

The Medically Uninsured

Prepared by

Russell A. Salton, III, MD

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The United States is the most technologically advanced health care system in the world, probably true. As the world's richest nation, we spend over 14% of our Gross Domestic Product on health care, definitely true! Yet by most accounts, there are 42 million Americans without health insurance. How can this be? This paper attempts to put a face on the uninsured, define the extent of the problem, review provider and community experiences in dealing with this issue, and concludes with a discussion of what could be done. There are no easy answers, but that fact does not justify the lack of leadership focused on this issue. It is as though most Americans deny the problem exists.

Political Considerations

M. Angell, MD suggests health care reform needs to be revisited in this country. The doctor sites medical inflation driven by technology, the uninsured, and a middle class fed up with managed care as the reasons. Clinton Reforms failed because they were too sweeping. Changes in our system need to be incremental in order to succeed. But Dr. Angell fears the patient rights bills will increase the uninsured because employers will pass along the cost to their employees. As a result more children and non-working spouses may not be covered. Publicly traded for-profit managed care organizations have a conflict of interest. If our employer-sponsored system for workers persists, family and dependent coverage should not be an option. Deep down this physician believes Medicare should be extended to all.¹

The American Nurses Association (ANA) also feels that incremental reforms will produce many more uninsured and supports universal Medicare.¹⁸ On the other side, a study from the Harvard School of Public Health revealed the public has a high level of support for our employer based health insurance system and parallel systems should be developed to insure those not currently covered by employers. Sadly, most Americans are oblivious to the uninsured.³

The Hastings Center points out the unfairness in tax treatments. Employer costs are tax deductible while the employee's are not. Less comprehensive plans attract the well and the better plans attract the sick, which defeats the purpose of insurance. Those who go without health insurance have a free ride, because hospitals and physicians do not and legally cannot turn away patients with serious illness. The health insurance industry has multiple conflicts of interest that add to these negative trends.² Employers may feel a responsibility for their employees but not necessarily their families. It has been suggested that a rate bias exists that discourages family coverage. Most of the uninsured are in fact, dependents! Managed Care Organizations (MCOs) are unlikely to correct this bias because in making family coverage more attractive, employee only rates would have to increase. This would result in a loss of business, so MCOs are unable to fix the problem which is a major factor producing the medically uninsured.

Some Data on the Medically Uninsured

Who are these 42 million uninsured citizens? In 1998 the number of workers without health insurance was 18.1% up from 14.6% in 1987. Of the entire uninsured population 56% are employed adults, and 83% have a working head of household with insurance available. 53% are under 35 years of age, but the highest rate of increase is among workers ages 55-64. Median household income was \$50,000, and in 96% of these households the range of income fell between \$25,000 and \$75,000.¹⁰ These income levels are much higher than most people would expect. Most Americans believe the medically uninsured are poor. They are not, but they are younger and healthier. Therefore, if added to current insurance pools rates would be reduced for everyone.

A study, published in *Pediatrics*, surveyed the families of 50,000 children. The population consisted of nearly equal numbers of Medicaid enrollees, privately insured patients, and a group of uninsured children with otherwise similar demographics. Surprisingly, 39.4% of the uninsured had a least one parent with a college education, and 91.2% had at least one adult in the household with full-time employment. This compares to 23 and 53.9% for Medicaid and 66.7% and 96.9% for privately insured children respectively.⁵ This data demonstrates that not only are the uninsured not poor, they are

fairly well educated and employed. The retarded, disabled, drug addicts, alcoholics, homeless, and working poor are real social problems and mostly uninsured, but their numbers should be down or at least stable, given the economic boom of the past decade. This subset of the uninsured population is important, it is a national disgrace given our prosperity that most of this group is uninsured, but the real growth in uninsured comes from middle class Americans who have insurance available, but choose to chance going without coverage. In this second subset affordability is also an issue. This subset will tend to be younger, starting out, self employed, or working for smaller companies. What value does a twenties-something college grad in his first job see in putting his stay at home wife on his plan when his company spends \$100 on his coverage and wants him to spend an extra \$300-\$400 for her coverage?

Other studies suggest the emergence of this working subset of the uninsured. Tulane University Medical Center in New Orleans examined some well-established sources of data for the years 1995-98. Data suggested that for every 1% increase in unemployment, the rate of medically uninsured rose 1.7%. While premium increases of 10% or more had little effect on the percentage of insured employees, it did reduce the number of covered spouses and children.⁸

Provider Experiences with the Uninsured

Emergency rooms are a favorite source of care for the uninsured. This retrospective review of An Austin TX community Hospital examined the profiles of patients who had 7-26 ER visits during 1996. This represented 10% of their patient population. Some 62% of these visits were non-urgent, much less true emergencies. In addition 64.7% of these patients were medically uninsured.⁴ A report in the Annals of Emergency Medicine suggests that the burden for caring for the uninsured falls to a health care safety net, which is an ill-defined network of ERs, public health clinics, community health centers, and residency training programs. The task force suggested:

- All Americans should have health insurance.

- ERs are over run by the great numbers of uninsured.
- ERs are essential to link the uninsured with primary care physicians and specialists when needed.
- ERs offer a site to reach the uninsured.
- ERs cannot prevent access by the uninsured, therefore
- ERs should be viewed as part of the solution.⁶

Community and public health clinics have patient bases with a very high percentage of uninsured patients. The School of Hygiene and Public Health at Johns Hopkins University found that most of their uninsured had household incomes of less 200 percentile of the federal poverty level. Most were single parents or part time workers. This may not be true of the uninsured population at large.⁹ The Hennepin County Community Health Department (Minneapolis) found that they attracted greater numbers of the working poor than more rural areas in their state. Their population was just above the poverty level, and probably not representative of the complete uninsured picture.¹⁶ Community health center, free clinics, and public health departments treat patients in the first subset of the uninsured described earlier. For unknown reasons, few people of any means use health departments in this country. Most experts would agree that most of the uninsured, the working subset, are using the private sector of our healthcare delivery system.

Managed care, Medicare, and the medically uninsured are producing financial stress for academic medical centers and residency programs throughout this our country. Academic medical centers are medical schools and their associated hospitals and community hospitals with residency programs. An article in “Academic Medicine” points out two major responsibilities and opportunities. First, academic centers must really push their research agendas to include the social behavior factors that are the preventable causes of many diseases. Second, one third of the costs of the medically uninsured are borne by academic medical centers. A solution must be found!¹⁷ Most experts would agree both points are true. An academic medical center’s economy is based on research, but at the same time they are part of the so-called “uninsured safety

net.” While extension of Medicaid and Medicare may solve the latter problem, the price controls they employ could dry up dollars for medical research.

A Harvard School of Public Health study looked at a large number of non-profit hospitals. They compared the value of their non-profit tax exemptions to the amount of charity or free care they provided to the indigent. The value of the tax exemptions exceeded the amount of free care provided even when 50% of their bad debt write-off was added. It was suggested that state and federal governments apply pressure to non-profit hospitals.¹³ The fact is that little is known or written about how hospitals and private physicians are dealing with the uninsured and the tremendous self-pay problems they must be creating. Certainly, the issue is not being approached in any organized way.

Community Efforts

A national survey of managed care plans serving Medicaid populations reveal that most achieved many of their goals such as matching patients to a primary care physician, reducing ER visits, and achieving better patient outcomes. However, more than 60% these plans are losing money.¹² The Urban Institute’s Health Policy Center in Washington DC followed thousands of families that found jobs, left welfare, and lost their Medicaid cards. After one year 49% of the women and 30% of the children were uninsured.¹¹ Another review by the University of Pennsylvania Center for Health Outcomes and Policy Research concluded that the number of uninsured children is rising at an alarming rate. Many are low income and Medicaid eligible but are not enrolled. Physicians and hospitals need to do a better job of checking insurance status, and refer to the appropriate agency. Medicaid needs to a better job of out reach.²⁰ Those who qualify should have it! Given the social complexities of this population, even those between 100%-200% of the federal poverty level who would not qualify for Medicaid are not good candidates for managed care for social, transportation, educational, and a host of other reasons. Should Medicaid expansion be considered for this subset of the uninsured?

The Center for Studying Health System Change is following and tracking efforts in five cities to apply a managed care approach to the medically uninsured. All attempt to assign low income uninsured patients to primary care physicians for routine and preventative services, which they hope will reduce costs. Funding comes from grants.⁷ In the 1990s Hawaii, Minnesota, Tennessee, and Washington approached working class families with a sliding scale premium based on income. The Urban Institute concluded that family cost sharing is feasible, but some plan design and operational complexities do exist. As expected the greater the cost sharing the lower the participation rates for these families.¹⁵

The University of New Mexico Health Services created a managed care plan for its community health patients. Patients were assigned to primary care physicians, case management was used for complicated cases, and 24-hour triage was made available. The number of admissions and the length of hospital stays have dropped. This resulted in more \$2 million in hospital savings, and members paid almost \$700,000 towards their care.¹⁴ While this approach conserves resources and creates some patient cost sharing, it falls far short of covering the cost of care for the 13,000 members if they were otherwise uninsured.

The Robert Wood Johnson Foundation, as reported by Brown University's Primary Care and Prevention Department, 39 projects and 7 different models to provide care for the uninsured. Two thirds were free clinics plus a referral network. Eleven Thousand MDs served 200,000 patients. Most will not survive after the initial funding is depleted, but continued success is directly related to physician leadership. All of these programs appear to make only a small but important impact on the uninsured problem.¹⁹

Discussion

As mentioned in the beginning, there are no easy answers for our medically uninsured population. There is a lack of leadership on this issue, and it is not simply

political. No forum exists where physician, hospital, health insurance, and academic medical leaders meet to discuss our problems and look for solutions. There is only contempt among these parties, where cooperation and collaboration belong. Every community should have task force working on this issue. Expanding Medicare to all Americans is an easy answer, but universal price controls at Medicare's current levels may adversely affect quality and limit investment into the new miracles we have come to expect on a daily basis.

Our country's uninsured population should be viewed as two distinct subsets. One is the poor working or not, and this group includes the retarded, the disabled, the homeless, and the addicted whose income levels are less than 200% of the federal poverty level. As a general rule most Americans at or below the poverty level qualify for Medicaid. Expanding Medicaid to those whose incomes fall between 100%-200% of the federal poverty level would cover most of this uninsured subset. We should eliminate Cobra and extend Medicare to the unemployed. Anyone who does not have employer sponsored health insurance available and early retirees should be allowed to participate in Medicare if their income levels are greater than 200% of the federal poverty level.

The second uninsured subset consists of households that are not poor. One or more of its family members have jobs where health insurance is available. If one believes our system is great because the employer-sponsored health insurance allows for profit, research and progress, then we need to figure out how to get this subset of the medically uninsured back in the insurance pool. Family coverage needs to be the law of the land. The minimum employer contribution should be 50% of family coverage. Many employers would pay more as a way to compete for employees. Both the employer and employee contributions to premium payments should be tax deductible, but currently employee contributions toward family coverage are not tax deductible. The real key here is that employees must be responsible for their dependents as a matter of law just as the employers should. Many in this group are healthy nonworking spouses and children; therefore, on an individual basis rates should come down as the insured pool expanded. At a minimum the rate bias toward spousal and family coverage would be eliminated.

These steps would virtually eliminate the uninsured without creating new programs and new bureaucracies. All that is missing is the social and political will to get the job done. By forcing out many healthy patients our health insurance industry has created a death spiral of increasing rates producing more and more uninsured. The sick retain their coverage while the healthy opt out of coverage. The problem must be addressed. Without bold action and honest leadership from multiple sectors, this trend will only repeat itself year in and year out. In the meantime none of our community efforts seem to offer any real hope without involving the private medical community. Doctors and hospitals must develop new ways to extend services and credit to their increasing self-pay populations. They need to develop or take part in payment programs rather than rely on collection agencies to deal with the uninsured. The number of patients without insurance or with inadequate insurance has risen to the point doctors and hospitals can no longer ignore the problem. In addition to the economic pressure to reach out to the uninsured, the social pressures for providers to take action are also increasing. We live in a country where medically, legally, and ethically providers are not in a position to deny care yet paradoxically it is only those who are without insurance pay true retail, while Medicare, Medicaid, and health insurance companies demand and receive significant discounts for both doctors and hospitals. These outreach payment programs should and probably will include discounts or sliding scales based family income.

References

1. Angell M. "Patients' Rights Bills and Other Futile Gestures." The New England Journal of Medicine. 342(22), June 2000: 1163-64.
2. Banja JD. "The Improbable Future of Employer Based Insurance." Hastings Center Report. 30(3), May-June 2000: 17-25.
3. Blendon RJ. Young JT. DesRoches CM. "The Uninsured, the Working Uninsured, and the Public." Health Affairs. 18(6), Nov-Dec 1999: 203-11.
4. Bond TK. Stevens S. Peters M. "Analysis of Chronic Emergency Department Use." Nursing Economics. 17(4), Jul-Aug 1999: 207-13, 237.
5. Byck GR. "A Comparison of Socioeconomic and Health Status Characteristics of the Uninsured." Pediatrics. 106, Jul 2000: 14-21.
6. Cetta MG. Asplin BR. Fields WW. Yeh CS. "Emergency Medicine and the Debate Over the Uninsured. A Report from the Task Force on Health Care and the Uninsured." Annals of Emergency Medicine. 36(3), Sept 2000: 343-46.
7. Felland LE. Lesser CS. "Local Innovations Provide Managed Care for the Uninsured." Clinics in Gastroenterology. Supplement 25, Jan 2000: 1-6.
8. Florence CS. Thorpe KE. "Private Health Insurance Coverage and the Uninsured: What We Can Expect by 2002?" Abstract Book/ Association for the Health Sciences. 16: 197.
9. Frick KD. "Employment Based Insurance Availability and Participation 1995-97." Abstract Book/ Association for Health Services Research. 16: 431.
10. Fronstin P. "The Working Uninsured." EBRI Issue Brief. 224, Aug 2000: 1-23.
11. Garrett B. Holahan J. "Health Insurance Average After Welfare." Health Affairs. 19(1), Jan-Feb 2000:175-84.
12. Gray BH. Rowe C. "Safety Net Plans: A Status Report." Health Affairs. 19(1), Jan-Feb 2000: 185:93.
13. Kane NM. Wubbenhorst WH. "Alternative Funding policies for the Uninsured: Exploring the Value of Hospital Tax Exemption." Milbank Quarterly. 78(2), Summer 2000: 185-212.

14. Kaufman A. Derksen D. McKerran S. Galbraith P. Sava S. Willis J. Fingado E. "Managed Care for Uninsured Patients at an Academic Health Center: A Case Study." Academic Medicine. 75(4), Apr 2000: 323-30.
15. Ku L. Coughlin TA. "Sliding Scale Premium Health Insurance Programs: Four States' Experiences." Inquiry. 36(4), Winter 1999-2000: 471-80.
16. Loeffler D. "Hennepin County: A Comprehensive Approach for Screening Health Coverage for the Uninsured." Abstract Book/ Association for Health Services Research. 16:92.
17. Reed S. "Spotlight on the Uninsured." American Journal of Nursing. 100(4), Apr 2000: 57-59.
18. Schroeder SA. "Understanding Health Behavior and Speaking Out on the Uninsured: Two Leadership Opportunities." Academic Medicine. 74(11), Nov 1999: 1163-71.
19. Scott HD. Bell J. Geller S. Thomas M. "Physicians Helping the Underserved: The Reach Out Program." JAMA. 283(1), 5 Jan 2000: 99-104.
20. Sochalski J. Villarruel AM. "Improving Access to Health Care for Children." Journal of the Society of Pediatric Nurses. 4(4), Oct-Dec 1999: 147-54