



The Kaiser Commission on

THE FUTURE OF MEDICAID

Kaiser Family Foundation



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TESTIMONY ON
MEETING THE HEALTH NEEDS OF THE
LOW-INCOME POPULATION IN
HEALTH REFORM

BY

DIANE ROWLAND, SC.D.
SENIOR VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION
AND
EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID

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SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
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Diane Rowland, Sc.D.

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Committee on Energy and Commerce
United States House of Representatives
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Thank you, Mr. Chairman and members of the Committee for this opportunity to testify on behalf of the Kaiser Commission on the Future of Medicaid on the health needs and implications of health care reform for low-income Americans. I am Diane Rowland, Senior Vice President of The Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid.

The Kaiser Commission was established by The Henry J. Kaiser Family Foundation in 1991 to function as a Medicaid policy institute and serve as a forum for analyzing, debating, and proposing future directions for health care for poor and vulnerable populations. The fourteen member bi-partisan national commission is chaired by James R. Tallon, Jr., President of the United Hospital Fund of New York and former Majority Leader of the New York State Assembly.

I am pleased to be here today to share the work of the Commission and to discuss the implications of health care reform for the low-income population. My statement reviews the health status of our nation's poor, the current gaps in health insurance coverage of the poor, and the importance and likely impact of health care reform.

Why is Health Care Reform Important to Low-Income Americans?

In 1991, 32 million Americans -- 15 percent of the non-elderly population ---

lived in poverty (Figure 1). For a family of three, this means struggling to pay for health and medical bills as well as for food and housing on an income of less than \$11,000 a year. Another 40 million Americans live on the edge of poverty with incomes between 100 and 200 percent of the poverty level. Nearly half (45 percent) of all Americans in poverty are children; one in five American children live in poverty. Minority children are particularly at risk of growing up in a poor household. Almost half (47 percent) of black children and 41 percent of Hispanic children are poor compared to 17 percent of white children (Figure 2).

Poverty and poor health are, unfortunately, inextricably linked in America. This link is demonstrated by lower self-reported health status and higher rates of disease and disability among the poor in contrast to the non-poor. Lack of insurance among the poor often compromises access to needed care. Health care reform provides an important opportunity to address these disparities by improving insurance coverage and access to care for all Americans.

Health Status

The low-income population is more likely to experience poor health than those with higher incomes. Among the non-elderly population, nearly one quarter (23 percent) of poor Americans rated their health as fair or poor in contrast to only 10 percent of those with incomes above 200 percent of the poverty level (Figure 3). Eleven percent of poor children compared to 4 percent of non-poor children are in either fair or poor health.

The association between poverty and poor health is reflected in high rates of

acute and chronic conditions among the poor. Rates of heart disease and diabetes for the poor are nearly twice the levels of the non-poor (Figure 4). Infectious diseases, including HIV and tuberculosis, are also disproportionately found in low-income communities (Fife and Mode, 1992; Centers for Disease Control, 1992). These acute illnesses and chronic conditions often require on-going medical treatment and management and can lead to severe disability and even death without appropriate and timely care.

Poor children, especially those in inner-cities and medically underserved areas, are particularly at risk for certain health problems. Inadequate prenatal care and environmental factors combine to leave many children impaired throughout life by conditions that are preventable during youth. Poor women are at higher risk of having babies of low birthweight, a leading cause of infant mortality and disability. In New York City, a recent study found that twice as many low birthweight births occurred in the poorest neighborhoods as in the wealthiest neighborhoods (Greater New York March of Dimes, 1993).

Children born into poverty are also less likely to receive health services which could prevent diseases in later life. Only 38 percent of poor two year old children are fully up-to-date on their immunizations compared to 61 percent of children above the poverty line (Children's Defense Fund, 1991). Rates of both pneumonia and frequent diarrhea -- potentially dangerous childhood diseases that are treatable -- are also higher among poor children (Hardy, 1991).

Health Insurance Coverage

Having health insurance coverage to help provide the financial means to pay for medical care is an important component of assuring access to health care for all Americans. Without insurance coverage or sufficient income to purchase care, it is difficult to obtain timely and appropriate treatment and preventive and primary care. Yet, in the United States, more than 35 million people are without insurance coverage and millions more are at risk of losing their coverage. Having insurance coverage is highly dependent on whether and where you or a member of your family works or whether you are aged or poor enough to qualify for public assistance for health coverage.

Given their lower health status and greater expected need for medical care, it is critical that low-income families have protection against large medical expenses and the broadened access to care that insurance provides. The poor are, however, at greater risk of being uninsured than the nonpoor. A third of the 32 million non-elderly Americans in households with incomes below the poverty level and 29 percent of Americans with incomes between 100 percent and 200 percent of poverty are without insurance (Kaiser Commission 1993). The poor not only are more likely to be uninsured than the nonpoor, but also are more likely to have a lapse in insurance coverage. Over a two year period, more than half of those in poverty compared to 15 percent of the non-poor were uninsured for at least one month (Bureau of Census, 1991).

Medicaid, our joint federal-state program for financing health care for the low-

income population, provides health insurance protection to 23 million non-elderly Americans, but still covers less than half (48 percent) of the non-elderly poverty population (Figure 5). Congressionally-mandated expansions have broadened Medicaid coverage beyond traditional welfare categories to include two-thirds of all poor children and require coverage for pregnant women with incomes below 133 percent of poverty. However, poor adults without children are still categorically ineligible for Medicaid unless they qualify as disabled under the Supplemental Security Income (SSI) cash assistance program. State variations in income and resource eligibility levels result in wide variations in the percent of poor covered by Medicaid. The income criteria for Medicaid eligibility ranges from 77 percent to 16 percent of the federal poverty level with eligibility levels below 50 percent of poverty in 35 states.

Despite the variations in eligibility across states, Medicaid coverage is essential to the poor because few have access to private health insurance -- even if they are employed. More than half (55 percent) of the 32 million poor are workers or dependents of workers, but only 9 percent receive employment-based insurance. Even the poor who work all year at full-time jobs are not guaranteed employer-based coverage. Only a quarter of poor full-year, full-time workers and their families receive employer-based coverage (Figure 6). This disparity results from the greater likelihood that poor individuals work in low-wage jobs and small firms that do not offer health insurance.

Underlying the disparities in coverage by income and employment are regional and racial differences. Individuals in minority groups are more likely to be uninsured

than whites regardless of their income.. In 1991, 33 percent of Hispanics and 22 percent of blacks were uninsured compared to 12 percent of whites (Kaiser Commission, 1993). The southern states also account for a disproportionate share of the uninsured; one-third of the American population lives in the southern states, but residents of these states account for 42 percent of the uninsured population (Congressional Research Service, 1993).

Impact of Health Insurance on Health Utilization

The lower health status of the poor would generally be expected to result in higher medical care utilization rates for the poor in contrast to the non-poor. In fact, the opposite is true. The benefits of the American health system are not uniformly available and utilized by all residents. Americans experience different health care utilization patterns that cannot be explained by health status variations alone and appear more related to insurance coverage and the availability of financial resources than health care needs.

Americans without insurance are more likely to forego or postpone needed care than those with insurance. A third (34 percent) of the uninsured reported that they went without needed medical care during the past year in contrast to 8 percent of the privately-insured population and 10 percent of those with Medicaid. Moreover, 71 percent of the uninsured in contrast to 21 percent of those with private insurance and 28 percent of the Medicaid population said they postponed needed care (Figure 7).

Comparisons of medical care utilization between the poor and the non-poor under age 65 using data from the 1987 National Medical Expenditure Survey also

reveal striking differentials in access to care by income and insurance status. For most indicators of access to care, the poor lag behind the non-poor and within the poverty population, the uninsured lag considerably behind those with Medicaid or private insurance.

Despite their lower health status, the poor are less likely than the non-poor to have had a physician contact for either preventive care or medical treatment over the past year. More than a third of the poor (35 percent) compared to 27 percent of the non-poor had no physician visits in the prior year (Figure 8). This indicates the poor are perhaps encountering financial or physical obstacles to obtaining initial access to the health care system.

Insurance coverage plays a crucial role in assisting low-income people in obtaining access to health care services. Among the poor non-elderly population, half of those who were uninsured had no physician visits in the prior year compared to one third (32 percent) of the privately insured and 22 percent of those with Medicaid. For the poor who had at least one physician visit during the year, use by the uninsured was notably lower than for that of those with insurance. The uninsured poor averaged only 4 visits per year compared to 6 visits for the poor with private insurance and 8 visits for those with Medicaid coverage (Figure 9). The higher visit rates for Medicaid reflect the disproportionately sicker population covered by Medicaid, including those who become eligible for coverage as a result of high medical expenses.

Having a regular source of medical care is often viewed as a measure of

improved access to care because a stable medical provider relationship can help foster use of preventive care and early intervention for treatment of disease. One third of uninsured poor Americans are without a usual source of medical care compared to 16 percent of those with Medicaid coverage. Despite its many problems in securing provider participation for its beneficiaries, Medicaid beneficiaries none-the-less are more likely than both the uninsured and the privately-insured poor to report a usual source of care (Figure 10).

Lack of insurance not only reduces utilization of health care services but also limits choice of health care providers. Many of the uninsured poor turn to community health centers, hospital out-patient departments, and emergency rooms for their care. Nearly one in five physician visits (19 percent) by the uninsured poor were to hospital outpatient departments compared to 9 percent of the visits by the poor with private insurance (Figure 11).

Lack of health insurance coverage has serious consequences for access to care for the uninsured population. Without health insurance coverage or available cash, many of the uninsured neglect obtaining preventive care and turn to the hospital emergency room when a medical emergency arises. Often care is not received until conditions have worsened, resulting in more serious illness and expensive treatment when care is ultimately rendered. Health insurance coverage is an important lever to access the health system. Without that access, the uninsured have limited choices regarding when and where they can obtain medical care.

What are the Implications of the Clinton Plan for the Poor?

The Clinton health reform plan seeks to provide universal coverage to a standard comprehensive set of medical and health benefits to all U.S. citizens and legal residents. To assure universal coverage for all Americans, the plan combines an employer mandate requiring all employers to offer and contribute to the cost of health insurance coverage for their employees and dependents with an individual mandate for the purchase of insurance. Enrollment in health plans would take place primarily through regional health alliances in each state that would negotiate with health plans on behalf of consumers and employers.

Under the Clinton plan, the low-income population like all other Americans would be provided universal coverage through health plans offered through regional health alliances. Medicaid coverage for acute care services for the low-income population would essentially be replaced by the new system. Low-income employed individuals and their families would be covered through either the regional alliance where they live or a corporate alliance if they work for an employer with more than 5,000 workers. Unemployed low-income individuals and families would be covered through the regional health alliance. Assistance with the family share (20 percent) of the premium would be provided to individuals with incomes below 150 percent of the federal poverty level. Employers would be responsible for paying 80 percent of the average premium cost in the alliance area for their workers and dependents.

Medicaid would retain responsibility for medical assistance to the cash assistance welfare population. Medicaid would pay the full premium share for cash

assistance recipients of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). Cash assistance recipients would also receive assistance with cost-sharing and supplemental benefits, such as dental or vision care. Former Medicaid beneficiaries who are not receiving cash assistance would no longer be covered by Medicaid and would not receive assistance with cost-sharing or supplemental benefits. They would either be covered through their employer or subsidized by the regional alliance. A new federally-funded program would be established to provide benefits to supplement the basic package for low-income children now covered by Medicaid, but not on cash assistance.

The Clinton plan would thus mean a major restructuring of responsibilities and benefits for the low-income population. Medicaid acute coverage would be replaced by the new system, employers would gain increased responsibility for their low-income workers and their dependents, and responsibility for coverage of current Medicaid beneficiaries would be shared by state governments and the new alliances. Long-term care services as well as coverage of the dual Medicare and Medicaid eligibles would remain Medicaid responsibilities.

Role of Employers and Medicaid in Coverage of the Poor

The Clinton proposal significantly improves coverage of the low-income population by mandating universal coverage and a standard benefit package for all Americans. It provides health insurance protection to 36 million uninsured Americans -- 60 percent of whom have incomes below 200 percent of the poverty level -- and eliminates the risk of being uninsured for millions more. Today, a third of poor

Americans and 29 percent of near poor Americans are uninsured -- covered neither by Medicaid nor private employer-based insurance. Under the Clinton plan, they will now be covered by their employer or through their regional health alliance.

Through the employer mandate and the creation of health alliances, the Clinton plan restructures health insurance coverage and substantially alters Medicaid responsibility for the low-income population. Subsidies and assistance to low-income people under the plan are generally available on a sliding scale basis for those with incomes below 150 percent of the federal poverty level or roughly \$15,000 for a family of three. Approximately 59 million Americans would qualify for assistance as using this definition of low-income. Two-thirds of the 59 million low-income Americans would be covered by employer-based coverage, 19 percent would have Medicaid premium payments because they are cash assistance recipients, and 14 percent would be covered in the alliance on an individual basis (Figure 12).

Under the Clinton plan, the employer mandate shifts the payment of the 80 percent employer share of premiums for 10 million current Medicaid beneficiaries to employers. Roughly half of all current Medicaid beneficiaries would now be covered through their employers. In addition, more than 70 percent of the uninsured population with incomes below 150 percent of the federal poverty level -- 13 million people -- would gain coverage through their employer. Employers would also have responsibility for paying the employer share of premiums for this population. The new responsibility for current Medicaid beneficiaries and uninsured workers and their families essentially triples employer coverage from current levels for the low-income

population.

Medicaid responsibilities for medical coverage under the plan primarily relate to coverage of cash assistance recipients under the AFDC or SSI programs. These individuals represent three quarters of the current Medicaid population (Figure 13). For the 11 million unemployed cash assistance recipients and their dependents, Medicaid pays the full premium cost. For the five million employed cash assistance recipients, both Medicaid and the employer contribute the employer share (80 percent) of the premium and Medicaid covers the family share (20 percent) of the premium.

Under the plan, assistance with cost sharing is only provided to cash assistance recipients covered under Medicaid. For cash assistance recipients, cost sharing in an HMO-type plan is reduced from \$10 per visit to \$2 per visit. No assistance is provided in the fee-for-service plan with its \$400 family deductible and 20 percent cost sharing, unless the alliance certifies that there are no HMO plans available in the area.

The six million Medicaid beneficiaries not on cash assistance today -- one quarter of the non-elderly Medicaid population -- would no longer be covered by Medicaid. The non-cash Medicaid population would receive no assistance with cost-sharing regardless of the plan chosen. For the non-cash assistance population, required cost-sharing levels would dramatically exceed the nominal levels permitted under Medicaid, especially if a fee-for-service plan were selected.

The regional health alliance plays a dominant role in the selection and negotiation of health plans for both low income and higher income Americans. The

regional alliance would have responsibility for enrollment, selection, and monitoring of health plans, functions now performed by Medicaid for the low-income population. Under the Clinton plan, 91 percent of the 59 million Americans with incomes below 150 percent of the federal poverty level would be covered through the regional health alliance where they live. Nine percent of the low-income population has a work attachment to an employer with 5000 or more employees and could potentially be covered through a corporate alliance.

Implications of the Clinton Proposal for the Low-Income Population

The Clinton plan takes a bold and progressive step forward in its commitment to universal coverage and comprehensive benefits with an emphasis on primary care and preventive services. Full coverage of all Americans regardless of income level, employment status, or state of residence will bring an end to the variations in eligibility and coverage of the low-income population under Medicaid today. Universal coverage to bring all Americans under the same system of care holds great promise for addressing the differentials in access to care and the inequities in today's health care system.

In fashioning an approach to reform the health system, it is, however, important to recognize that all Americans are not equal with regard to either health needs or ability to share in the cost of health care. The poor are by definition without the economic means to meet financial obligations. They are also more likely to be ill and need more medical care than other Americans. Thus, most of the poor are likely to face large and potentially onerous financial obligations under any plan that requires

substantial cost-sharing and out-of-pocket payments.

The Clinton plan would require significant cost-sharing by most low-income Americans. Only cash assistance recipients would have reduced cost-sharing levels and then only if they joined an HMO-type plan. No assistance is provided for anyone who chooses a fee-for-service plan regardless of income or cash assistance status unless there is no HMO option available in the alliance area.

Subsidies for premiums are limited to a sliding scale amount based on the average weighted premium in the area. The additional cost of any plan in excess of the average weighted premium is not subsidized and must be paid by the family. Many of the HMO-type plans with the lower cost-sharing amounts could be higher in premium cost than the fee-for-service option.

The implications of this subsidy policy for the low-income population requires further examination. The premium and cost-sharing levels in the plan may prove burdensome for low-income people and compromise access to care for those with health problems who use the most services.

Moreover, limiting assistance with cost-sharing only to recipients of cash assistance perpetuates welfare categories, policies, and state variations in the provision of medical assistance to low-income people, undermining the decoupling of medical assistance and welfare assistance embodied in the Medicaid expansions of the last decade. Income-based need, not categorical definitions, should be used to determine assistance with premiums and cost-sharing under any reform plan.

The combined impact of the premium structure, cost-sharing levels, and price

competition among health plans under the Clinton proposal may severely limit the choice of plans available in the alliance for low-income people. The cost-sharing structure effectively limits choice of plans for the poor to HMO-type plans with cost-sharing based on a per visit rather than percentage basis as under the fee-for-service option. If the fee-for-service plans with high cost-sharing, not the HMO-type plans, have the lowest premiums, the cost-sharing levels in the fee-for-service plan could financially preclude low-income people from selecting the lowest cost plan. These policies may also result in significant churning of the poor among plans if the poor move annually to stay in the lowest cost plan.

Finally, the role and responsibilities of the regional alliance with regard to coverage of the low-income population warrant further examination. Alliances will replace the Medicaid program's role in determining eligibility for subsidies, negotiating with and paying providers, and monitoring health plans. Plan selection and arrangements with essential providers to maintain community-based care networks for the poor as well as income determination for subsidies are all responsibilities to be assumed by the alliance. The ability of alliances to carry out many of these functions, particularly with regard to a low-income population, remains untested. Lessons from the Medicaid experience point to the importance of outreach and special initiatives to improve program participation and appropriate service use by the poor. Mounting such programs could be a challenge for most alliances, but may be necessary to promote access to care for the poor.

Conclusion

The current health care system provides inadequate coverage to the American people and leaves the poor particularly at risk of being uninsured and unable to afford care. Although Medicaid provides essential coverage for nearly 30 million low-income Americans, millions more are outside its reach. The financial stress facing Medicaid today in the states constrains the use of Medicaid as a vehicle to broaden coverage for low-income and vulnerable populations.

It is time to break the cycle of poor health, poverty, and inadequate insurance for America's poor. Adequate protection for health care will only be secured when all Americans are insured. Insurance coverage is critical to assure access to timely and appropriate care, not just emergency care or charity care when ill. Providing universal insurance is essential so that no American delays care or is denied care because they cannot pay. Affordable coverage for all and universal protection should be foremost on this nation's agenda so that the potential of universal coverage can become a reality for all Americans.

The President has provided both a blueprint for reform and a challenge to make it happen. The Kaiser Commission is committed to working with you in the Congress and with the Administration to bring fundamental reform to our health care system and improve coverage and access to care for all Americans, especially the poor and disadvantaged who have too often been left behind in our current health care system.

Thank you for this opportunity to appear before the Committee today.

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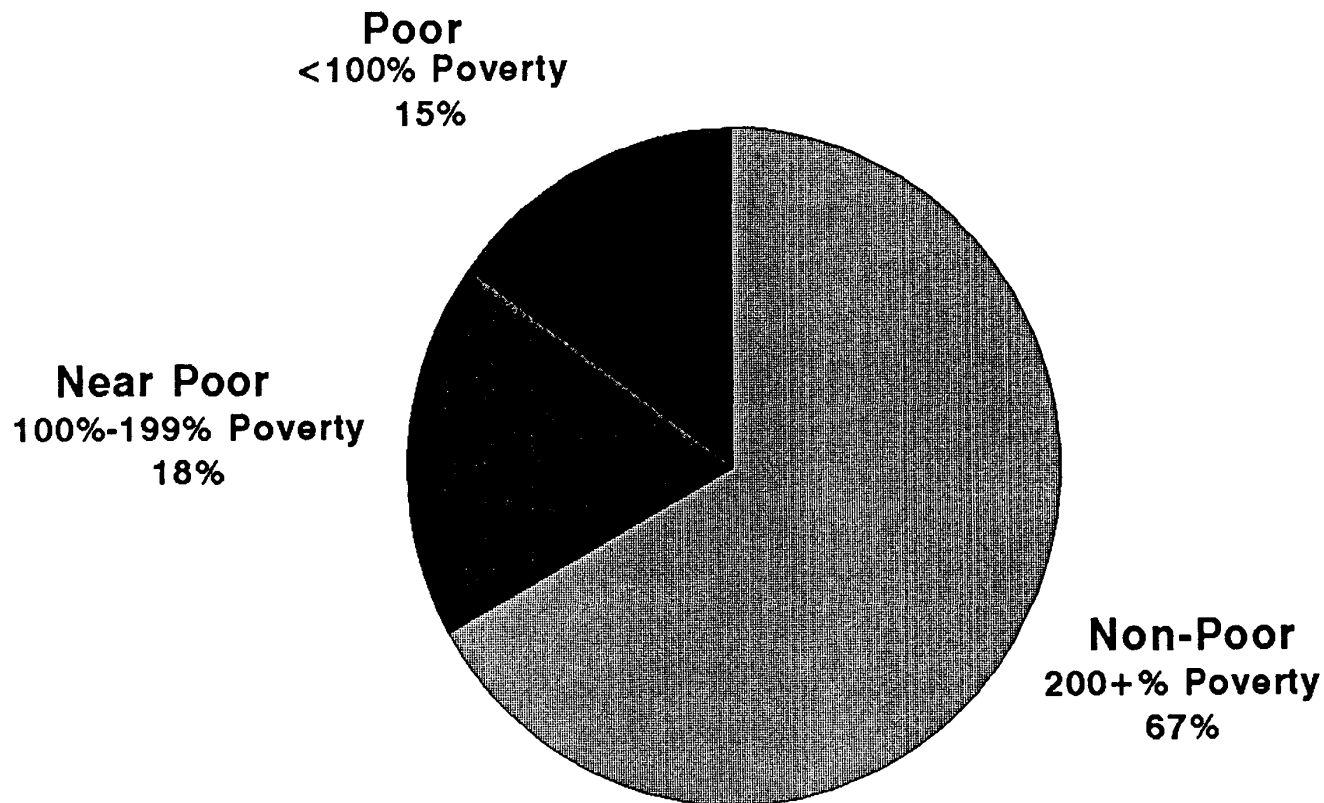
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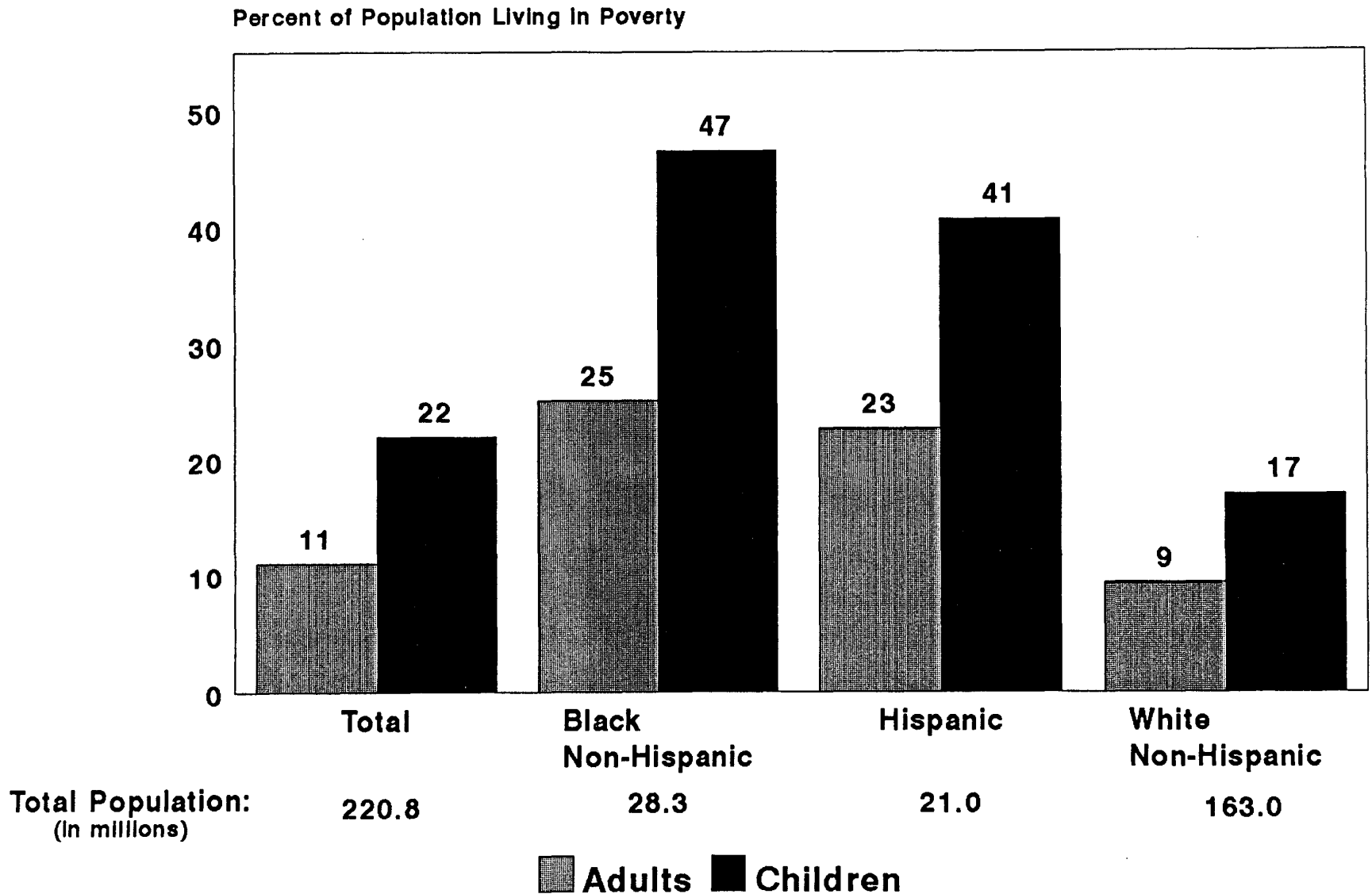
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**Figure 1 Distribution of the Nonelderly Population,
by Poverty Level, 1991**



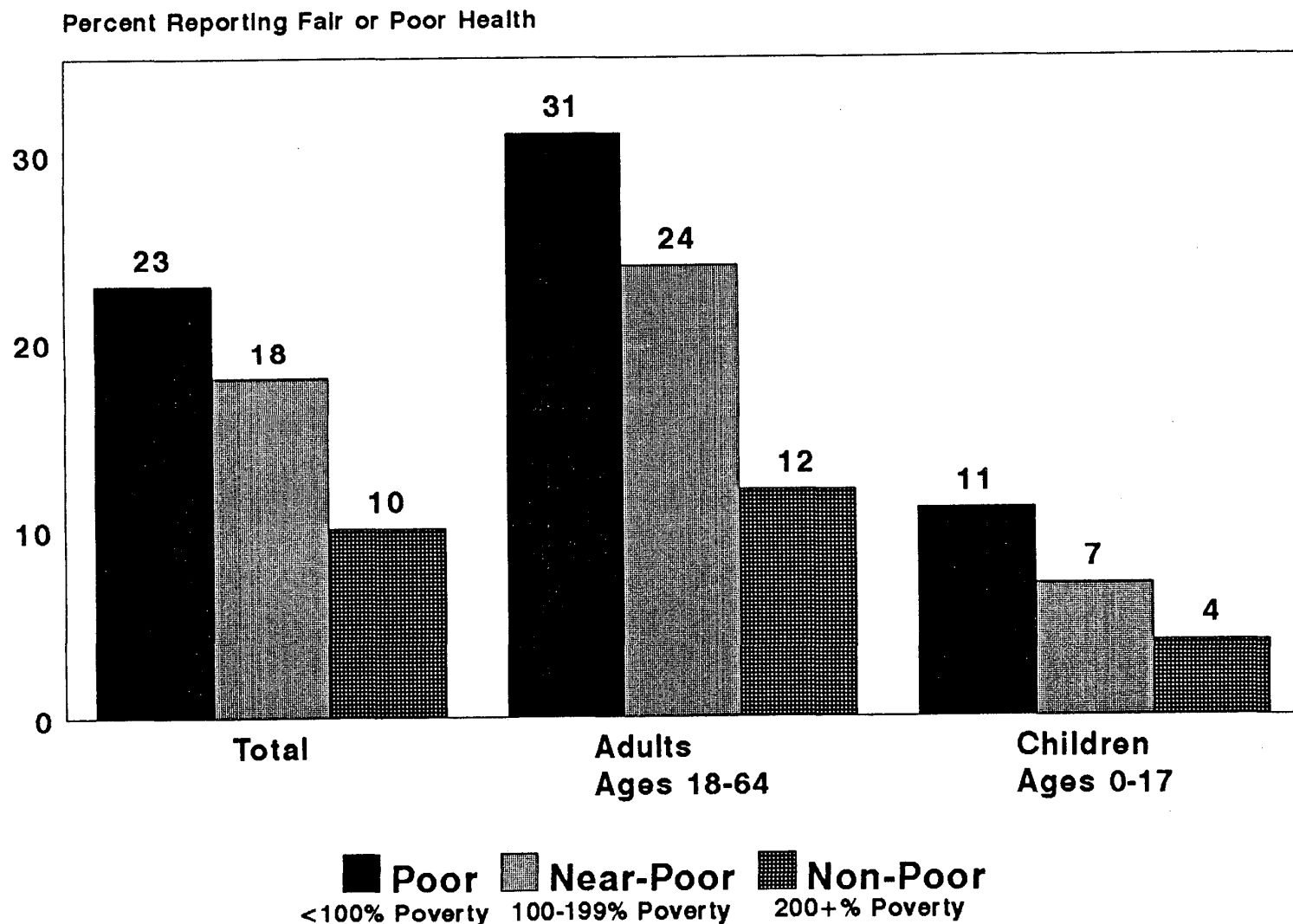
Total = 220.8 Million Persons

Figure 2 Poverty Rates, by Race/Ethnicity and Age, 1991



Source: March Current Population Survey, 1992.

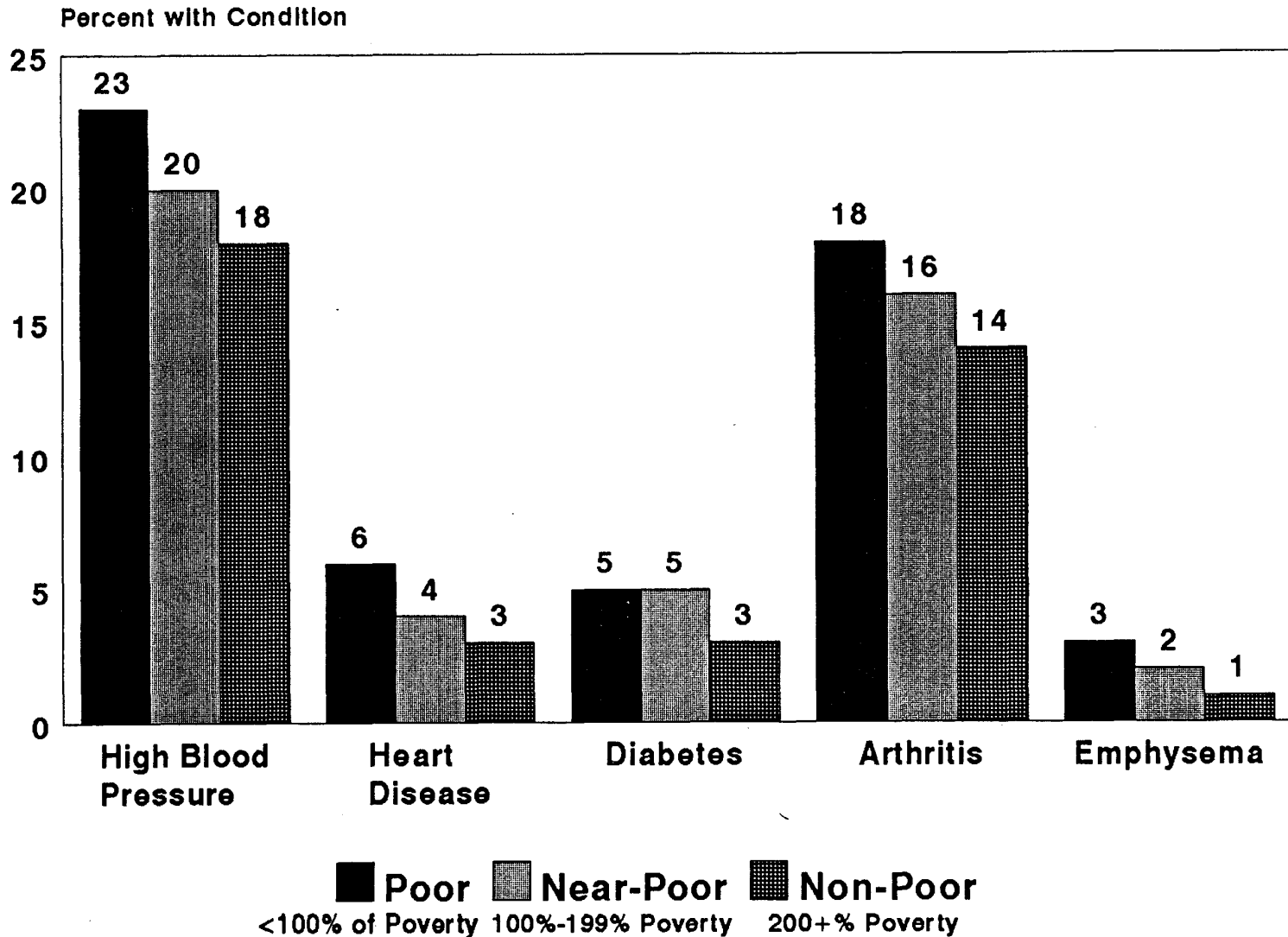
Figure 3 Percent of Population Reporting Fair or Poor Health, by Age and Poverty Level, 1987



Source: National Medical Expenditure Survey, 1987.

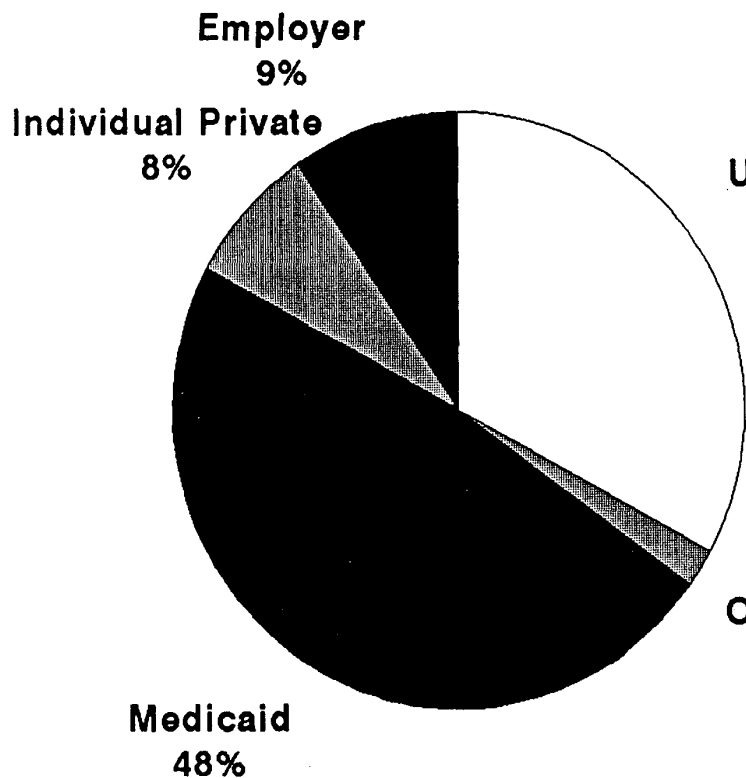
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Figure 4 Selected Chronic Health Conditions in Nonelderly Adults, by Poverty Level, 1987

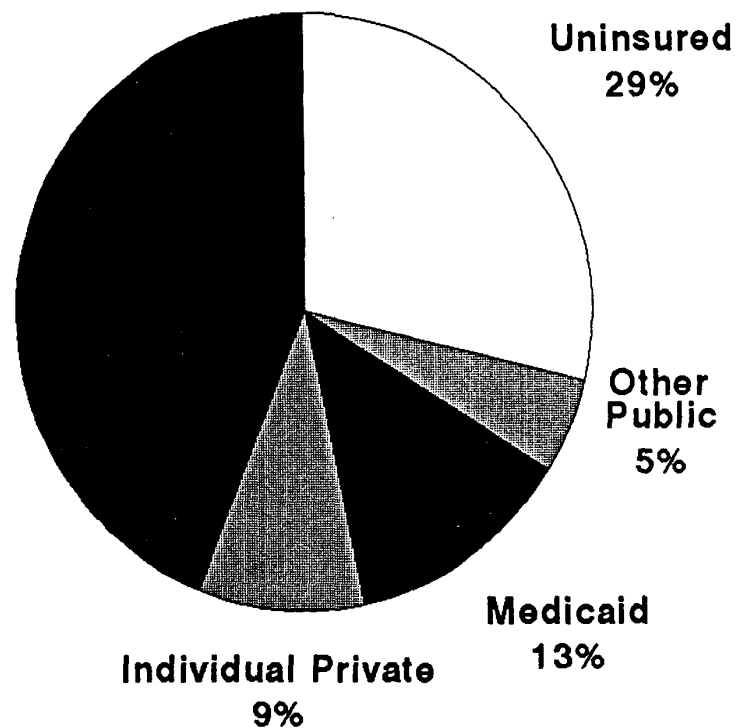


Source: National Medical Expenditure Survey, 1987.

**Figure 5 Distribution of the Low-Income Population,
By Health Insurance, 1991**

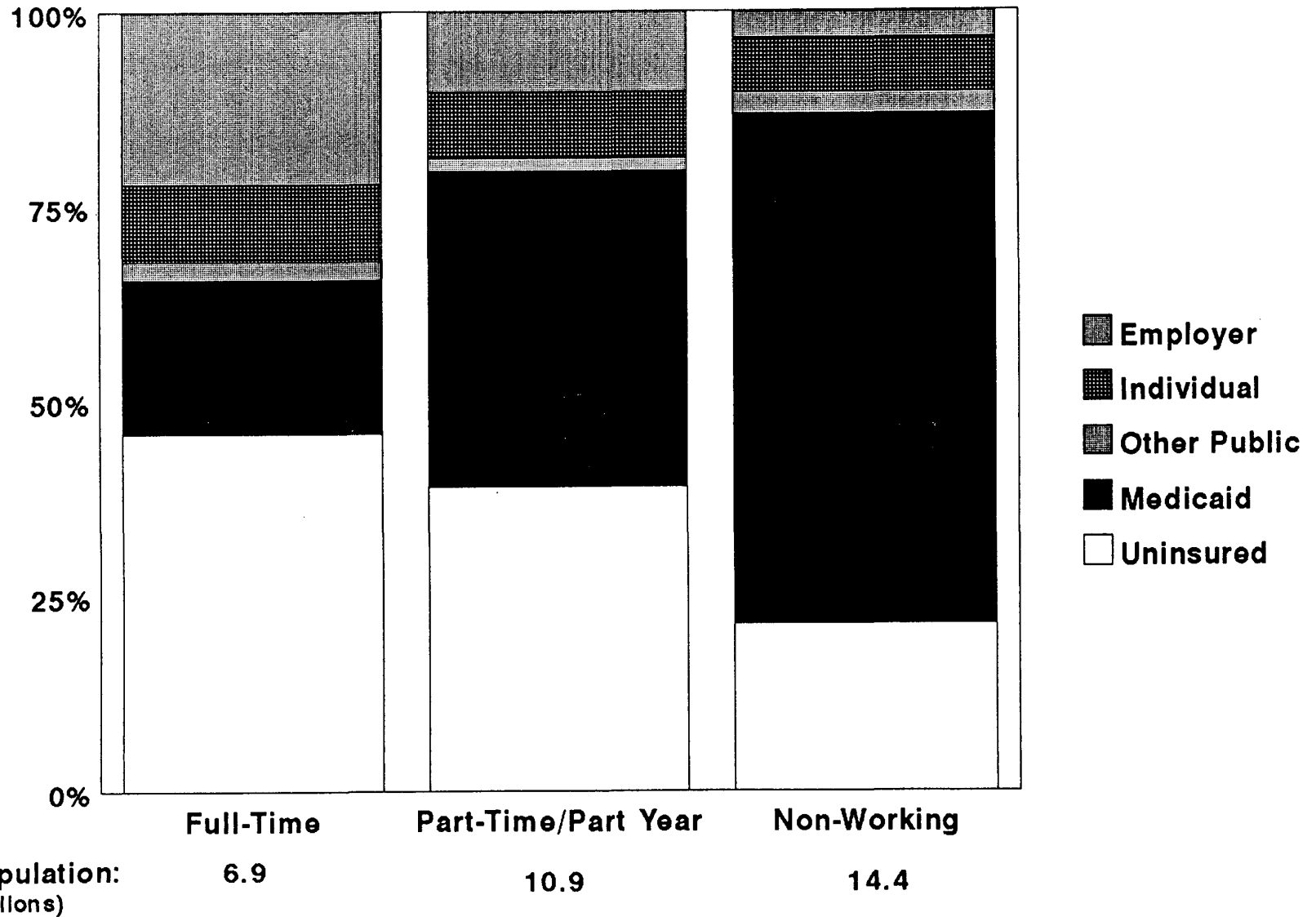


**Poor (<100% Poverty)
Total = 32.1 Million**



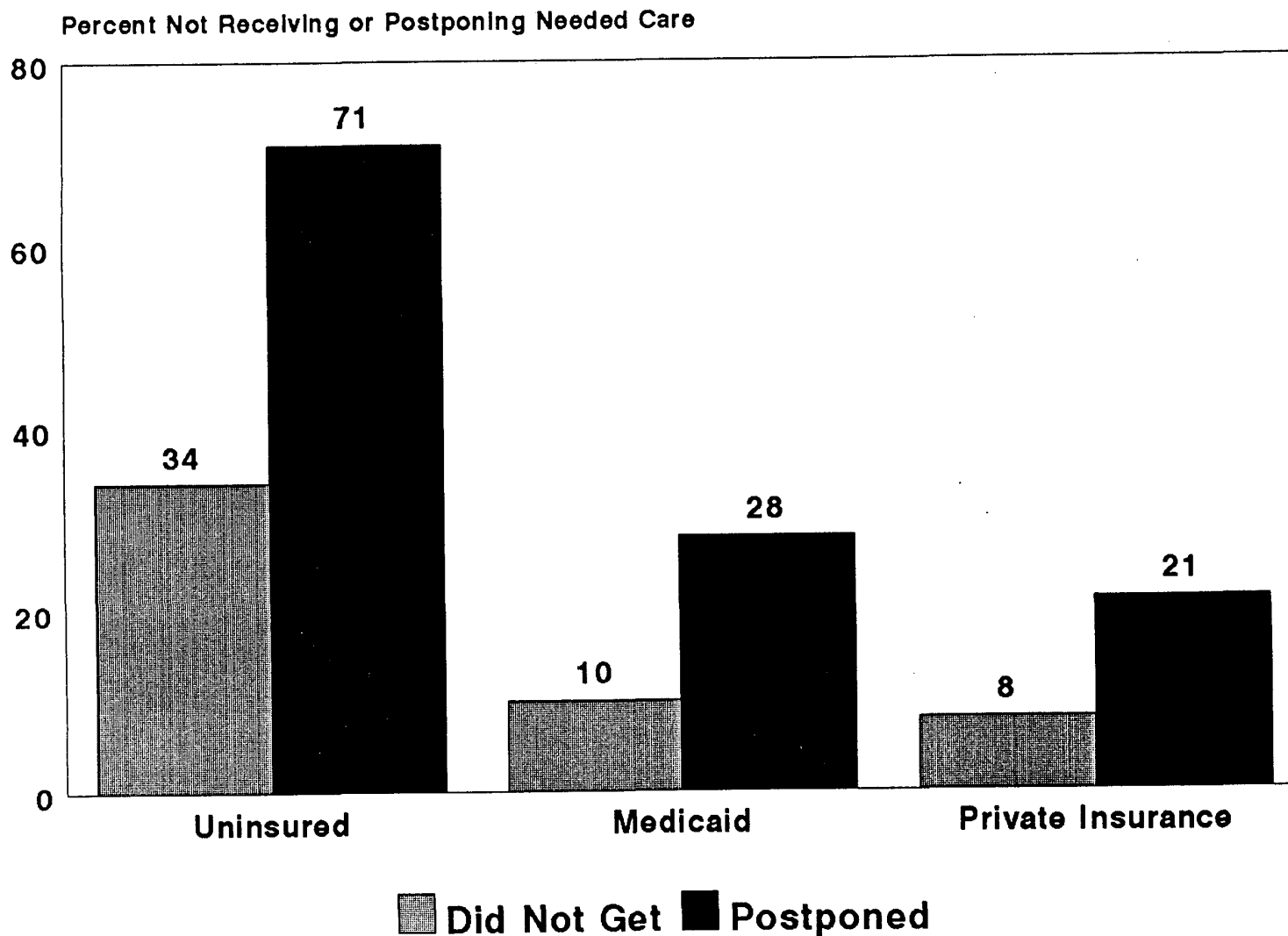
**Near-Poor (100%-199% Poverty)
Total = 40.0 Million**

Figure 6 Health Insurance Coverage of the Poor Population, by Work Status, 1991



Source: March Current Population Survey, 1992.

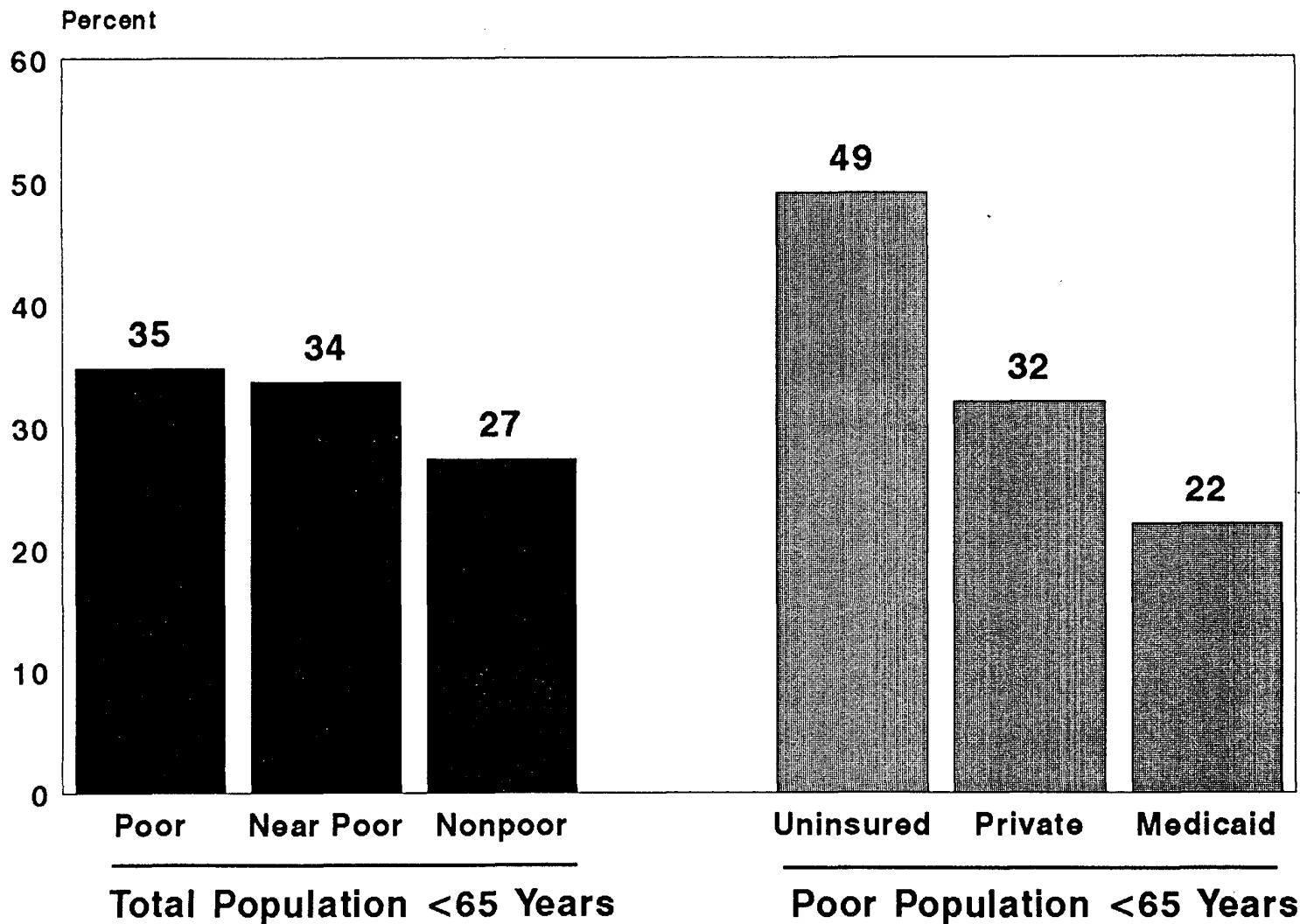
Figure 7 The Uninsured Are More Likely to Not Receive or to Postpone Needed Medical Care



Source: Kaiser/Commonwealth/Harris Poll, 1993.

Figure 8

Percent of the Nonelderly Population with No Physician Visit in Past Year, by Poverty Level and Insurance*, 1987

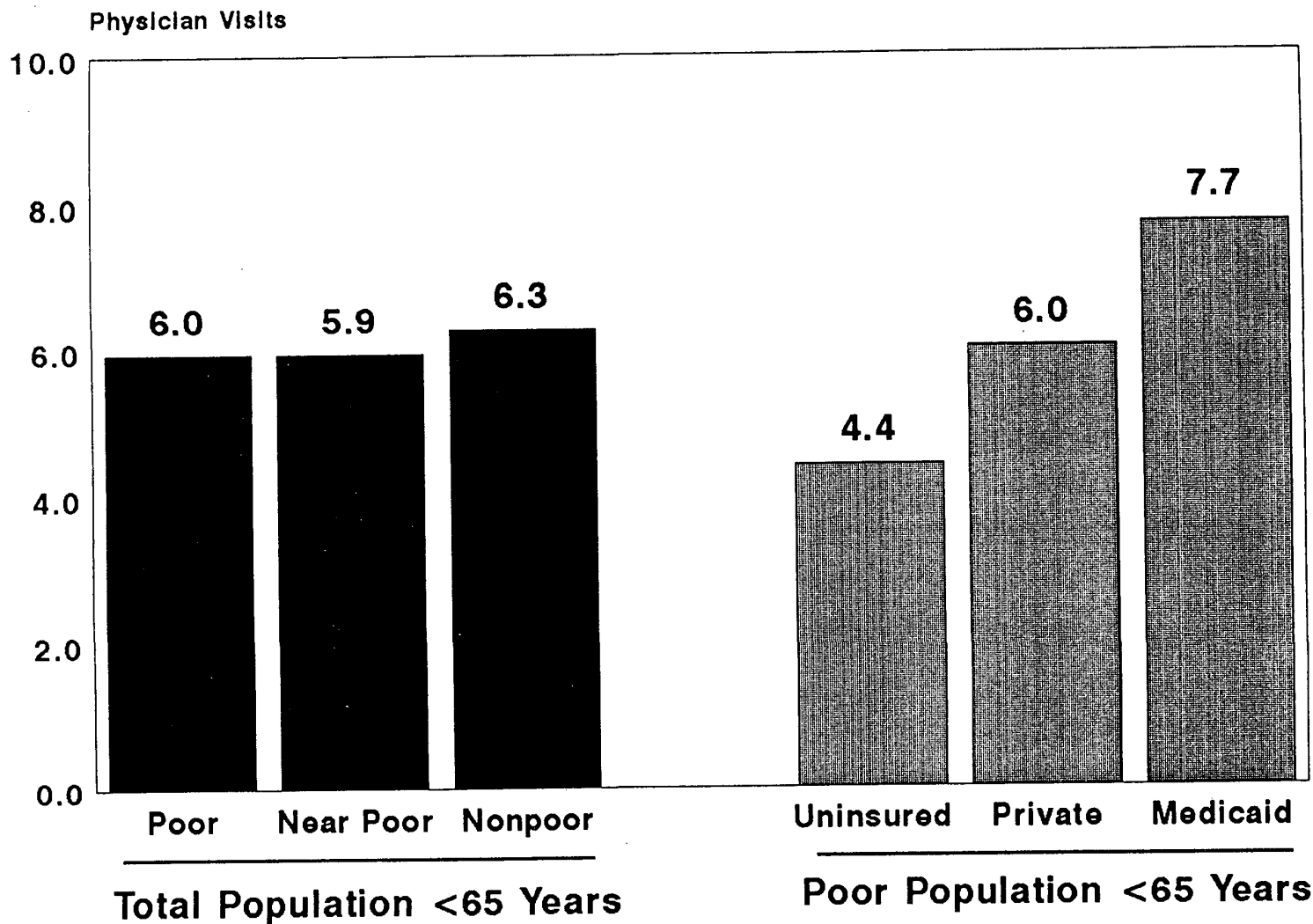


* Full-Year Coverage

Source: National Medical Expenditure Survey, 1987.

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Figure 9
Mean Annual Physician Visits among the Nonelderly Population
with at least One Visit, by Poverty Level and Insurance*, 1987

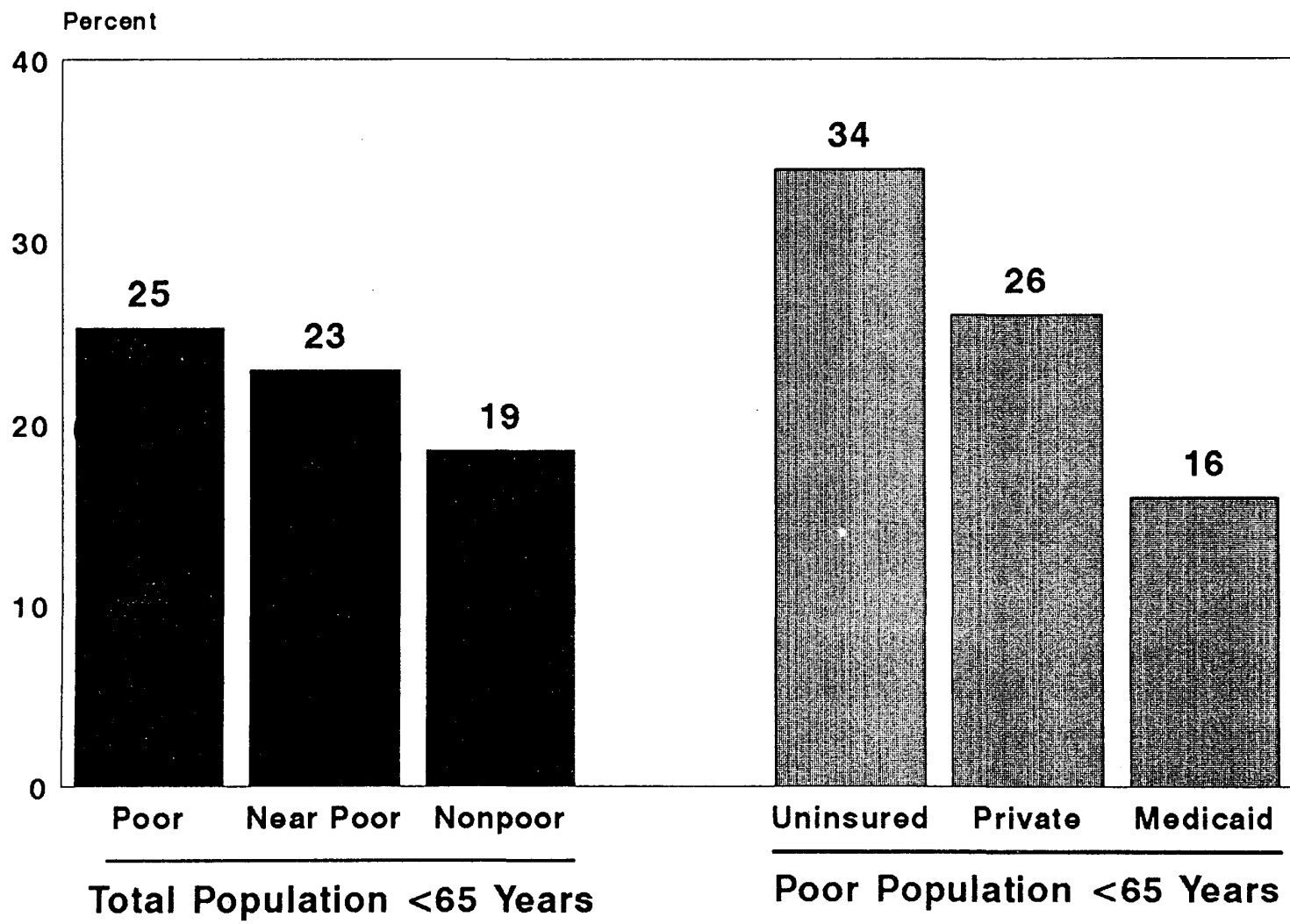


* Full-Year Coverage

Source: National Medical Expenditure Survey, 1987.

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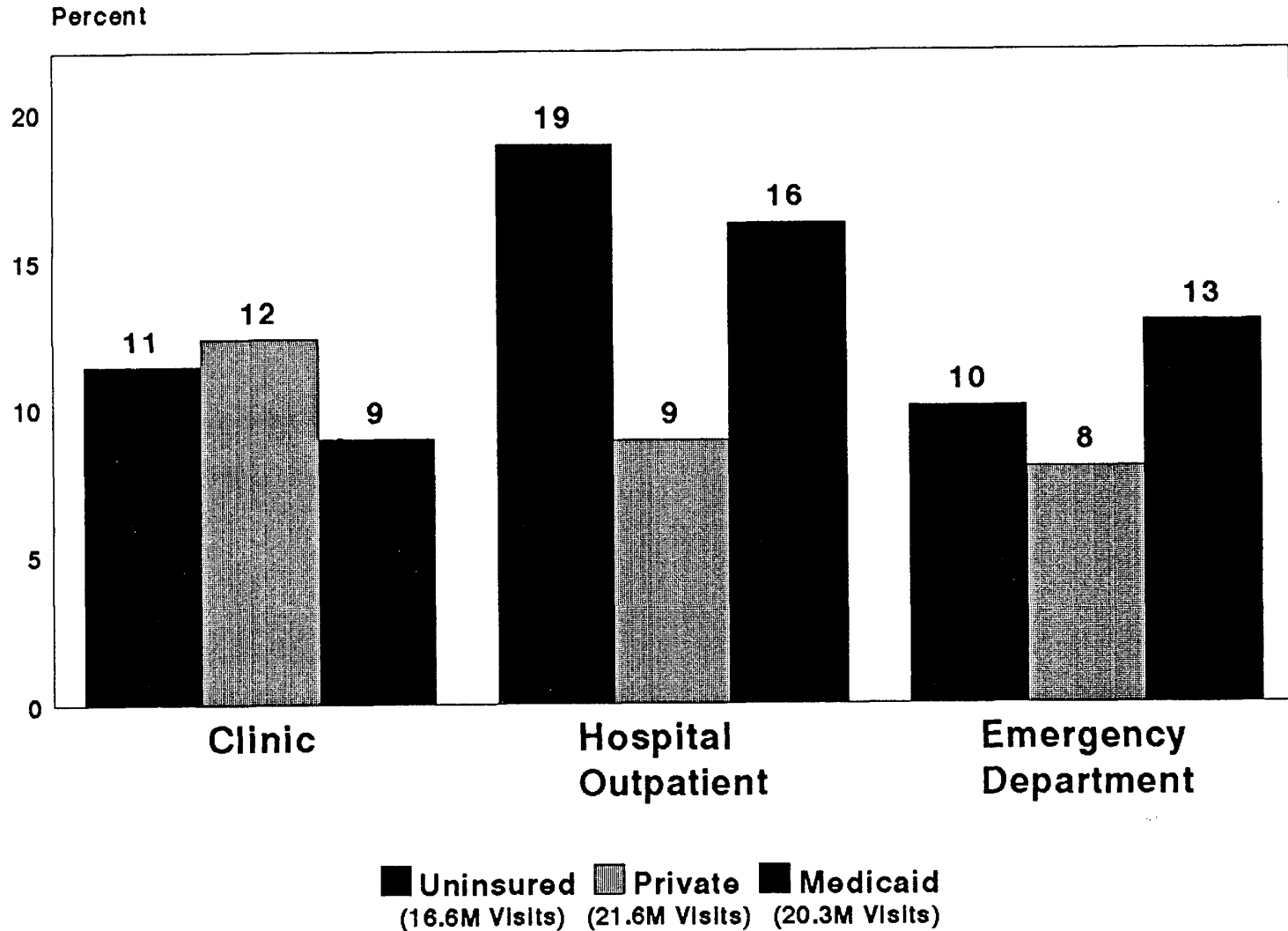
Figure 10 Percent of the Nonelderly Population with No Usual Source of Care, by Poverty Level and Insurance*, 1987



* Full-Year Coverage

Source: National Medical Expenditure Survey, 1987.

Figure 11 Percent of Physician Visits Obtained at Hospitals and Clinics by the Poor Population, by Insurance,* 1987



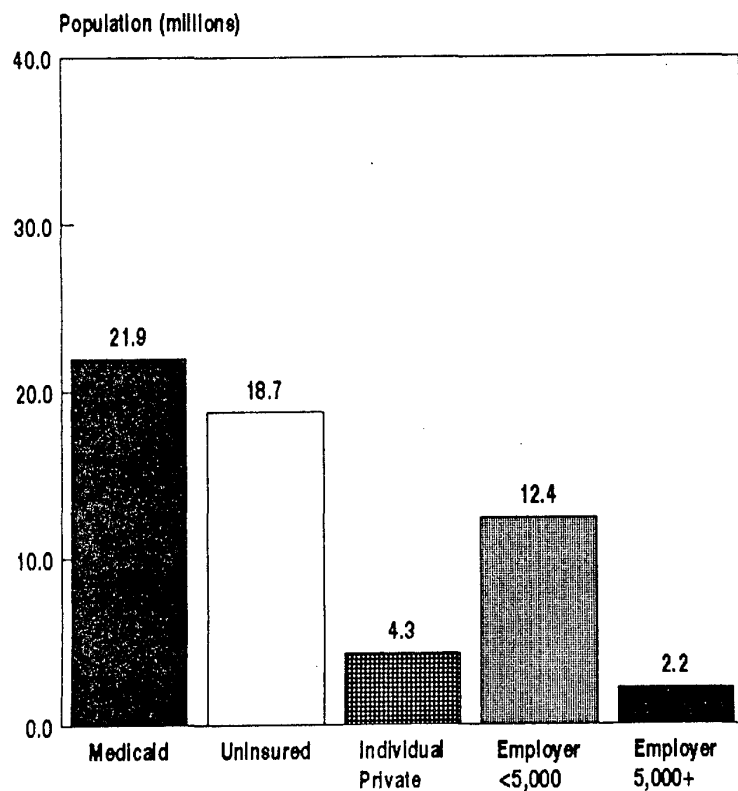
*Full-Year Coverage

Source: National Medical Expenditure Survey, 1987.

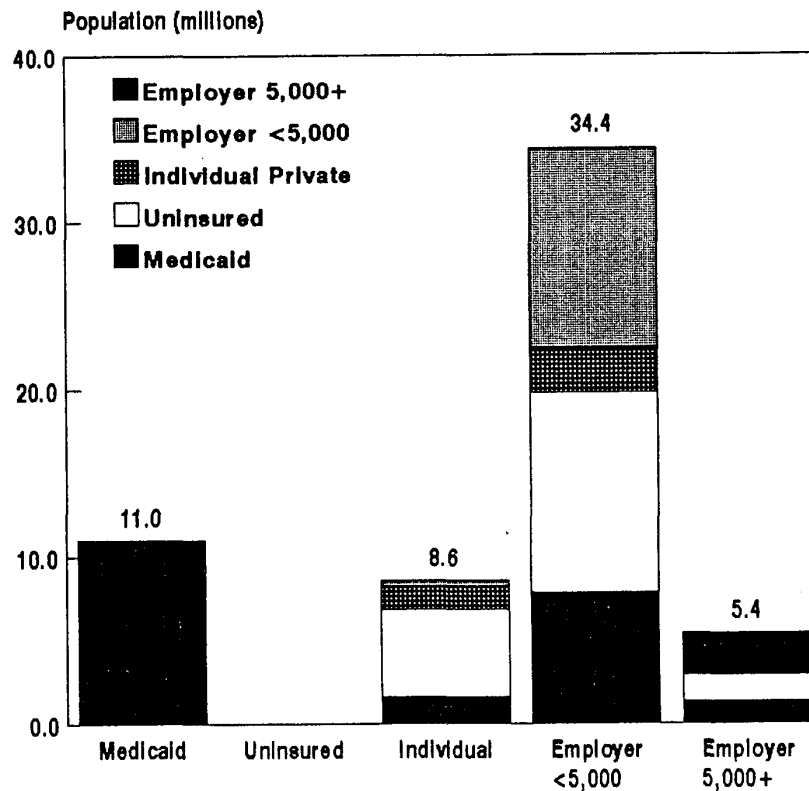
Figure 12

Distribution of Insurance of the Nonelderly Population with Incomes Below 150% of Poverty under Clinton Plan

Current Situation

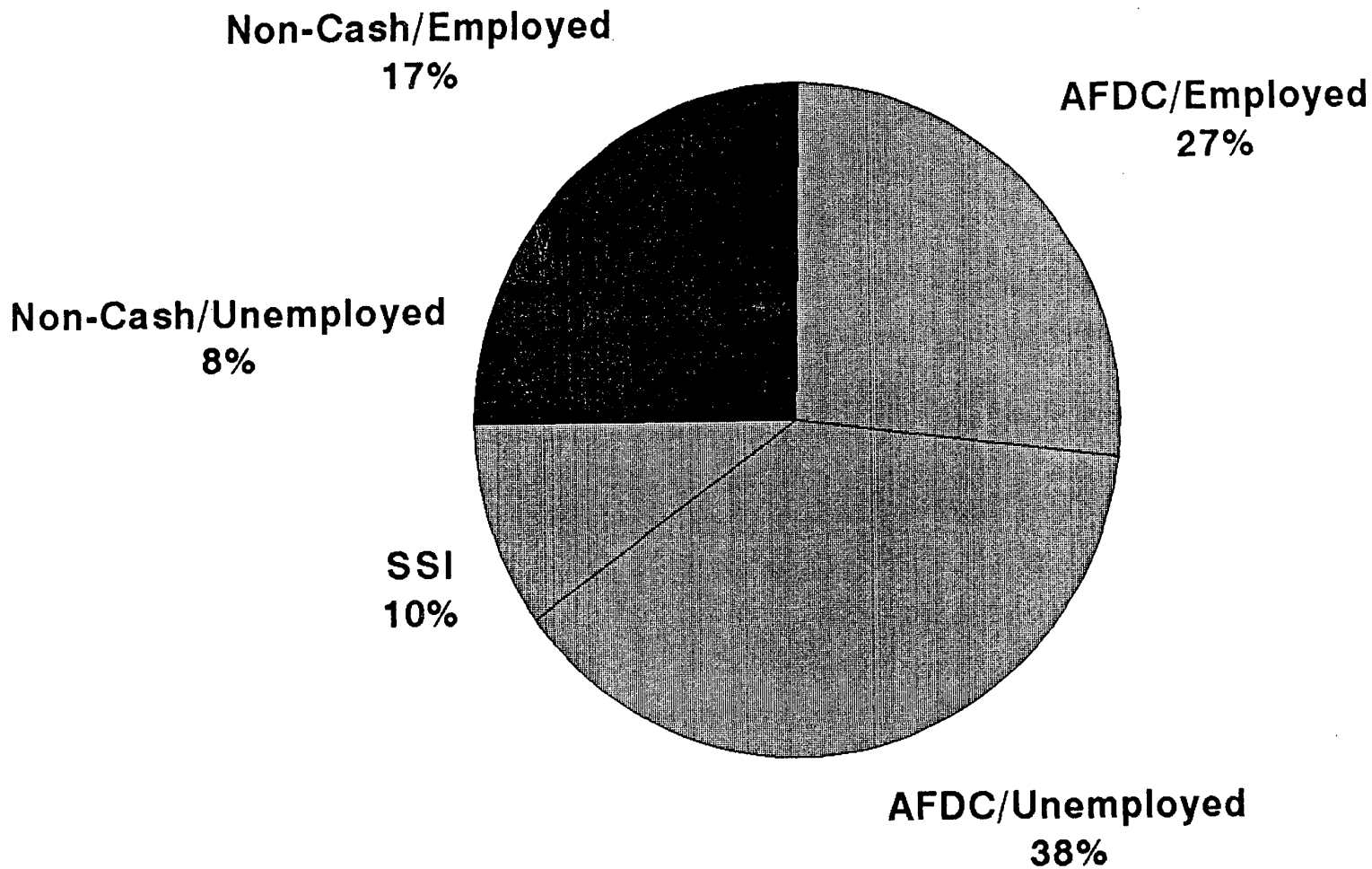


Under Clinton Plan



Source: Urban Institute, 1993.

**Figure 13 Distribution of the Nonelderly Medicaid Population
by Welfare and Employment Status, 1991**



Total = 23.4 Million in 1991