kaiser commission on medicaid and the uninsured
KEY FACTS
THE HENRY J. KAISER FAMILY FOUNDATION

Underinsured in America: Is Health Coverage Adequate?

July 2002

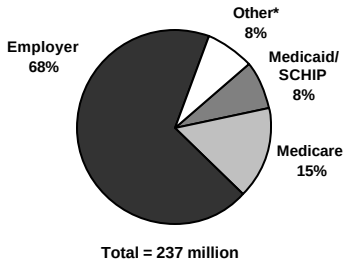
Though much of the policy debate over health coverage in America focuses on extending insurance to the 38 million uninsured individuals, attention has also recently turned to the population who may be *underinsured*. The underinsured have health insurance but face significant cost sharing or limits on benefits that may affect its usefulness in accessing or paying for needed health services. "Health insurance"—while key to accessing care—describes a wide range of plans that offer varying levels of coverage and protection; most have limits on the protection provided.

Health Insurance Coverage in America

The majority (68%) of insured Americans obtain their coverage as a fringe benefit through their jobs (Figure 1). Most workers with employer-sponsored coverage receive health insurance through a managed care plan, with 48% enrolled in PPOs, 23% in HMOs, and 22% in POS plans.

Figure 1

Primary Source of Health Coverage Among the Insured Population, 2000



Total = 237 million

* Other includes unspecified private coverage, non-group coverage, and other public coverage.
Note: An additional 38.5 million Americans had no source of health insurance in 2000.
SOURCE: Urban Institute and Kaiser Commission estimates based on March 2001 Current Population Survey.

The availability of employer-sponsored coverage, however, varies greatly, and many — mostly low-income workers — do not have access to such coverage. Some purchase non-group coverage on their own, and many low-income Americans (especially children) are covered by Medicaid or the State Children's Health Insurance Program (SCHIP). Nearly all of the elderly are covered by Medicare.

There is no "standard" health insurance plan, and coverage—particularly for services such as vision and dental care, prescription drugs, and mental health—varies. In 2001, 10% of insured nonelderly adults reported that they lacked drug coverage, and about a third reported that they had no dental or vision coverage (29% and 37%, respectively). While plans typically cover physician and hospital care, there is significant variation in the cost sharing required for services and in the scope of benefits covered. Most health plans have deductibles, requiring individuals to spend anywhere from $100 to over $500 before they will cover most services. Insured individuals also must pay a share of the cost of a service. In some cases, as in doctor visits in an HMO plan, these costs are about $10 per encounter; however, in other types of plans, individuals can be required to pay for 20% of the total bill for covered services.

Individuals who purchase coverage on their own are more likely to have limits on coverage. In fact, 63% of the plans offered to applicants have benefit restrictions or additional cost sharing. In particular, coverage for maternity benefits, mental health care, and prescription medications tends to be limited, especially in comparison to what is typically offered under group health plans. Under Medicare and Medicaid, individuals are guaranteed a certain level of benefits by federal law; however, gaps in coverage remain, as in lack of prescription drug coverage under Medicare.

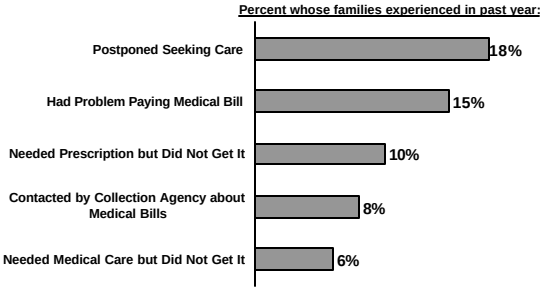
The expense of uncovered services and cost sharing can quickly accumulate and become burdensome. Nearly a quarter (24%) of insured families spent $2,000 or more out-of-pocket on their health care in a year (including their share of health plan premiums). Individuals with chronic conditions spend significantly more, largely due to their higher expenses for necessary prescription drugs. High out-of-pocket health costs have led to medical bills being the second most frequently cited reason for bankruptcy in the nation.

Health Insurance and Access to Care

Though health insurance is one of the most important factors in assuring access to health care, gaps in coverage can create access problems even among the insured. Thirty-eight percent of insured individuals report that they or their families experienced at least one problem accessing

Figure 2

Barriers to Health Care Among the Insured, 2002



SOURCE: NPR/Kaiser Family Foundation/Kennedy School of Government *Health Care Survey,* May, 2002

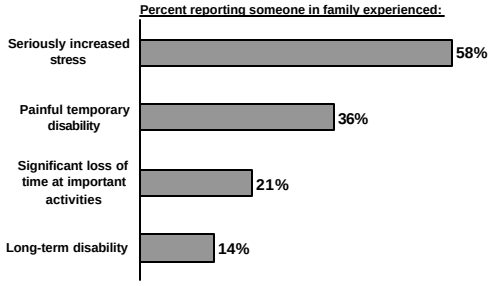
medical services in the past year. Nearly one-fifth (18%) report that they postponed seeking medical care, 15% had a problem paying medical bills, 10% did not get a prescription drug they felt they needed, 8% were contacted by a collection agency about a medical bill, and 6% didn't get care they felt they needed (Figure 2).

Many of these problems arise because some individuals' health plans do not cover all the services they need. In other cases, individuals cannot afford the cost sharing associated with covered benefits. Occasionally, individuals may also run up against benefit caps, or a maximum amount that a health plan will pay for an individual over his or her lifetime. While most plans cap lifetime benefits at a certain level, these maximums are typically quite high ($1,000,000 or more).

Problems accessing health services have long-term consequences. Among insured Americans who said they postponed seeking medical care they felt they or their family needed at some point in the past year, 36% said it resulted in a temporary disability that included significant pain and suffering, and 14% said it caused a long-term disability (Figure 3). The incidence of serious consequences was even higher among those who did not get the care they needed, versus just postponing care.

Figure 3

Consequences of Barriers to Care Among the Insured*, 2002



* Those who reported that someone in their family postponed medical care in the past year.
SOURCE: NPR/Kaiser Family Foundation/Kennedy School of Government *Health Care Survey,* May, 2002

Underinsured individuals have little recourse for obtaining services that are not covered or that they cannot afford. While most states mandate that plans cover certain services, about half of covered workers are in plans that are exempt from state laws. On the federal level, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to treat all patients who present with an emergency medical condition until they are stable, but it does not apply to patients in other situations.

For some low-income individuals, Medicaid is a key source of coverage to fill in gaps in coverage. Medicaid provides services not typically available in private health plans (for example, ongoing long-term care) at little or no cost. In many states, people whose medical expenses reduce their net income to a very low level (typically below poverty) may qualify for Medicaid as "medically needy;" however, coverage is generally limited to low-income children and parents, individuals with disabilities, and the elderly. By and large, adults without children are not eligible for Medicaid coverage.

Future Prospects

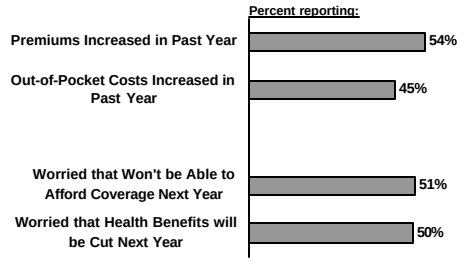
Recent trends in health insurance indicate that the problem of inadequate coverage may be on the rise. While employees' share of premium costs and the level of benefits they receive through their health plans have not changed significantly in recent years, both employers and workers indicate that increasing health care costs are likely to end this trend. Premiums for employer-sponsored coverage rose on average 11% between 2000 and 2001, the largest increase since 1992, and are expected to rise even more this year. Forty-four percent of employers reported that it is likely that they will pass some of these costs on to employees by requiring them to pay more for coverage.

In addition, public programs are facing budget constraints that may lead to benefits cuts. In FY2002, 36 states reported Medicaid budget shortfalls, and 41 states are predicting such shortfalls in FY2003. Some states are looking to restrict benefits (including dental care, home health, eyeglasses, and psychological counseling) or impose new cost sharing in the face of fiscal pressures.

Many insured individuals are already feeling the impact of rising health care costs, either through higher premiums or greater out-of-pocket costs (Figure 4). Over half of individuals with insurance coverage are worried about not being able to afford insurance (51%) or having benefits cut back (50%) in the coming year.

Figure 4

Impact of Health Insurance Trends on Individuals with Coverage, 2002



SOURCE: NPR/Kaiser Family Foundation/Kennedy School of Government *Health Care Survey,* May, 2002

While the uninsured are most at risk, researchers estimate that about a fifth of insured individuals are underinsured and face limits on coverage or substantial financial costs if faced with an illness. Given the recent increase in health care costs, it is likely that this problem will escalate in coming years. With a growing body of evidence showing that many insured individuals still have problems accessing health care and experience long-term financial and health consequences, these issues are gaining prominence on the national policy agenda.

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The Kaiser Commission on Medicaid and the Uninsured was established by the Henry J. Kaiser Family Foundation to function as a policy institute and forum for analyzing health care coverage, financing and access for the low-income population and assessing options for reform. The Kaiser Family Foundation is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.