income amongst family members) had paid employment, a large majority of the respondents, 85.0 percent, reported that no family members had more than one job, while 9.0 percent reported one family member, 5.0 percent reported two family members, and 1.0 percent reported three family members.

3. **Percentage of Principal Breadwinners with More Than One Job:** "During the first 5 months of 2009, did the principal breadwinner have more than 1 paid job (e.g., a full-time job and, at the same time, a part-time job; 2 or more part-time jobs)?"

   In those families whose principal breadwinner had paid employment, a large majority, 91.2 percent, reported that the principal breadwinner had only one job, while only 8.8 percent reported that the principal breadwinner had more than one job.

The survey also included a question about family income for 2008:

"For the year 2008, which of the following ranges of incomes best describes your family's total gross (before taxes) income (including wages, salaries, commissions, bonuses, tips, self-employment income, interest, dividends, rental incomes, pensions or social security income, royalty incomes, and income from estates and trusts, and other sources)?"

The following table presents the income ranges for those 76 respondents (out of the 100 completing the survey) who answered the question:

Table A-9. **Income Ranges of Respondents**

Family Gross Income for 2008	Percent of Families
Under $10,000	4.0
$10,000–$19,999	4.0
$20,000–$29,999	13.2
$30,000–$59,999	39.4
$60,000–$79,000	19.7
$80,000 and Over	19.7

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