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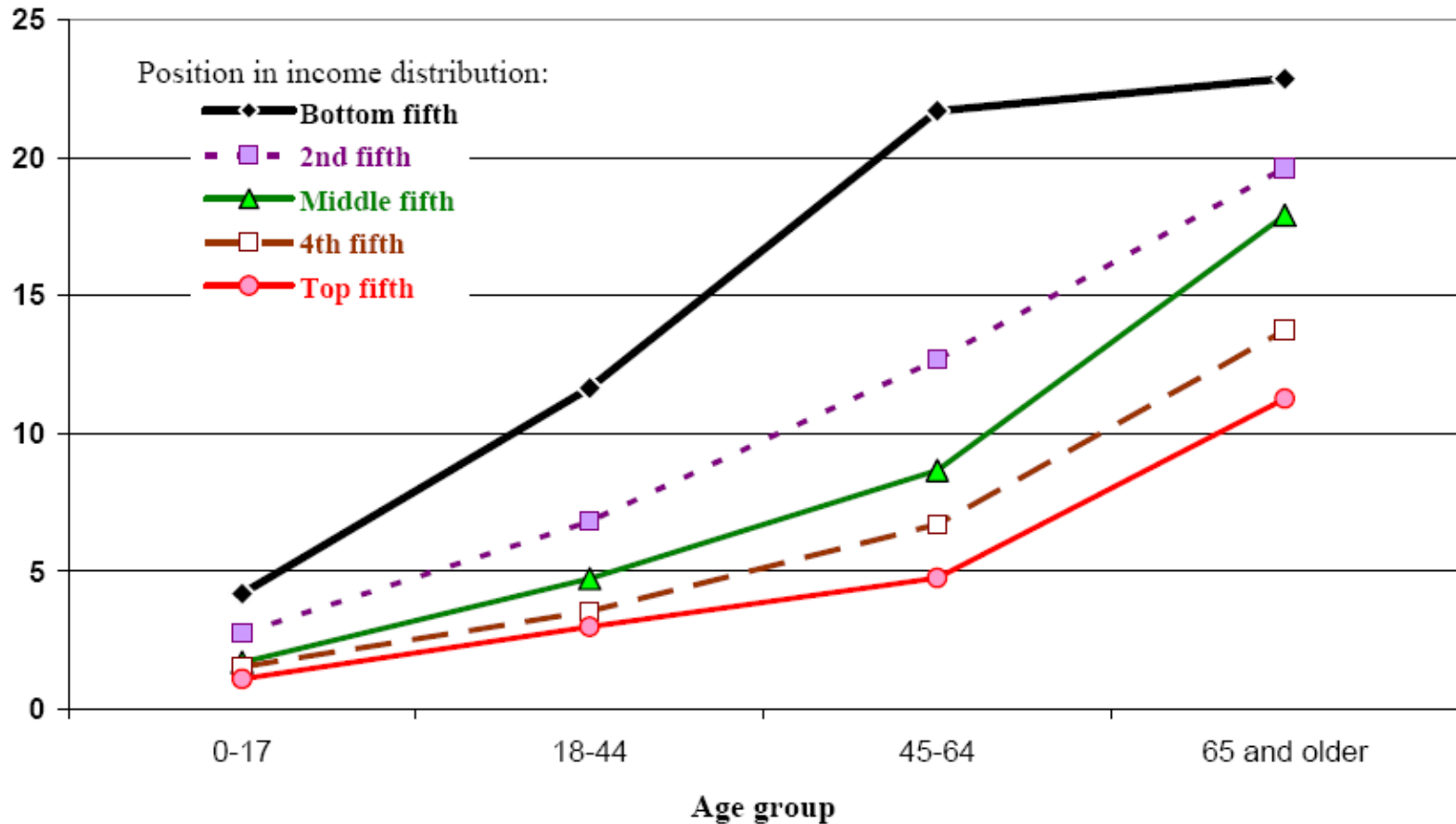
U.S. HEALTH POLICY AND THE POOR

Barbara Wolfe

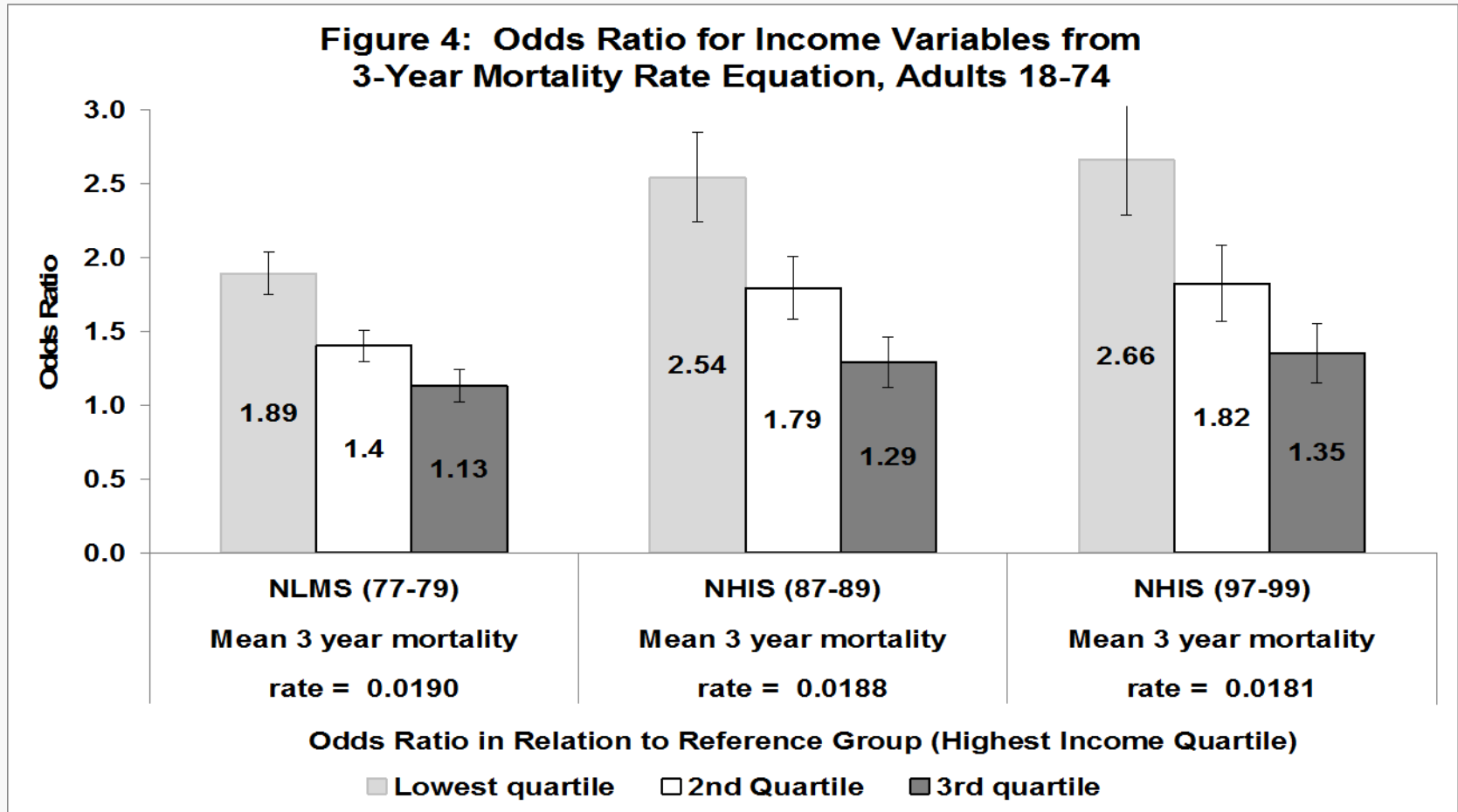
Range of topics

- Disparities in health
- Health insurance coverage & Access to Care
- Public Policies
 - Supply side
 - Demand Side
 - ACA
- International Comparisons

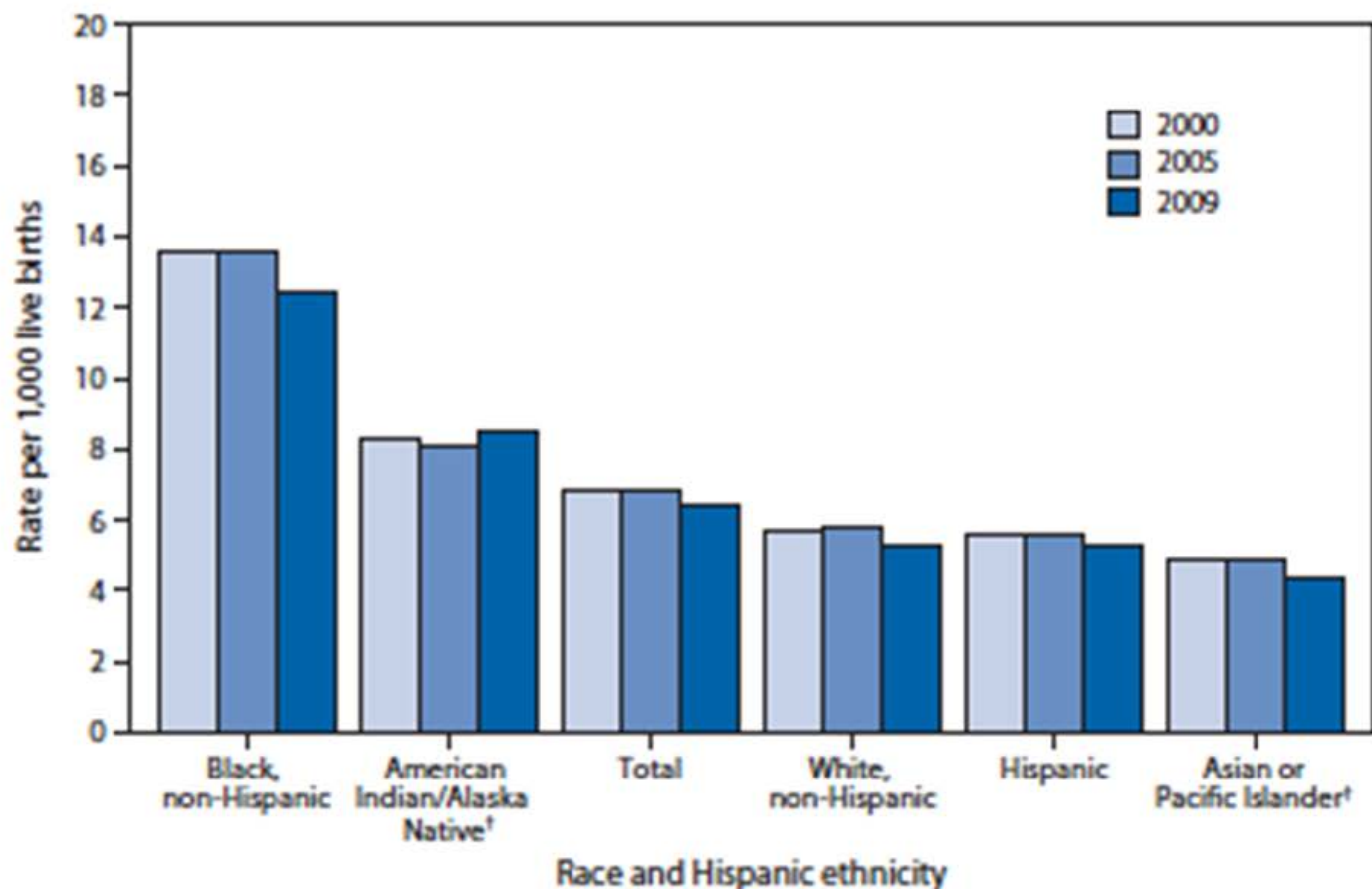
Ties between Poor Health Status, Income and Age, USA 1996-2005



Tie between Income and Mortality- evidence that it is getting worse.



Infant Mortality Rates,* by Race and Hispanic Ethnicity of Mother — United States, 2000, 2005, and 2009



* Per 1,000 live births.

† Includes persons of Hispanic and non-Hispanic ethnicity.

Literature on Disentangling the Influence of Income on Health

Motivation

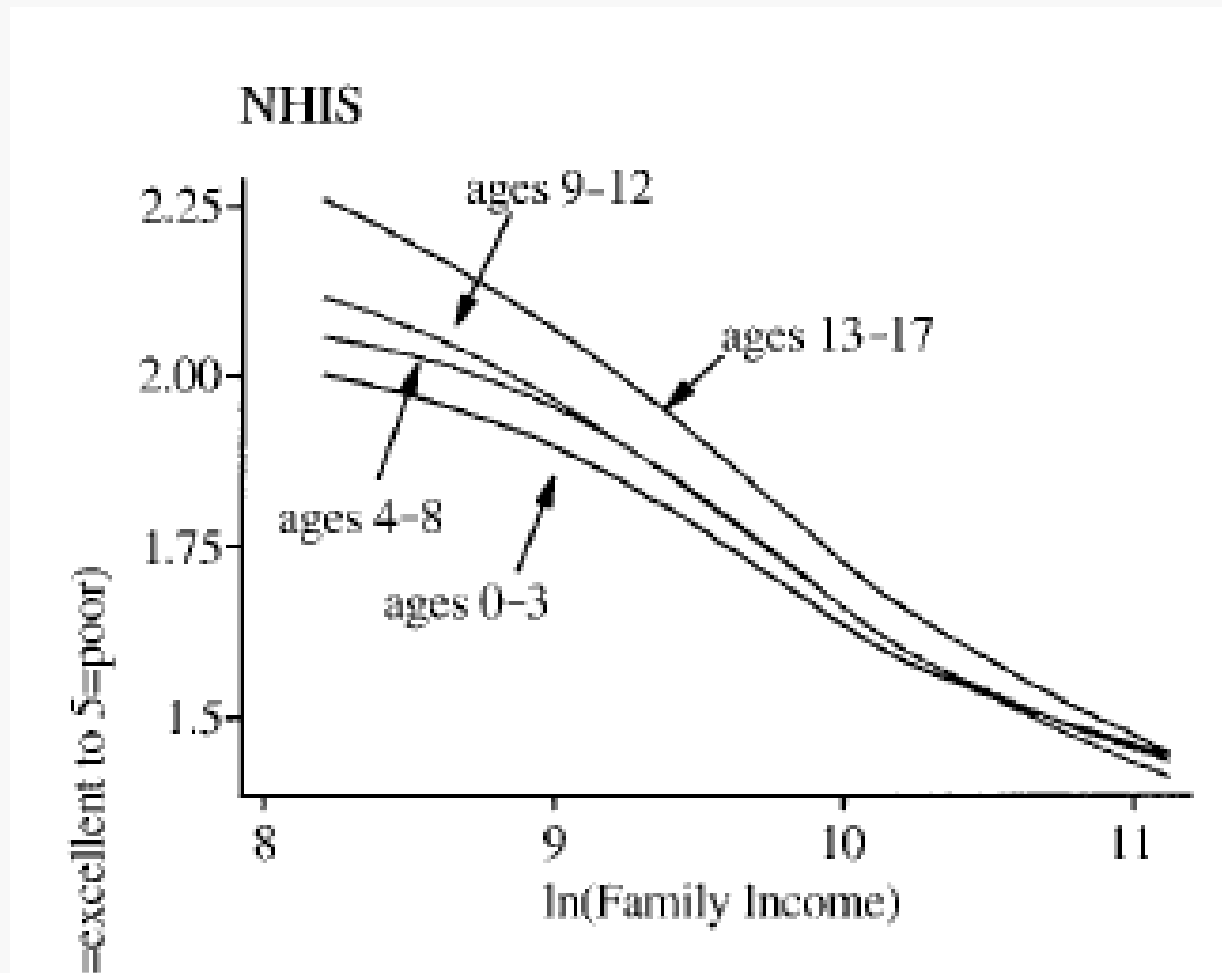
- Large literature documenting income-health gradient
 - Most studies in developed countries focus on children to move closer to causality
 - Children do not contribute to household income
- Concern that health insults during childhood have lasting effects
 - Origin of the adult income or SES gradient
 - Maintained over generations (Fetal origins literature)
 - Family income may cushion impacts/reduce frequency
 - Need for targeted policies?
- Limitations with current research

Estimation issues— Causality and Measurement

$$health = \beta_0 + \beta_1 \log(income) + \beta_2 X + \varepsilon$$

- Endogeneity—family income may be reduced from poor health/disability (labor supply reductions)
- Health measurement—use of self (mother) reported health status (5 point scale: excellent—poor)
- Income measurement—contemporaneous vs. permanent; family vs. neighborhood; data limitations

Case et al 2002 results for general health (1=excellent to 5=poor)



Other approaches to try to increase our understanding of the income health gradient that focus on children.

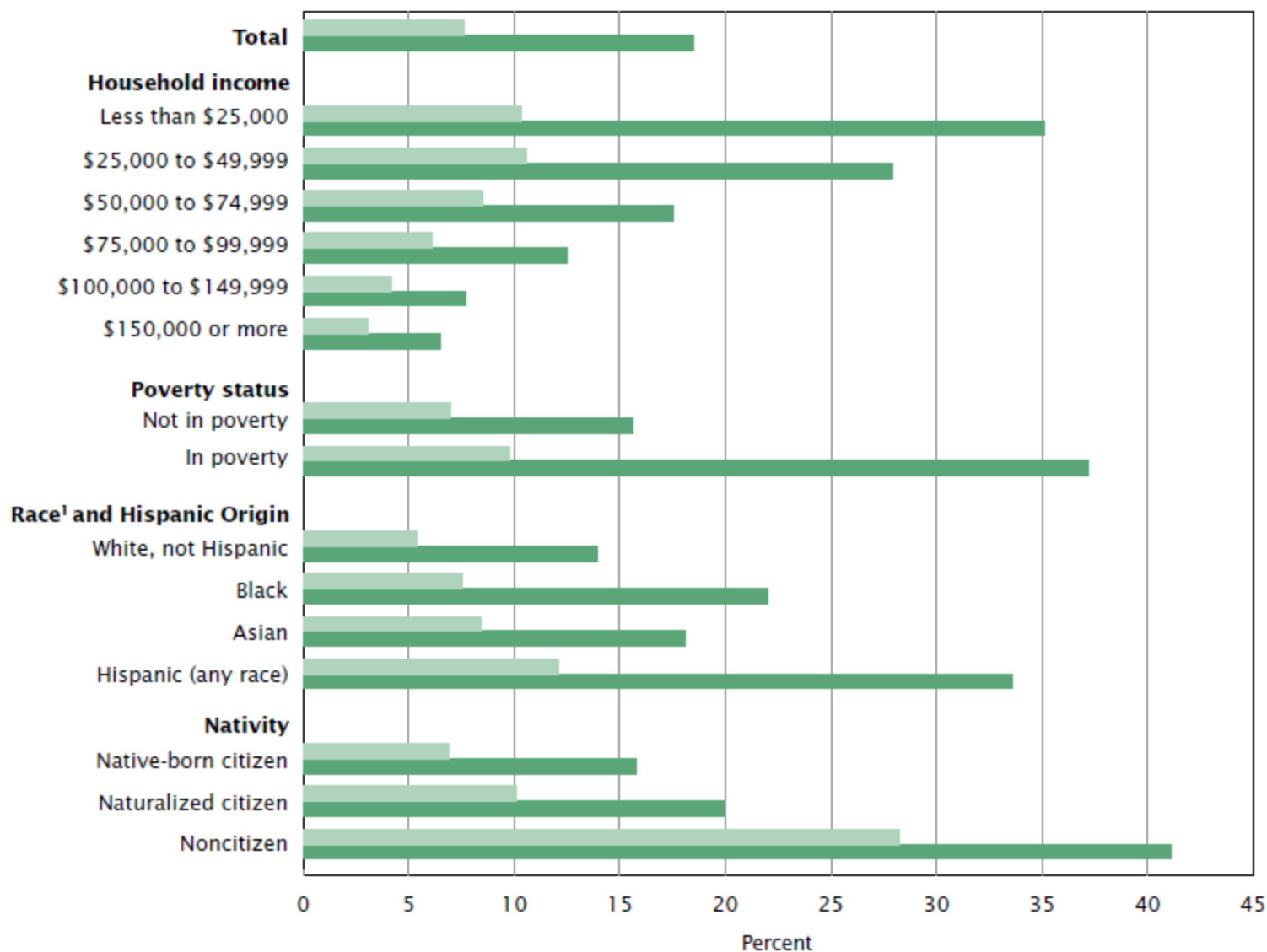
- Natural experiments
- Study pathology and link to SES
- Brain scans

- Next – tie between poverty and the probability of being uninsured.

Figure 6.

Children Under 19 Years of Age and Adults Aged 19 to 64 Years Without Health Insurance Coverage by Selected Characteristics: 2013

Children under 19 years
Adults aged 19 to 64 years



¹ Federal surveys give respondents the option of reporting more than one race. This figure shows data using the race-alone concept. For example, Asian refers to people who reported Asian and no other race.

Health Insurance Type and Family Income Relative to Poverty Level, and Distribution by Insurance

Type within Each Income Group, 2013 Insurance

Family Income Relative to Federal Poverty Level CPS data

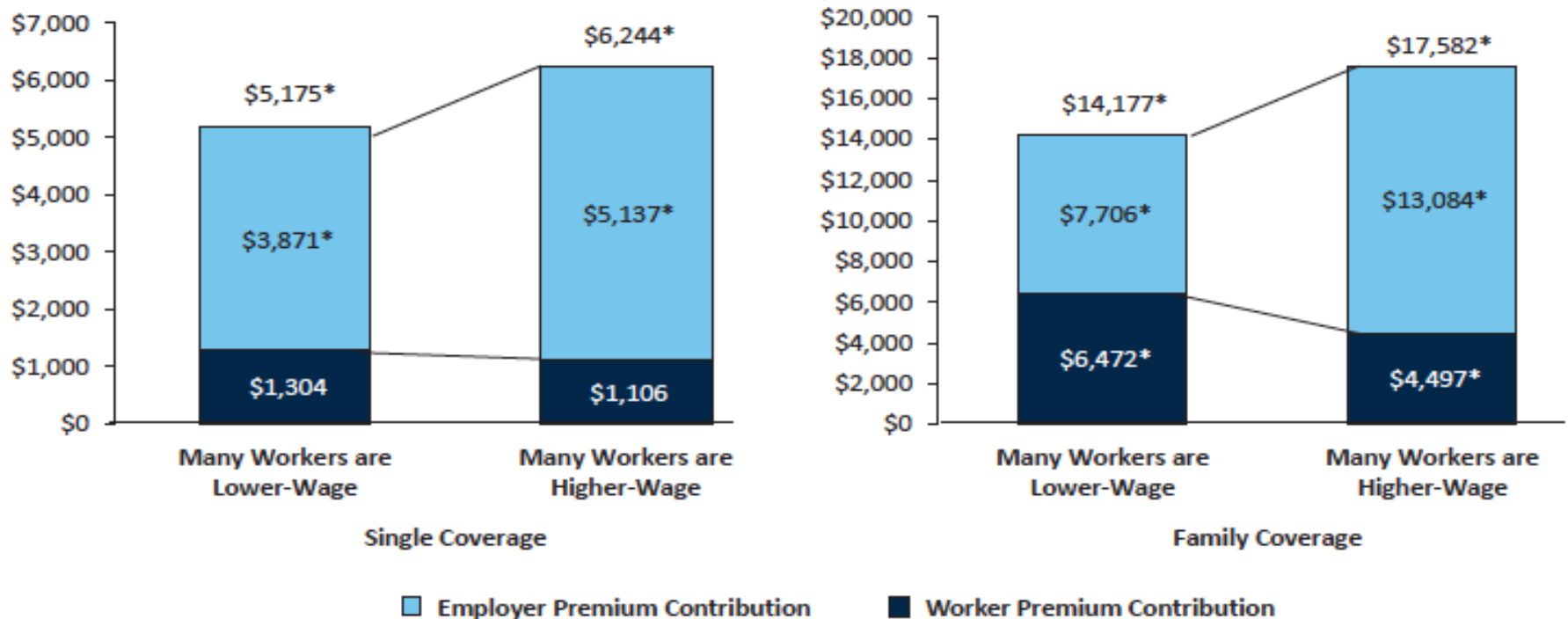
| Income Status | < poverty | 1.0-1.99 | 2.0-2.49 | >=2.5 | Overall |
|-----------------|-----------|----------|----------|-------|--|
| Uninsured | 24.9% | 20.9% | 16.2% | 7.5% | 16.6% (42 million) |
| Private* | 22.8% | 42.7% | 61.7% | 82.3% | 64.2% (201 million) 84% of these have ESI |
| Public | 58.6% | 48.8% | 36.1% | 23.0% | 34.3% (107.6 million) |
| <i>Medicare</i> | | | | | 49 mil |
| <i>Medicaid</i> | | | | | 54.1 mil |
| CHAMPUS/VA | | | | | 14.1 mil |

What lies behind this pattern?

Even if work, required contribution tends to be high

Among small firms (<50 workers) only about half offer health benefits vs. 90% larger firms

Average Worker and Employer Premium Contributions For Covered Workers at Higher- and Lower-Wage Firms, 2014



*Estimate for many workers are lower-wage is statistically different from estimate for many workers are higher-wage, within coverage type ($p < .05$).

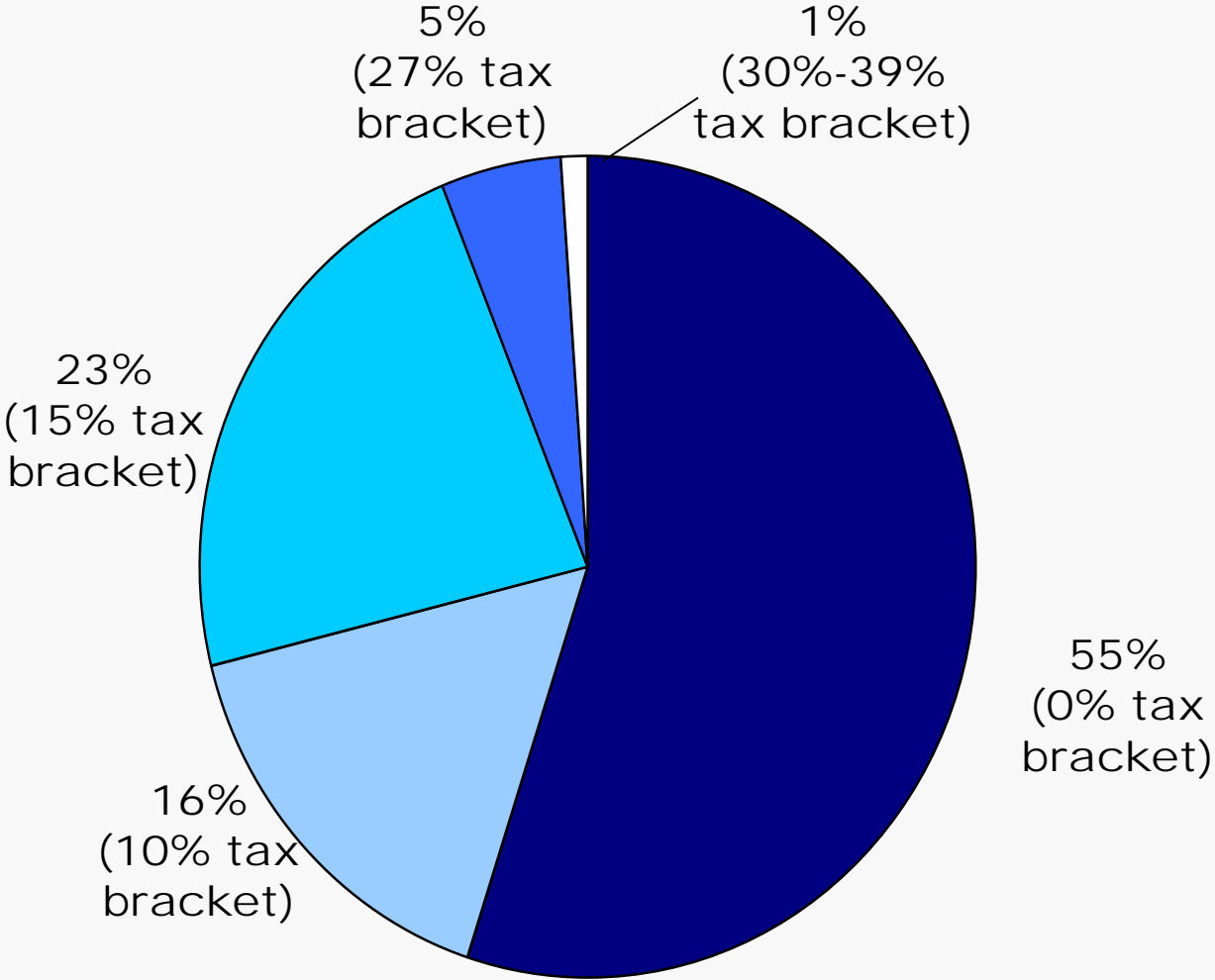
Demand Side: Role of Current tax subsidies

- Under current tax law, health insurance premiums are largely tax exempt if the insurance is provided through an employer; that is,
The share of the premium paid by the employer is not counted as income to workers and retirees under laws for federal income, Social Security payroll taxes and most state income taxes.
- Employee's share of the premium also can be tax-exempt in firms with flexible spending plans). And, can be deducted from federal income tax if above threshold level.
- Many employees have access to a reimbursement account under their employer's flexible spending plan, through which out-of-pocket health costs can be paid in pretax dollars.

Tax Subsidy Varies by income

- Income tax rates rise with income
- Payroll tax
 - Amount subject to social security tax is capped so rates fall with income
- Average marginal tax rates for federal income and payroll taxes combined range from 8% for incomes < \$10,000 to 45% for incomes > \$1 Million per year.
- ACA limits the tax subsidy via the “Cadillac Tax”
 - Beginning in 2018, ESI benefits with premiums >\$10,200 (single) or \$27,500 (family) subject to tax of 40% on amounts over these thresholds.

Income Tax Distribution of Uninsured: suggests tax subsidy for those at low marginal tax rates. Most uninsured face low rates of income tax



Source: S. A. Glied and D. K. Remler,

Public Programs in the Health Sector

Ways Governments involved in health care-Overview

- **Health insurer.**
 - In most developed countries, governments guarantee health insurance to the entire population.
 - The United States is an outlier; insure some, but not all, of the population.
- **Direct provider of medical services.**
 - Medical care delivery is entirely public in some countries and even in the privately-dominated US, governments run ~15 percent of the hospitals.
- **Tax subsidies.**
 - In the United States, the Federal government subsidizes employer-provided health insurance by excluding contributions for this insurance from taxable income.
- **Tax goods with adverse health consequences, such as smoking and drinking, with the idea of improving health.**
- **Regulate health care.**
 - Governments restrict insurance companies (what can be offered and to whom), license medical care providers, and approve new drugs and devices before they can be sold.
- **Subsidize or carry out research**

Types of Public Subsidies that influence low income population

- Demand side

- Subsidize insurance via tax system
- Medicare for elderly and disabled
- Medicaid for certain low income groups
- CHIP for lower income children and in some cases parents
- ACA subsidies for lower income families

- Supply side

- Community Health centers
- VA system
- Subsidies to educate providers
- Subsidies to build facilities
- Indian Health Service

Hill-Burton Act—to public and non-profit facilities. **Hill Burton or Hospital Survey and Construction Act of 1946**

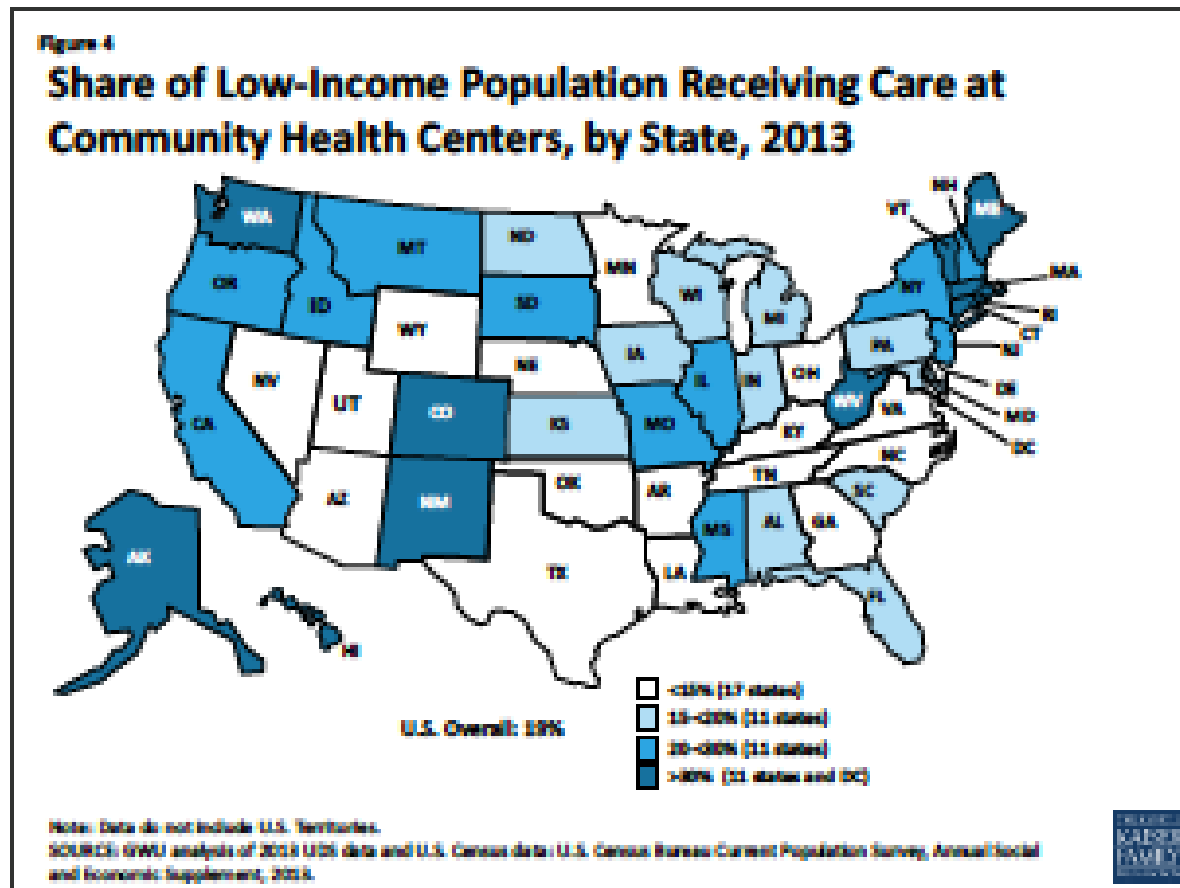
- Act provided grants and low interest loans for hospital construction only if recipients accept obligation to provide charity care for 20 years.
- In early years, requirement set at a reasonable volume of free services to persons unable to pay. In later years (1979) in form of explicit quotas regarding amount of “charity care”.
 - 3% of operating costs
 - Continue to pay if did not meet in past but no extra credit for going above target. Creates incentive to find patients with limited uncertainty in cost of care.
- Grants and loans to 6,800 facilities in 4,000 communities.

Community Health Centers (CHCs)

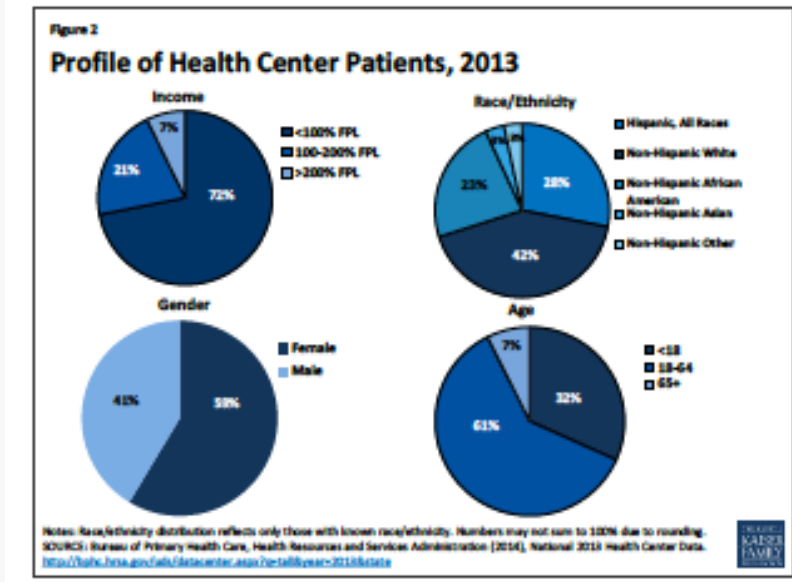
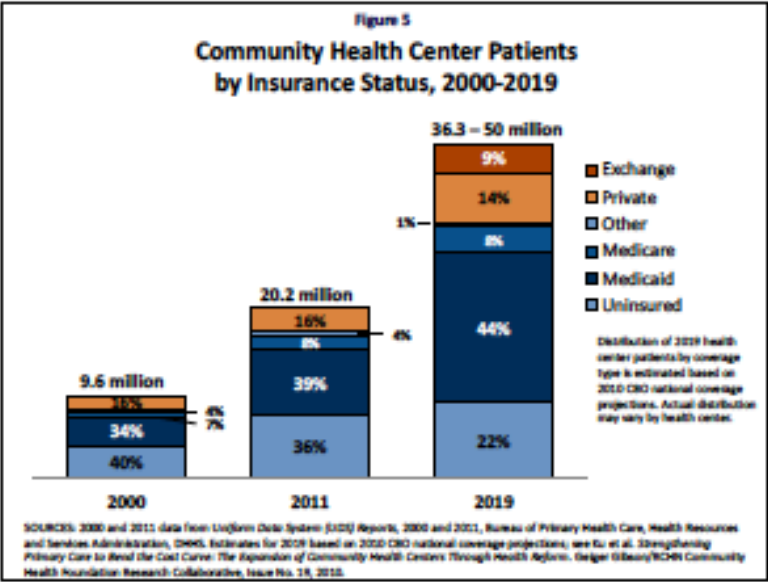
- Part of the War on Poverty in the mid-1960s.
 - By early 1970s, about 100 neighborhood health centers established under the Economic Opportunity Act (OEO). Centers provide accessible, affordable personal health care services to low income families.
- CHCs provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities.
- Medically Underserved Areas (MUA) defined in mid 1970s based on infant mortality rate, % of elderly, primary care MDs/population, poverty rate.
- Need MUA designation to be eligible to be CHC (1975). Now termed Health Professional Shortage Areas.
- In 2013, 1,202 FQHC operating in 9,170 sites. Served 21.7 million patients., 86 million visits. There were also 100 lookalikes serving 1 million additional patients.

% of Population served by CHC's by State

Lots of Variation



Who is served by CHC's?



Evaluation of CHCs

- Analysis of up to date on recommended screenings (Dor et al 2008) found CHCs do better for minority and poor women.
- Higher proportion get recommended cancer screens than comparable women using private providers
- Lower rate of preventable hospitalizations. (Reynolds and Javorek 1995)
- Among Medicaid covered population, those use CHC have fewer preventable hospitalizations and fewer hospital days. (Rothkopf et al 2011)
- Costs of care less for similar patients.
- Decrease mortality rate of infants and those 50+
- But trouble attracting providers, esp. specialists
- Trouble arranging referrals

Issues re effectiveness of Supply Side Activities

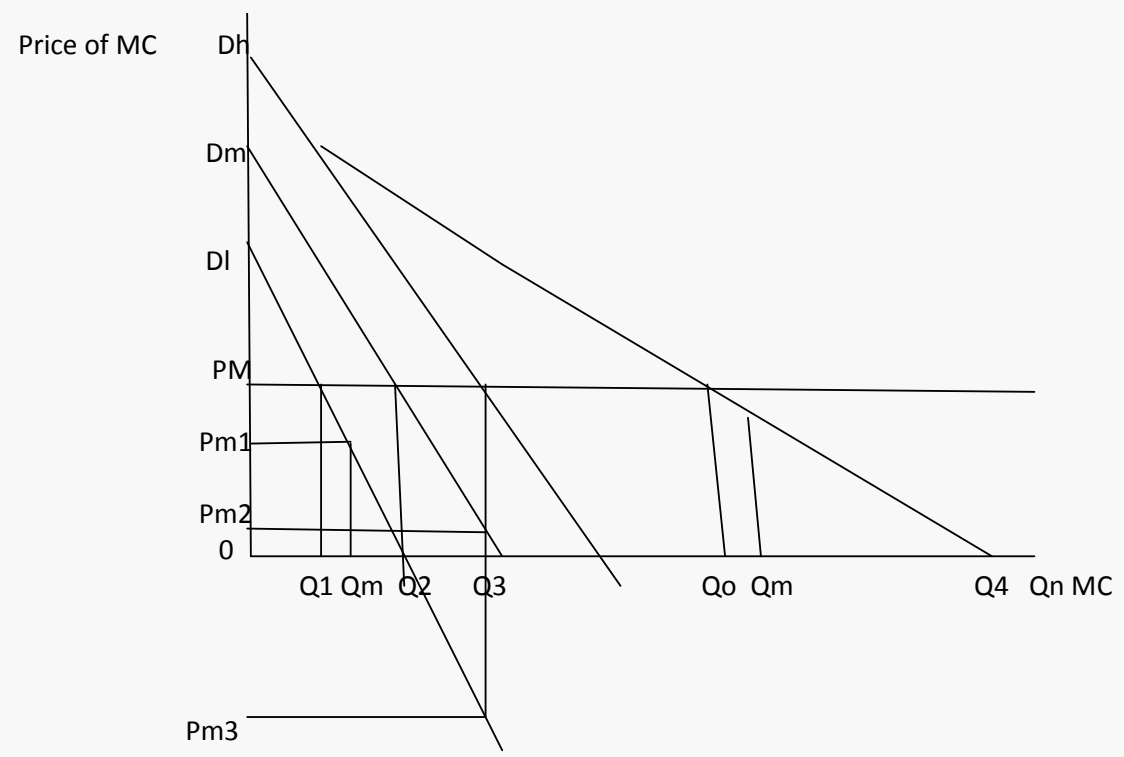
- Funding education of particular professionals or of facilities may influence mix employed – potential of inefficiencies
- Funding facilities to provide care only provides access to those live in area.
- Issue of attractiveness of practice remain
- Consider influencing state licensing laws to permit more use of paraprofessionals

A bit of history about demand side interventions

- Until 1935 assistance with medical care expenses generally done by ad hoc efforts by groups within communities to help some of the poor living there.
 - The poor most likely to receive such help were people who might be termed deserving poor; i.e. not responsible for their poor status
 - children with physical and mental health problems,
 - pregnant women and infants,
 - the blind, and the elderly –
 - According to Swartz, the belief that state and local governments should have primary responsibility for decisions about providing health care to the poor can be traced back to this earlier age.
- In 1935, the Social Security Act was passed. In addition to the trust fund providing pension benefits, the Social Security Act created federal grants to states for income assistance for poor elderly, dependent children and their mothers (what became Aid to Families with Dependent Children), the blind, and crippled children. These categorical grant programs provided federal funds on a matching basis to states that set up the aid programs and the states were in charge of administering the programs. States could set the income eligibility criteria --the precursor to the significant variation that now exists across states with Medicaid eligibility criteria.
- In areas where public hospitals did not exist, welfare departments reimbursed private hospitals for care provided to recipients of the assistance –at rates below the hospital charges to private patients. The pattern of paying below market rates for care of the poor was continued when Medicaid was implemented three decades later.

Demand subsidies: Basic reason – externalities in consumption but what is goal?

Minimum to poor; equal financial access? Equal treatment for equal needs? Equal health status? How achieve each of these? Equal price does not create equal utilization. High income consume more



- Goal Minimum provision: subsidize low income $(PM - Pm1) * Qm$ or make free to all $(PM * Q4)$
- Goal Equal financial access: free to all $(PM * Q4)$
- Goal Equal treatment for equal needs – for low income subsidy $(PM - Pm3)$, for middle income $(PM - Pm2)$ so may require a negative price for some groups.
- Goal Equal health – we do not know how to achieve this.

Public Insurance: Medicaid's Milestones (re: eligibility)

July 30, 1965: The Medicaid program is enacted, to provide health care services to children from low-income families and their caretaker relatives--individuals eligible for Aid to Families with Dependent Children (AFDC), the federal welfare program.

1996: The AFDC entitlement program was replaced by the Temporary Assistance for Needy Families (TANF) block grant. The welfare link to Medicaid was severed, and enrollment (or termination) of Medicaid was no longer automatic with the receipt (or loss) of welfare cash assistance.

Medicaid is:

- Jointly funded by federal and state governments.
- State-administered within broad federal guidelines. 25 mandatory eligibility groups.
- States may elect to cover optional eligibility groups. More than 50 eligibility groups in all.

Eligibility Pre ACA:

- Children in low income families; pregnant woman
- All elderly and disabled individuals who qualify for Supplemental Security Income (SSI), disability cash benefits
- Certain categories of low-income, Medicare-eligible elderly individuals
- 39 states cover “medically-needy” individuals, whose high medical costs could completely deplete income and assets. Eligibility calculated by deducting medical costs from annual income (“spend down”).
- 40 states have expanded coverage for children up to at least 200% of the FPL (SCHIP - enacted in 1997).

Major questions of design

- Eligibility
- Enrollment – how to encourage enrollment of eligible population?
- Payments – how to design so that care is available while minimizing cost of program
- Coverage – what to cover and for whom?
- Design of cost sharing – premium, deductible, co-pays. On whom? For what?
- Length of eligibility before redetermination of eligibility.
- How to minimize crowd out
- State differences in eligibility and coverage

Oregon study – Medicaid Lottery

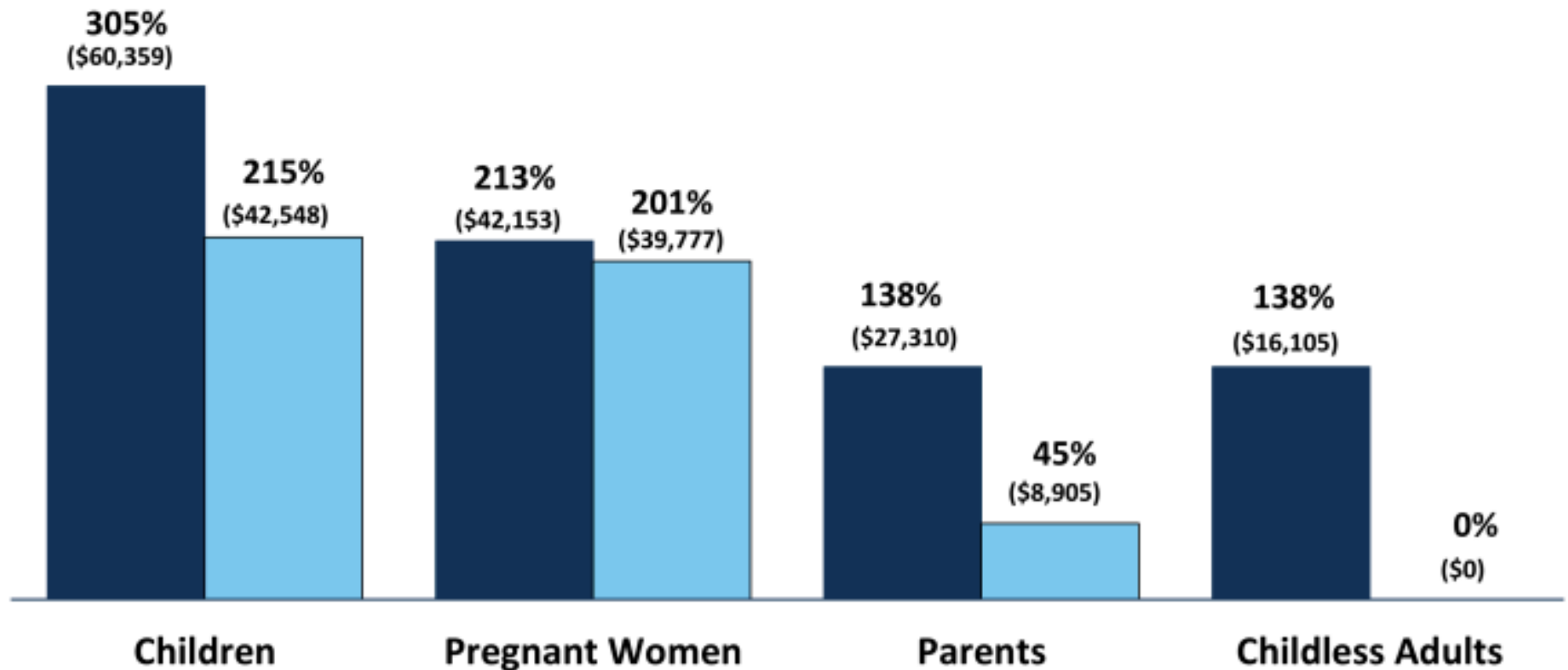
- 2008 lottery: open waiting list for Medicaid for 10,000. 90,000 applied. State drew names, then had to be eligible.
- Study population included 20,745: 10,405 selected in the lottery (the lottery winners); 10,340 not selected (the control group).
- In study-**Controls (N = 5842); Lottery Winners (N = 6387)**
- First year follow-up
 - Greater use of ER
 - Increased use of outpatient care by 35%
 - Increased use of inpatient care by 30%
 - Decreased probability of having an unpaid medical bill sent to collection agency by 25%
 - Increased probability of self reporting good to excellent health (vs PF) by 25%
 - Reduced probability of positive screen for depression by 10%

CHIP-newer public program designed to increase coverage of children

- Joint state federal plan giving states flexibility
- Goal – increase coverage of low and moderate income children. Implemented as part of welfare reform.
- Method – enhanced match by federal government
- Great variability re eligibility, coverage, use of premiums, whether tied to Medicaid or separate.
- **Issues – to what extent succeed in covering targeted children?**
 - **Crowd out? Concern of public sector**
 - **Coverage of parents? Low take-up**
 - **How long will program exist and if sunsets, how will these children be covered?*(set to expire 9/30/2015)**

Median Medicaid/CHIP Income Eligibility Thresholds, January 2015

■ Adopting the Medicaid Expansion (28 states) □ Not Adopting at this Time (23 states)



NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) for a family of three for children, pregnant women, and parents, and for an individual for childless adults. In 2014, the FPL was \$19,790 for a family of three and \$11,670 for an individual. Thresholds include the standard five percentage point of the federal poverty level (FPL) disregard.

SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

ACA Policy Goals

- Expand coverage
- Control costs
- Improve quality of health

Passed in 2010; key implementation in 2014.

ACA: Key Provisions

- Coverage requirement
- Dependent coverage
- Pre-existing conditions
- Medicaid expansion
 - 2010 U.S. Supreme Court Ruling
 - Expansion in 27 states and DC

ACA: Insurance Exchanges

- Individual markets set up and regulated by states to aggregate and ease purchase of individual market insurance plans
- Markets set up state by state, *but* states who don't want to set up their own market can "default" to federally operated version of market
- States have some limited leeway in regulation for things, often in terms of being able to make state federal regulations stricter
 - For example, states can mandate greater minimum plan benefits, or can restrict ratio of age pricing to lower than 3:1
- **Key duty of each state exchange is to operate a platform for consumers to easily compare and purchase insurance plans. This is the website fiasco that occurred last fall.**

ACA: Insurance Exchanges

Federal regulations require that in *any state exchange*, plans must fall within one of four *actuarial value tiers* governing the % of expenditures a plan pays for in an average population.

In many states, specific plan characteristics set for each tier.

Tiers (different levels of partial insurance):

60% actuarial value, called "Bronze"

70% actuarial value, called "Silver"

80% actuarial value, called "Gold"

90% actuarial value, called "Platinum"

Regulation of 60% level for lowest tier is most important, essentially mandates minimum level of insurance

ACA: Subsidies

Subsidies are designed so that specific type of plan offered in exchange (second lowest cost “silver” plan) has following actual premium payments for consumers based on income:

- < 133% FPL pays 2% of income
- 133%-150% FPL pays 3-4% of income
- 150%-200% FPL pays 4-6.3% of income
- 200%-250% FPL pays 6.3-8.05% of income
- 250%-300% FPL pays 8.05-9.5% of income
- 300%-400% FPL pays 9.5% of income

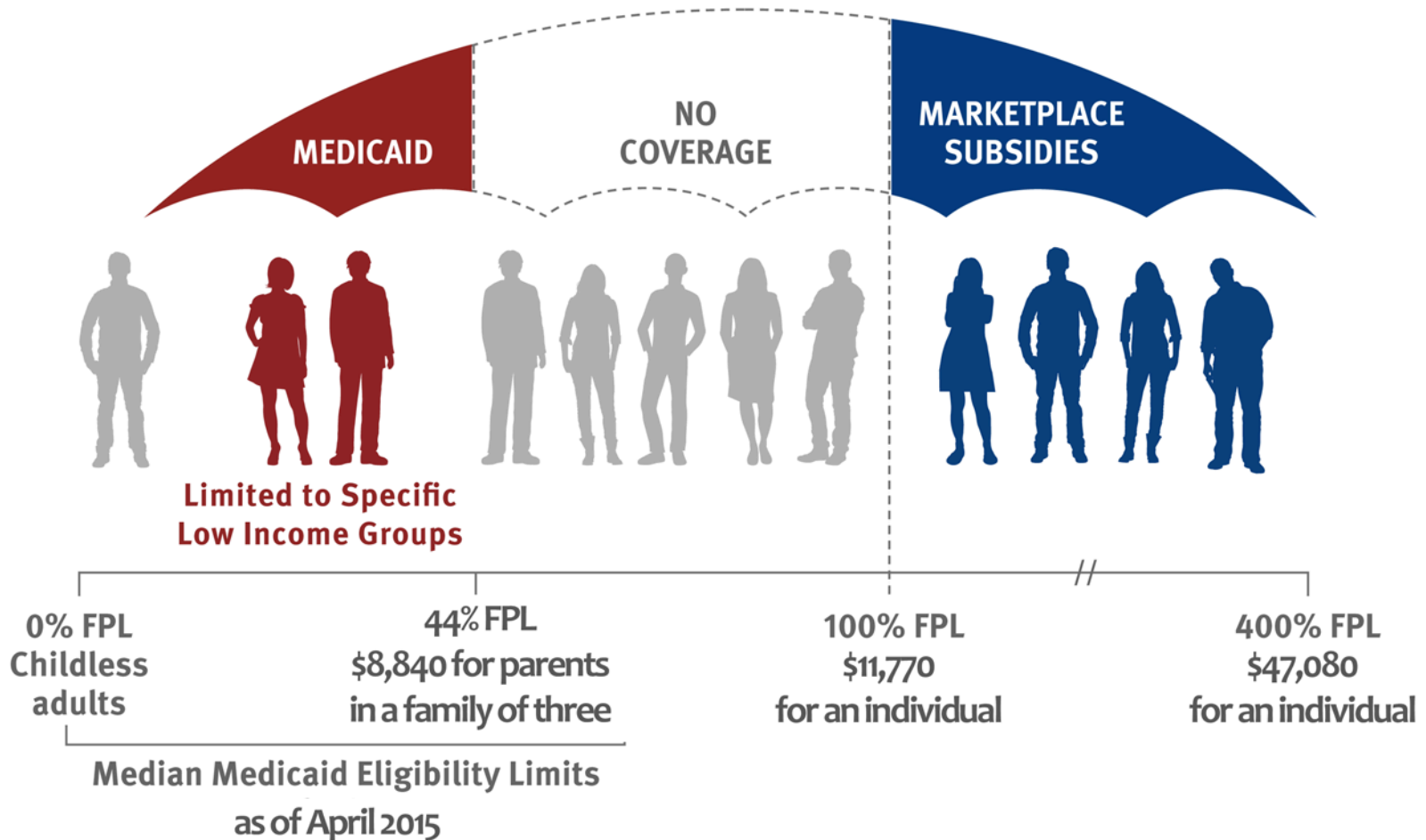
Example: family of 4 earning \$35,000 per year will pay about 7% of income, or \$2,450 per year, for health coverage.

ACA and the Poor- Access to Care

- Major increase in funding for CHCs
- Expansion of program to subsidize training of professional who practice in under-served areas (NHSC)
- Medical Homes for those with Chronic conditions
- Increased provider payments under Medicaid
- insurance companies can no longer charge a deductible or co-pay for recommended preventive services, such as mammograms, flu shots and other immunizations
- No lifetime maximums or cancellation of coverage if get sick
- Those on Medicare get certain preventive services and annual visit without any deductible or co-pay
- Those have part d coverage – in donut hole, series of modifications over time

Figure 1

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.



Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels, updated to reflect state Medicaid expansion decisions as of March 2015, and 2014 Current Population Survey data.

Coverage: ACA, 2014 First 3 Quarters

10 million added coverage (Carman & Elbner 2014; Collins et al. 2014)

Uninsured rate down about 4-5 PP (from 17.9 to 13.9% by or estimate; (Long et al. 2014)

- About 6 PP in Medicaid expansion states (Sommers et al. 2014)

Bigger gains in Medicaid expansion states (Sommers et al. 2014)

Subgroup differences (Enroll America, Civis Analytics)

- Hispanic and Black down by 8-9 PP
- Whites 4 PP
- Ages 18-34 by 7 PP
- Poorest 20% neighborhoods by nearly 9-17.5 PP

Not enough on coverage by those with pre existing conditions.

Basic sources of data and current events

- Kaiser Family Foundation-kff.org
- Commonwealth Fund- www.commonwealthfund.org
- CMS or federal government site: <http://www.medicaid.gov/>
- Health United States (annual) <http://www.cdc.gov/nchs/hus.htm>
- Robert Wood Johnson Foundation News Digest - Health Policy.
 - Can sign up to receive this.
- Daily Health Policy Report: Kaiser Health News.
- Urban Institute:
 - <http://www.urban.org/health/medicaid.cfm>
 - <http://www.urban.org/health/statistics.cfm>

Literature on tie between income and health

- Review chapter on the SES and Health Gradient: Brief Review of the Literature by Wm. Evans, B Wolfe and N. Adler in the Biological Consequences of Socioeconomic Inequalities. Russell Sage Fdn. 2012.
- A. Case, D. Lubotsky and C. Paxson 2002. "Economic status and health in childhood: the origins of the gradient." American Economic Review. 92-5 1308-34.
- Janet Currie. 2009 "Healthy, Wealthy and Wise: Socioeconomic Status, Poor Health in Childhood, and human capital development. JEL. 47-1 87-122.
- Background on programs addressing gaps in coverage
 - Chapter on "The Legacy of the War on Poverty's Health Programs for Non-Elderly Adults and Children" in The Legacies of the War on Poverty, Russell Sage Fdn. (for historical perspective)