Health Policy and the Poor:
Disparities, Public Policies and the ACA

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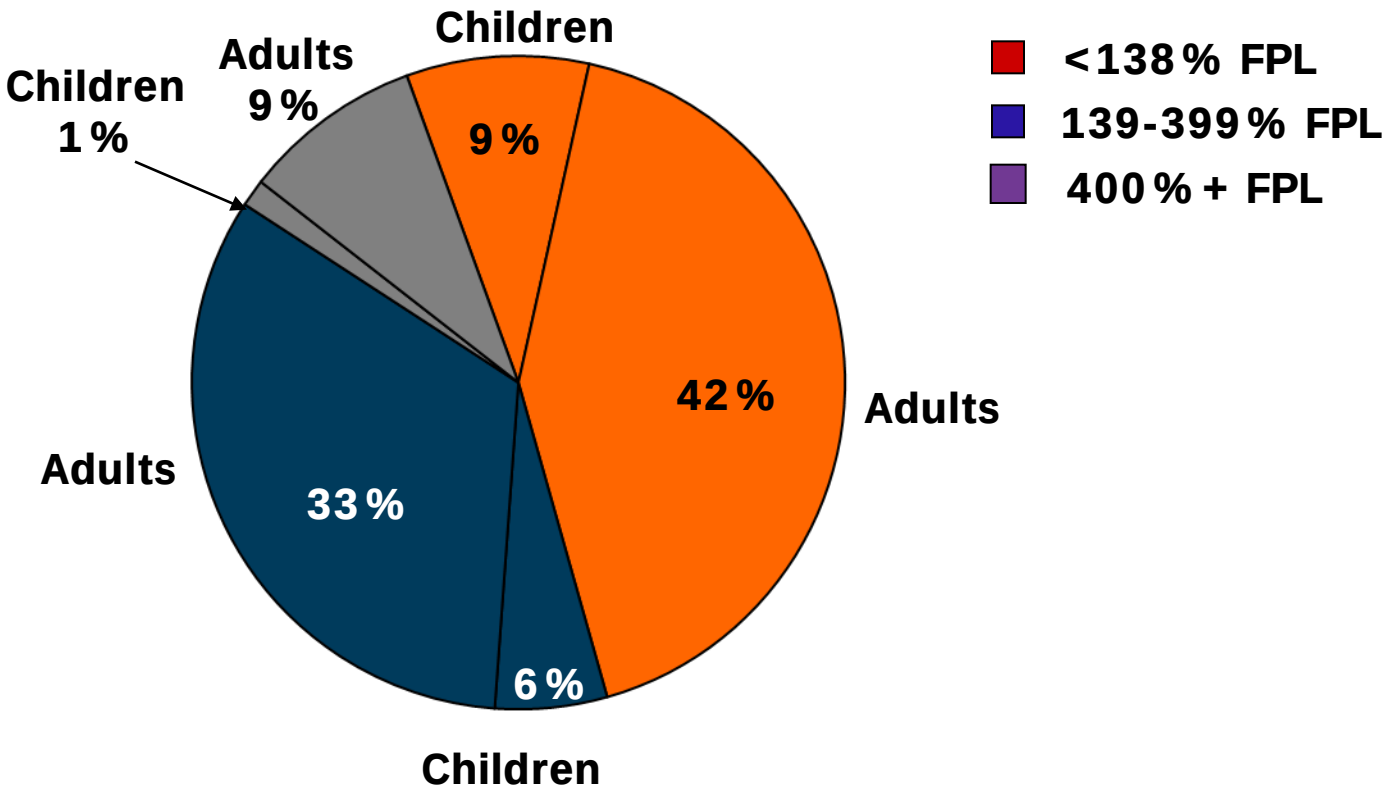
June 4, 2013

Problem Number 1: Lack of Coverage

Nonelderly Uninsured by Poverty Levels and Age, 2011

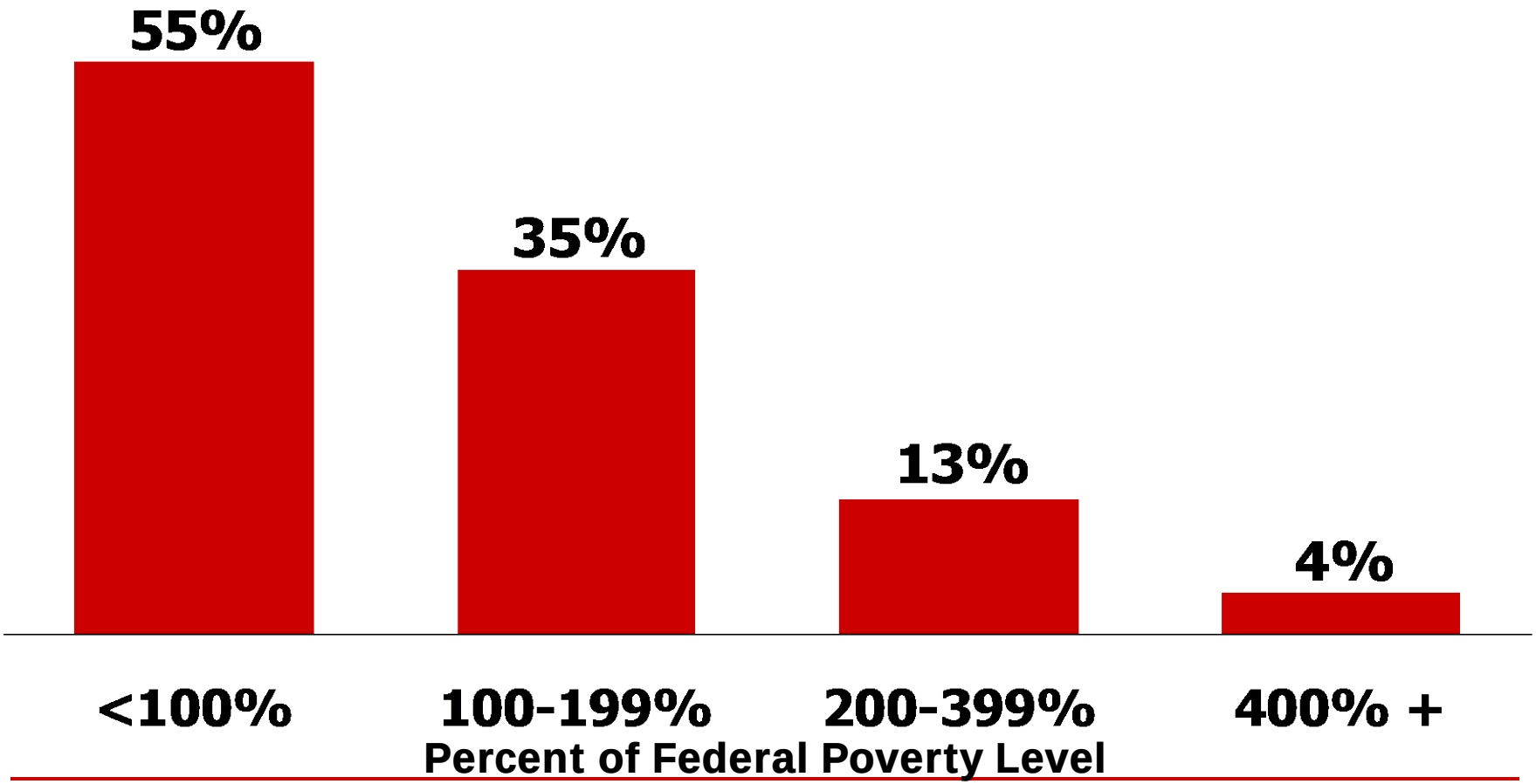


Total = 47.9 million uninsured

Note: Federal Poverty Level (FPL) for a family of four in 2011 is $22,250/year. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

Access to Insurance through the Workplace by Income, 2005

Percent of employees not offered insurance through own or spouse's employer



Source: Urban Institute analysis of the February and March 2005 CPS Supplements, 2006, for the Kaiser Commission on Medicaid and the Uninsured.

Demand Side: Role of Current tax subsidies

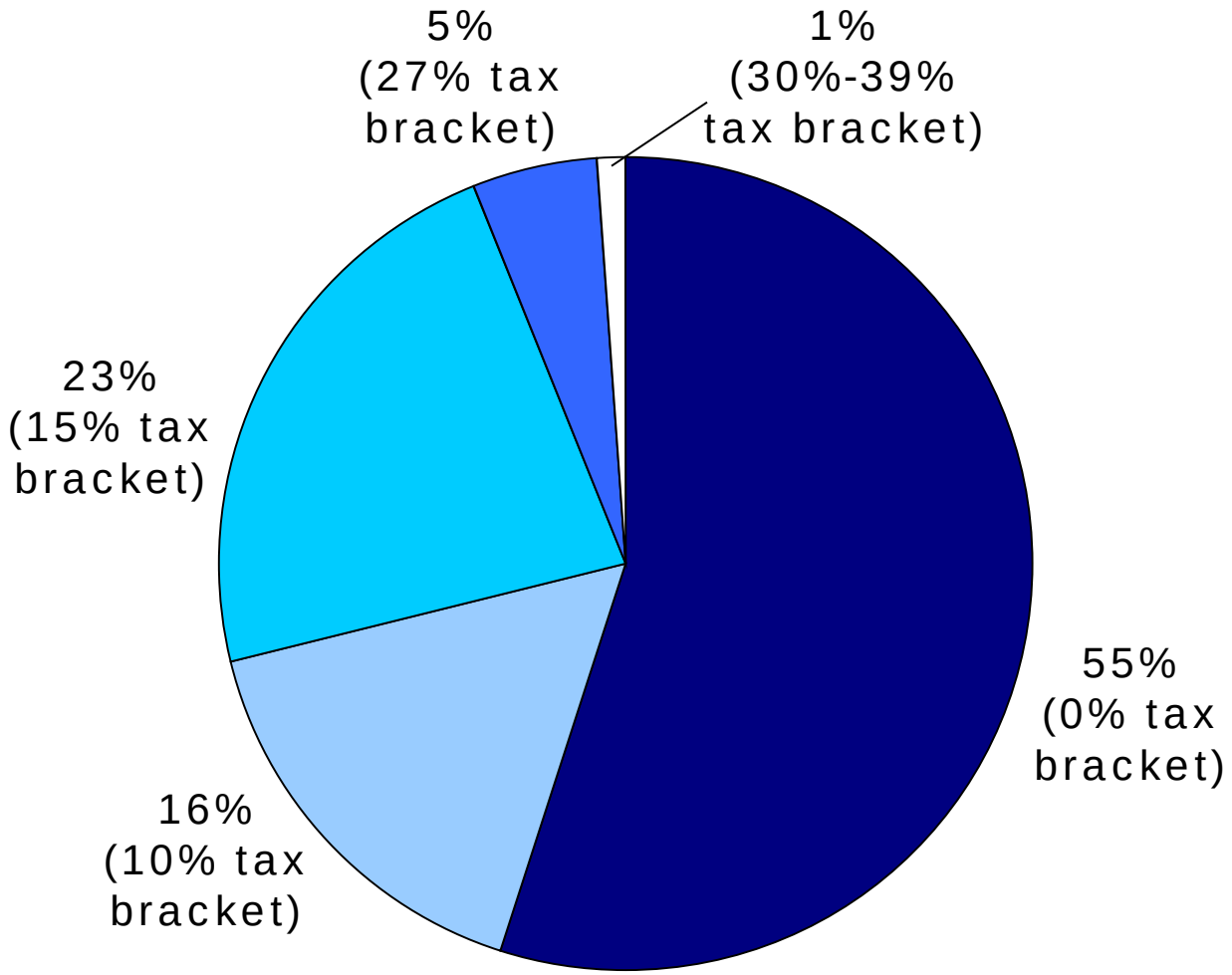
- Under current tax law, health insurance premiums are largely tax exempt if the insurance is provided through an employer; that is,

  The share of the premium paid by the employer is not counted as income to workers and retirees under the 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.

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,

Distribution of Tax Subsidies for ESI

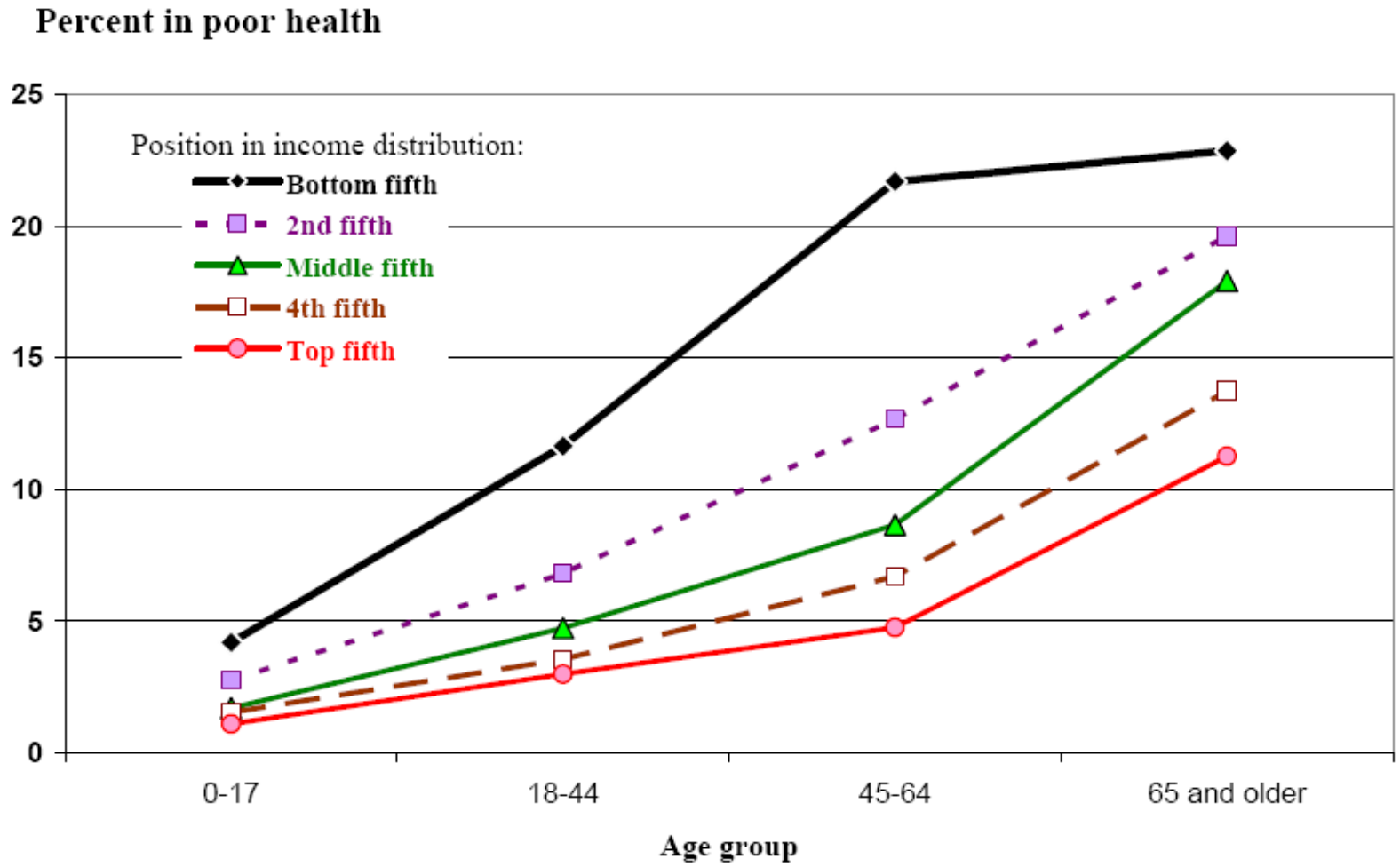
Table 1: ESI subsidies

income (in thousands of dollars)	<10	10–20	20–30	30–40	40–50	50–75	75–100	100–200	200–500	500>
Subsidy rate (%)	7	20	28	30	29	29	30	34	37	35
Premium burden (%)	52	28	18	15	13	11	10	7	4	1
Average subsidy ($)	491	1,535	2,089	2,289	2,314	2,653	3,219	4,234	4,791	4,586

Source: Urban-Brookings Tax Policy Center Microsimulation Model
Note: Income includes value of employer contributions to health insurance. Subsidy includes income and payroll tax savings.

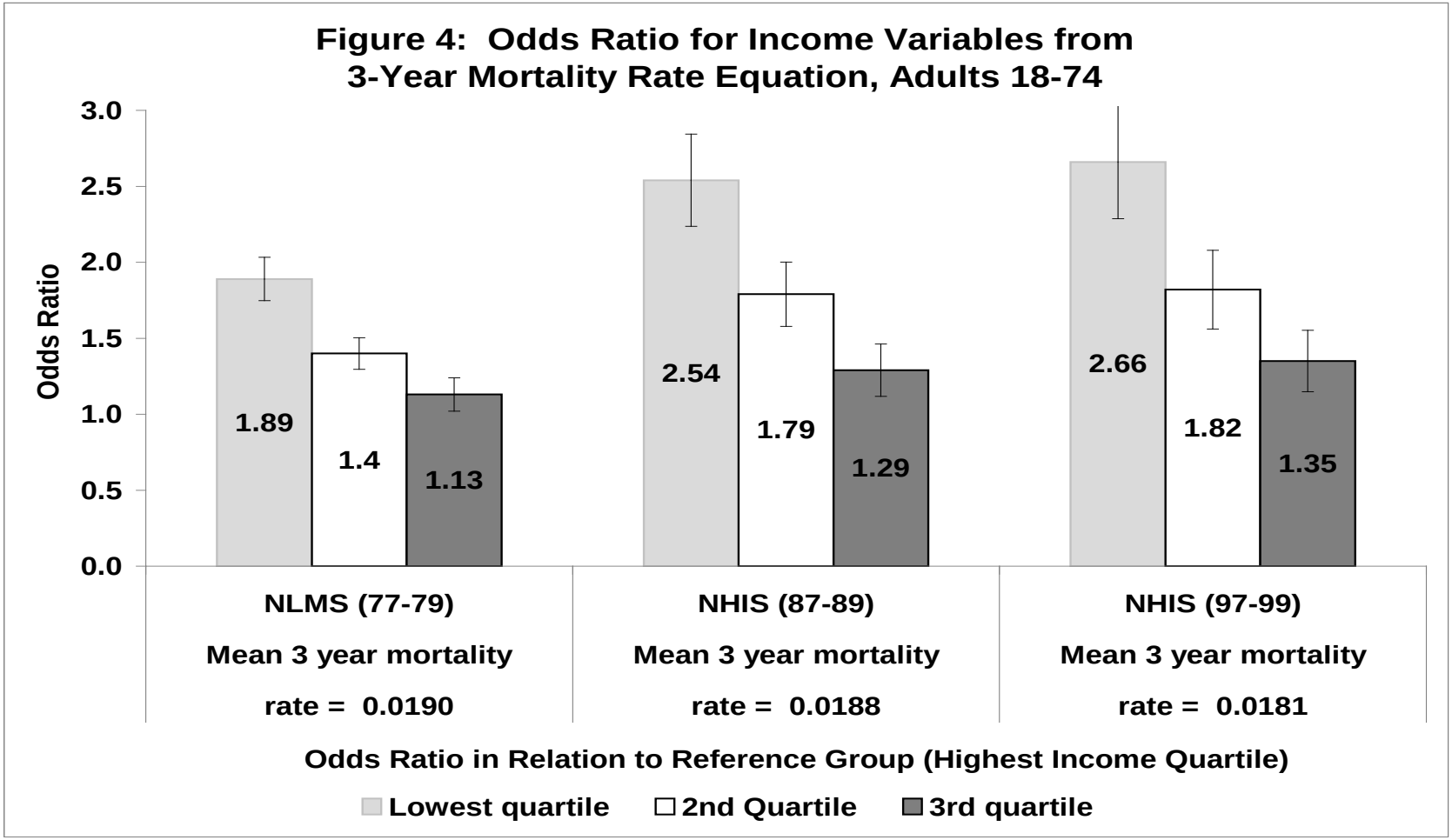
Some measures of Disparities in Health by Income and race/ethnicity

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



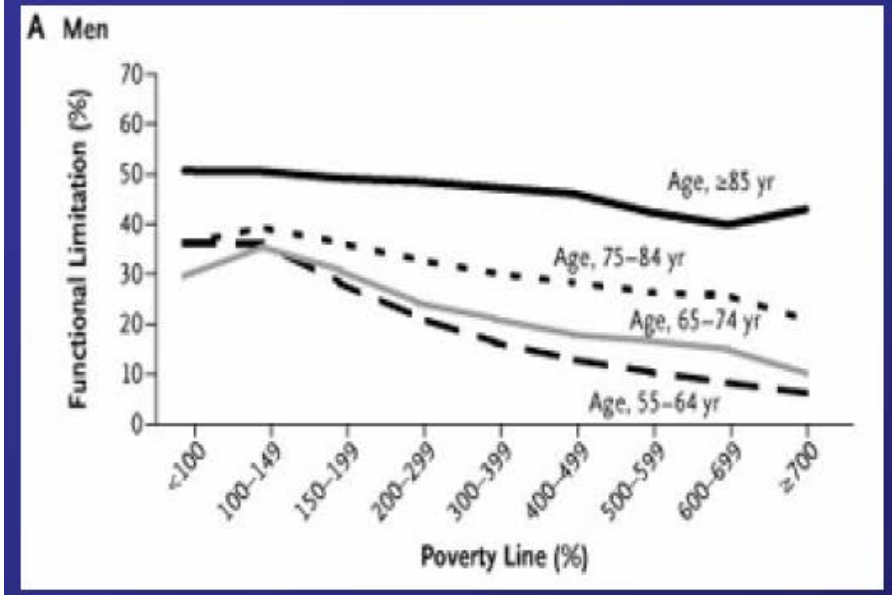
Source: Authors' tabulations of 1996-2005 MEPS household files.

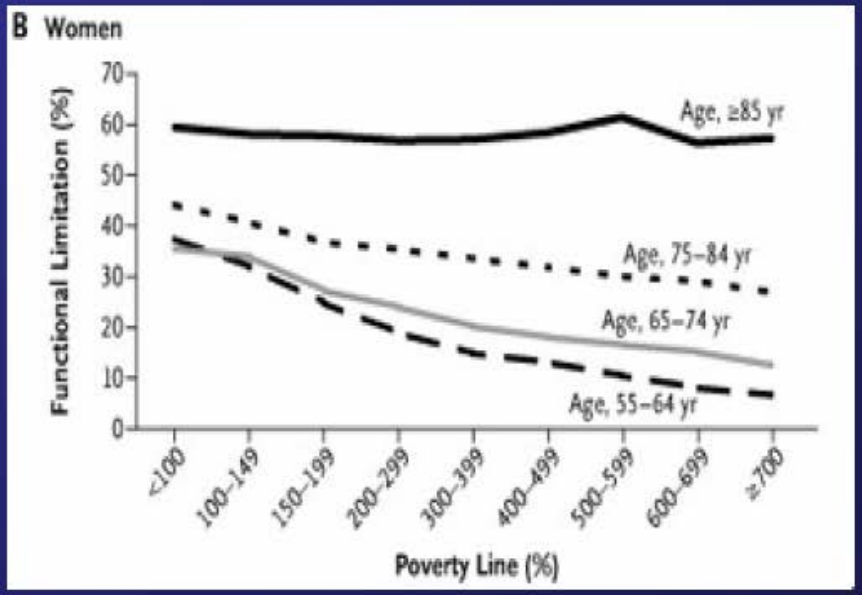
Tie between Income and Mortality-evidence that it is getting worse.



Ties between poverty and activity limitations by sex

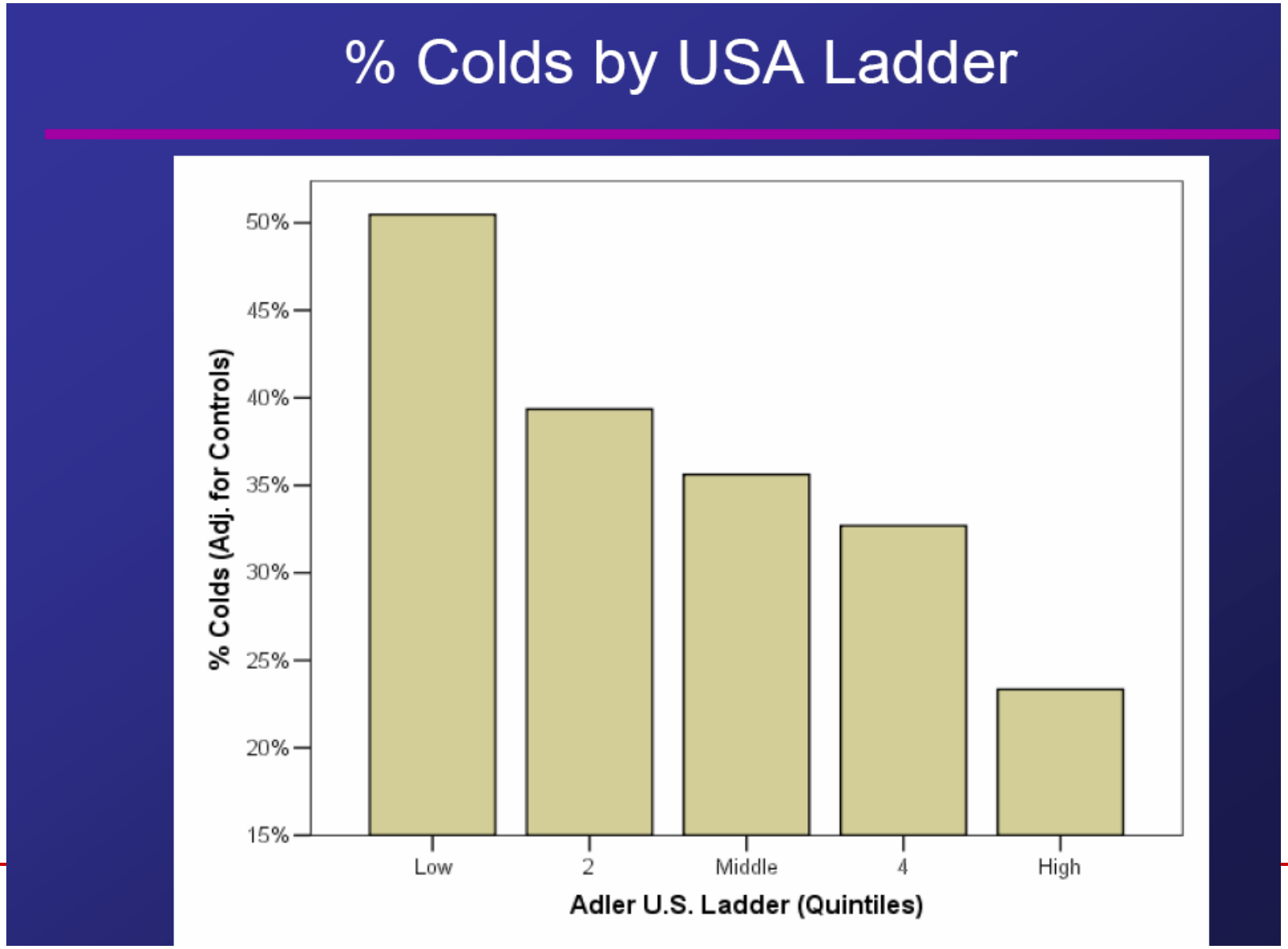
Percentage of men (panel A) and women (Panel B) with functional limitations, according to poverty status





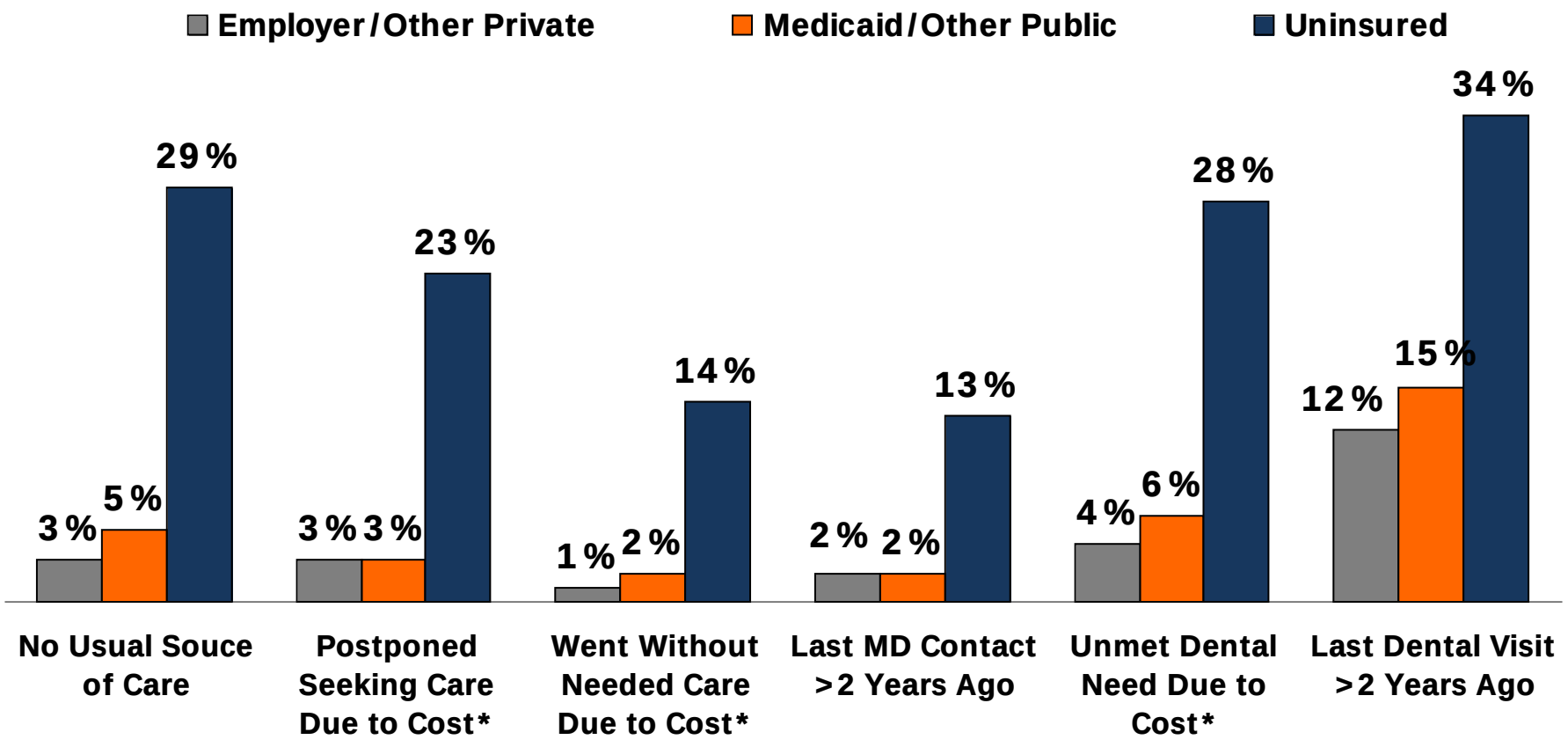
Source: Minkler M, Fuller-Thomson E, & Guralnik JM (2006). Gradient of Disability across the Socioeconomic Spectrum in the United States. *New England Journal of Medicine*; 355:659-703. Figure 1, p. 699.

Even common colds are associated with SES



Disparities in Use of Medical Care

Children's Access to Care, by Health Insurance Status, 2009



* In the past 12 months

NOTE: Questions about dental care were analyzed for children age 2-17. MD contact includes other health professionals. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.

SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of 2009 NHIS data.

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
  - Family income may cushion impacts/reduce frequency
  - Need for targeted policies?

Estimation issues—
Causality and Measurement

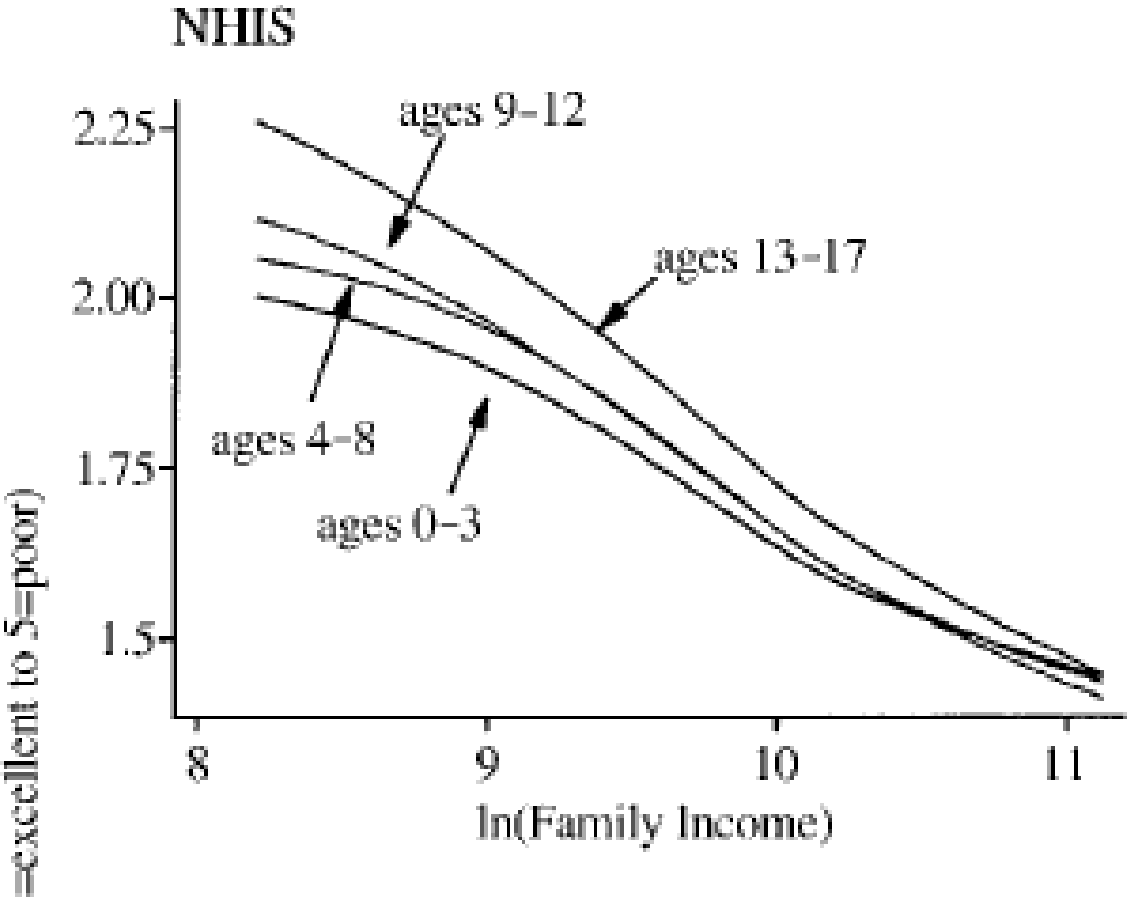
$$health = \beta_0 + \beta_1 \log(income) + \beta_2 X + \varepsilon$$

- 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, A., Lubotsky,D., and Paxson, C., 2002 "Economic status and health in childhood: The origins of gradient." *American Economic Review* 92 pp.1308-1334

- Investigates the relationship between parental income and health during childhood in the U.S.
- Data: Cross-sectional data mainly from the 1986-1995 National Health Interview Survey (NHIS).
  - US children aged 0-17.
  - The main health measure is maternal-reported general health status of children.
- Method: Ordered probit regression
- Findings: Children's health is positively related to family income at every age, and the slope of the gradient increases for older children.
- Implications: The negative effects of low family income on children's health tend to *accumulate during childhood*. Thus, children from lower income families may suffer from both lower SES and poorer health when they transition into adulthood.

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—examples include Indian Casinos, EITC, Progresa, Depressions, Wars

Study pathology and link to SES-example is asthma

Brain scans

New Approach: Study How environment influences biology of child – Edith Chen and her team at UBC; study 30 low and higher income children with Asthma to determine biological process by which low SES influences them.

- Select illness that is more prevalent among those with low SES
- Try to understand the *pathophysiology of the disease of interest*
  - Asthma is a disease involving inflammation of the airways.

    Certain cytokines (chemical messengers of immune system) important

    Test whether SES could be linked to specific biological processes that are implicated in disease

    Hypothesize that SES shapes how individuals perceive their social world

    Developed a set of videos that depict life events with different types of outcomes; ask child to imagine that video applies to themselves

    Document that threat interpretations constitute a statistically significant pathway between SES and the biological (cellular and genomic) processes activated during asthma exacerbations

Chen, E., Hanson, M. D., Paterson, L. Q., Griffin, M. J., Walker, H. A., & Miller, G. E. (2006). Socioeconomic status and inflammatory processes in childhood asthma: The role of psychological stress. *Journal of Allergy and Clinical Immunology*, *117*(5), 1014-1020.

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.
  - The amount of revenue foregone by this exclusion is about 15 percent of direct government payments for medical care.
- **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

- 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
- Supply side
  - Community Health centers
  - VA system
  - Subsidies to educate providers
  - Subsidies to build facilities

Hill-Burton Act—to public and non-profit facilities.

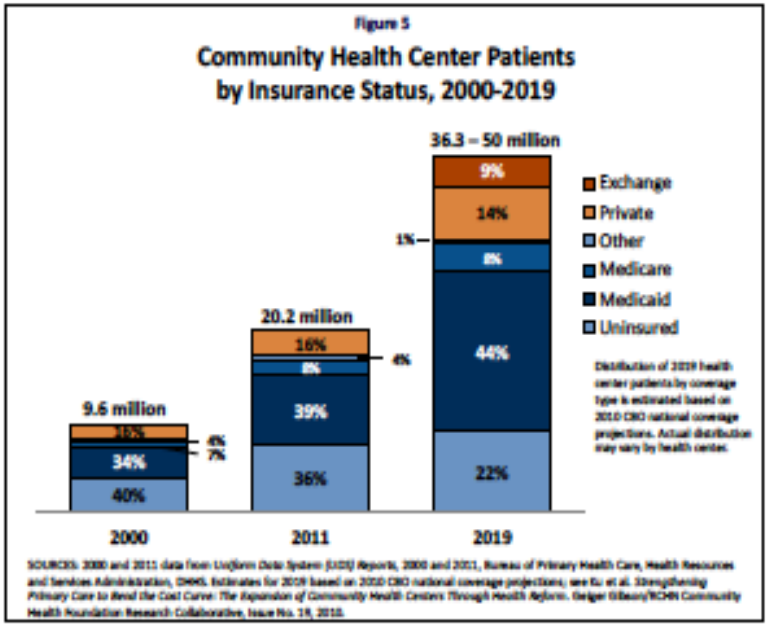
Hill Burton or Hospital Survey and Construction Act of 1946

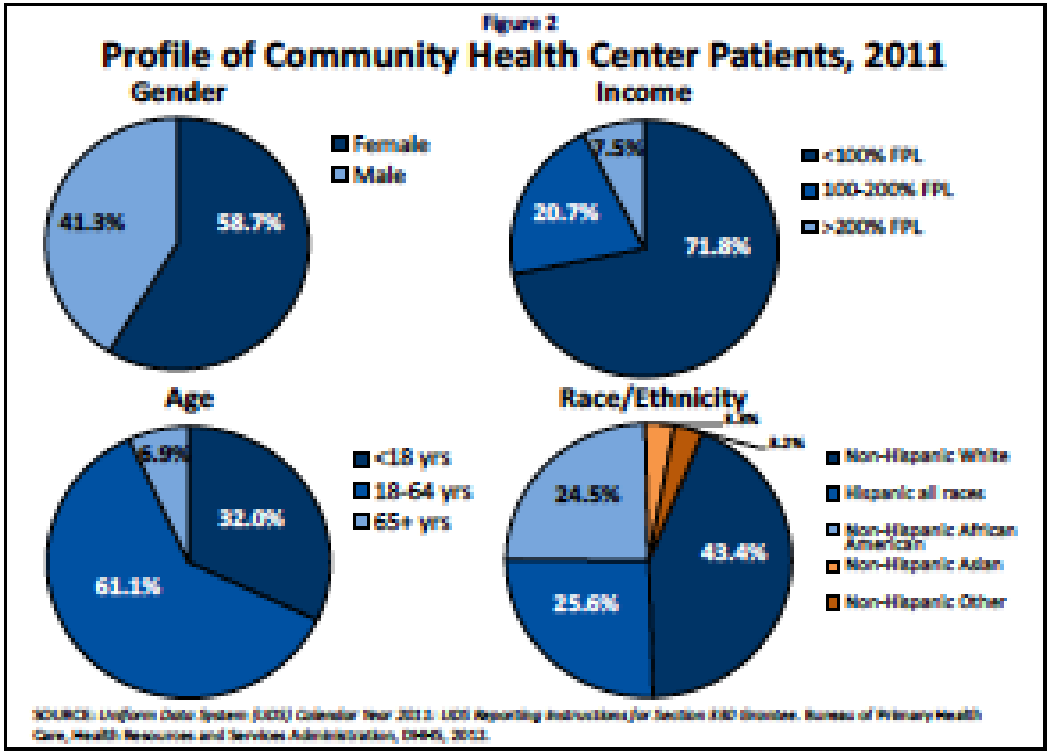
- Act provided grants and low interest loans for hospital construction *only* if recipients accept obligation to provide charity care for 20 years.
- In early years, requirement set at a reasonable volume of free services to persons unable to pay. Beginning in 1979 explicit quotas re amount of "charity 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.
- July 1947 – June 1971 central government invest > 4.6 billion in grants and 1.5 billion in loans for construction, modernization of existing facilities
- 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 2011, 1,128 FQHC operating in 8,500 sites. Served 20.2 million patients, 80 million visits. There were also 100 lookalikes serving 1 million additional patients.

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

Issues re effectiveness of Supply Side Activities

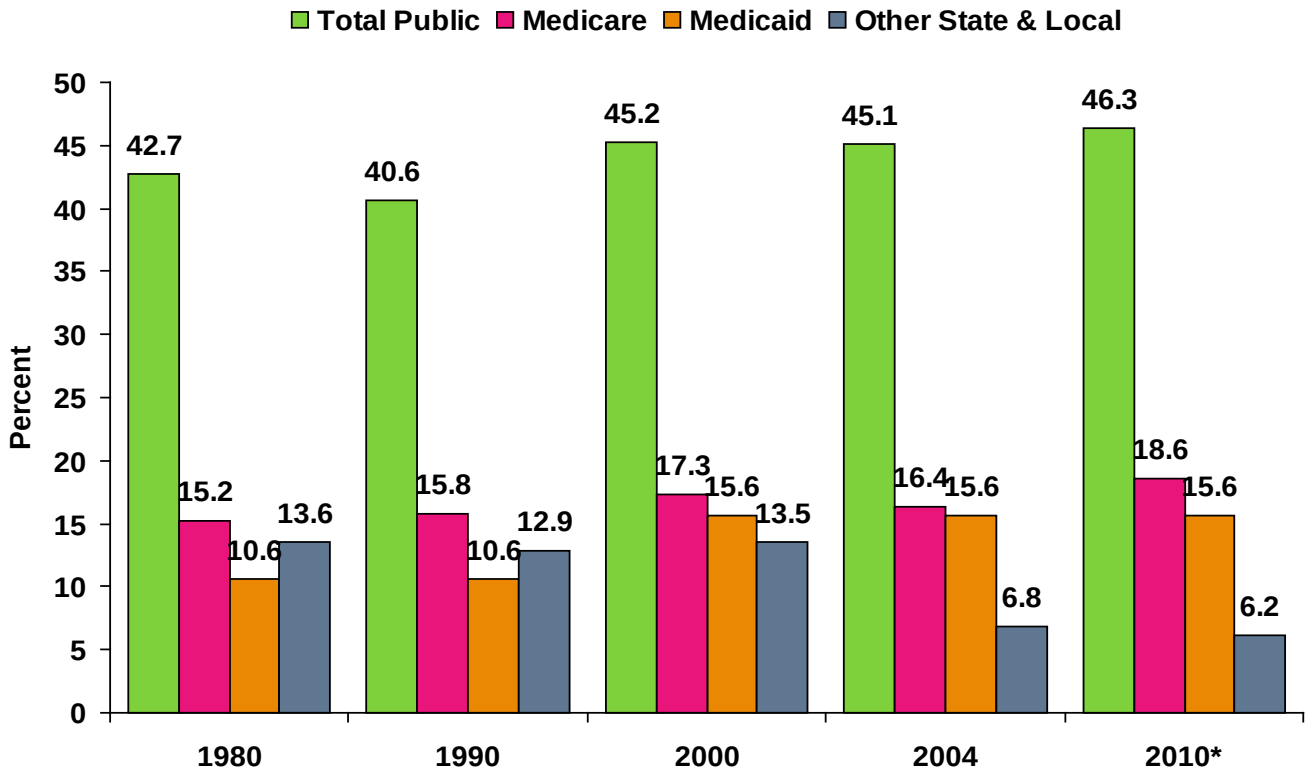
- Funding education of particular professionals or of facilities may influence mix employed –potential of inefficiencies
- Funding facilities to provide care only provides access to those live in area.
- Issue of attractiveness of practice remain
- Consider influencing state licensing laws to permit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

Table 4.1
Public Payers' Share of National Health Spending, 1980-2010

The share of national spending by public payers has increased slightly over the last two decades, driven by faster growth in Medicare and Medicaid spending.

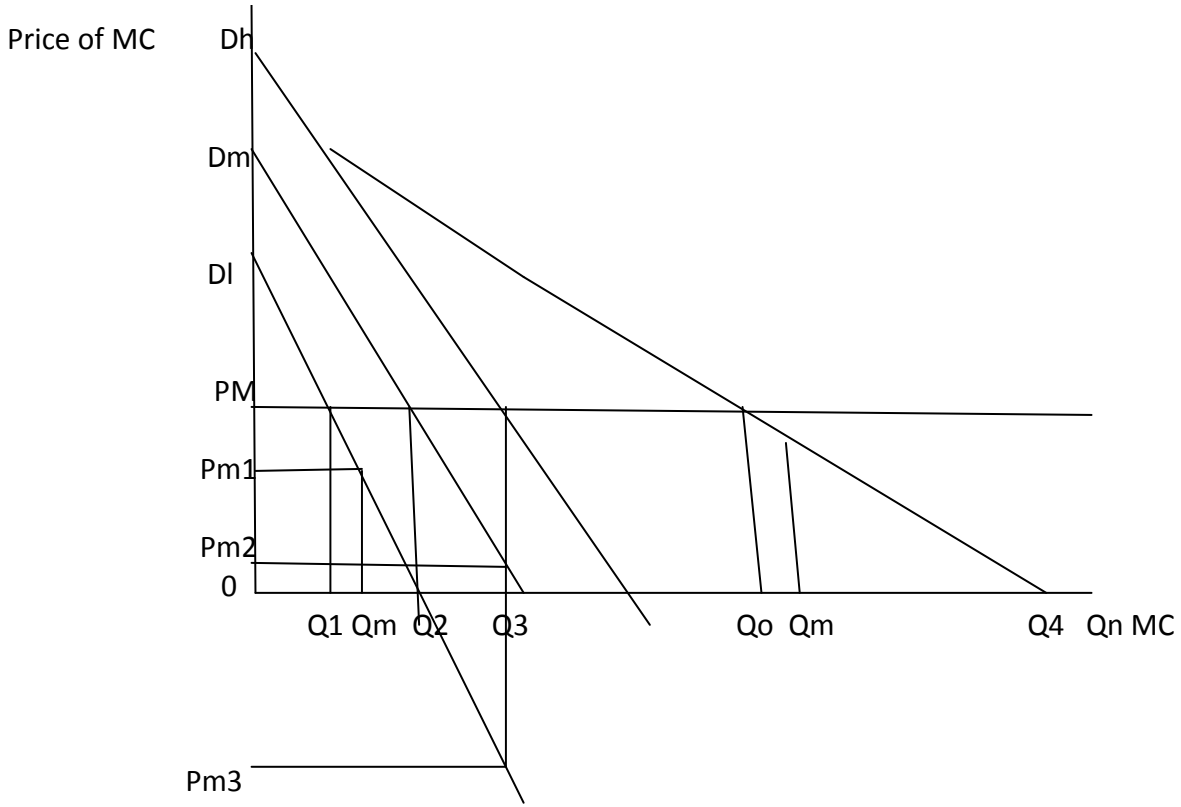


Note: Total public includes Medicare, Medicaid, other federal (not shown) and state and local spending.
*2010 is a projection.

Source: CMS, Office of the Actuary, National Health Statistics Group.

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 subsidiy (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:

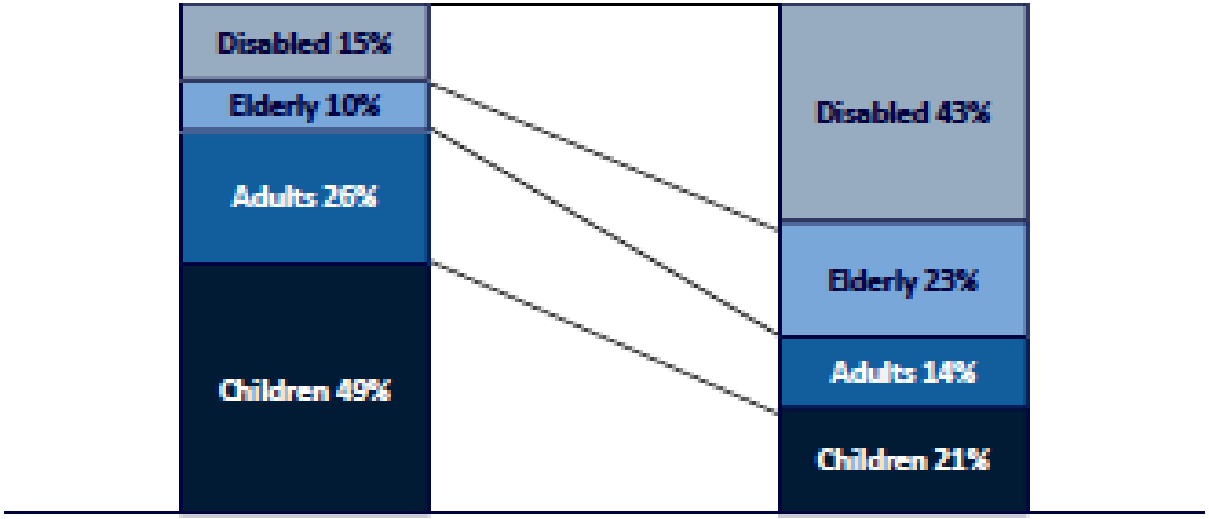
- Jointly funded by federal and state governments.
- State-administered within broad federal guidelines. 25 mandatory eligibility groups.
- States may elect to cover optional eligibility groups. More than 50 eligibility groups in all.

Eligibility:

- 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).

FIGURE 15

The elderly and disabled account for the majority of Medicaid spending.



NOTE: Percentages may not add up to 100 due to rounding.
SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012.
MSIS FY 2009 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.

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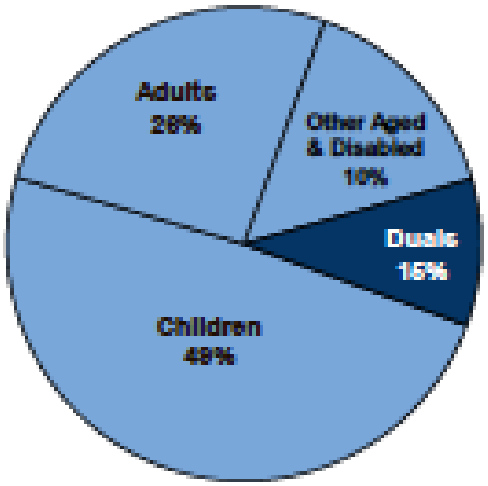
FIGURE 17

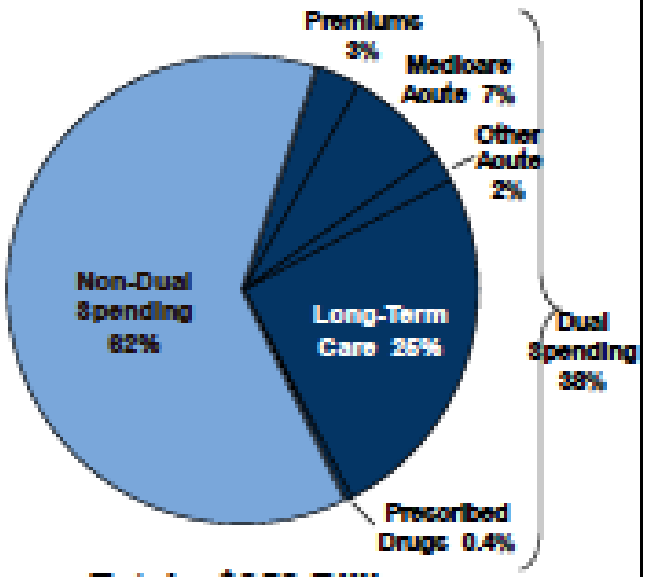
Duals account for 38% of Medicaid spending.

Medicaid Enrollment, 2009



Total = 63 Million

Medicaid Spending, 2009



Total = $359 Billion

SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012.
MSIS FY 2008 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.

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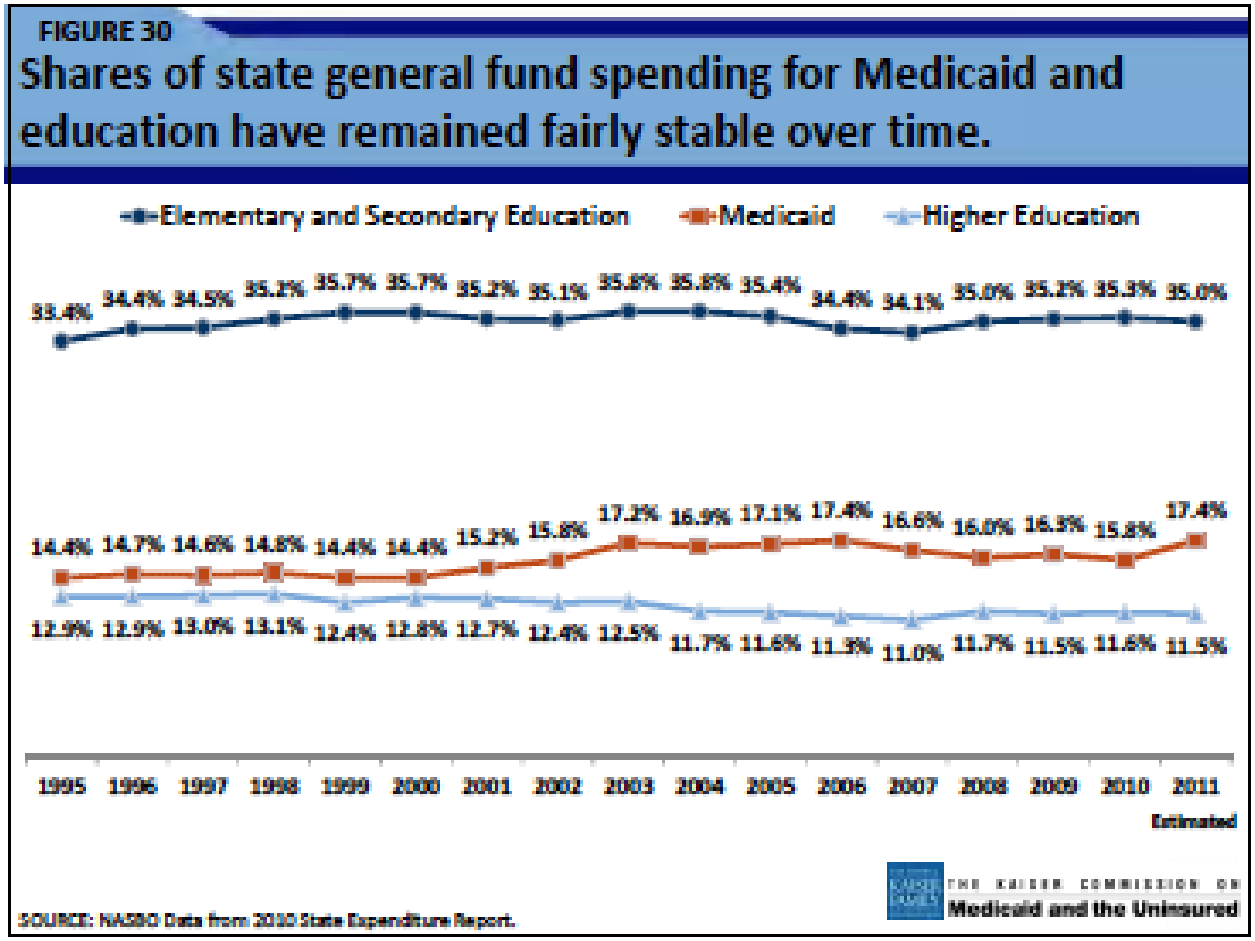
Medicaid is a major expenditure among states



Major questions of design

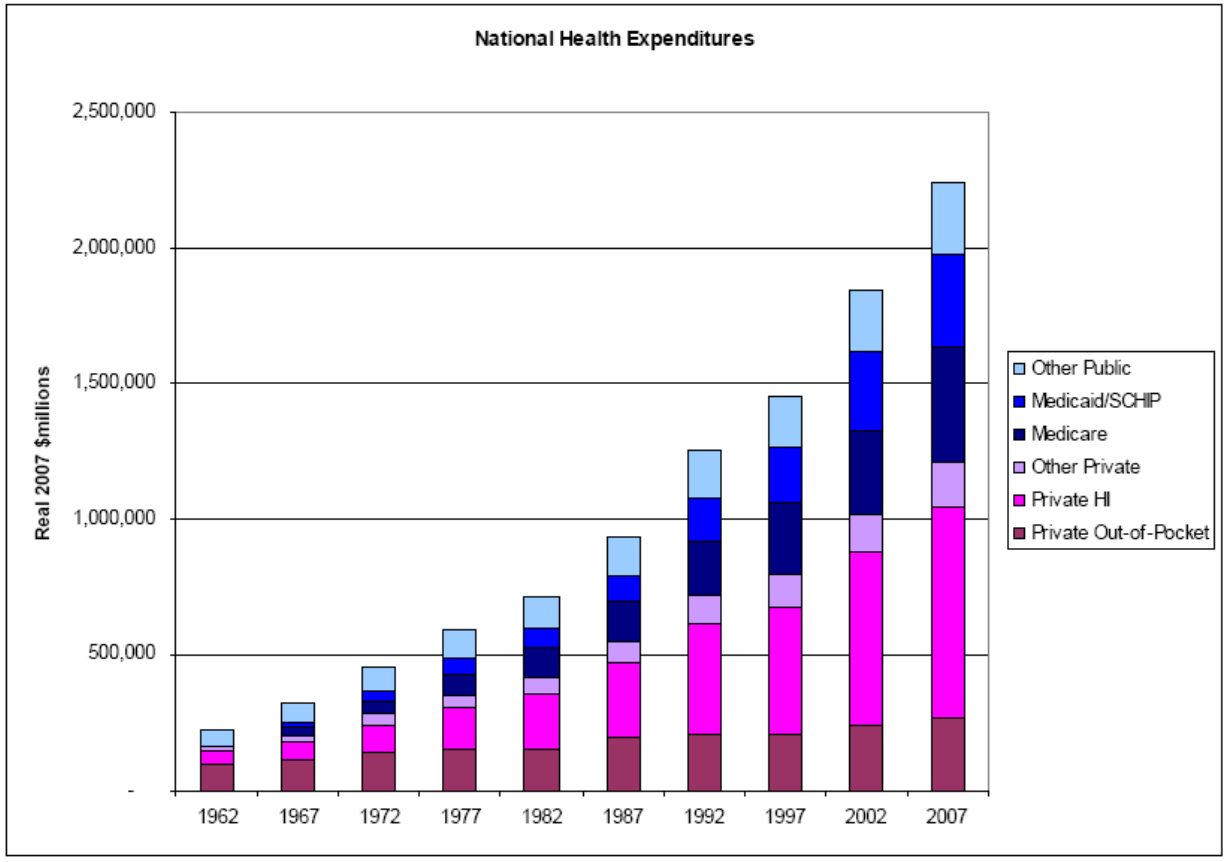
- Eligibility
- Enrollment – how to encourage enrollment of eligible population?
- Payments – how to design so that care is available while minimizing cost of program
- Coverage – what to cover and for whom?
- Design of cost sharing – premium, deductible, co-pays. On whom? For what?
- All or nothing design may increase uninsured population.
- Length of eligibility before redetermination of eligibility.
- Cost sharing with States

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 study? How learn from design?

Public Sector expenditures are large and growing. Even though the US has a low proportion (relatively) funded by the public sector, our public expenditures are ranked third among OECD countries in terms of public per capita spending.

$2,051 US vs. $2202 Iceland, $2063 Germany, $1826 Canada
Weighted OECD = $1424



Source: National Health Expenditures, CMS

Health Care Reform: ACA. A brief overview of Reform

Kaiser Foundation Health Reform hits Main street

- http://healthreform.kff.org/the-animation.aspx

- http://link.brightcove.com/services/player/bcpid1875349721?bctid=608833805001

ACA and the Uninsured-features

- Expand Medicaid- to minimum of 133% FPL – really 138% (MAGI allows 5% deduction of income)
- Subsidies to those with incomes 100 to <400% FPL
- Tax Credits to small firms (<50 employees) and exempt from penalties
- Individual Mandate to buy coverage with limited exclusions-enforced through tax system. Max 2.5% Y
- Penalties to firms if do not offer coverage-up to $2,000 per FTE (excluding 30)
- “Children” eligible to stay on parents’ plan to age 26
  - Do not have to live with parents to be eligible or be a student
  - May be married but spouse and children not covered

Issues with coverage under ACA for the poor

- Numerous states are electing not to expand Medicaid which leaves many adults (childless, single) with incomes <FPL without eligibility for Medicaid or federal subsidies.
  - Children, pregnant women will be covered but depending on the State's 1996 AFDC eligibility, working parents and non working parents may not be covered and childless adults will not be covered unless they are legal immigrants.
  - See http://www.nytimes.com/2013/05/25/us/states-policies-on-health-care-exclude-poorest.html?hp&_r=1&pagewanted=all& for recent update and http://www.kaiserhealthnews.org/Stories/2013/May/02/medicaid-expansion-by-state.aspx for detail on state by state decisions on expansions.
  - Making transition from Medicaid to exchanges and reversed simple and expedient

Constrained Access to Care

- Major increase in funding for CHCs
- Maximums for co-pays for those with incomes <400% FPL—tied to income=constrained.
- 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 is 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

Access problems in terms of health literacy

- **Definition**: skills to function in the health care environment and act on health care information.
- Problem: Associated with poor understanding of written or spoken medical advice, adverse health outcomes, and negative effects on the health of the population.
  - **Utilization**: increased risk of hospitalizations, less use of screening, and fewer recommended vaccinations.
  - **Health**: more teen smoking and other risky behaviors such as carrying a gun, or be in fight requiring medical care.
  - Among diabetes, adherence to testing and levels of HbA1c
- Some indication that interventions such as videos may improve compliance and health among those with particular conditions however studies to date are limited.
- ACA sets aside funds to experiment with ways to improve some aspects including interpreters present at NHCs

Private Insurance Market Problems

- Establish Exchanges
  - Improve comparability
  - Establish minimum benefit standards
- Government site with information on plans
- Eliminate separate market for individual plans- non group market
- Small firms can use exchanges
  - Prohibit insurers from denying coverage or charging people more because they are sick
  - Prohibit insurers from rescinding coverage or placing annual or lifetime limits on coverage
- Facilitates multi state plans

Underserved Areas

- Increase in CHCs
- Financial incentives to providers to locate in underserved areas
  - 10% Medicare bonus payment for primary care services and 10% to general surgeons if practice in HC shortage area
- Loan payoffs to medical students if agree to serve in these areas
- Increase in compensation
- On Indian Reservations loosen requirements, increase flexibility

Gains to those with incomes below 400% of FPL

- Cost sharing subsidies
  - 100-150% FPL 94%
  - 150-200% 85%
  - 200-250% 73%
  - 250-400% 70%
- Premium credits for use at exchanges
  - Set max. contributions to premium tied to lowest cost "silver" plan in area
    - 133-150%FPL 3-4% of income
    - 150-200% 4-6.3%
    - 200-250% 6.3-8.05%
    - 250-300% 8.05-9.5%
    - 300-400% 9.5%

Basic sources of data and current events

- Kaiser-kff.org
  - http://www.kaiseredu.org/en/Topics/Medicaid_SCHIP.aspx
  - http://www.kaiseredu.org/en/Topics/Health-Reform.aspx
- Commonwealth Fund- www.commonwealthfund.org
  - http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx
  - http://www.commonwealthfund.org/Topics/Vulnerable-Populations.aspx
- 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” forthcoming in *The Legacies of the War on Poverty*, Russell Sage Fdn. (for historical perspective)

Discussion of insurance design

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