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Health Care Poverty

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This paper introduces and describes health care poverty. Underinsurance and its consequences for access to health care are highlighted. Definitions of underinsurance and its prevalence are presented. Groups that experience disproportionate barriers to obtaining medical care are identified. Manifestations of underinsurance are explicated and their relationship to receipt of medical care, such as vaccinations and medications is discussed. A reframing of the health care debate is suggested with emphasis moving from uninsurance to access to health care.

Key words: access to health care, underinsurance, unmet needs, social justice

Introduction

In the debate on health care in the United States, one might conclude that being poor and uninsured are the sole determinants of access to and utilization of health care. The effect of poverty on health insurance status, access to health care and health outcomes has long been established. But that dialogue is driven exclusively by economic status. It emphasizes both the relationship between poverty (as defined by the Federal Poverty Level, FPL) and the *complete* lack of health insurance (uninsurance), and, subsequently, the relationship between being uninsured and having access to health care. For

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instance, it is well-documented that individuals living in poverty experience higher rates of uninsurance (Holahan & Cook, 2005; Kaiser Commission on Medicaid and The Uninsured, 2004a) and consequently, a lower likelihood of having a usual source of care (Families USA, 2003; Kaiser Commission on Medicaid and the Uninsured, 2004b).

While it is vital to recognize the scope of health care consequences for those living in poverty without any health insurance, this paper contends that there are additional factors critical to the examination of health care in the United States. It introduces a different application of poverty in the health care debate – health care poverty – which significantly broadens the focus. Health care poverty expands examination of issues related to health insurance and access to health care to additional, and significant, groups of individuals who are disenfranchised not solely due to poverty status and a complete lack of health insurance. It includes those who have private health insurance that is inadequate to meet their needs, regardless of their income level. In other words, the term refers to poverty of access to health care. This situation has been labeled underinsurance, and includes, but is not limited to: yearly and lifetime limits on benefits, lack of coverage for medication and other ancillary services, daunting premiums and deductibles, and levels of copayments and/or coinsurance that inhibit ability to obtain health care.

Individuals in this predicament do not meet the criteria for inclusion in counts of the uninsured nor are they represented in discussions of access to health care. They are invisible because the focus of such discussions is on the presence or absence of health insurance, as if the presence of health insurance is synonymous with access to health care. However, this assumption is naïve. Healthy People 2010 acknowledged multiple factors that contribute to problems with access to health care:

Financial, structural, and personal barriers can limit access to health care. Financial barriers include not having health insurance, not having enough health insurance to cover needed services, or not having the financial capacity to cover services outside a health plan or insurance program. (Healthy People 2010a)

This paper addresses the situation in which health insurance coverage is “not enough” to meet health care needs. It contends that the insured/uninsured discussion, while important, neglects the critical issue of underinsurance. Consequently, identification of the extent of unmet need is precluded. This paper describes the nature and degree of underinsurance and discusses implications for access to health care for individuals and families. Thus, the focus is moved from whether one has health insurance to whether one has access to needed health care. These represent two very different, although related concerns. This paper submits that the presence of health insurance should not be considered the ultimate goal, because it is only a means to the desired end – access to health care.

Examination of underinsurance is particularly important as cost sharing has replaced managed care as a strategy to control the rising costs of health care. Cost sharing occurs when patients are required to pay for part of the costs of their medical care (Hsu et al., 2004). It is believed to promote efficient use of medical services by raising patient awareness of medically related costs (Hsu et al). Hence, “...cost sharing is aimed directly at consumers” (Wong, Andersen, Sherbourne, Hays, & Shapiro, 1989, p. 892). This relatively recent increased emphasis on cost sharing as a cost containment strategy directs the “...focus away from the supply (physician) and toward the demand (consumer) side of the health care market and from uniformity toward variety in products and prices” (Robinson, 2004, p. 1880). In some markets, consumers are given choices regarding the type of health insurance product they desire. Whether by consumer choice or employer/insurer mandate, the consequences of underinsurance are problematic. The potential for more negative health outcomes due to cost sharing has been identified because individuals reduce their use of needed medical care due to financial concerns (Wong et al.). This paper asserts that cost sharing represents another manifestation of underinsurance with consequences that must be identified and quantified.

Poverty Defined

Poverty has been described as an indicator of deprivation

with both absolute and relative dimensions (Karger & Stoesz, 2006). Absolute poverty identifies a distinct point (i.e. dollar amount) below which individuals and families are deemed poor. Determinations of eligibility for benefits from social welfare programs are based on the federal poverty guidelines (also known as the FPL) which are determined every year by the Department of Health and Human Services (U.S. DHHS, 2005). The FPL represents an absolute indicator of poverty. The existence of governmental social welfare programs for individuals deemed "poor" underscores an acknowledgement of governmental responsibility for the welfare of its citizens.

Relative poverty compares the wealth of members of a society to one another. It has been described as a representation of social inequality (Karger & Stoesz, 2006). It is possible that individuals may not meet the criteria for absolute poverty but experience relative poverty, nonetheless, - that is deprivation compared to the condition of others within their environment. There is no clear mandate that the government, or any other entity, holds responsibility for the welfare of those experiencing relative poverty, despite evidence of a clear level of need.

This paper contends that the framework used to define poverty - incorporating absolute and relative - should be applied to analyzing the health care system in the United States. Two reasons exist for this position. The first addresses the need to understand the true prevalence of the lack of access to health care. The current strategy, which emphasizes primarily the "absence or presence" of health insurance during a certain period of time is insufficient to reveal the true prevalence of problems with to access to care. A clearer picture of the magnitude of health care poverty would be revealed through identification of individuals with health insurance who lack access to the needed services. Thus, consideration of "absolute" poverty of health care would examine those who have no health insurance (and presumably no access) while "relative" poverty would include underinsurance and its effect on access to health care and utilization of medical services.

Health Care Defined

"The enjoyment of the highest attainable standard of health

is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 2005). This definition underscores the importance of health to individuals in a society. However, in the United States there is no agreement on the basic level of health care to which all individuals should be entitled. Although the medical establishment has provided goals for health and the provision of health care, related both to prevention and treatment through initiatives like Healthy People 2010, the current system of financing medical services impedes their implementation. Healthy People 2010 identified two goals for improving health in the United States: 1). extending life expectancy and increasing quality of life and, 2). eliminating health disparities among subgroups of the population (Healthy People 2010b). The first of the 28 focus areas directed at these primary goals is "access to quality health services" (Healthy People 2010b). It is addressed in chapter one and includes a number of corresponding objectives. Health insurance coverage for 100% of the population is objective 1-1 (Healthy People 2010c). While this objective can be supported universally, it does not necessarily equate with access to health care services. This is the point at which considerations of underinsurance become relevant. Even if the goal of 100% of the population having health insurance is reached, it does not guarantee that the overarching goals of increasing length and quality of life and eliminating health disparities will be achieved. Interestingly, objective 1-6 in Healthy People 2010 identifies the goal of reducing the percentage of those who delay or do not obtain required medical care from the 12% reported in 1996 to 7% (Healthy People 2010d). The inclusion of objective 1-6 despite the presence of objective 1-1 could be interpreted to reflect an understanding that the presence of health insurance coverage does not always translate to access to needed medical services.

It appears that the broad goals identified by the government in Healthy People 2010 are not accompanied by social welfare policies to ensure their achievement. Specific areas do exist in which the government has intervened to assure a certain level of compliance with medical recommendations (e.g. immunization of children) and even those have not achieved the desired

goals. However, aside from Healthy People 2010, there appears to be no consensus on the level of health care or amount of health services that should be "normative."

Underinsurance and Cost Containment

In recent years, concern for rising health care costs has resulted in various cost containment strategies. Two strategies used by employers to control escalating health care costs have been to increase either the employee share of the insurance premium or other health care related costs (Trude, 2003). Cost sharing has been frequently used to address medication related costs (Anis et al., 2005; Reed, 2005). Examples of costs that are shared by employees include deductibles, copays and coinsurance (Goff, 2004; Trude). A copay is a predetermined amount paid by an individual at the point of care, regardless of the actual charge of the service. A cost to the individual that is based on the actual charge for care at the point of service represents coinsurance (Goff). This increase in out-of-pocket expenses (cost sharing) is driven by the presumption that greater expenses will moderate the use of health care services by individuals who share the financial risk of obtaining medical care (Chernew, Rosen, & Fendrick, 2006; Trude). In other words, "...the purpose is to sensitize consumers to the financial consequences of their choices" (Goff, p. 7). Cost tiers have been established in areas such as prescription drugs and hospitals that result in differential costs to the employee based on preferred status of the medication or provider (Goff).

Prescription drugs provide an example of the prevalence and consequences of underinsurance. Nine percent of a national sample of individuals between ages 19-64 had no prescription drug benefit despite the fact that they had private health insurance (Schur, Doty, & Berk, 2004). As previously stated, prescription drug coverage is an area that has been targeted for cost containment strategies. One such strategy, benefit-based copayment, occurs when the use of medications with more documented benefit is encouraged by lowering its required copayments and raising those of less effective medications (Goldman, Joyce, & Karaca-Mandic, 2006).

Underinsurance: Definitions and Prevalence

Underinsurance occurs when health insurance is insufficient to cover all needed health care services (Moniz & Gorin, 2003). Although it receives relatively less attention than uninsurance, it is not a new phenomenon. Thirteen years ago, four components of underinsurance were identified that included: "a) too few services are covered or the coverage is inadequate; b) amounts of out-of-pocket expenditures, with or without regard to family income, are excessive; c) insurance is perceived to be inadequate; or d) some combination is present" (Bashshur, Smith, & Stiles, 1993, p. 202). More than 15 years ago, the Pepper Commission identified "inadequate coverage" as health care costs that exceeded 10% of income (as cited in Bodenheimer, 1992).

A recent classification of categories utilized in previous research on health insurance coverage identified: economic, structural and attitudinal perspectives (State Health Access Data Center). Studies from an economic perspective investigate the relationship between out-of-pocket expenses and total individual/family income. Examination of which health care benefits are omitted from benefit packages that should have been included is the focus of structural studies. Finally, attitudinal research considers health care coverage from the perspective of the beneficiary. These studies investigate individuals' feelings about the adequacy of their coverage. Each of the three strategies has strengths and limitations and reflects a different perspective on the adequacy of health insurance coverage. (State Health Access Data Assistance Center). This typology of studies appears consistent with the components identified in earlier works.

Similar to uninsurance, estimating the incidence of underinsurance has proven challenging due to varying definitions and measurements (Kogan, Newacheck, Honberg, & Strickland, 2006; Oswald et al., 2005). Estimates of underinsurance have ranged from 7%-53% (Beebe as cited in Kogan et al.). A national study of insurance coverage in 2003 reported that approximately 16 million individuals age 19-64 were underinsured (Schoen et al., 2005). This represented 12% of those who reported having health insurance during the entire year.

Data from the National Survey of Children with Special Health Care needs was used to estimate the prevalence of underinsurance, both at the national and state level. The percentage of underinsured children with special health care needs nationally was estimated at 32.3% (Kogan et al.). Additionally, the underinsurance rate of 680 children with special health care needs residing in Virginia was estimated at 25.6%, 2.9%, and 28.9% using the economic, structural and attitudinal strategies, respectively (Oswald et al.).

Another manifestation of underinsurance is coverage that does not include behavioral health care (Wu & Schlenger, 2004). Data from the National Household Survey on Drug Abuse during 1995-1998 reflected that 38% of the 36,214 privately insured adults age 18-64 either did not have behavioral health insurance or were uncertain of their coverage (Wu & Schlenger). Underinsurance also has been identified for mental health and substance abuse services among 434 managed care organizations nationwide (Hodgkin, Horgan, Garnick, & Merrick, 2003). More than 66% of the sample required copayments for substance abuse and mental health services, with payments of \$20.00 or more per visit at 42.6% for substance abuse treatment and 45.8% for mental health services. Coinsurance was less prevalent at 28.8% of substance abuse services and 29.6% of mental health services. However, a coinsurance payment of 50% of the charges was required by 15% of the managed care products (Hodgkin et al.).

African Americans (Reed, 2005), Hispanics (Kogan et al., 2006; Wu & Schlenger, 2004), those living in poverty (Kogan et al.; Oswald et al., 2005; Schoen et al., 2005; Schur, Doty & Berk, 2004; Wu & Schlenger), individuals living in single-adult households (Oswald et al.), individuals age 18-25 (Wu & Schlenger), and those without a high school education (Wu & Schlenger) are more likely to be underinsured.

Underinsurance and Access to Care

Underinsurance has been associated with less access to health care. A recent study of 3,293 nonelderly adults nationwide reported that those who were underinsured were significantly more likely to forego medical care due to concern for

costs than individuals who had sufficient insurance (Schoen et al., 2005). Furthermore, nearly 33% of underinsured individuals reported not seeking attention from a physician for a medical problem due to concern for costs (Schoen et al.). It is particularly important for individuals with chronic illness to obtain timely health care. A national study of 1,700 adults with chronic illness reported that cost sharing (i.e. the amount of copayment) was significantly associated with reduced likelihood of seeking medical care (Wong et al., 1989). Despite being chronically ill, individuals with high copayments were significantly less likely to pursue medical care for serious symptoms than those with low or no copayments (Wong et al.). Additionally, individuals with chronic illness with any required copayment (low or high) were significantly less likely to seek care for minor symptoms than individuals without a copayment (Wong et al.). Thus, cost sharing reduced the use of medical services by individuals already at increased risk for adverse health outcomes. An association exists between cost sharing and utilization of health care in an emergency. Hsu et al. (2004) reported a relationship between patient beliefs regarding the copayment amount of an emergency room visit and likelihood of pursuing treatment from an emergency department. Individuals were significantly less likely to pursue treatment in an emergency room if they believed that their copayment was \$20.00 or more. The percentages of those who delayed or decided gave up emergency room care related to belief about copayment were 20% (believed copayment \$20 or more) and 6% (believed copayment was less than \$20) (Hsu et al.).

The relationship between underinsurance (cost sharing) and obtaining prescribed medication also has been documented. A study of 1997-2000 claims data of 526,969 employees at 30 U.S. employers, including predictions of the effect if their current copayment for medications, was doubled (Goldman et al., 2004). The reduction in percentage of spending for eight classes of medications ranged from 25% to 45% in response to a 100% increase in copayment. Furthermore, decreased spending of 8% to 23% on the same classes of medications was predicted for a subsample of chronically ill individuals (Goldman et al.). Foregoing prescribed medications due to cost concerns was

reported by 15.2% of a nationally representative sample of individuals who were ages 18-64 and had private insurance (Reed, 2005). The aforementioned study found that privately insured, working age adults constituted 40% of individuals with chronic conditions who expressed difficulties obtaining medications due to cost concerns. Once again, this underscores the increased risk of adverse outcomes for individuals with chronic illness. It is noteworthy that 35% of low-income adults reported cost issues concerning prescribed medications. Financial barriers to obtaining prescription medications significantly increased between 2001 and 2003 to 12.8% (Reed). Not only were non-elderly insured adults who did not have a prescription drug benefit more likely to forego obtaining needed medication than those with prescription coverage (28% and 16%, respectively), and significantly more likely to forego obtaining other needed medical services, such as obtaining ordered medical tests, they were also significantly more likely to report having problems paying for medical bills (Schur et al., 2004). Additionally, 38% of underinsured adults reported not obtaining a prescribed medication due to financial concerns. This percentage was identical to that of individuals who completely lacked health insurance, suggesting that, in this area, individuals with inadequate health insurance were more similar to the uninsured than to individuals with sufficient coverage. Finally, although a literature review of 30 studies published between 1974 and 2005 regarding medication and cost sharing reported mixed results with regard to impact on the utilization of health care services, it did show that increased amount of cost sharing was associated with lower rates of initiation of prescribed therapies and discontinuation of prescribed medication (in some cases) (Gibson, Ozminkowski & Goetzel, 2005). Moreover, three of four examined studies reported a relationship between higher cost sharing and lower adherence to prescribed drug regimens. The authors concluded that although cost sharing has been effective, in some cases, at achieving its goals "It is also becoming clear that cost sharing is not always a benign instrument, and at times it may come at a price." (Gibson et al., p. 739).

Children represent a population for which goals for care have been identified (in some specific areas) and social welfare policies have been created to extend access to health care.

Receipt of vaccinations is an important area in which underinsurance has severe implications for access to care. The vaccination rates for children and adults remain below the goals set by Healthy People 2010 (Davis & Fant, 2005). The Institute of Medicine (IOM) evaluated the current system of making vaccines available to children and adults and offered recommendations for improving access (Institute of Medicine, 2003). It reported that 11% of children age 5 or under and 59% of adults are underinsured for vaccinations, and noted that increasing cost sharing by insured individuals has been occurring (IOM). Similar to adults with chronic illness, children with special health care needs who were continuously, but inadequately, insured experienced significantly more problems with access to health care than those with adequate coverage (Kogan et al., 2006). Consequences for these children of inadequate coverage included delays or skipping care, unmet needs for medical services, difficulty obtaining referrals for specialty care and the occurrence of financial strain on the family due to the child's medical status (Kogan et al.).

As expected, income level is associated with access to health care among underinsured individuals. Reduced use of health care services by those in a lower socioeconomic status has been documented, despite having health insurance (Fiscella, Franks, Gold, & Clancy, 2000). Data from the 2001 Medical Expenditure Panel Survey (MEPS) suggested that low income families with private health insurance experienced significantly more out-of-pocket financial burden related to health care than uninsured families or families with public health insurance (Galbraith, Wong, Kim, & Newacheck, 2005). One-fourth of insured adults under age 65 with incomes less than \$20,000 indicated that financial concerns caused difficulty obtaining medical care, visiting a physician when they experienced a medical problem, and filling a prescription (Donelan, DesRoches, & Schoen, 2000). These individuals were three times more likely than insured individuals with incomes \$60,000 or greater to forego obtaining needed care or skip completing recommended tests or treatment (Donelan et al.). Finally, despite being insured, low-income women did not receive preventive care that was medically recommended, including Pap tests, breast exams and dental visits (Almeida, Dubai, & Ko, p. 44). The

relationship between reduced access to care for low income individuals, despite the presence of health insurance also has been reported for dental care (Kenney, McFeeters, & Yee, 2005). Data on 9,714 children from the 2002 National Survey of America's Families suggested that children living in families with private health insurance that did not include dental coverage had similar percentages of unmet dental needs to those living in families without any health insurance 12.9% and 13.7%, respectively (Kenney et al).

Although access to health care is more financially burdensome for low-income individuals and those who are uninsured, the presence of health insurance does not assure that health care will be received, regardless of economic status. A national study of 1,771 bankruptcy cases filed during 2001 found that more than half (54.5%) were a consequence of medically related expenses (Himmelstein, Warren, Thorne, & Woolhandler, 2005). The assumption that individuals who experienced medically related bankruptcy did not have health insurance coverage is erroneous. More than three-fourths (75.7%) of those whose medical problems led to bankruptcy reported that they had health insurance, primarily private, at the time they, or their family member, became ill (Himmelstein et. al). A study that included a nationally representative sample of about 25,400 families reported that 14% experienced problems paying for medical bills during the previous year (May & Cunningham, 2004). More than two-thirds (68%) of those for whom paying medical bills was problematic had health insurance. Also, 12.4% of families with incomes between 300%-400% FPL and 7.4% of those with incomes more than 400% FPL experienced cost related problems (May & Cunningham).

A national survey conducted April-June 2005 of 1,531 adults reported that 23% expressed problems paying for medical bills; of those who identified problems, 61% had health insurance (USA Today, Kaiser Family Foundation, & Harvard School of Public Health, 2005). Notable as well, 28% of respondents indicated the inability to pay for medical care during the previous year; 62% of whom had health insurance (USA Today et al.).

Conclusion

While we never can lose focus on the health care dilemma faced by the poor, we must recognize that health care is a challenge – even an insurmountable obstacle – for countless others in our society. Drawing together data from various studies conducted in the field allows a complex picture to emerge – one markedly different from that created through common misconceptions. We discover a phenomenon that can, and should, be called *health care poverty*. Rather than being tied to a simple insured/uninsured template, it is more far reaching. In analyzing the traditional poor/poverty case, we apply both absolute and relative criteria. By using the same approach to the total health care picture, we reach some striking conclusions.

- Underinsurance can be as crippling as uninsurance. Nearly one-fourth (23%) of a nationally representative sample of adults surveyed during spring, 2005 reported problems paying their medical bills; 61% who reported problems had health insurance (USA Today et al., 2005). The percentage of individuals with health insurance, who indicated being “very worried” was 40% regarding paying medical bills when elderly, 37% regarding paying for costs related to a serious illness or accident, 31% regarding affording prescribed medications (USA Today et al.).
- The regressive nature of out-of-pocket costs (cost sharing) must be acknowledged and addressed (Bodenheimer, 1992). Individuals with lower incomes experience relatively greater barriers to care.
- Although more burdensome for individuals with lower incomes, underinsurance poses barriers for individuals above the poverty level, as well. More than one-fourth (26%) of non-elderly insured individuals with annual incomes < \$75,000 reported problems paying for medical bills. However, so did 5% of insured individuals with yearly incomes \geq \$75,000 (USA Today et al.). Furthermore, 13% percent of individuals with annual incomes \geq \$75,000 reported that they did not obtain a medical test or prescribed medications or took less than the prescribed amount of medication due to financial concerns (USA Today et al.).
- The potential for worse health outcomes due to

decisions made by patients involved in cost sharing should be acknowledged and addressed proactively (Lee & Zapert, 2005). Plan adjustments that reduce financial disincentives to obtaining needed health care for individuals who are low income should be introduced and complete coverage for appropriate preventive care should be provided (Lee & Zapert).

- It has been suggested that the very existence of the concept “underinsurance” assumes consensus regarding an expected amount of “protection against health care expenditures” (Bashshur et al., 1993, p. 205). Dialogue must occur in the public and private arenas that results in measurable goals for access to health care against which the current system can be evaluated. The insured/uninsured dichotomy is not appropriate to achieve the goals of Healthy People 2010.

The macro picture becomes clear and compelling. These inequities are created by the absence of a national mandate for the type of universal health care present in most other industrialized nations. Our government spends billions on health care, but the funding lacks coherence. It is not allocated based on the realities explicated in this paper. Unless and until there is recognition of this unacknowledged challenge – and the will and wherewithal to solve it – health care poverty will expand, enveloping increasing numbers of victims.

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