Rhode Island Policy Reporter

Issue 29 **26 December 2007**

Got insurance?

A New Look at Rhode Island's Underinsured

DAVID A. ROCHEFORT

HAS UNDERINSURANCE BECOME de facto health policy? The question deserves to be asked in view of far-reaching developments within both the private and public sectors that are transforming insurance coverage in this country. The reality is that the underinsured are a growing group in Rhode Island and elsewhere, one that cuts across standard demographic categories but is bound by shared financial uncertainty as well as difficulty in maintaining access to care. More and more, they are also becoming a primary stakeholder in the quest for comprehensive health care reform.

Health care underinsurance is not a new problem. A comprehensive review of research on the topic was published more than a decade ago by Alan Monheit, an employee of the federal Agency for Health Care Policy and Research. He wrote then that the underinsured "may face difficulty obtaining and paying for medical care and their plight has become a primary reason for national health care reform".[1] While noting that "estimates of the population with inadequate health insurance have been uncommon," the author recorded that the earliest systematic study of this group was completed in 1985 with data from the 1977 National Medical Care Expenditure Survey (p. 469). According to that early estimate, those inadequately covered comprised 12.6% of all nonelderly persons in the country belonging to private health insurance plans.

[1]Alan C. Monheit, 1994. "Underinsured Americans: A Review." Annual Review of Public Health 15: 461-85.

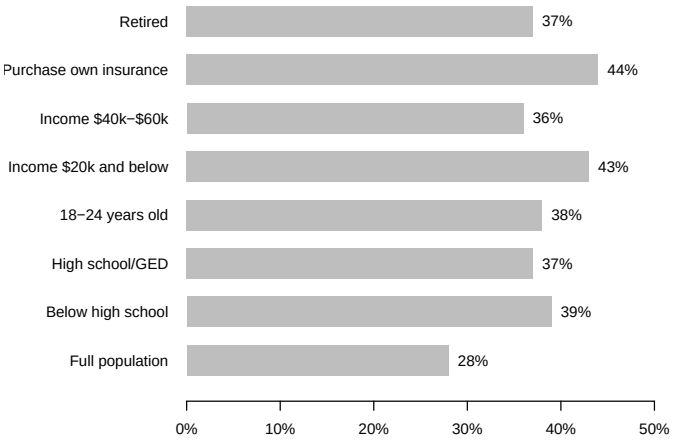

Figure 1: Who are the underinsured? Around 28% of Rhode Island's population spends more than 10% of their income out-of-pocket on health expenses. These are some of the population sectors hardest hit by the problem.

In the late 1980s, the U.S. Congress created a "Bipartisan Commission on Comprehensive Health Care."[2] When the commission's influential Final Report appeared in 1990, it called attention to an estimated 20 million Americans who "are exposed to the risk of devastating financial losses or are unable to obtain needed care because their insurance protection is inadequate."[3] Three factors were highlighted as contributing to high out-of-pocket costs among the insured: the exclusion of particular services from coverage, cost sharing requirements, and maximum benefit limits imposed by insurers per illness, per year, or per lifetime.

Is the real health care problem the uninsured or the underinsured?

Announcing its ill-fated Health Security Act just three years after the appearance of this report, the Clinton Administration similarly acknowledged that, in addition to those without health insurance, "Millions more have health coverage so inadequate that a serious illness will devastate their family savings and security."[4] Despite the overall complexity of the president's reform proposal, his solution for this issue was remarkably straightforward and bold. Clinton sought to establish via federal law "a comprehensive package of benefits that can never be taken away." He intended that all Americans should have protection "equal to that provided by America's major employers, such as Fortune 500 companies." The Act proposed limits on out-of-pocket spending and especially generous benefits for preventive services, with a waiver of "the usual co-payments and deductibles."

Leap ahead to 2007 and Hillary Clinton's campaign for president. Her health care proposal, [5] which was released in September, bears little resemblance to The Health Security Act of 1993. Taking the decidedly less disruptive approach of emphasizing choice among a variety of existing and new private and public coverage plans, Mrs.

David A. Rochefort is Arts and Sciences Distinguished Professor of Political Science, Northeastern University and Visiting Professor, Taubman Public Policy Center, Brown University. His articles on health policy have appeared in Health Affairs, Journal of Health Politics, Policy and Law, Medicine & Health Rhode Island, and other publications. He can be contacted at: d.rochefort@neu.edu.

[2]Subsequently known as The Pepper Commission after its first chair, Representative Claude Pepper of Florida.

[3]U.S. Bipartisan Commission on Comprehensive Health Care. 1990. A Call for Action. Final Report. Washington, D.C.: U.S. Government Printing Office, p. 23.

[4]White House Domestic Policy Council. 1993. The President's Health Security Plan. New York: Times Books, pp. 2, 26, & 42–43.

[5]Find it at *http://www.hillaryclinton.com/feature/healthcareplan*.

Clinton has stopped short of confronting directly the rising out-of-pocket health care costs experienced by many Americans. Her plan, like the one passed last year in Massachusetts, also incorporates a mandate on individuals to purchase affordable coverage. Yet, just as in Massachusetts, much will depend on how this abstract concept of "affordability" is operationalized, as well as the types of benefit plans made available to those lower-down the income ladder.

Much has changed in the health insurance market since 1992. Mostly, we pay more.

The difference between Clinton I and Clinton II is not insignificant. Rather, it reflects a fundamental fact: Increased consumer cost sharing has become an institutionalized feature of the American health insurance landscape, so much so that the situation often is no longer seen as one of the basic problems needing to be remedied by reform. Two dynamics of recent years account for this striking turn of affairs.

First is the erosion of employment-based coverage. Over the past decade, the percentage of employers providing coverage to their workers has fallen sharply. In Rhode Island that figure went from 79% in 1999 to 74% in 2005, or a reduction of about 800 employers.[6] Simultaneous with this "disinsurance" trend, covered workers have had to absorb a greater amount of the cost of medical care due to increased deductibles, copays, and other financial and service limitations within their plans. Again, Rhode Island offers an apt example. By 2005, 18 percent of employers offered plans with deductibles of $1,000 or more for single coverage, and 17% offered plans with deductibles of $2,000 or more for families.

The reasons for this cost sharing movement underline the systemic character of today's underinsurance phenomenon. During the 1980s and 1990s, the dominant approach to health care cost containment was "managed care." Relying heavily on review mechanisms that restricted choices by consumers and providers alike, managed care ultimately met with a political backlash and extensive regulatory controls. The counter-move by employers and insurers was a strategy of cost shifting that presented consumers with new financial "incentives" to restrain their medical spending and use of care.[7]

Second, public officials confirmed this approach within health policy. The Bush health care agenda has focused on combining "High Deductible Health Plans" with special "Health Savings Accounts" to be used by individuals in paying for their medical bills.[8] In Rhode Island, to help balance the state budget, Governor Carcieri proposed steeply higher cost sharing in the health plan of state workers (now on hold due to a court ruling), and the General Assembly approved drug copay increases in the low-income Medicaid program. Seeking to expand coverage among small businesses in the state, the Office of Health Insurance Commissioner also designed a benefit package featuring substantial out-of-pocket costs depending on whether or not workers adhere to certain "wellness" guidelines.

In short, the growth of underinsurance is neither an accidental nor a superficial development. Rather, it is woven into the very fabric of medical care and health insurance in our society, having become an integral part of the contemporary framework for fighting rampant health cost inflation. Until and unless other types of system-wide planning and controls are adopted, the prospect is that this cost shifting will continue.

A recently completed survey of public opinion provides new information on underinsurance in Rhode Island. The research was carried out on October 27-28, 2007, as part of a collaboration between Northeastern University's Community-Based Research Initiative and Ocean State Action.[9] The full sample consists of 410 registered voters 18 years and older, with a margin of error of approximately five points. These data make it possible not only to estimate the extent of underinsurance among the state's population, but also to identify some of the groups most affected and to explore the connection between insurance status and attitudes about health care reform.

Official state and federal policy does not resist, but endorses, the trend.

New data on underinsurance in Rhode Island

Beginning with a standard economic perspective, one question in the Northeastern/OSA survey asked respondents: Would you estimate that you spent more than 10% of your annual income for health care last year in out-of-pocket costs? Among those with insurance coverage,

[6]Office of the Health Insurance Commissioner. 2006. 2005 Rhode Island Employer Survey Report. Providence, October.

[7]Robinson, James C. 2002. "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design." *Health Affairs* Web Exclusive: w139–w154.

[8]The White House. 2003. Fact Sheet: Guidance Released on Health Savings Accounts (HSAs). Available at: *http://www.whitehouse.gov/news/releases/2003/12/20031222-1.html*.

[9]See *http://www.cbri.neu.edu* and *http://oceanstateaction.org*.

Rhode Island Policy Reporter
What's really going on, instead of what's said about it.
Box 23011, Providence, RI 02903-3011
www.whatcheer.net ❦ *editor@whatcheer.net*
subscriptions: $35/11 issues, $20/6 issues
editor & author of unsigned articles: Tom Sgouros
Issue 29 ❦ 26 December 2007 (1.11)

28% stated this was the case. If accurate, this subjective estimate yields a striking percentage of registered voters who meet the spending criterion for underinsurance, and a higher number than many similar studies.

Less rigorous evidence of the issue isn't hard to find. A recent article in the New York Times on health reform in the U.S. Senate told the story of a Capitol elevator operator who faced enormous medical bills because his late mother suffered a stroke during a period when she was temporarily without health insurance.[10] Coverage that fluctuates is another sign of underinsurance. Many insured individuals in our study reported exposure to risk of this type. A total of 10% with insurance today said they did not have coverage at some time in the last 24 months. There were also 33% who felt "very" or "somewhat" concerned they personally might lose their current health insurance coverage.

28% of Rhode Islanders spent more than 10% of their income on health care last year.

With respect to comprehensiveness of coverage, we focused on two service areas that often have gaps: dental care and mental health care. Thirty-four percent of respondents feel that their dental benefits are inadequate, while 14% said the same about their mental health benefits. Interestingly, however, a substantial group of people, 43%, don't know if their insurance for mental health problems is adequate or not, compared to only 12% who gave this response for dental care.

Foregone care and medical debt are serious conse-

[10]Pear, Robert. 2007. "Just Off Insular Senate Floor, Life of the Uninsured Intrudes." New York Times, November 25, p. 24.

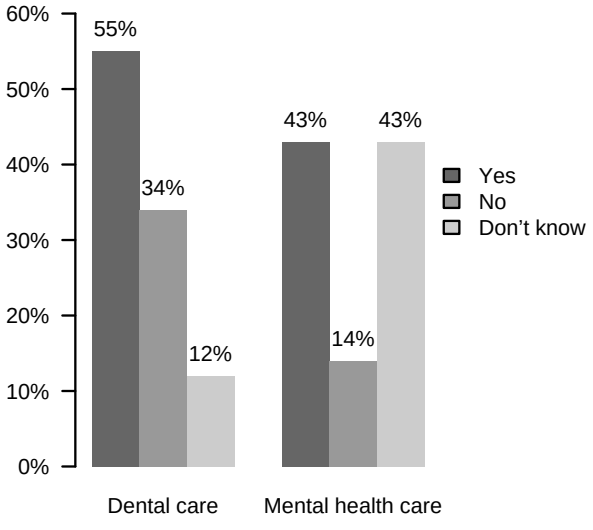

Figure 2: Perception of coverage adequacy in two service areas. Survey respondents were asked whether their insurance coverage for these services was adequate.

A Measurement Quandary

There is considerable uncertainty when it comes to gauging the size of the underinsured population. As noted by Monheit, one must determine *both* the varying levels of individual and household coverage *and* the different possible standards for drawing the line between adequate and inadequate coverage. Whether it is for driving an automobile, protecting a home, or paying for medical treatment, insurance arrangements by their nature involve the assumption of some risk by both the insurer and the insured. What, then, is an improper amount of risk, or vulnerability, in health insurance?

Despite the growing body of researchers who have delved into this issue in recent years, no consensus has emerged. Writing in the journal Medical Care Research and Review in December of 2006, Blewett, Ward, and Beebe catalogued two dozen research studies on underinsurance published between 1985 and 2005.[a] These scholars use a well-known framework to organize studies according to their use of economic, structural, and attitudinal criteria. An economic approach tends to focus on levels of out-of-pocket spending. A structural approach identifies gaps in the set of insurance benefits provided. An attitudinal approach considers perceptions of vulnerability on the part of the insured individual.

Reflecting these alternate definitions, as well as different study populations, empirical estimates of underinsurance in the United States have ranged broadly. Among the group of twenty-four studies compiled by Blewett and her colleagues, the lowest estimate was 4% and the highest was 53%. The most recent study of the general population was done by The Commonwealth Fund in 2003 as part of its biennial Health Insurance Survey.[b] The Commonwealth team defined underinsurance in terms of at least one of three financial indicators: (1) medical expenses equal to at least 10% of income; (2) among low-income adults, medical expenses equal to at least 5% of income; and (3) health plan deductibles equal to or greater than 5% of income. The finding was that 12% of insured people between 19 and 64 were underinsured.

In the Rhode Island survey discussed here, a collection of alternative indicators was used for assessing underinsurance, rather than relying on a single operational measure. These indicators include elements of all three of the economic, structural, and attitudinal approaches summarized here. –DR

[a]Blewett, Lynn A., Ward, Andrew, and Beebe, Timothy J. 2006. "How Much Health Insurance Is Enough? Revisiting the Concept of Underinsurance." Medical Care Research and Review 63: 663-700.

[b]Schoen, Cathy, Doty, Michelle M., Collins, Sara R., and Holmgren, Alyssa L. 2005. "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive: w5-289 to w5-302.

quences, as well as indicators, of underinsurance. Both problems were reported in this survey. We asked, "In the past 12 months, have you or a member of your family put off any sort of medical treatment because of the cost you would have to pay?" and 18% of those with insurance said "yes." Also, 14% of insured respondents confirmed they had medical bills they were paying off over time.

Who is most affected? Underinsurance is not a problem spread evenly across society. For reasons related to the operation of the health insurance and employment markets, as well as the income and age criteria of government programs, certain demographic subcategories are more likely to be underinsured than the population in general. Figure 1 (page 1) identifies some of the social groups more commonly affected by underinsurance in Rhode Island. Young adults, low- and middle-income, respondents with high school education or less, people who purchase health insurance on their own, and retired individuals were those most frequently reporting they met this standard. While this analysis highlights where underinsurance is most prevalent, even groups with below-average rates tend to be affected by this problem to a noteworthy degree. For example, 24% of *full-time workers with insurance* in our sample reported they met the underinsurance spending criterion.

14% say they are paying off medical bills over time, 18% say they've put off care for financial reasons.

Health status is obviously an important concern when considering underinsurance. Two questions in our survey enabled us to explore this relationship. First, we asked respondents to characterize their own health status as excellent, good, fair, or poor. As shown in Figure 3, both those self-reporting as in poor and in fair health had higher prevalence of underinsurance using the out-of-pocket spending measure. Second, we asked respondents if their household included someone with a disability or chronic illness. Those who said "yes" were also more likely to qualify as underinsured.

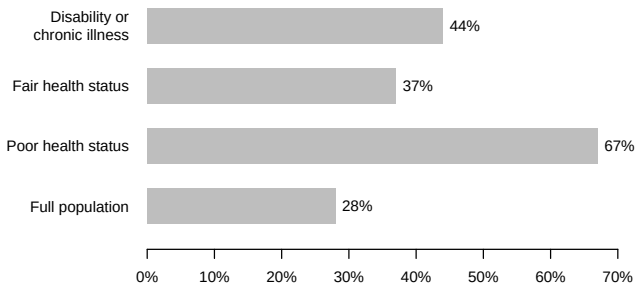

Figure 3: Underinsurance and health status.

Health reform views of the underinsured The primary goal of this survey was to investigate public opinion on the moral and practical issues surrounding health reform in Rhode Island. Included on the questionnaire were numerous items concerning the perceived need for reform and the role of government in addressing problems of access and cost-control. Many of these opinion items took the form of simple declarative statements with which respondents could agree, disagree, be neutral, or give an answer of "don't know."

Does insurance status help to explain differing views on health reform policy principles? To answer this question, respondents in this survey have been divided into three groups: insured, underinsured and uninsured. When the opinions of these three strata are compared, interesting patterns appear.

As displayed in Figure 4, pro-reform views increase as the respondents' coverage decreases. The underinsured fall between the insured and the uninsured in their beliefs that: health care reform deserves to have the highest priority for government to work on among a list of public issues; health care is a right that no one should be denied; and the problems of the health system will eventually be solved by private businesses and health insurance companies without government stepping in.

For two other items, however, the underinsured give even stronger pro-reform responses than either the insured or uninsured. This is evident in their tendency to characterize the health care system in Rhode Island as being "in a state of crisis" and in the number willing to pay more in taxes each year "if it meant that all people in Rhode Island would never have to worry about being without health insurance coverage, no matter what."

10% said they didn't have insurance sometime in the past two years. 33% are concerned about losing theirs.

While not all of these descriptive data would pass a test of statistical significance, taken as a whole they do suggest that the underinsured represent an important constituency for health reform, one whose views are consistent and, at times, distinctive in the desire for government action.

Conclusion A recent report from the Office of the Health Insurance Commissioner (2005) on employment-based coverage in Rhode Island stated the following:

> . . . employers are addressing rising health care costs by lowering their premium contributions and passing the cost on to employees, and by utilizing health insurance plans with higher deductibles, making it necessary for employees to pay more at the point-of-service. Both of these

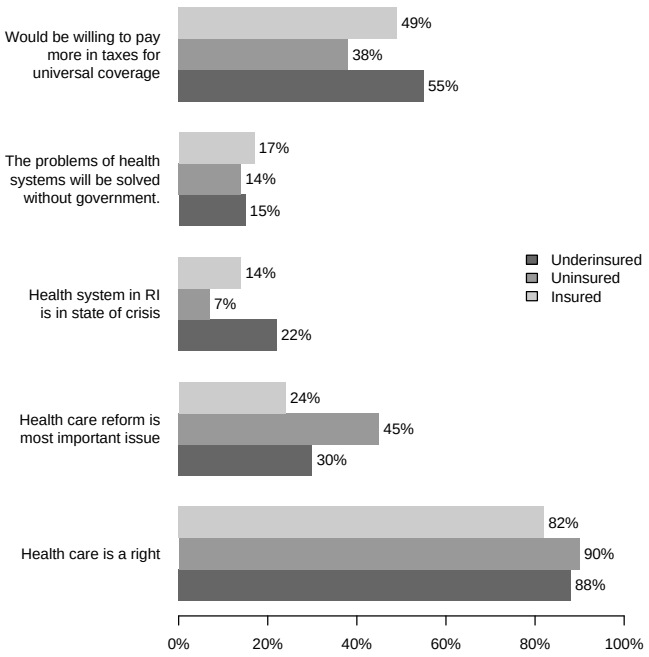

Figure 4: Health insurance status and views on reform of the system.

> strategies can result in employees being underinsured, with potentially significant health consequences. (p. 21)

So it is that the plight of the underinsured is increasingly coming into focus with awareness of the dramatic changes taking place in today's health insurance and employment markets. If Rhode Island is to deal effectively with underinsurance as part of the process of health reform, policy makers and researchers must devote more attention to monitoring this precarious status and its detrimental effects on families and individuals. This article is but a beginning step in that needed effort.[11] ■

[11] You can find more about the Northeastern University/Ocean State Action survey at *whatcheer.net*.

Economic geography in Rhode Island

One of my favorite Christmas presents this year came by email. It was a big wad of IRS data from a friend in Washington: a breakdown of 2005 tax returns by income categories for each of the 91 zip codes in Rhode Island.

A serious problem with statistical analysis is that often when you make an average, you wind up averaging away all the interesting stuff. Here's an example: According to this data, the average Rhode Islander reported gross income of $53,000. Predictably, the three richest zip codes are in Barrington, the East Side of Providence (02906), and East Greenwich, in that order. The average incomes of those places are within spitting distance of each other, around $110,000. You're shocked, I know.

But here's something interesting. I averaged the incomes of everyone who earned more than $100,000, and it turns out the average income of rich people on the East Side is about a third greater than in the suburban towns. (It's even more in 02903, which is College Hill and downtown.) So what pulls down the average? Well, poor people, of course. The East Side zip code also covers Mount Hope, not to mention a ton of more-or-less indigent students. They hide the wealth of the East Side.

One of the proposals that surfaces regularly when people discuss the inequities of the property tax is that of a statewide property tax. Such a proposal hasn't found a prominent champion (thankfully), but I've heard it come up in many forms over many years in discussions about how school funding isn't fair because rich towns can finance better education for their students than poor towns. Several states have enacted some version of a statewide property tax, including Vermont and New Hampshire. Since a great part of the inequity of the property tax is due to the variation between towns, it seems to make sense that making the tax somehow more uniform would be a way to address the problems.

Sometimes averages just hide the interesting parts of the data.

Establishing a statewide property tax, or allocating part of the property taxes collected to a statewide fund would

have the effect of raising property taxes in some towns, and lowering them in others. That would be the whole point, not just an unintended consequence. For the most part, it would be the rich places where the tax went up and the poorer ones where it went down. I learned from looking at these data that this would be a terrible idea, because the towns aren't uniform: there are some pretty rich people in the poor towns, and some pretty poor people in the rich towns, and the effect on both groups would be exactly the opposite of the intention.

For example, Central Falls (02863) is one of the poorest places in our state, and yet there were 48 people there who reported more than $100,000 income. Woonsocket, the 11th poorest, still had 654 six-digit earners. On the other end of the scale, there are 1007 people who reported incomes between $10,000 and $25,000 in Barrington. (They also reported 227 dependents, so they're not all young singles living with their parents.) North Kingstown's 02852 zip is among the dozen or so richest in the state, but it has almost the same percentage of poor children as Bristol's 02809, where the average income is 18% lower.

We talk about rich towns and poor towns, but there are rich people in the poor towns and poor people in the rich ones.

In many ways, our state is fairly segregated. There are poor areas and rich ones, and the residents from each don't mix much. But these areas are much smaller than towns, and even smaller than most zip codes. We might use "rich towns" and "poor towns" as shorthand when discussing school funding issues, but the reality is much more complicated than that, and policy solutions that don't account for that complexity are doomed to failure. The Vermont property tax reform didn't, and was so controversial that it was essentially scrapped within a few years of enactment. (A vastly watered-down version remains on the books.) A statewide property tax here might create the entertaining spectacle of rich people moving into poor towns for the tax advantage, but more likely it would only exacerbate the divisions, by forcing the few remaining poor people out of the rich towns where they'd made their homes.

I also had some fun looking at records of contributions people deducted from their taxes. As usual, the results depend a bit on how you measure. The Elmwood neighborhood of Providence (02907) was 6th from the bottom in contributions when dollars are divided by the number of returns. No real surprise, it's a poor place. But when you divide the dollar amount of contributions by the incomes of the givers, they were the second-most generous in the state, behind only the residents of College Hill.

Measured a different way, the results are a little more provocative. I looked at the contributions by people who earned more than $100,000. When you look at the numbers of these contributions among the state's three richest areas, East Greenwich and Barrington lead the East Side by a hair, with 95% of their rich people making contributions. But when you look at dollar amounts (divided by the givers' income, to be fair), those East Siders' generosity swamps all the competition, followed by Block Island (02807), North Kingstown (02852) and South Kingstown, near URI (02881). Barrington was well back, a hair above the state average, and those rich people in East Greenwich lagged even the state average by a considerable amount, 47th out of 91 zip codes.

There are lots more fascinating details[12] and future **RIPR** issues will contain more of them. Until then, the next time you hear someone tossing around state averages and state rankings, be very suspicious. Not all averages are wrong, but you have to pay attention. ■

[12]Not least that 30 people file returns from 02902, a zip code that apparently contains only the Providence Journal building in downtown Providence.

Here's to a New Year of informed discussion! Don't you have a friend or relative who needs a subscription?

stamp

Rhode Island Policy Reporter
Box 23011
Providence, RI 02903

Issue 29