



Cathy A. Schoen

Improving Health Insurance Coverage and Access to Care

For families in the United States, stable health insurance can unlock the door to timely and effective medical care and economic security. Yet current estimates indicate that more than one in seven Americans, 15 percent of the population, lack this essential key, and an even greater share have coverage inadequate to meet their medical care needs. Restructuring the nation's health insurance system to meet the needs of a 21st-century workforce through the retirement years is therefore central to the mission of The Commonwealth Fund.

The United States health insurance system depends on job-based coverage, provided and paid for by employers on a voluntary basis. Two out of three Americans under age 65 are insured through employers, and employer-sponsored insurance also supplements Medicare benefits for one-third of all senior citizens. Today, as in the 1980s and early 1990s, an economic slowdown and double-digit premium inflation threaten to destabilize that base and add millions to the ranks of the uninsured. Sustained until recently by tight labor markets, employer-based coverage and retiree benefits are being cut back, and employees asked to

pay more for premiums and deductibles. Changes like these, which shift costs off payrolls and onto family budgets, will hit low-wage workers and retirees hardest and accelerate the decline in coverage among low-income Americans.

By the end of 2001, the number of Americans who lacked health insurance all year exceeded 41 million, a one-year increase of more than 1 million according to the most recent census survey. Nearly one of five adults ages 18-64 (19 percent) were uninsured, with rates reaching 50 percent among low-income workers. Millions more were uninsured for part of the year. Overall, then, over one-quarter of Americans under 65 were uninsured for all or part of the year. The recession is also undermining state-level efforts to increase coverage through public programs. In 2002, with state budgets in deficit across the country, states that had previously extended coverage to uninsured children, low-income working parents, and other adults began to freeze enrollment or roll back expansions, while others reduced the scope of benefits.

Mounting evidence suggests that the erosion in private coverage is also affecting middle-income families. Even major employers purchasing coverage are now facing annual increases in excess of 15 percent, with some jumps as high as 25 percent, and the market for individual insurance and small firms appears even more unstable. Sharp increases in cost-sharing for those with insurance increase the risk of pushing more into the ranks of the “underinsured.”

Threats to insurance coverage can also have a local dimension. In New York City, the September 11th attack put additional strain on a city already struggling with underlying erosion of private health insurance. Emergency Medicaid enrollment extended coverage to 350,000 low-income New Yorkers, while also revealing substantial unmet health care needs and undiagnosed illness. The challenge now will be to make a smooth transition to planned new public programs.

Inadequate coverage is also of growing concern for seniors. Medicare beneficiaries are particularly at risk, as premiums for private insurance with medication coverage become unaffordable and Medicare managed care plans limit drug benefits. Medicare’s lack of prescription coverage also undermines states’ ability to finance care for low-income residents: around the country, states pick up drug costs for 6 million Medicare beneficiaries who also qualify for Medicaid. As a result of serious gaps in coverage, prescription drug benefits for Medicare’s 39 million aged and disabled beneficiaries stayed at the center of national debate throughout the year.

Three Fund programs focus on improving coverage and access to care. Each supports work to develop and study promising insurance expansions, understand barriers to access to care, and identify emerging concerns.

- The *Task Force on the Future of Health Insurance* seeks ways to expand rates of coverage and improve the quality and stability of coverage for the under-65 working-age population.
- The *Health Care in New York City Program* strives to reduce the high rate of uninsured among city residents and ease financial and other barriers to care for low-income and other vulnerable groups. The program works in tandem with the task force to understand and apply national, state, and local lessons.
- The *Medicare’s Future Program* works to preserve and strengthen the current and future ability of Medicare to guarantee access to health care for elderly and disabled beneficiaries.

Task Force on the Future of Health Insurance

The Commonwealth Fund Task Force on the Future of Health Insurance is an independent, nonpartisan forum for exploring strategies to expand and improve health insurance coverage for the under-65 population, with an emphasis on efforts that would meet the needs of American workers and their families. Drawing its members from business, labor, government, and policy research, the task force works to improve the stability, quality, and affordability of health insurance, develop policy options and assess promising models for insurance coverage, and keep the debate on coverage for the nation’s uninsured and underinsured high on the

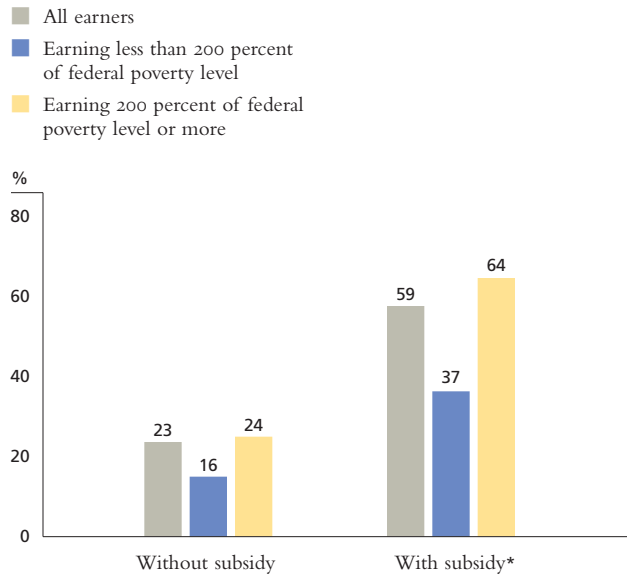
national agenda. The task force is directed by Cathy Schoen of The Commonwealth Fund and chaired by James J. Mongan, M.D., president of Massachusetts General Hospital.

In a year when the prospects for significant health care reform seemed slim, the task force continued to supply policymakers with information about the most vulnerable in our society. In December 2001, the Fund released findings from The Commonwealth Fund 2001 Health Insurance Survey at a special briefing for Congressional staff in Washington. According to the survey report, *Security Matters*, the number of uninsured adults under age 65 was high during the first half of 2001, with a quarter of working-age adults reporting that they were either currently uninsured or had been uninsured during the past year, despite an extended period of economic prosperity and high employment. Those who had been uninsured for part of the year were about as likely as the long-term uninsured to say they had delayed seeking care or had experienced financial stress due to medical bills. One-third of those who had been uninsured for any period of time said they had been contacted by collection agencies for medical bills. Released at a time of growing job loss and intense debate over how to respond, the survey findings spoke directly to the need for new efforts to stem the loss of health insurance.

Between January 2001 and January 2002, more than 2 million workers lost their jobs, as unemployment rates climbed from 4.2 percent to 5.6 percent. A report by Jeanne Lambrew of George Washington University, *How a Slowing U.S. Economy Threatens Employer-Based Health Insurance*, warned that the number of uninsured workers could rise sharply absent prompt action to provide premium assistance for the unemployed.

Although many people who lose their jobs are entitled to purchase health insurance through their former employers, relatively few currently employed workers believe they could afford to do it. A recent Fund survey suggests that a federal subsidy could encourage a much larger share of laid-off workers to take up their COBRA option.

Adults (ages 18–64) with employer-sponsored insurance who are “very likely” to buy COBRA if they lose their jobs



*With the proposed subsidy, premium would be \$50 per month for individual coverage or \$150 per month for family coverage.

The Commonwealth Fund 2002 Workplace Health Insurance Survey.

Although as many as three-quarters of laid-off workers would be eligible to continue coverage through their former employers, relatively few would be able to afford the premiums without help. Premium assistance would also be of value to low-wage workers, who may turn down coverage because they cannot afford the cost.

To assess the impact of the changed economy—including the return of double-digit increases in health insurance premiums—the task force followed up the 2001 survey with a survey in January 2002.

One-third of adults reported cuts in benefits or higher cost-sharing for medical bills, one-fourth faced significantly higher premiums, and two-fifths were paying more in premiums or cost-sharing. The follow-up survey also revealed that only 23 percent of adults said they would take up their COBRA option if they lost their jobs, although the rate jumped to 59 percent if premium assistance were available.

Signs that employers and states are cutting back on the scope of benefits, along with changes in the individual insurance market, have raised concerns that a growing number of people are “underinsured.”

In *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity*, Mark Merlis

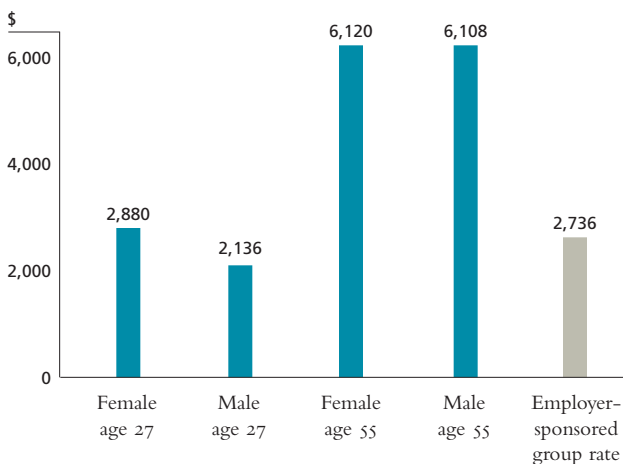
found that even in 1996, at the height of coverage expansions and more comprehensive HMO benefits, 16 percent of American families spent more than 5 percent of their incomes on out-of-pocket expenses for medical bills, and 7 percent spent more than 10 percent. Among low-income families, 23 percent spent more than 5 percent and 14 percent spent more than 10 percent. Many were continuously insured yet incurred high uncovered expenses relative to their incomes. Estimates based on the Fund’s 2001 Health Insurance Survey suggest that 30 million adults were underinsured.

To address concerns about coverage and premium affordability, the Bush Administration and some Congressional leaders have proposed new federal tax credits to help low-income workers buy coverage in the individual insurance market. Task force studies indicate, however, that tax credits that rely on the individual insurance market would mainly benefit young, healthy men. Low-income women and older adults would be less likely to gain from tax credits, since insurance carriers typically charge young women higher premiums than men (whether or not the carrier offers maternity benefits) and premiums rise dramatically with age. In the report *Are Tax Credits Alone the Solution?* Jon Gabel and colleagues at the Health Research and Educational Trust (HRET) suggest that low-income women of all ages and older men would require substantial tax credits to make coverage affordable. In a separate study published in *Health Affairs*, Gabel argues further that, because of high overhead, the individual market offers inferior benefits relative to cost, compared with group insurance.

Individual market health insurance premiums vary widely by age and sex, even for healthy adults. By pooling health risks and ages, employer-sponsored group coverage provides better coverage and lower costs than plans sold on an individual basis. Flat rate federal tax credits for low-income adults would offer unequal access to coverage by sex, age, and health status if linked to individual markets.

Median annual single-person premium in 15 geographic areas

■ Individual market premium for a healthy, nonsmoking adult for plans similar to employer-sponsored coverage



A report, coauthored by Sherry Glied of Columbia University, Cathi Callahan and James Mays of the Actuarial Research Corporation, and Jennifer Edwards of The Commonwealth Fund, detailed which benefits would need to be trimmed to produce a “bare bones” policy with substantially reduced premiums. To reduce premiums by 30 percent, policies would leave low-income adults exposed to high deductibles or without key benefits such as prescription drugs. A typical “bare bones” package would not provide adequate financial protection or access to care for low-income adults, who make up the majority of the uninsured. These findings, along with an analysis of what would constitute an adequate and attractive benefits package, were featured at a roundtable discussion with senior Congressional staff on tax credits as an expansion strategy, sponsored by the Alliance for Health Care Reform.

Two articles in *Consumer Reports* by Fund grantee Trudy Lieberman brought the issue of the adequacy of insurance to a broad public audience and addressed consumer concerns about the eroding quality of health coverage. A June 2002 article, *The Unraveling of Health Insurance*, showed how medical savings accounts and similar strategies are designed to cut costs for insurers and employers by shifting costs to consumers through copayments and deductibles. Lieberman found widespread evidence of decline in the quality of insurance and warned consumers that new approaches could undermine the risk pooling on which group coverage depends. An August 2002 companion article, *The Perils of Buying Your Own Policy*, ranked 63 individual and family policies around the country and painted a troubling picture of the difficulty consumers face when seeking coverage on their own.

Other task force work continues to find that Hispanics are the group most likely to be excluded from health insurance. Hispanics account for one in four uninsured Americans: overall, one-third of Hispanics lack coverage, more than twice the rate of the rest of the population. A Commonwealth Fund report, *Diverse Communities, Common Concerns*, based on the Fund’s 2001 Health Care Quality Survey, drew the connection between lack of health insurance and the problems many Hispanics face in getting access to primary and preventive care and in their relationships with physicians. During the year, task force and Fund staff presented findings about disparities affecting Hispanics and other minorities at numerous professional meetings. Also, with Fund support, the National Hispanic Medical Association sponsored regional meetings in Los Angeles and Atlanta to focus the attention of legislators on the need for action.

The future of employer-based health insurance, through which two in three Americans under age 65 receive coverage, is also a continuing priority for the task force, especially in light of new economic pressures. Sharon Silow-Carroll and Lisa Duchon produced a Fund field report summarizing what is known about a new type of benefits strategy that makes employees more responsible for selecting components of their plans, yet also places them at greater financial risk. Collectively known as “defined contribution” approaches or “consumer-driven” models, these efforts could result in more fragmented coverage. Ongoing work under the direction of Tom Rice, of UCLA, and Jon Gabel is gauging how



Elena Rios, M.D.

Rios, president of the National Hispanic Medical Association, spoke to policymakers in Atlanta.

widely the new benefit designs have been adopted by employers and the influence on group coverage. Initial findings suggest that “defined contribution” has not become a national trend, and that benefits consultants recognize that the model risks splitting healthier workers from sicker ones, a shift that could ultimately raise total employer premiums and expose sicker workers to substantial financial risk. With Fund support, the Employee Benefit Research Institute convened a meeting to discuss the findings among insurers offering consumer-driven models, employers, and researchers.

Retiree health benefits are also at risk. Employer surveys conducted in 2000 and 2001 by HRET on behalf of the Fund and the Kaiser Family Foundation found that the downward trend in retiree health benefits is likely to continue. The proportion of large firms offering retiree benefits fell to just 34 percent in 2001, down from 66 percent in 1988. Even those offering benefits are likely to reserve coverage for long-term employees. Half of firms providing retiree health benefits said they had increased retirees’ share of premiums in the past two years, and nearly three-quarters said they were likely to increase premium shares or reduce prescription benefits in the near future.

During the 1990s, many employers sought to form purchasing coalitions to increase their leverage over premiums and quality of care. Although these groups could in theory be expanded to include small firms and the self-employed, case studies by Jack Meyer of the Economic and Social Research Institute (ESRI) indicate that large employers and groups have not reached out to smaller businesses. In *Business Initiatives to Expand Health Coverage for Workers in Small Firms*, Meyer concludes that voluntary efforts by employer groups are unlikely to solve small businesses’ insurance access problems.

Nearly 30 states operate some type of high-risk pool for people left out of private markets because of high health risks. In *Insuring the Uninsurable: An Overview of State High Risk Health Insurance Pools*, Lori Achman and Deborah Chollet of Mathematica Policy Research outline the various state arrangements and calculate that high-risk pools currently reach a small share of the market, collectively covering only 105,000 individuals. Some pools are closed to new enrollment because they lack adequate funding; others have waiting lists or delay full coverage, even after enrollees start paying premiums, because of restrictions on pre-existing conditions. Although state subsidies keep premiums relatively low, they are still too high for many potential enrollees.

The task force also continues to formulate the details of a “2020 Vision for Health Care,” as originally proposed in an article coauthored last year by Fund officers Karen Davis, Cathy Schoen, and Steve C. Schoenbaum, M.D. Working with leading health policy researchers and thinkers in the field, the task force is exploring ways to achieve universal health coverage by the year 2020.

Moving these and other ideas into action will require involvement beyond the policy community. At a kick-off event in February, the Association of Academic Health Centers announced plans for a public awareness campaign, “Why Not Everyone? It’s Time for Action on the Uninsured.” With Fund support, the campaign will involve academic health center and university leaders in mobilizing public support for high-quality health coverage for all Americans.

Health Care in New York City Program

The Health Care in New York City Program works to 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, it helps public and private sector leaders understand the changing local health care environment and develop solutions to pressing problems. In addition to making a positive impact on the Fund's home city, the program serves as a testing ground for promising approaches that could be replicated nationally.

In recent years, the state of New York has created a generous but complicated patchwork of public coverage programs for low-income residents. Integrating those programs into a seamless system and making it easier for eligible families to apply could go a long way toward solving the state's uninsured problem. Current estimates indicate that over one-third of New York's 3 million uninsured residents are eligible for Medicaid, Child Health Plus, or Family Health Plus but are not enrolled.

Many New Yorkers are deterred from applying for public health insurance programs because of lengthy and complex enrollment processes. Programs in states such as California and Georgia have managed to attract new applicants through the use of faster, simpler computerized enrollment. Drawing on their experience assessing the California initiative and with support from the Fund, the Lewin Group will provide technical assistance to the New York State Department of Health as it develops an electronic application for children and adults. If pilot tests are successful, the project will move toward statewide replication, with the eventual

goal of shifting the entire system to the internet.

Technological advances can succeed only if the underlying gaps between programs are overcome. The Children's Defense Fund of New York is expanding an earlier, successful project to examine what changes would foster seamless coverage for low-income adults and children. In particular, the project will study how the implementation of Family Health Plus adds to the complex puzzle of coverage, thus aiding New York's leaders in consolidating incremental coverage expansions into a more rational system. Aligning eligibility criteria, application requirements, recertification processes, and benefits administration would make it simpler for whole families to get coverage and keep it, even when family circumstances change.

New York's coverage system became more inclusive last year when Medicaid eligibility for legal adult immigrants was restored under court order and extended to include Family Health Plus. An analysis of those policy developments by Deborah Bachrach of Kalkines, Arky, Zall and Bernstein LLP revealed that approximately 200,000 state residents could qualify as a result. Further, the legal arguments that prevailed in New York could resonate beyond the state to other courts and perhaps encourage the restoration of federal financing of health coverage for legal immigrants.

At the same time, a weakening economy and rising health premium costs threaten further erosion in the health benefits provided by New York employers. A Fund-sponsored survey of employers in 2001 found

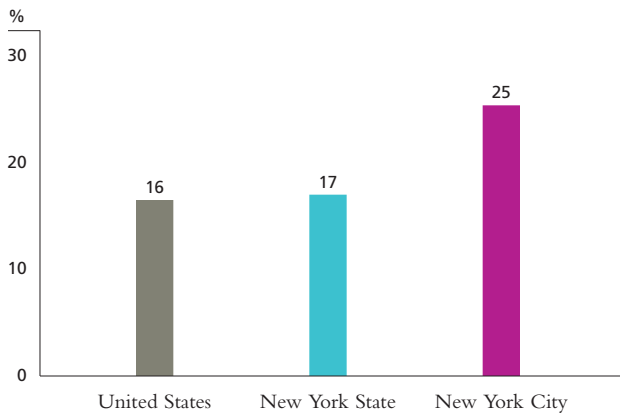


Wanda Evans

Betances Health Center, where Evans is director, serves many low-income New Yorkers.

Immigration, poverty, the erosion of employer-sponsored coverage, and the confusing enrollment processes of Medicaid and other public programs are among the factors that make lack of health insurance a common problem among New Yorkers.

Percent of nonelderly population without health insurance, 2000



March 2001 Current Population Survey, analysis by United Hospital Fund of New York.

New York premiums to be above the national average, with small firms paying particularly high rates despite receiving less comprehensive benefits. Interviews with benefit managers revealed widespread intentions to shift costs to employees through increased worker premium shares or cost-sharing. Half of small firms and low-wage firms already restrict eligibility for benefits by limiting participation to full-time workers or by imposing waiting times for new employees.

Several projects focus on what can be done to shore up the base of private, employer-sponsored insurance, through which about two-thirds of the state's nonelderly population receive their health coverage. Steven Rosenberg, M.D., of Columbia University evaluated the Small Business Health Insurance Initiative

and is now conducting a follow-up project on HealthPass, which enables small firms to offer employees a range of health insurance options and set a defined contribution. Katherine Swartz of Harvard University School of Public Health evaluated the prospects of Healthy New York, a statewide program that requires HMOs to offer a new insurance product with substantially reduced premiums for small firms. Swartz found that, although premiums are probably still too high to draw substantial participation, the program could feasibly be made more attractive. Low enrollment in its first year may also allow the program to use unspent funds to reduce premiums and draw new enrollment. Finding creative demonstrations like these will be even more crucial in coming years, as employers grapple with large premium increases.

With private and public coverage in flux, there is a pressing need for current information to understand New Yorkers' experiences with health care coverage and access. With Fund support, NuStats Partners LLP will survey 2,000 low- and moderate-income New York City adults on their access to employer-sponsored coverage, difficulties they encounter when trying to get needed care, the role of public programs, and other issues. The 2003 survey will also enable comparisons with a previous Fund-sponsored New York City survey, conducted in 1998.

Program on Medicare's Future

Since 1995, the Program on Medicare's Future has been committed to preserving 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. Current efforts focus on three areas: analyzing proposals for major and incremental reforms to the structure of Medicare, monitoring Medicare managed care and extracting lessons that could be helpful in assessing proposals to expand privatization in Medicare, and helping eligible low-income seniors participate in supplementary programs that could save them significant amounts of money and enhance access.

The lack of prescription drug coverage in traditional Medicare is perhaps the greatest deficiency in a benefits package that has failed to keep pace with modern medical practice. Enacting at least a partial benefit has been a major theme in recent national elections and has consistently been rated as a priority for the public. It has also been near the top of the Congressional agenda. Numerous Fund projects have raised the level of debate with independent, non-partisan analyses of the need for a drug benefit and how the benefit might be structured to maximize limited federal dollars. Bruce Stuart and colleagues at the University of Maryland evaluated trends in prescription drug coverage for Medicare beneficiaries during the 1990s as a way to project future costs and needs. Based on data from 1993 to 1998, their analyses indicate that beneficiary drug coverage peaked in 1998 or shortly thereafter and has been in decline ever since.

At the height of Congressional interest, a *Health Affairs* article—authored by Dana Gelb Safran and a team from Tufts-New England Medical center, along with colleagues at the Fund and the Kaiser Family Foundation—used results from a new survey of 11,000 seniors in eight states to demonstrate that lack of drug coverage poses serious health and financial problems. A companion chartbook was published jointly by the foundations. The survey showed that nearly one-quarter of the elderly skipped doses or failed to fill prescriptions because of costs. One in four seniors also spent \$100 or more per month on prescription medicines in 2001. Access to drug coverage and the scope of benefits vary considerably by location; in some states, nearly one in three seniors lacked prescription drug coverage of any type.

States' inability to close coverage gaps on their own was underscored in a report on state pharmacy assistance programs by Steven Crystal and colleagues at Rutgers University. Only 3 percent of Medicare beneficiaries, or about 1 million people, are enrolled in the programs, and just three states—New York, New Jersey, and Pennsylvania—account for nearly three-quarters of all pharmacy assistance expenditures and more than half of enrollment nationwide.

Together, these studies highlight the need for a national policy solution. With support from the Fund, Marilyn Moon of the Urban Institute modeled programs that would benefit the neediest seniors using a modest level of federal expenditure. Moon's work

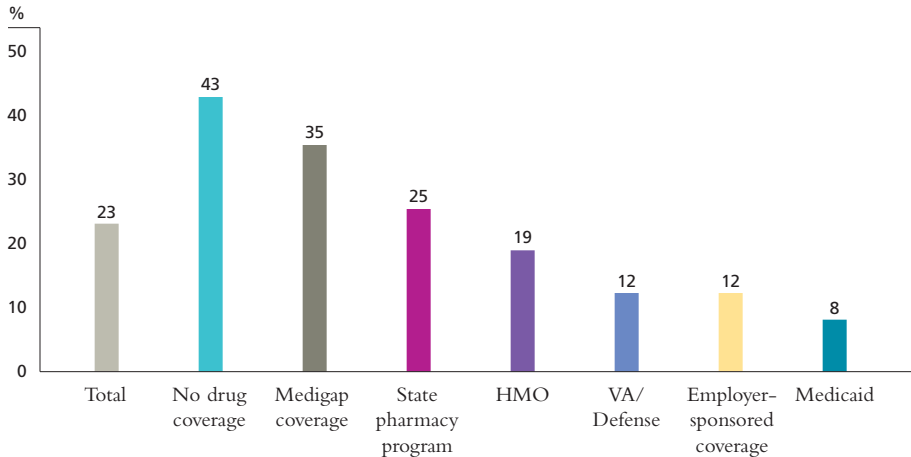


Dana Gelb Safran

Safran's analysis informed this year's discussion of prescription drug coverage under Medicare.

Nearly a quarter of seniors surveyed recently in eight states reported that they spend \$100 or more each month on prescription medications, even though many have some type of drug coverage.

Seniors spending \$100 or more per month on medications, by source of drug coverage



Kaiser/Commonwealth/Tufts-New England Medical Center 2001 Survey of Seniors in Eight States.

demonstrates that it is nearly impossible to craft a voluntary drug benefit that would appeal to a wide range of beneficiaries and help those most in need within the \$350 billion ten-year price tag specified in many leading Congressional proposals. By raising the federal contribution to approximately \$450 billion, however, a modest universal benefit, including low-income subsidies and a cap on catastrophic spending, could be provided. Such an approach would lay the groundwork for further expansions over time.

With some Congressional plans calling for medication coverage benefits to be provided by private insurers, experience with Medicare+Choice—which permits beneficiaries to join private managed care plans—could be highly relevant. Last year was another marked failure for Medicare+Choice. According to a series of reports by Marsha Gold at Mathematica

Policy Research, additional plans withdrew from the program, benefits eroded, and cost-sharing for beneficiaries, especially those in poor health, increased sharply. In *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001*, Lori Achman and Marsha Gold analyzed the effects of shrinking managed care benefits on enrollees by examining trends in estimated out-of-pocket costs from 1999 to 2001. Enrollees in poor health were most at risk for rising costs: total annual costs for that group increased 62 percent, compared with 43 percent among enrollees in good health. In 2001, enrollees in poor health laid out about three times as much in annual out-of-pocket costs, including premiums and cost-sharing, as those in good health, or \$3,578 and \$1,195 respectively.

Medicare+Choice was also the subject of numerous analyses by a research team at George Washington University that examined seven markets to understand the sources of program instability. Led by Brian Biles, M.D., the project found that local factors such as plan withdrawals, physician turnover, and benefit reductions were widespread and not easily reversed with a national fix such as higher reimbursement rates. After the project team argued that “lock-in” provisions, which would force enrollees to stay in a plan for a specified period, should be delayed, Congress postponed the implementation of lock-in policies for three years. The team also concluded that benefits packages should be standardized to facilitate informed beneficiary choice and that geographic inequities plaguing the program must be corrected.

Since 1998, Congress has enacted several Medicaid-financed programs to assist low-income beneficiaries in paying for their Medicare premiums and copayments. Even so, millions of eligible seniors are not enrolled. Two Fund projects initiated in the past year are working to identify and enroll eligible seniors who would benefit from participating. Benefits CheckUp, an internet application developed by the National Council on the Aging, matches user-provided personal information with eligibility requirements for nearly 1,000 federal and state benefits programs, then gives information on how and where to apply. A second project, in partnership with the State Solutions Initiative of the Robert Wood Johnson Foundation, is helping Minnesota simplify its eligibility and application rules and conduct more successful outreach for state-funded programs.