

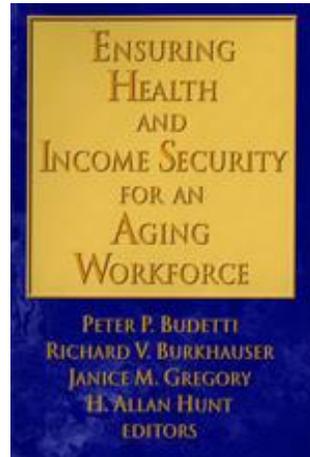
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## Commentary [on Filling Gaps in Health Coverage]

Diane Rowland  
*Kaiser Commission on Medicaid and the  
Uninsured*



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# Commentary

Diane Rowland

*Kaiser Commission on Medicaid and the Uninsured*

Well, this has been a good panel, and I have learned a lot from all the presentations.

From Len Nichols, I have learned that when you go and think outside the box, sometimes you come back to the box as the best option. And that is what I am going to talk about: the box of public programs and where they fit into the solution. What I have been listening to today has convinced me that we ought not to throw out the good in our public programs, since we seem to encounter even more problems when we try to replace them with new strategies—when we go outside the box.

Before I begin to explain why I feel this is true, I would like to mention a few issues that we should bear in mind. First, people without health insurance at any age are vulnerable, and our health insurance agenda for the uninsured should not segment people by age. It should segment them by need, and need is the greatest among the lowest income people at all ages. Today we are focusing on a group of particularly vulnerable people within the low-income population, because we know that uninsured children are healthier than their older counterparts—the non-elderly group that we are talking about today. This group also merits special attention because, while we have made political advances in coverage of children (because they are popular and cheap to cover), we have not done so for the population we are talking about today, a group that is more expensive to cover because they have greater health needs.

Second, in focusing on the most vulnerable populations, I think it is very important to go beyond the work that John Eisenberg and his colleagues at AHCPR did in looking at workers in the near-elderly age group and look at those in that age group that are outside of the workforce, as they may in fact be among the most vulnerable. The non-workers may in fact be those who have higher health needs, contributing to their departure from the workforce. Most importantly, I think we need to look at the fact that there are some significant differ-

ences in this group and the general population in terms of the duration of periods without insurance. These individuals often tend to be out of the workplace if they are uninsured. Therefore, they are more likely to have long and extended stays of uninsurance instead of being in the transitions from one job to another, which is the case with many of the younger uninsured.

Finally, I would like to remind you of some of the problems with retiree benefits. Frank McArdle talked a little bit about the work he did for the Kaiser Family Foundation on this topic. Deborah Chollet also did some related work for the Kaiser Foundation on the individual market, which I think really points out the vulnerability of the people in the near-elderly age group in terms of access to the individual market and affordable insurance. Her work highlights that states don't absolutely protect older Americans from being excluded from insurance coverage because of preexisting conditions and shows that the cost of coverage can be as high as a \$1,000 a month for a 60-year-old male without pre-existing conditions in a high-cost state.

With those issues in mind—the need to help the most vulnerable groups, the problems with access to employer coverage, and the barriers in the individual market—we can turn to understanding this population. We did some work back in 1996 looking at the very low-income population, those under 200 percent of poverty, in the 50- to 64-year-old age group. We found some striking differences in health status between younger and older uninsured low-income people. Nearly half (46 percent) of those age 50 to 64 in our survey reported fair or poor health, compared with 18 percent of those 18 to 24 and 24 percent of those 25 to 49. Health status has been shown to be a solid indicator of health needs. So that as hard as the problem is and will remain helping low-income people to gain access to insurance, low-income older people have some greater health needs that magnify the challenge.

In addition, differences in access to care between low-income people without insurance and low-income people with insurance is striking. When we looked at access to care for uninsured people who were sick—people reporting their health status as fair or poor in the age 50 to 64 group with incomes under 200 percent of poverty—29 percent of that group said they had no physician visits in the prior year, and 22 percent reported that they had no usual source of care. These figures contrast sharply with those for individuals with Medicaid or private

insurance who are equally low income and equally in poor health, only 8 percent of whom report any of these difficulties.

Clearly all of the evidence on health needs and insurance differentials with the pre-elderly group makes a strong case for helping this age group as well as for the younger uninsured. And when we look at how Medicaid performs against private insurance for this age group—they are typically not eligible yet for Medicare—we see that Medicaid is performing as well as private coverage in guaranteeing access and improving coverage.

So, what that leads me to conclude is that we should really look at the public programs, both Medicare and Medicaid, as a strategy for protecting this population. First, I think we really need to look very carefully at Medicare. It hasn't been discussed much here today, but we have some policymakers proposing raising the age of eligibility for Medicare. That clearly is a totally counterproductive policy to the needs of this near-elderly group we are talking about. I did a call-in show in New Hampshire, and I had about seven uninsured people call in, of whom five were in the age 60- to 65-year-old group saying, "I am uninsured and I am waiting for Medicare. I am trying to do all these things to keep my health going or I am postponing different tests because I need to wait until I am eligible for Medicare." So, one strategy that I would strongly recommend is looking at ways to let people gain Medicare coverage on a buy-in basis earlier than age 65, with subsidies for the lower income. Clearly, raising the age of eligibility of Medicare would be a counterproductive step.

I would also urge that for people who retire early and take Social Security benefits at 62, their ability to access Medicare at that point be changed to allow them to be able to gain Medicare coverage along with their retirement coverage. We know that workers who retire early tend to be people who have health problems, so this is a particularly vulnerable group that may in fact not have any access to the individual insurance market when they retire if they can't gain access to Medicare.

Second, I would also urge that we really take a harder look at the policies we have today for coverage of adults under the Medicaid program. Medicaid has increasingly become—with its decoupling from welfare—a program for children and pregnant women. We are now talking about extending coverage to the parents of children who are covered by Medicaid, but we are not talking about what happens to sin-

gle adults and childless couples, who no matter how poor now are ineligible in almost every state for the Medicaid program.

If we want to look at a direct, cost-effective, and efficient way to cover low-income adults, we really need to look at decategorizing Medicaid and making it an insurance program by income, not by category, and really begin to focus on bringing in low-income adults below the poverty level. That would help a substantial number of the people in this age group. We can overcome the state variations in Medicaid coverage that Len Nichols noted by doing the unpopular thing of mandating coverage across states at a specific income level, as we have done for children.

The experience with children has shown that public coverage at the lowest incomes work. But regardless of the specifics of the policy, we really need to take a much harder look across the age spectrum at how our low-income program, Medicaid, and its companion CHIP, are covering not just children, but the adults in those states.

And, finally, I would urge that as we look at all of this, we have the ability to afford coverage as our main criteria, and we do not try to link any of these efforts to the health status of individuals. I have looked at Len Nichols' proposal several times, and I know it is fairly attractive to say we would provide coverage to those who are in fair or poor health. However, I don't think we are quite ready to develop the instruments and measures that would enable us to do so. What we see especially in this age group is that health status can change quite dramatically from one day to another, and we really don't want to link your ability to get health coverage to whether you were sick yesterday or are sick today.

In conclusion, I think that as we look forward to trying to provide better coverage for all Americans, we ought to focus not just on children and not just on their parents, but on people of all ages that are without health insurance. It doesn't matter what your risk is. If you are uninsured, you face problems. And we ought to really look at building upon the Medicare program and the Medicaid program as strategies to provide that protection quite efficiently and with help to those most in need among the low income through the Medicaid program.