Health Policy Report

# The American Health Care System

## Health Insurance Coverage

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THE most prominent feature of American health insurance coverage is its slow erosion, even as the government seeks to plug the gaps in coverage through such new programs as Medicare+Choice, the Health Insurance Portability and Accountability Act (HIPAA), expansions of state Medicaid programs, and the $24 billion Children's Health Insurance Program of 1997. Despite these efforts, the proportion of Americans without insurance increased from 14.2 percent in 1995 to 15.3 percent in 1996 and to 16.1 percent in 1997, when 43.4 million people were uninsured. Not as well appreciated is the fact that the number of people who are underinsured, and thus must either pay out of pocket or forgo medical care, is growing even faster.

This report addresses several trends that account for the erosion of health insurance coverage. The most important trend is the deterioration of employer-provided coverage, the source of health insurance for nearly two in three Americans.[1] I will discuss this cause in detail in the next article in this series. To summarize briefly for now, a few employers have eliminated coverage entirely because of the escalating costs of premiums. Most employers have narrowed the choice of plans and shifted costs to employees by capping the employer's contribution, choosing plans with higher out-of-pocket payments, or both. These changes, in turn, have caused some employees to forgo coverage for themselves and their families and have also led to underinsurance, since many employees, especially those who receive low wages, cannot afford the out-of-pocket charges.

The following trends are also eroding insurance coverage of all types.

**Rising premium costs, both for persons who have access to insurance through their employers and for those who buy insurance individually.** Costs will rise in 1999 for both groups, but more sharply for persons with individual coverage.[2,3]

**The trend toward temporary and part-time work, which seldom includes health care coverage.** In 1997, about 29 percent of working Americans held "non-standard" jobs, a category that includes temporary, part-time, contract, and day-labor positions.[4]

**A reduction in explicit coverage, most notably pharmaceutical benefits.** Most plans cap outpatient pharmaceutical benefits. Prescription drugs now constitute the largest category of out-of-pocket payments for the elderly, and the costs are rapidly rising.

**Greater de facto limitations on covered care, especially by health maintenance organizations (HMOs).** More stringent utilization reviews and economic disincentives for physicians and hospitals are resulting in denial of care and shifting of costs to patients.

**A broad shift from traditional HMOs requiring very low out-of-pocket payments to point-of-service plans and preferred-provider organizations (PPOs) requiring higher payments by patients.** Ostensibly, the rationale for this shift is to provide greater choice for consumers, but consumers often enroll in a PPO or a point-of-service plan not because HMOs restrict choice but because they are perceived as restricting care. By 1997, there were more than twice as many Americans enrolled in point-of-service plans or PPOs as there were in HMOs.[1]

**Loss of Medicaid coverage due to welfare reform.** The 1996 welfare-reform law separates Medicaid eligibility from eligibility for public assistance, but it also pushes many former welfare recipients into low-wage employment that does not provide health insurance. Although the termination of welfare benefits does not necessarily entail loss of Medicaid coverage, preliminary reports suggest that in practice the added administrative complexity is leading to reduced enrollment in Medicaid.[5]

**The rising cost of "Medigap" coverage for the elderly, which leads to substantial underinsurance.** In some states, such as Massachusetts, comprehensive Medigap policies are now in a death spiral: only a small number of persons with high medical expenses find it cost effective to buy such policies, and low enrollment, in turn, leads to even higher premiums and lower enrollment.

**The crackdown on illegal immigrants and the reduction in services to legal immigrants.** These policies are forcing many immigrants to forgo Medicaid and other forms of health coverage that are legally available to their children who are citizens.

**The trend away from community rating of individual insurance premiums, which results in rising costs and, hence, reduced rates of coverage for middle-aged persons.** For the 8.7 million Americans who buy insurance individually, premiums are partly adjusted for age and are also adjusted for prior medical conditions.

As a result of these trends, lack of insurance and underinsurance are becoming more widespread problems. Not surprisingly, it is lower-income Americans who bear the disproportionate costs, since as compared with higher-income Americans, they are more likely to work for employers who do not provide

health care coverage or who require employees to make sizable contributions to insurance premiums, they are more likely to have part-time or temporary jobs with no health care coverage, and they are less able to afford individual insurance or high out-of-pocket payments.

Surprisingly, unemployment is scarcely implicated in these trends. Indeed, all of them have occurred while unemployment rates have been declining. Other things being equal, a decline in the unemployment rate should bring an increase in health insurance coverage, given the prevalence of employer-provided coverage. But the low unemployment rates of the late 1990s have not been sufficient to offset the above-mentioned trends. Today, the vast majority of uninsured persons are employed.

## THE UNINSURED

The number of uninsured persons rose from 41.7 million (15.6 percent) in 1996 to 43.4 million (16.1 percent) in 1997, according to a September 1998 Census Bureau report (Tables 1 and 2).[6] This widely publicized increase tends to understate the extent of the problem, however. The Census Bureau also calculated that a much larger number of Americans, about 71.5 million, lacked insurance for at least part of the year. The latter figure was based on a study conducted from 1993 through 1995.[7] Poor and low-income persons, as well as members of minority groups, were most likely to have periods without coverage. Twenty-five percent of non-Hispanic whites had at least one month without coverage, as compared with 37 percent of blacks and 50 percent of Hispanics.

Lack of insurance is very closely correlated with low income. Whereas 8 percent of Americans with incomes over $75,000 and 16.1 percent of all Americans lacked health insurance in 1997, 24 percent of those with incomes of less than $25,000 had no coverage. Fifty percent of persons with incomes below the poverty line had at least one month without insurance, as compared with 27 percent of those with higher incomes. Despite Medicaid, 11.2 million persons with incomes below the poverty line, or 31.6 percent of all the poor, had no health insurance at all in 1997.[6]

The high cost of health insurance relative to income is the main reason for high rates of uninsurance among poor and low-income persons. A study conducted by KMPG Peat Marwick for the Commonwealth Fund found that a person with an annual income at the poverty threshold would need to pay 26 percent of that income to purchase health insurance. In more expensive markets, this cost rises to 40 percent of income for a family of four.[8] Since such families are barely able to pay for food and shelter, these figures suggest that for poor and low-income persons, health insurance is effectively unaffordable unless it is provided by employers or the government.

Lack of insurance is also correlated with loss of employment. According to the Census Bureau, during the period from 1993 to 1995, 44 percent of persons who lost their jobs also reported loss of insurance coverage. At the same time, however, almost

**TABLE 1.** TYPE OF HEALTH INSURANCE AND COVERAGE STATUS, 1997.*

| STATUS AND TYPE OF COVERAGE | THOUSANDS OF PERSONS (%) |
|---|---|
| **All persons** | |
| Total | 269,094 (100.0) |
| Covered | 225,646 (83.9) |
| Private | 188,533 (70.1) |
| Employment-based | 165,092 (61.4) |
| Government | 66,685 (24.8) |
| Medicare | 35,590 (13.2) |
| Medicaid | 28,956 (10.8) |
| Military | 8,527 (3.2) |
| Not covered | 43,448 (16.1) |
| **Poor persons** | |
| Total | 35,574 (100.0) |
| Covered | 24,336 (68.4) |
| Private | 8,264 (23.2) |
| Employment-based | 5,521 (15.5) |
| Government | 18,585 (52.2) |
| Medicare | 4,637 (13.0) |
| Medicaid | 15,386 (43.3) |
| Not covered | 11,238 (31.6) |

*Data are from the U.S. Census Bureau.[6] Percentages add up to more than 100 because some people had more than one type of coverage.

**TABLE 2.** PERSONS WITHOUT HEALTH INSURANCE FOR THE ENTIRE YEAR, ACCORDING TO SELECTED CHARACTERISTICS, 1997.*

| CHARACTERISTIC | ALL PERSONS | UNINSURED PERSONS |
|---|---|---|
| | thousands of persons (%) | |
| Total | 269,094 | 43,448 (16.1) |
| Sex | | |
| Male | 131,705 | 23,130 (17.6) |
| Female | 137,390 | 20,319 (14.8) |
| Age (yr) | | |
| <18 | 71,682 | 10,743 (15.0) |
| 18–24 | 25,201 | 7,582 (30.1) |
| 25–34 | 39,354 | 9,162 (23.3) |
| 35–44 | 44,462 | 7,699 (17.3) |
| 45–64 | 56,313 | 7,928 (14.1) |
| ≥65 | 32,082 | 333 (1.0) |
| Race or ethnic group | | |
| White | 221,651 | 33,242 (15.0) |
| Non-Hispanic white | 192,179 | 23,135 (12.0) |
| Black | 34,598 | 7,432 (21.5) |
| Asian or Pacific Islander | 10,492 | 2,172 (20.7) |
| Hispanic | 30,773 | 10,534 (34.2) |

*Data are from the U.S. Census Bureau.[6]

half (49 percent) of fully employed people with incomes below the poverty line had no insurance.[7] The figure was even higher in 1996, when 52 percent of poor full-time workers had no insurance. This study was conducted before the enactment in 1996 of the HIPAA, which makes it easier for persons who have lost employer-provided insurance to qualify for other coverage.

However, to the extent that loss of insurance coverage is the result of lost purchasing power due to job loss, HIPAA is of no help, because it provides no subsidy and does not regulate price. The 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA), which allows people leaving employment to pay insurance premiums out of pocket for up to 18 months in order to retain their coverage, likewise fails to address economic barriers to coverage. Moreover, although HIPAA prohibits outright denial of insurance because of previous medical conditions, it allows insurers to charge people with previous conditions substantially higher premiums, thus sharply limiting effective coverage.[9] Although in principle HIPAA protects as many as 25 million people from loss of insurance, in practice it benefits only a few hundred thousand.[10]

A 1997 national survey of health insurance conducted by Louis Harris Associates for the Henry J. Kaiser Family Foundation and the Commonwealth Fund confirms these trends. According to the survey, one in three adults between the ages of 18 and 64 years had been without insurance at some point in the previous two years. The survey confirmed that persons with low incomes were most likely to lack coverage: 59 percent of adults with incomes below $20,000 had been without coverage, as compared with 8 percent of adults with incomes above $60,000.[11] The survey also confirmed that lack of insurance was more often due to the high cost of coverage (reported by 51 percent of respondents) than to job loss or the employer's failure to provide access to coverage (reported by 25 percent). Fifty-seven percent of respondents without insurance were employed full time.[12] The survey also showed considerable discontinuity of coverage, with one third of insured adults reporting that they had been enrolled in their current health plan for less than two years.[13]

## CHILDREN WITHOUT INSURANCE

Several reports have documented high and rising rates of uninsurance among children. According to a March 1997 Families USA report based on Census data, approximately one child in three had no insurance coverage for one or more months during 1995 and 1996.[14] Almost half these children (47 percent) were uninsured for a year or more. Unemployment of the family breadwinner was not the main reason, since 91 percent of the children who lacked health coverage for the entire two years lived in households where the breadwinners were employed all or part of the 24-month period. Lack of insurance was more closely correlated with low income. Fifty percent of children with family incomes between $15,000 and $25,000 had no health care coverage. For the very poor, Medicaid in principle provides coverage. According to the General Accounting Office, however, nearly 3 million children who are eligible for Medicaid are not enrolled in the program[15] because of inadequate outreach, fears on the part of immigrants that enrollment will lead to problems with the authorities, and other barriers.

On the basis of a survey of health care coverage for children, the Census Bureau reported that the proportion of children lacking insurance rose from 12 percent in 1989 to 15 percent in 1996,[16] a period of increasing prosperity in general, decreasing unemployment, and nominal expansion of eligibility for Medicaid. Noting that the number of poor children covered by Medicaid fell from 16.5 million to 15.5 million between 1995 and 1996, the Census Bureau observed, "The growth in the number of children lacking health insurance is largely attributable to the fall-off in Medicaid coverage."[16] Some 34 percent of the survey respondents whose children did not receive regular medical care reported that the reason was that they had no insurance and could not afford visits to doctors.[17] Approximately 800,000 children were taken to emergency rooms for all their care.[18]

In 10 jurisdictions, at least 37 percent of children went without insurance for some portion of the period from 1995 through 1996: Texas (46 percent), New Mexico (43 percent), Louisiana (43 percent), Arkansas (42 percent), Mississippi (41 percent), the District of Columbia (39 percent), Alabama (38 percent), Arizona (38 percent), Nevada (37 percent), and California (37 percent).[19]

Not surprisingly, several studies confirm that children without health insurance receive less care in the form of diagnostic, screening, and immunization services than children with coverage. Uninsured children have fewer checkups, are less likely to be treated for chronic conditions such as asthma and recurrent ear infections, are less likely to be treated by doctors for injuries, and are more likely to go without eyeglasses or prescribed drugs.[20]

## THE UNDERINSURED

The increasing prevalence of underinsurance may well be the more serious trend. Underinsurance here refers to medical needs that either are not covered by health plans at all or are covered but with high copayments that force beneficiaries to forgo treatment. Stringent "management" of care that results in denial of medically necessary treatment may also be considered a form of underinsurance.

Studies by the Employee Benefit Research Insti-

tute, several private consultants, and Consumers Union all document substantial cost shifting and rising rates of underinsurance. A January 1998 study conducted by the Lewin Group for Consumers Union found that 11 million families without elderly members (1 in 8 families) spend on average more than 10 percent of their income on out-of-pocket health care costs and health insurance premiums not paid for by employers.[21] This figure rises to 20 percent for families with members who are 55 to 64 years old, and to 50 percent for families with members who are 65 or older. Among all age groups, the 10 percent of people with the most serious health problems spend an average of $21,000 a year in premium and out-of-pocket payments.[21]

In addition, recent trends in both employment and health insurance have made ties between patients and doctors less stable. The Kaiser–Commonwealth survey found that 34 percent of insured adults under the age of 65 had been enrolled in their current health plan for less than two years.[22] Only 36 percent had had the same primary care doctor for five years or more.[23] Respondents with conventional Medicare or Medicaid coverage actually had more stable relationships with providers than those in managed-care plans, a finding that is largely due to the fragmentation and turbulence of the managed-care industry.

## PHARMACEUTICAL COVERAGE

The costs of prescription drugs continue to rise faster than the costs of other components of health care, and they are increasingly less likely to be covered by insurance. Total expenditures for prescription drugs increased by 85 percent between 1993 and 1998, with an estimated 17 percent increase from 1997 to 1998 alone, or more than four times the rate of increase for all health care expenditures in that period.[24] In 1995, more than half of all pharmaceutical costs were paid out of pocket,[25] and the proportion is almost certainly higher now.

The elderly are most dependent on prescription drugs, which Medicare does not cover. More than 19 million elderly persons, or about half of all Medicare enrollees, have no drug coverage. Press reports indicate that countless prescriptions go unfilled because elderly patients cannot afford to pay for them.[26] Expenditures for prescription drugs account for 34 percent of medical expenditures by the elderly, representing a larger proportion of expenditures than that for either hospital charges or physicians' services, according to the American Association of Retired Persons.

In 1995, elderly people with some pharmaceutical benefits received them through HMOs (12 percent), Medicaid (6 percent), employer-provided supplemental policies for retirees (26 percent), or privately purchased Medigap policies (9 percent).[27] Each of these sources, however, is being cut back, either in diminished coverage or in diminished enrollment. In 1998, some Medicare HMOs quit the business and others capped or dropped drug coverage. In the case of Medigap plans, only 3 of the 10 standard plans mandated by the 1990 federal Medigap legislation provided any prescription-drug coverage, and only a small minority of people who bought Medigap coverage purchased these plans. According to the Lewin Group, the proportion of employer-provided supplemental plans for retirees that included prescription-drug coverage declined from 90 percent in 1989 to 81 percent in 1995.[28] And the proportion of employers offering retirees supplemental health coverage declined from over 60 percent in the 1980s to less than 40 percent today, according to the General Accounting Office.[29]

Virtually all supplemental plans for the elderly require copayments for prescription drugs. In 1998, only 9 percent of Medicare beneficiaries who were enrolled in HMO plans had unlimited prescription-drug benefits; 43 percent were in plans that had no annual dollar cap but that limited coverage to generic drugs or drugs on an approved formulary. In the case of plans that provided coverage for brand-name drugs, more than half of enrollees had an annual cap of $1,000 or less.[30]

McCormack et al.[31] reported in 1996 that 84 percent of Medigap policies in six states provided no drug coverage at all, and only 7 percent provided "high-option" coverage (Plan J), with an annual benefit cap of $3,000. Such plans cost over $200 per month, which few elderly people can afford. The lower-option policies (Plans H and I) required a $250 annual deductible for drug costs, a 50 percent copayment, and a $1,250 annual cap. The Lewin Group, using a different method, found that 28 percent of persons with Medigap policies had some pharmaceutical benefits but confirmed that most did not have the high-option plan. Medigap policies paid for only 3 percent of all prescription-drug costs for the elderly. The largest source of insurance coverage, accounting for 21 percent of the costs, was employer-provided supplemental plans; 52 percent of drug costs were paid out of pocket.[32] Obviously, as drug prices keep rising, the relative value of the covered benefit declines. The drug industry continues to resist efforts by Representative Pete Stark (D-Calif.) and others to add drug coverage to Medicare by using federal purchasing power to buy discounted drugs, and such measures currently have little chance of enactment.

## THE OUTLOOK

Few of these trends toward increasing numbers of uninsured and underinsured Americans show signs of abatement or reversal. Although managed care dramatically reduced the inflation in health insur-

ance costs for employers in the mid-1990s, this seems to have been a one-time savings. The underlying demographic and technological trends are unchanged, and employers and benefit consultants report sharply rising premium costs in 1999.[3] Employers, facing little resistance from unions or public policy, are continuing both to reduce the options for coverage and to shift costs to employees, leading to both lack of insurance and underinsurance.

Likewise, despite the early promise of Medicare HMOs, the gaps in Medicare coverage are growing larger. Even before the implementation of Medicare+Choice (which allows the insurance industry to market a wider variety of point-of-service plans and PPOs), private insurers had already begun to reduce benefits or withdraw from selected markets. In October 1998, insurers announced they were dropping coverage for some 400,000 of the approximately 6 million enrollees in Medicare HMOs.[33,34]

With premium costs continuing to rise, more employers are dropping or reducing coverage than are expanding it. Health care coverage is seen as a particular burden by smaller businesses, which represent the fastest-growing sector of American employers.[35] And as the shift from full-time to part-time and temporary jobs continues, more employees are likely to find themselves with no benefits.

Congress, in several budget resolutions beginning in 1989, has extended Medicaid eligibility, especially to children who are living in poverty but are not on welfare. Some states, such as Oregon and Tennessee, have sought to turn Medicaid into a nearly universal health insurance program for the working poor as well as the indigent. However, these programs entail a degree of rationing, which is either explicit, as in the Oregon program, or implicit, as in Tennessee's stringent approach to managed care. Rationing, in turn, gives people the "choice" of paying for uncovered services out of pocket or doing without them. The shift to Medicaid managed care suggests that although more people will be nominally covered, many will in effect have less coverage.

The expansions in Medicaid are also offset by the 1996 welfare-reform law, Temporary Assistance to Needy Families, which limits the duration of welfare benefits. As the welfare limits gradually become effective in most states during 1999, millions of people will lose their eligibility for Medicaid along with their welfare benefits. Many heads of households will take relatively low-paid jobs, most of which do not offer health insurance; even those that do tend to require high premium payments by employees.

One small bright spot is the likelihood that the number of uninsured children will decline, thanks to the new Children's Health Insurance Program. Enacted as part of the 1997 Balanced Budget Act, the program provides the states with $24 billion over a period of five years. Some states are using these funds to expand Medicaid, and others are setting up new, parallel children's programs.

However, the interactions among Medicaid, the welfare-reform law, and the Children's Health Insurance Program are highly complex and confusing. For example, most children whose mothers will lose Medicaid coverage under welfare reform may retain their eligibility for Medicaid, but coverage is not automatic. Moreover, press reports indicate that immigrants, both legal and illegal, are reluctant to obtain coverage for their children for fear that enrollment will bring investigations by the immigration authorities. As of November 1998, California, which has a complex 28-page application for coverage that includes several questions about immigration status, had enrolled only 4 percent of 580,000 eligible children,[36] despite a payment of $25 to $50 to insurance vendors for every child they enroll. The Congressional Budget Office estimates that the net effect of the welfare-reform law, the Children's Health Insurance Program, and Medicaid expansions will be to extend coverage to some 2 million of the 10.6 million children who were uninsured as of 1997.[37]

With unemployment rates approaching a 30-year low, the overall trend in declining health insurance coverage is, if anything, understated. In the next recession, when the unemployment rate increases, loss of coverage is likely to increase apace. Because all sources of coverage are eroding, the long-term trend is toward a continued decline in both nominal and effective rates of coverage, unless there is a dramatic change in national policy.

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