1996 AHSR Presidential Address

Uninsured in an Era of Managed Care

Karen Davis

Health services research is focusing extensively on ways in which managed care is affecting the U.S. health care system. Questions addressed range from managed care and cost, quality, and continuity of care to managed care and Medicare, Medicaid, and special needs populations.

But the one group least likely to benefit from the growth of managed care is the uninsured. The numbers of uninsured are likely to grow as employment-based health insurance continues to erode and as cutbacks in Medicaid and welfare reduce the numbers of low-income Americans covered (Davis 1996; Thorpe 1995). Not only are the numbers of uninsured forecast to continue to grow, but the sources of free care available to the uninsured are likely to be increasingly scarce as the growth of managed care plans squeezes out any cross-subsidies that may have helped finance such care in the past. With both pressures from the marketplace and cutbacks in public funding, the capacity of safety net providers to provide care for those without insurance is increasingly at risk. As a result, the uninsured face an increasingly bleak and harsh future without new coverage options.

Given trends in today's health care markets, the uninsured cannot wait for national consensus on the broader issues of universal health insurance coverage or comprehensive reforms. But more limited steps could go a long way toward addressing the most serious barriers to quality health care for these most vulnerable Americans. By targeting the populations at greatest risk and building on existing mechanisms that enable Americans to obtain health insurance, steps can be taken now to ease barriers and lay a healthier foundation for the future.

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Karen Davis, Ph.D., 1996 President of the Association for Health Services Research, is President of The Commonwealth Fund, One East 75th Street, New York, NY 10021.

Building support for such measures, however, will require ongoing research to counter the myths that still persist about the characteristics of the uninsured, as Steve Schroeder (1996) in his excellent article in *The New England Journal of Medicine* has ably outlined. Even more importantly, we need new research for a better understanding of the health consequences of being uninsured or underinsured. Further, policy options for the incremental extension of health insurance coverage need to be developed and analyzed to counter the fears that covering the uninsured requires massive income redistribution or administratively complex systems.

THE UNINSURED

To review what we do know, we know that the uninsured have not disappeared–40 million Americans were uninsured in 1994, up from 34 million five years earlier (EBRI 1996).[1] Measured over a two-and-a-half-year period, 64 million people were uninsured at least one month (Bennefield 1995).

While the number of uninsured has increased steadily during the past decade, the characteristics of the uninsured have remained relatively stable. Most are low-income, and the vast majority live in families headed by workers (EBRI 1996). Three in five are low-income: 28 percent had incomes below the poverty level, and another 32 percent were near-poor (family incomes between poverty and twice poverty). Counting uninsured children and adults, 85 percent of people with no health benefits are in families where the head of the family works full- or part-time.

Typically, stereotypes of the uninsured position them as young, healthy college graduates, the unemployed, or those with a preexisting health condition. Although these Americans, compared with other Americans, are at greater risk of being uninsured, the inescapable fact is that low income is the predominant risk factor. Americans are uninsured because they cannot afford health insurance coverage and, if working, because their employer is not paying for coverage.

Indeed, one of the principal causes of the rise in the number of uninsured Americans is the decline in employer-based coverage. Employer health insurance coverage for working families has been declining slowly but steadily since it peaked in the late 1970s (EBRI 1996). By 1993, only 61 percent of the under-65 population had employer-sponsored insurance, down from 66 percent five years earlier. This decline is due largely to the changing nature of where people work today and to a general decline in the share of premium

paid by those firms offering health insurance. A particularly steep decline is felt in firms employing under 200 employees. As jobs have moved out of manufacturing, workers have moved away from industries with relatively generous sponsorship of family insurance coverage as well as individual coverage to industries significantly less likely to provide health insurance at all, and with much less generous premium coverage, especially for family plans (Thorpe, Shields, Gold, et al. 1995). The net result is a steep decline in children with private, employment-based insurance from 66 percent in 1988 to 59 percent in 1994 (Holahan, Winterbottom, and Rajan 1995), and an increase in uninsured workers who work for employers who do not offer affordable, or perhaps any, health care benefits.

Most recently, federal and state policymakers have focused on incremental reforms that would improve access to insurance for those with preexisting health conditions. However, a 1993 Kaiser/Commonwealth Fund health insurance survey found that only 3 percent of the uninsured are uninsured for health reasons (Davis, Rowland, Altman, et al. 1995). Given the low-income profile of the uninsured, enactment of the Kassebaum-Kennedy bill is unlikely to make a marked difference in health insurance coverage, whatever the merits might be of ending discrimination against those in poor health and of improving mobility among jobs.

The one bright note in trends of health insurance coverage is the declining proportion of the poor who are uninsured, particularly poor children. Medicaid expansions have been able to offset otherwise steep declines in private health insurance coverage by raising income eligibility standards for young children and pregnant women. As a result, 40 percent of all pregnant women and infants are now covered by Medicaid, assuring financing for essential prenatal care, delivery, and well-baby care (Holahan and Rajan 1996). Among poor families, 85 percent of pregnant women and infants are covered by Medicaid, while only 6 percent of them are privately insured and 9 percent are uninsured. Similarly, among poor children ages one to five, 88 percent are covered by Medicaid, 5 percent are privately insured, and 7 percent are uninsured.

Medicaid coverage tapers off for low-income children six years or older, and the rate of uninsured children increases. Among poor children ages 6 to 12, 78 percent are covered by Medicaid, 9 percent are privately insured, and 13 percent are uninsured. As of 1994, 60 percent of poor children ages 13 to 18 were covered by Medicaid, 13 percent were privately insured, and 26 percent were uninsured. Under current law, Medicaid coverage of poor children ages 13 to 18 under Medicaid will be fully phased in by the year 2002.

Mothers of poor children, however, are not well protected. Nearly a third of poor and near-poor women are uninsured (Short 1996). Pregnancy affords many low-income women temporary Medicaid coverage; one-fourth of all nonelderly women who enroll in Medicaid do so because of pregnancy. However, pregnant women qualifying for Medicaid's higher income standards for pregnancy are covered only for their term of pregnancy and 60 days postpartum, and then only for care related to the pregnancy. Coverage may continue after the birth of her children only if a mother qualifies for Medicaid through welfare, which has much lower income eligibility standards. For many poor women, coverage ends with the pregnancy; 15 percent of the women leaving Medicaid do so because of childbirth.

Women leaving Medicaid typically do not receive private health insurance. Over a two-year period, 28 percent of women on Medicaid will leave Medicaid, including those who leave by virtue of obtaining a job or becoming married or for other reasons (Short 1996). Nearly two-thirds of them will become uninsured.

The unemployed are also at high risk of being uninsured. A third of the unemployed are uninsured, and half are either currently uninsured or have been uninsured at some point in the last two years (Davis, Rowland, Altman, et al. 1995). In 1985, the Comprehensive Omnibus Budget Reconciliation Act (COBRA) contained provisions permitting the unemployed to retain their employer health insurance coverage for up to 18 months by paying the group premium rate. The loss of income that comes with unemployment, however, often makes such contributions infeasible. Only an estimated 20 percent of eligible people take COBRA coverage (Claxton 1996).

Perhaps the most seriously at risk are adults between the ages of 55 and 64. While these older adults are less likely than younger people to be uninsured, they are more likely to be in fair or poor health, to face high individual health insurance premiums when coverage is available at all, and to risk financial hardship if they incur major medical expenses (Davis 1990). Two-and-a-half million Americans between the ages of 55 and 64 are uninsured, and almost one million are doubly vulnerable–they are in fair or poor health and have no health insurance coverage. Some are early retirees who have stopped working for health reasons; others have been involuntarily retired because of corporate downsizing. A few are spouses of Medicare beneficiaries and do not qualify for Medicare because they have not yet reached age 65.

Declines in employer-based coverage have been particularly steep for those retirees ages 55 and older. From 1988 to 1994, the proportion of retirees

55 or older receiving health coverage from a prior employer fell from 44 to 34 percent–a 23 percent decline (U.S. Department of Labor 1995).

CONSEQUENCES

The consequences of being uninsured include failure to get preventive care, inadequate maintenance of chronic conditions, preventable hospitalizations, and lack of a regular source of continuing care (Berk, Schur, and Cantor 1995; Bindman, Grumbach, Osmond, et al. 1995; Hadley, Steinberg, and Feder 1991; Hafner-Eaton 1993; Himmelstein and Woolhandler 1995; Kogan, Alexander, Teitelbaum, et al. 1995). There are relatively few strong studies documenting the adverse clinical health outcomes (Ayanian et al. 1993; Braveman, Schaaf, Egerter, et al. 1994; Franks, Clancy, and Gold 1993; Lurie et al. 1986; Weissman and Epstein 1990). More is known from surveys of the uninsured and their own perceptions about the accessibility of care. Those who are uninsured report being less likely to get needed medical care and more likely to postpone care and wait until medical needs become an emergency. The 1993 Kaiser/Commonwealth Fund health insurance survey found that 34 percent of the uninsured failed to receive needed care, and 71 percent postponed needed care (Davis, Rowland, Altman, et al. 1995).

Studies have documented that the uninsured are much less likely to obtain preventive care. For example, 52 percent of uninsured women did not obtain a Pap smear in the last year, compared with 36 percent of insured women, and 69 percent of women ages 40 to 64 did not get a mammogram, compared with 38 percent of insured women (Brown, Wyn, Cumberland, et al. 1995).

We also know that those with chronic illnesses who are uninsured are least likely to receive proper maintenance and continuous care, with the result that untreated conditions such as hypertension or diabetes can lead to serious health consequences (Lurie et al. 1986). As valuable as these studies are, they really only scratch the surface of understanding the health consequences of inadequate health insurance.

As a result, many believe that the uninsured are able to get care when they need it. This belief has never been completely true, and it promises to be even less true in the future. Mounting stresses on safety net health care providers–public hospitals, community health centers, and others that have traditionally served poor and uninsured people–are rapidly eroding the capacity and willingness to provide uncompensated care. These stresses

include cutbacks in state and local government funding, the diversion of Medicaid revenues to managed care organizations, proposed reductions in disproportionate share funding under Medicare and Medicaid, and the reduced ability to cross-subsidize care as managed care plans demand reduced payment rates as the price of entry into networks. As financial pressures on hospitals and other health care providers mount, the health consequences for the uninsured are likely to intensify.

Research to analyze and document the consequences of these trends should be a major priority. Understanding the risks and implications of managed care absent universal coverage is one of the central, critical public policy concerns for the years ahead. The major research questions include:

- How quickly will the number of uninsured and underinsured grow? What forces underlie the decline of employer-sponsored insurance?
- Will Medicaid continue to absorb some portion of the uninsured?
- Will safety net health care providers be able to continue delivering uncompensated care in the absence of cross-subsidies?
- What negative health care outcomes could result from a lack of insurance and access to health care?

Health services research has played a leading role in informing policy and program development (Ginzberg 1991). It is imperative that funding for such research on both public and private levels be maintained as that expertise turns to examining the current health care system and keeping up with constant changes. This is important because the information gathered can be the basis for making modifications, shaping change, or providing mid-course corrections. It is also imperative to keep the concerns of the most vulnerable, including poor families, the frail elderly, and the chronically ill, before the public eye.

EXPANDING COVERAGE

Reengaging the issue of expanding health insurance coverage is a difficult task–both economically and politically. Yet seeing that expanded health insurance coverage gets back on the national agenda is especially urgent in the changing U.S. health care system. In light of the ongoing erosion of employment-based coverage, the strong opposition by small business to the concept of mandating employment-based health insurance coverage, and the fact that jobs are no longer as long-lasting or stable as they once were, linking health insurance to employment may work even less well in the future.

Research is needed to lay the groundwork for incremental steps to expand health insurance to those most vulnerable, including older poor children, poor parents, the unemployed, and older uninsured adults. Incremental changes that would expand health insurance coverage to groups most likely to benefit from access to care would reduce the immediate burdens created by the shrinking availability of free care.

Absent a new foundation on which to build toward universal coverage, more modest, pragmatic steps should be explored. Building on bases capable of insuring and, as necessary, subsidizing costs of coverage for the uninsured offers the opportunity to broaden access to care at a time when market forces threaten to close doors previously open to the uninsured. Incremental options worthy of consideration include

- expanding Medicaid to all low-income children and their parents;
- subsidizing COBRA premiums for the unemployed;
- opening up Medicare buy-in for adults ages 55 and over;
- giving small employers and individuals access to administrative mechanisms that now exist to provide an array of managed care and indemnity coverage options such as the Federal Employees Health Benefits Plan, state public employees health benefit plans, and, increasingly, Medicare and Medicaid.

Considerable work needs to be done to analyze the advantages and disadvantages of these mechanisms: quantify and characterize the populations likely to benefit; estimate the costs of coverage, including any subsidies required for low-income or higher-risk populations; and explore the most efficient mechanisms for assuring stable and affordable health insurance coverage. While public policy support for these initiatives may not be immediate, laying the groundwork is an essential step to revitalizing the debate on moving toward universal health insurance coverage.

This is a major challenge. And the headiness of research on new forms of delivery–also, certainly, a major challenge–should not eclipse concern with those left out of the U.S. health care system. We face a challenge–an opportunity–that the health services research field is well able to meet.

NOTE

1. The Current Population Survey questionnaire and EBRI methodology have changed periodically, likely understating the growth in the numbers of uninsured.

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