

# Improving Health Insurance Coverage and Access to Care

After several years of relatively modest growth, health plan premiums are once again rising at double-digit rates, far outpacing growth in wages and general inflation. Increased costs of prescription drugs, in particular, are forcing premiums up for employers and public programs and adding to the financial burdens of patients without prescription drug benefits. Meanwhile, a slowdown in economic growth has pushed many state budgets from surplus to deficit and cut sharply into estimated federal surpluses. These trends portend a rise in the number of uninsured and pose additional challenges for the uninsured and those with inadequate insurance.

Despite recent years of tight labor markets and incremental reforms to publicly funded health insurance programs, uninsured rates among working-age adults have remained stubbornly high. About 40 million people are uninsured all year, including almost one in five adults (19 percent of people ages 19–64), while several million more experience breaks in coverage, with a spell of being uninsured during the year. Lack of coverage — for any period — puts health at risk. For low-wage

workers, job-based insurance is often hard to come by. Welfare-to-work programs have increased the supply of workers in search of low-wage jobs, with little pressure to improve wages or benefits. Where job-based coverage exists, employee premium shares, especially for family coverage, may be unaffordable for those at the bottom of the economic hierarchy.

Among federal and state policymakers, the success of the State Child Health Insurance Program (CHIP) — along with recognition that private markets seem unable to provide sufficient insurance coverage even in good times — has renewed interest in working to close the gaps. Several states, including New York, have recently enacted programs to expand health insurance to parents and the working poor. Legislative proposals at the federal level would follow the states' lead. Even so, blending public and private programs so that they provide continuous coverage and access to care remains difficult.

Inadequate insurance — especially lack of coverage for prescription medications — also puts health at risk. Rising prescription drug costs are simultaneously pushing up expenses for plans that cover medications and increasing out-of-pocket costs for millions of elderly and disabled Medicare beneficiaries. The lack of a prescription drug benefit under Medicare has emerged as a central topic of debate, along with the question of how to put the program on a secure financial foundation for the long term. The Medicare program, which provides near-universal coverage for basic benefits to 39 million men and women age 65 and over and disabled individuals, will struggle in the years ahead to meet the needs of an aging population.

Medicaid — the source of insurance for 41 million low-income adults and children — faces significant challenges now and in the future, as states struggle with budget deficits and program costs continue to rise. Despite changes in federal welfare laws, Medicaid expenditures have continued to climb, in large part owing to rising costs for prescription drugs for low-income aged and disabled beneficiaries. In other words, gaps in benefits under Medicare are driving up the costs of state programs that supplement coverage for low-income beneficiaries. States are now searching for ways to expand coverage to additional working-age adults and families, while also continuing to support frail elders and disabled adults.

Ensuring access to health care is a continuing challenge in urban areas, especially those that are gateways to the world. Price competition under managed care has left many urban safety net hospitals with diminished capacity to provide care for poor and uninsured patients. American cities must find ways to meet the needs of an ever more diverse working population — a task that requires fundamental rethinking of public insurance programs that have historically served poor, elderly, and disabled people.

Health insurance and access to care are essential to the future health and well-being of American children, workers, and older people. The Fund therefore pursues work to expand coverage and access, while also seeking to understand barriers, financial and nonfinancial, to receiving needed care. Three national programs concentrate primarily on improving health insurance and access to health care:

- The Task Force on the Future of Health Insurance is dedicated to improving health insurance coverage for the under-65 population.
- The Health Care in New York City Program supports solutions to reduce New York’s high rate of uninsured residents and barriers to care for vulnerable groups.
- The Program on Medicare’s Future seeks to increase understanding of the experiences of Medicare beneficiaries and effective approaches to ensuring access to care for the elderly and disabled, particularly those vulnerable by virtue of low income or health problems.

## Task Force on the Future of Health Insurance

The Commonwealth Fund Task Force on the Future of Health Insurance, established in 1999, pursues a core mission of helping to build a health insurance system that meets the needs of the 21st century workforce. Drawing its members from among business, labor, and state-level program and policy leaders and national experts in health care and related fields, the task force is an independent, non-partisan forum for debate and exploration of strategies to expand and improve health insurance coverage for American workers and their families, especially through employer-sponsored insurance. Key goals of the task force are to help improve the stability, quality, and affordability of health insurance; to develop policy options and assess promising models; and to keep the debate on coverage for the nation's uninsured and underinsured high on the national agenda. The task force is directed by Cathy Schoen of The Commonwealth Fund and chaired by James J. Mongan, M.D., president of Massachusetts General Hospital.

In December 2000, the task force organized a conference, "Turning Campaign Promises into Reality: Opportunities for a New President and Congress to Expand Health Insurance Coverage," for 120 policymakers, analysts, journalists, and researchers. The program featured presentations by public officials whose states have

developed innovative expansion initiatives and examined potential strategies for expanding coverage. Twelve option papers, released in the series *Strategies to Expand Health Insurance for Working Americans*, offered detailed solutions to the challenges of expanding coverage incrementally, focusing especially on approaches that would rely on individual tax credits or premium assistance as incentives to purchase coverage. The series was published in a special summer 2001 issue of the journal *Inquiry*.

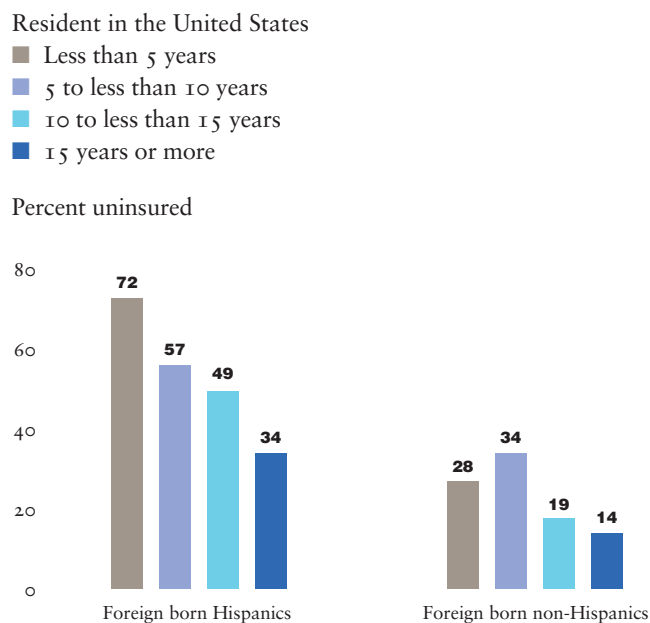
To provide a more comprehensive view of how existing insurance bases could be built upon to reach a high proportion of the uninsured, Fund officers Karen Davis, Cathy Schoen, and Stephen Schoenbaum, M.D., developed and authored a report entitled *A 2020 Vision for American Health Care*. First presented by Davis as a keynote lecture for the 2000 annual meeting of the Association of Academic Health Centers, the paper lays out a vision for improving coverage and the quality of care for insured and uninsured Americans over the next several decades. Drawing on several of the option papers, the authors propose a mix of public and private approaches. Enthusiastic responses to the speech, along with the publication of the paper in *Archives of Internal Medicine*, have led to plans for follow-up work under the leadership of Lawrence S. Lewin. Lewin will bring together health care leaders and experts to explore methods for making coverage more automatic and to help build consensus among health care providers for a system that improves care as well as coverage.

Other highlights included the release of several reports featuring the different “faces” of uninsured Americans, particularly Hispanics and older adults ages 50–64. Recognizing the growing contribution of Hispanics to the nation’s workforce, the task force has made it a top priority to address the problem of lack of health insurance among Hispanics, who account for a quarter of the uninsured in the United States and have a better than one in three chance of being uninsured. Seeking to explain those percentages, the task force commissioned focus groups among insured and uninsured Hispanic workers. The resulting report by Michael Perry and colleagues, *Barriers*

*to Health Coverage for Hispanic Workers: Focus Group Findings*, revealed that many uninsured Hispanics have had negative experiences with previous insurance policies: some have been left paying unaffordable bills, have received only partial family coverage, or have been charged premiums that were simply too high relative to their incomes.

A study by Claudia Schur of Project HOPE found that inequities are greatest among recent immigrants but persist over time. Her report, *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured*, cited far higher uninsured rates among Hispanic immigrants than

**Hispanic immigrants are more likely than other immigrants to lack health insurance. Indeed, although the uninsured rate drops gradually for those who remain in the country longer, foreign born Hispanics still have a one in three chance of being uninsured after living in the United States for more than 15 years.**



Source: Claudia L. Schur and Jacob Feldman, *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured*, The Commonwealth Fund, May 2001.

among native born Hispanics or other immigrants, even after 15 years in the United States. The study confirms a general pattern of lack of job-linked insurance, with differentials persisting across family type and work arrangements. The results were presented at an Alliance for Health Reform congressional staff briefing, attended by more than 200 people.

With millions of the working-age population uninsured, policymakers are considering whether Medicare could be a source of coverage for those nearing the age of eligibility, including the 5.6 million adults between ages 50 and 64 who currently lack coverage. A Fund survey, released in July 2000, found that many adults ages 50–64 are eager to join Medicare early; indeed, Medicare is seen by people in that age group as the most trusted potential source of health insurance. The survey report, *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70*, by Fund staff Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis, documents that current Medicare beneficiaries are more likely than people under 65 to be very confident in their ability to obtain high-quality medical care when needed and to be satisfied with the quality of their care. For people in this age group without access to employer group coverage, alternatives tend to be unaffordable. An article in *Health Affairs* by Simantov, Schoen, and Stephanie Bruegman used internet data on plan costs in the individual insurance market as well as results from the Fund survey

to consider the viability of alternatives for uninsured adults ages 50–64. Their report, *Market Failure? Individual Insurance Markets for Older Americans*, concludes that, even with tax credits, direct purchase options would still force many midlife adults to pay 25–40 percent of their pretax income for health insurance.

Responding to growing concerns about the lack of affordable insurance for older adults who are not yet eligible for Medicare, the task force commissioned analyses of the risks of being uninsured and options for allowing uninsured older Americans to “buy in” to the Medicare program. In “Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare,” published in *Health Affairs*, Dennis G. Shea, Pamela Farley Short, and M. Paige Powell of Pennsylvania State University found that a Medicare buy-in targeting people ages 62–64 would miss a large group of older Americans with significant health problems and limited economic resources. A means-tested buy-in program available to everyone ages 55–64 would benefit a segment of the population with a significant need for access to affordable health insurance. In a related report, *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?*, authors Shea, Short, and Powell found that targeting a Medicare buy-in only to those who have just lost their employer health benefits would reach relatively few people.



A Fund-sponsored gathering of New England lawmakers, including New Hampshire's Governor Jeanne Shaheen, gave state-level leaders an opportunity to compare notes on what they are doing to expand

health insurance and bring uninsured rates down. Researcher Sherry Glied (right) supports the work of the Fund's Task Force on the Future of Health Insurance by analyzing emerging trends in insurance coverage, particularly for workers.



A companion report by John Sheils and Ying-Jun Chen of the Lewin Group, *Medicare Buy-In Options: Estimating Coverage and Costs*, notes that substantial subsidies would be required for a Medicare buy-in to achieve a sizable reduction in the number of older uninsured adults, many of whom live on low incomes and cannot afford typical health insurance premiums. Without assistance in purchasing Medicare coverage, the analysis finds that few uninsured adults nearing age 65 would be able to participate, since likely costs would be unaffordable relative to their income. The report analyzed the level of premium assistance necessary to hold costs to no more than 5 or 10 percent of income and estimated the increase in participation rates that could result from a buy-in combined with assistance for those with lower incomes.

The task force is also examining state and local insurance expansion efforts. Jack Meyer and colleagues at the Economic and Social Research Institute developed profiles of promising state and local initiatives to expand coverage to workers. Published in two reports — *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* and *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* — the profiles have generated considerable discussion among local leaders interested in replicating some of the initiatives. Meyer and his team are currently monitoring work by 20 states to develop

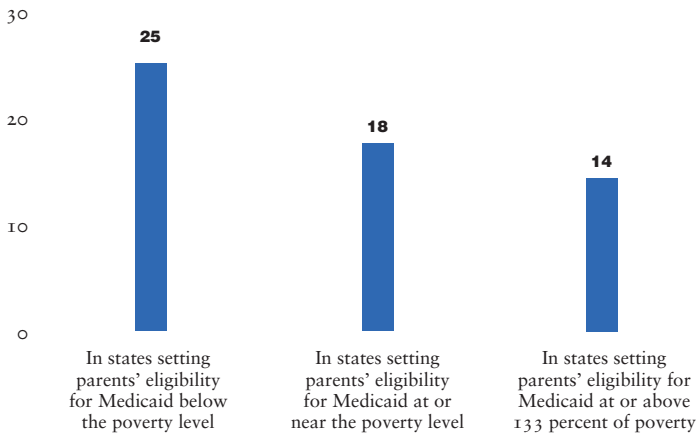
comprehensive approaches for expanding insurance coverage under federal Health Resources and Services Administration (HRSA) planning grants. Case studies and summary reports will inform future federal and state policies and address the challenge of integrating incremental measures.

Strengthening employer-based coverage is another important area for analysis. In collaboration with the Committee for Economic Development, the task force brought together more than a dozen Fortune 500 business leaders to exchange views about the current employer-based health insurance system. Also, with task force support, the Midwest Business Group on Health and the Health and Medicine Policy Research Group sponsored a meeting of business leaders in Chicago to discuss approaches for expanding coverage. Highlights from the discussions were featured at a statewide meeting of stakeholders under the auspices of Illinois's HRSA planning grant.

A new task force report, *How the New Labor Market Is Squeezing Workforce Health Benefits*, by James L. Medoff and colleagues at the Center for National Policy, documented the erosion of own-employer-sponsored health insurance over the last 20 years. It showed that, although two-thirds of private-sector workers had health insurance coverage through their own employer in 1979, the share had dropped to just over

**Efforts to expand coverage to parents seem to be paying off in lower rates of uninsured children. While a quarter of low-income children remain uninsured in states with the most restrictive policies for covering parents, states offering coverage to parents with higher incomes have significantly lower rates of uninsured children.**

Percent of low-income children without health insurance



Source: Jeanne M. Lambrew, *Health Insurance: A Family Affair*, The Commonwealth Fund, May 2001

half by 1998. The decline was sharpest among the lowest-paid workers, with rates of own-employer coverage falling from 42 percent to 26 percent among workers in the bottom fifth of the hourly wage scale. While coverage has improved slightly for higher-paid workers in the last five years, lower-wage workers have not shared in this improving picture.

The Fund also sponsored a study published in *Health Affairs* by Jon Gabel and colleagues, “Embraceable You: How Employers Influence Health Plan Enrollment,” which analyzed data from a survey of employers to examine the effects of employer policies on the percentages of workers eligible for and enrolled in a firm’s health plan. Waiting periods

and rules restricting enrollment by part-time workers were the strongest determinants of eligibility rates, while wages and employee premium contributions had the strongest effect on participation.

The task force continues to build on its reputation as a source of new information and fresh insights regarding insurance trends and the consequences of inadequate coverage. An article in *Health Affairs*, “Patterns of Insurance Coverage within Families with Children,” by Karla Hanson of New School University, highlighted the issue of partially insured families by showing that one-quarter of all families with children are completely uninsured or have at least one member uninsured. A May 2001 report, *Health Insurance: A Family Affair*, by Jeanne Lambrew of George Washington University, found that expansions that extend coverage to low-income parents are likely to improve coverage rates for children, as well. In states that have raised income eligibility for parents as well as children, overall participation rates have improved and uninsured rates have dropped among low-income families.

A range of task force studies have underscored the risks to access and financial security of spells without insurance and inadequate coverage. Future work related to a new Fund-sponsored national survey will explore the extent of insurance instability and quality of coverage and experiences in individual insurance markets.

## Health Care in New York City Program

The Health Care in New York City Program was established in April 1998 to help reduce the number of uninsured residents and improve access to needed health care services. By generating independent information on the city's health system and supporting demonstrations of new ideas, the program helps public and private sector leaders understand changes as they happen and develop solutions to pressing problems. In addition to making a positive impact on the Fund's home city, the program's work serves as a laboratory for promising approaches that could be replicated nationally.

New York has a generous but complicated patchwork of public health insurance programs serving low-income residents. Integrating Medicaid and Child Health Plus into a seamless system of coverage for children was the focus of a Fund report by the Children's Defense Fund of New York that described discrepancies between the two programs and recommended ways to align them. Specific changes, most of which could be made by the state without federal review, include eliminating Medicaid's requirement of a face-to-face interview as part of the application process, shortening application forms, minimizing documentation requirements, and halting new enrollment into health plans that do not participate in both programs.

The recent enactment of Family Health Plus — a landmark coverage expansion for low-income, working adults — has the potential to cover as many as 600,000 additional New Yorkers. Reaching that goal, however, will demand even greater efforts to unify and coordinate the state's multiple programs into a single system that families can easily navigate. Rima Cohen of the Greater New York Hospital Foundation assessed the experiences of 13 other states to identify examples of effective outreach and enrollment strategies, simplified application processes, coordinated program guidelines, and streamlined procedures for allowing enrollees to retain adequate coverage when family circumstances change.

Making sure that legal immigrants are included in coverage expansions in New York was the purpose of work by Deborah Bachrach of the law firm Kalkines, Arky, Zall & Bernstein, LLP. Her analysis showed that as many as 167,000 legal immigrant adults have incomes low enough to qualify for either Medicaid or Family Health Plus but have been barred from coverage through policies associated with federal welfare reform. Opening up these programs to legal immigrants — who comprise about a fifth of the state's population and pay about 15 percent of its income taxes — would cost less than 0.1 percent of

New York's current Medicaid budget. Recent decisions by the state's highest court and actions by the state legislature hold promise for allowing immigrants to receive coverage on the same footing as native born citizens.

Connecting people with coverage, and making sure they stay enrolled, remains a priority for the Fund. A public education campaign created by Robbett Rosenthal & Jennings alerted New Yorkers who had left or were about to leave welfare rolls for the workforce that they and their children could keep their Medicaid coverage. Ads in English and Spanish ran on all New York City subway lines and aired on four major radio stations in spring 2001. Statewide Youth Advocacy created a communications and best practices network linking agencies around the state that are facilitating children's enrollment into Medicaid and Child Health Plus. Future work will focus on preparing that network to assist adults with Family Health Plus enrollment and maintaining coverage of children who have been successfully enrolled. The New York Public Library is also helping New Yorkers get access to health benefits through its Community Health Onsite Information Centers (CHOICES), a program that is now being expanded to all 85 branches in the Bronx, Manhattan, and Staten Island.

Shoring up employer-sponsored coverage and making it affordable for small businesses is another promising strategy. The state's Healthy New York program encourages firms with 50 or fewer workers to purchase health coverage by offering them a new, subsidized health benefits package. Katherine Swartz of the Harvard School of Public Health developed options for operating and marketing the program to achieve maximum participation. Stephen Rosenberg, M.D., of PriceWaterhouseCoopers, LLP, evaluated the Small Business Health Insurance demonstration, a partnership between the city's public hospitals and a private insurer that offered small employers a steeply discounted insurance plan with a limited provider network. Its failure to attract participants was attributed to poor marketing and the plan's limited appeal to business owners — valuable lessons for future efforts to improve access to coverage for small firms. A survey of employers by Jon Gabel of the Health Research and Educational Trust will further inform efforts to strengthen private-sector coverage.

The program's work is extended through the assets of the former Health Services Improvement Fund. In addition to funding projects related to coverage and access, these funds support doctoral dissertation research by students on health care issues that concern New Yorkers.



Through its Health Care in New York City Program, the Fund investigates specific changes that could open the way to health care for immigrants, employees and owners of small businesses, artists and actors, and other hard-to-insure groups. In a detailed study, Deborah Bachrach (right)

estimated that as many as 167,000 low-income legal immigrant adults are barred from receiving coverage for which they would otherwise qualify by policies associated with federal welfare reform.



## Program on Medicare's Future

Since 1995, the Program on Medicare's Future has been committed to helping preserve the role of Medicare — one of the most popular and effective federal programs — in guaranteeing access to health services for the nation's elderly and disabled. With Medicare's short-term solvency now secure, the Fund focuses on analyzing how specific reform proposals would affect beneficiaries, how participation in supplemental programs could be boosted among low-income seniors, and how Medicare could prepare for the retirement of the baby boom generation.

Lack of prescription drug benefits is a serious concern shared by Medicare beneficiaries and those on the cusp of eligibility. Adding a pharmaceutical benefit to Medicare is likely to be one of the most contentious and actively debated issues faced by Congress and federal policymakers in the coming years. In a Fund issue brief, *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?*, Bruce Stuart and colleagues of the University of Maryland explained that most Medicare beneficiaries will not qualify for prescription drug coverage if annual income alone is used to determine eligibility. A broader definition of need — one that encompasses people without continuous and stable drug coverage, with high expenditures, or with multiple chronic conditions — would make nearly 90 percent of beneficiaries eligible for coverage.

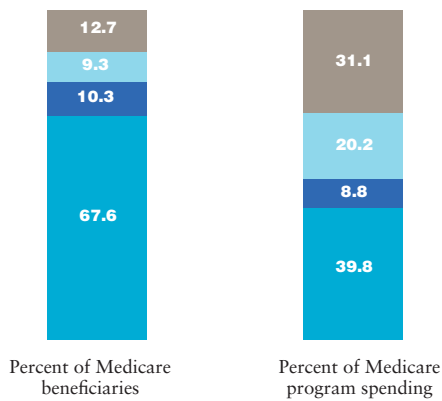
The vulnerability of the elderly to high out-of-pocket health care expenses was examined in Fund-supported work by Marilyn Moon and colleagues at the Urban Institute. In *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, released in January 2001, authors Stephanie Maxwell, Marilyn Moon, and Misha Segal showed that, with no expansion in benefits, average out-of-pocket costs for services not covered by Medicare could almost double by 2025. Medicare beneficiaries already spend 22 percent of their incomes on health care; by 2025, that share could rise to 29 percent. Further work by Moon and colleagues modeled four options for improving the Medicare benefits package so as to decrease out-of-pocket costs for many beneficiaries, especially those with the highest expenses, while remaining almost budget-neutral in terms of federal spending. For example, under one option spelled out in their report, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, elderly beneficiaries would save \$763 per year on average.

Because benefit expansions such as drug coverage may be enacted as part of broader and more fundamental Medicare restructuring, several Fund projects have focused on extracting lessons learned from Medicare's experience with managed care. Another study by Marilyn Moon and colleagues, *What Do Medicare HMO Enrollees Spend Out-of-Pocket?*, released in August 2000, found that managed care does not necessarily protect enrollees

**The most vulnerable Medicare beneficiaries—those with both physical and cognitive conditions—incur unusually high health care costs, averaging \$20,332 annually. Although they make up only 12.7 percent of the Medicare population, they account for 31 percent of program spending. Their out-of-pocket spending is typically very high, as well, totaling nearly \$4,000 in 1997.**

Medicare beneficiaries with

- Physical and cognitive conditions
- Physical conditions only
- Cognitive conditions only
- Neither



Source: Marilyn Moon and Matthew Storeygard, *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems*, The Commonwealth Fund, September 2001. Based on analysis of 1997 Medicare Current Beneficiary Survey.

from high out-of-pocket spending: for example, Medicare+Choice enrollees in fair or poor health spend 18 percent of their incomes on out-of-pocket health care costs.

Complementary case studies of Medicare managed care implementation in four large urban areas, conducted by Geraldine Dallek of Georgetown University, found that the majority of enrollment is concentrated in a few large plans and that greater competition among newer types of managed care organizations has

yet to materialize. Dallek's report, *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg*, coauthored with Donald Jones, was issued by the Fund in August 2000. Follow-up case studies in seven cities and states by a team led by Brian Biles, M.D., of George Washington University found that movement by physicians into and out of networks has become a major source of instability, as have plan withdrawals and changes in benefits. Coauthored by Jennifer Stuber, Claire Edwards, Dallek, and Biles, the case studies also found that benefit choices are becoming ever more complex and inequitable across markets as plans retrench.

Marsha Gold of Mathematica Policy Research updated earlier work to confirm that Medicare managed care plans continued to raise premiums and scale back benefits in 2001, just as they did in 2000. Recent increases in federal payments to Medicare+Choice plans have done little to reverse the withdrawal of plans from the program or reductions in benefits. In "Medicare+Choice: An Interim Report Card," published in *Health Affairs*, Gold awarded a barely passing grade to the program overall. Growing evidence of turmoil was the central topic of a Fund-sponsored Alliance for Health Reform roundtable in September 2001 on the future of the Medicare+Choice program.