

Health Care Access

GLOSSARY

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal law that requires employers to offer continued health insurance coverage for 18 months to certain employees and their beneficiaries whose group health insurance coverage has been terminated.

Federal poverty level/guidelines

The minimum annual income required by a family to meet food, shelter, clothing, and other basic needs: in 1998, \$13,650 for a family of three; the figure varies by family size and is calculated by a formula established by the federal government.

Health Insurance Portability and Accountability Act (HIPAA)

Federal legislation passed in 1996 (also known as Kennedy-Kassebaum) that addresses coverage for three populations: (1) uninsured people who are self-employed or employed by a small business (2) insured workers without coverage during an employment transition; and (3) people with a preexisting medical condition.

High-deductible plan

In the context of the Health Insurance Portability and Accountability Act, a health plan for which the annual deductible is \$1,500–2,250 for self-only coverage and \$3,000–4,500 for family coverage; annual out-of-pocket expenses (excluding premiums) may not exceed \$3,000 for self-only coverage and \$5,500 for family coverage.

BACKGROUND

Access to health care is a measure of the ease with which people obtain the health care they need in a timely fashion. Sometimes people cannot obtain care because their insurance does not cover certain services, or they do not have insurance at all. Sometimes people's access is limited because even if they have insurance, there are few or no providers (e.g., doctors, hospitals, clinics) within convenient distance.

Health Care Coverage

Studies reveal that health insurance is the key factor that determines most people's access to health care services; without it, many cannot afford care. Those with no or minimum coverage often forgo preventive services or delay seeking care until their problems advance and become more difficult (and costly) to treat than they otherwise would have been.

Many people (or their dependents) are without coverage because

- their employer does not provide it (employers are the greatest single source of Americans' health insurance coverage, but many find it too expensive to purchase insurance for their workers);
- their employer covers them but not their dependents (one way employers cut costs); or
- they have declined their employer's coverage because they cannot afford their share of the premium.

In 1995 (at this writing, the latest year for which comparable data are available), nearly 970,000 Michiganians (almost 10 percent of the state population) were without health insurance for the entire calendar year. Nationwide, the rate was over 15 percent (41 million people). Several factors, including age and income, play a role in determining whether a person has coverage.

- In Michigan and nationwide, the nonelderly (those aged 0–64) are less frequently covered by health insurance than the elderly, mainly because Medicare covers virtually everyone aged 65 and older. The majority of the uninsured population is aged 18–29 (nearly 60 percent of Michigan's uninsureds and more than 80 percent of the nation's).
- In general, nonelderly minority populations have a substantially higher uninsured rate than do whites. In Michigan, fewer than 10 percent of nonelderly whites are uninsured, while 17 percent of blacks and 13 percent of Hispan-

Managed care

A broad term for any comprehensive approach to health care delivery that (1) coordinates patient care so as to ensure appropriate utilization of services, and (2) routinely monitors and measures the health providers' performance so as to control cost and maintain or improve the quality of care.

Medical savings account (MSA)

An account styled after individual retirement accounts; uninsured people (or those who have health plans with a high deductible) may use an MSA to purchase high-deductible, low-cost health insurance. MSAs may be sponsored only by small employers (2–50 employees) and self-employed people.

Portability

In regard to health insurance, being permitted to take insurance coverage from one job to another or carry it during unemployment.

Preexisting condition

An injury, disease, or physical condition that a person has at the time a health insurance policy is issued.

Primary care

Basic or general health care provided when a patient first seeks medical assistance; generally entails care and treatment of less complicated, more common illness. A primary care provider usually assumes ongoing responsibility for maintaining the patient's health and treating him/her.

ics are uninsured. Nationally, the figures are 13 percent, 22 percent, and 35 percent, respectively.

- Despite Medicaid, the nonelderly poor—those with income below the federal poverty level (FPL) (in 1995, the year in which these figures were compiled, the FPL was \$12,590 for a family of three)—account for more than a quarter of the nation's uninsured. In Michigan, families with income below 200 percent of the FPL comprise 57 percent of the state's uninsured.
- In Michigan, nonelderly people who live in rural areas are more likely to be uninsured than those who are urban dwellers: state data reveal that almost 15 percent of the former and 10 percent of the latter have coverage. Nationally, the figures are 18 percent and 17 percent, respectively.

Although in 1995 many people were without health insurance, a vast majority had some coverage for at least part of the year (90 percent in Michigan and 85 percent nationwide). More than 70 percent of all Americans were covered by private insurance either offered by an employer (or union) or purchased individually. Almost 14 percent were covered by government-sponsored health insurance, such as Medicare, Medicaid, or a military health plan.

While having health insurance increases the likelihood that one will be able to afford and, therefore, obtain necessary care, even those who are covered often have trouble getting services. Some are *underinsured*—that is, certain services are not covered under their plan; others encounter other barriers.

According to the Medical Expenditure Panel Survey (MEPS) conducted by the U.S. Department of Health and Human Services, in 1996 (most recent data available), almost 12 percent of families seeking care encountered such barriers as cost, having their claim(s) denied, and transportation or communications problems. (Note: The MEPS examines only whether people have *difficulty* in accessing health care; it does not ascertain whether they ultimately do or do not obtain the service.) Of those reporting difficulty, nearly half had insurance for the entire year; the remainder were uninsured for all or part of the year. Among the difficulties cited were cost, the insurance company's denial of a claim, and such other problems as not having transportation, the doctor's not speaking their language, not getting time off from work, and failing to find a babysitter.

Access to Doctors and Hospitals

Health insurance is vitally important in determining whether a person has health care access, but another critical factor is provider availability. A person living in a rural area may have excellent insurance, but if the nearest provider is an hour's drive away, his/her access to care suffers limits. Measures of provider access are the (1) ratio of population to primary care physicians and (2) number of cases in which hospitalization can be avoided if appropriate outpatient or ambulatory care is available.

Over the last ten years, the ratio of Michigan population to primary care physicians has remained stable. The national standard established for adequacy is a ratio of 1,500 people to one physician (1500:1).

- In 1996 the Michigan population-to-physician ratio was 1429:1, virtually unchanged for a decade.
- Although statewide the ratio is better than the national standard, the statewide ratio is barely or not met in more than three-quarters of Michigan's 83 counties: In 65 counties, the number of people for every one physician ranges from 1,430 to 6,270.

State officials also contend that high hospital-admission rates for conditions that could be treated otherwise may be indirect evidence of an access problem and/or deficiencies in outpatient management. In the last decade, Michigan's preventable-hospitalization rate has declined (data indicating how Michigan compares to the nation are not available).

- In 1994 Michigan's preventable-hospitalization rate was 14 per 1,000 population, down from 17 in 1985.
- The rate in metropolitan Detroit is higher than in most other major urban areas in the United States.

DISCUSSION

For the large majority of people, health insurance—provided through an employer or government plan—covers a large portion of their health care costs. If the health plan does not pay the entire bill, the individual must pay the balance out of pocket. For many, the out-of-pocket portion imposes little burden, but for others the expense can be considerable. Those without health insurance must pay for all treatment out of pocket, and this can mean financial ruin. If a person simply is unable to pay his/her health care bill, s/he either must forgo treatment, or the provider(s) must absorb much—and sometimes all—of the expense (this means higher health care bills and restricted access for others).

American law dictates that providers must render emergency care to whomever needs it, regardless of the patient's ability to pay, but the law does not require hospitals and doctors to provide preventive care (e.g., regular checkups) to those who cannot pay.

Proponents of the current U.S. health care delivery system contend that it ensures that virtually everyone has access to medical services. Through private insurance plans, most families have generous health care coverage, while millions of elderly, disabled, and low-income Americans are covered by Medicare, Medicaid, and other government programs. Finally, the uninsured are able to receive critically needed care on a charity basis.

Critics argue that the system, as good as it is, has serious flaws. For example, they point out that people can amass ruinous health care bills even if they are insured; a patient's health plan may not cover needed services or may cover only part of the expense. Critics also believe that the system reduces health care to a commodity that is provided as charity to the poor but enjoyed at will by the more affluent, which amounts to class-based discrimination. They contend that access to basic health care is a privilege that should be enjoyed equally by all.

Choosing a Reform Strategy

Some policymakers favor a *universal* (covers everyone) health care delivery system that would ensure at least certain health care benefits for everyone, regardless of employment status or income. In 1993 President Clinton proposed a system based on this premise, and for almost ten years, some Michigan legislators have proposed creating a state-run, publicly funded universal health plan.

A universal plan receives most support from those who believe that access to basic health care is a right; they argue that it is government's responsibility to guarantee people's rights, and, therefore, it should play an integral role in providing health care coverage for all citizens. They also contend that the only way to control rising health care costs is through government inter-

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vention. The government could, for example, cover early and preventive care that is relatively inexpensive but ultimately saves money by ensuring that certain conditions do not occur or worsen (opponents point out that many health plans already cover an array of preventive services because they recognize the cost- and health-saving benefits of such care).

Opponents to universal coverage argue that the law already ensures people's access to care by requiring providers to render emergency service. They maintain that it should not be government's responsibility to guarantee health care. If it were, the government would have to tax heavily and limit its provision of numerous other non-health (e.g., education, defense, foreign aid) services. Finally, they argue that if the federal government becomes the nation's health insurer, many people actually would lose access to certain services. For example, universal health care proposals may entail health care *rationing*—deciding in certain circumstances *not* to perform certain procedures.

Neither the Clinton nor Michigan's universal health care legislation has been enacted. This session's re-introduction of the Michigan legislation (HB 4367) likely also will die.

Although most Americans are happy with the current health delivery system, a good many also believe that it needs substantial repair. Rather than revamp the entire system, however, policymakers are focusing on reforms that will extend health care access to certain populations, particularly children, the elderly, and the poor. Policymakers also are concerned with protecting consumers' rights when it comes to health insurers' decisions regarding whether they will cover certain benefits. The following summarizes the major national and state policy initiatives to improve people's access to health care.

Federal Health Insurance Portability and Accountability Act (HIPAA)

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 (also known as the Kennedy-Kassebaum bill) is heralded by some as the most substantial health care access legislation

adopted in the past decade. The HIPAA specifically addresses access for the following populations:

- Generally healthy people who are (1) uninsured or have high-deductible plans and (2) self-employed or work for a small business (2–50 employees)
- Workers with health care coverage who lose or leave their job and normally would be without coverage during the employment transition
- People who have a preexisting condition (e.g., a physical disability, chronic illness, cancer) and for whom coverage under a new plan could otherwise be delayed or denied

Medical Savings Accounts

The HIPAA established medical savings accounts (MSAs) to help uninsured people (or those with high-deductible health plans) pay for their health insurance. During a 1997–2000 pilot program, the federal government will allow 750,000 small employers (2–50 employees) or self-employed individuals to establish tax-exempt MSAs.

The accounts allow the holder to purchase a high-deductible, low-cost health insurance policy, which is less expensive than one with a lower deductible and higher cost. People put into the MSA the money they save by purchasing the lower-cost plan and then draw from the MSA to help pay the higher deductibles.

Supporters of MSAs explain that they are an attractive option for young, healthy people who have few health problems. Not only may people use an MSA to pay for their health insurance, but they also may enjoy a tax advantage for doing so. If one does not make substantial withdrawals from the account to pay for his/her health deductibles, the account will develop a surplus that may be used in later years to pay for expenses not covered by Medicare. Critics point out that the accounts are not well suited to those in poor health, who could exhaust their MSA completely and still have to pay the deductibles out of pocket.

Health Insurance Portability

The HIPAA ensures that workers who lose or leave their job have health insurance “portability”—that

is, they may carry coverage with them. They may purchase new health coverage or keep their former coverage if they have (1) maintained continuous private coverage for 18 months prior to enrolling in a new plan and (2) exhausted their Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits.

Michigan, however, was ahead of the federal government in this regard. About ten years ago, mandatory group-conversion coverage was adopted in Michigan, which allows people to assume full payment of their health premium so as to keep the coverage they had with their previous employer; workers may choose this option regardless of whether they are eligible for COBRA.

The HIPAA's portability provisions are lauded as (1) preventing "job lock," which occurs when a person is forced to stay in a job for the sake of having health insurance and (2) protecting people from losing health care because they become unemployed or self-employed. Some observers point out, however, that although the HIPAA allows people to keep coverage, they must assume the full cost for it once they leave their employer (before, in most cases, their employer shared this expense). Still, supporters argue that HIPAA's portability provisions give people employment-transition health-insurance options they formerly did not have.

Preexisting Conditions

The HIPAA prohibits insurers from denying coverage because one has a preexisting condition that has been diagnosed or treated in the preceding six months. An insurer may delay covering a preexisting condition (except in the case of newborns, adopted children, or pregnant women) but only up to 12 months; moreover, 12 months is a lifetime limit, and no further waiting periods may be imposed unless the individual allows coverage to lapse for more than 63 days. (Again, Michigan has bested the federal government: The state Patient Bill of Rights [see below] restricts preexisting exclusions to six months.)

The act also prohibits insurers from designing policies that intentionally exclude workers or their de-

pendents on the basis of the worker's health status, and no worker or self-employed person may be charged rates higher than those charged to others in his/her group, nor may one be denied coverage enjoyed by all others in the group.

Although HIPAA's preexisting-condition exclusion provisions ensure that people may not be excluded indefinitely from health insurance, critics point out that the legislation does not restrict what an insurer may charge for group or individual coverage, and insurers may charge one group or person more than others. This means that health insurers could charge certain groups so much that they could not afford the insurance. Policymakers are considering caps on the amount health plans may charge for coverage so that certain groups (e.g., those with high-risk populations that likely will require substantial and costly medical services) will not be excluded from access to health insurance.

Patient Bill of Rights

Public Acts 472 and 515-18 of 1996 comprise Michigan's Patient Bill of Rights. The laws prohibit health insurers doing business in Michigan from excluding or limiting coverage for a preexisting condition for more than six months. As does federal law, the Michigan statute prohibits insurers from excluding/limiting coverage for anyone previously covered under a group health plan.

The Michigan Patient Bill of Rights also guarantees insurance renewability—that is, health plans and insurers must renew group and individual health policies except in cases of fraud or premium nonpayment. This ensures that if a person's health policy expires, his/her health plan will continue to extend coverage. The package also instituted a grievance process that allows patients to appeal an insurer's decision to deny payment for a certain covered benefit.

Other Michigan Access Initiatives

Mandated Benefits

Pending before Michigan lawmakers are several bills to expand insureds' access to certain services, such as homocysteine testing, which many claim can pre-

dict a person's risk of heart attack or stroke, and diabetes equipment and supplies. Although some health plans provide such coverage, others do not.

Tax Breaks

Michigan lawmakers have before them several bills that would give employers and individuals tax incentives to purchase health insurance. Among them are

- SB 30, permitting individuals to take an income tax deduction for all monies paid for health care,
- SBs 332–33, creating a single business tax credit for certain employers who offer specific health policies, and
- HB 4152, establishing another income tax deduction for premiums paid for coverage from Michigan health plans

Proponents of tax breaks that individuals may apply to certain health care costs point out that businesses are allowed to deduct all costs in providing health insurance to their employees, and they argue that workers also should be permitted such deductions. They contend that tax breaks will encourage more people to buy into health insurance plans and also provide relief to insureds who incur substantial medical expenses despite their coverage.

Those who support additional employer tax breaks also argue that many firms still do not offer health insurance to their workers, and these employers should be encouraged as much as possible to offer at least basic coverage.

Others contend that tax breaks alone are insufficient to encourage employers to purchase health coverage for their employees or for people to buy it themselves: Even with the proposed tax deductions and credits, employers and individuals still must assume most of the cost themselves.

Expanding Medicare

President Clinton proposes lowering the Medicare eligibility age and allowing others—the uninsured and those aged 55–64—to buy into the program with a \$300–400 monthly premium. This would allow Michi-

gan citizens who meet the age requirements and currently are without health insurance to buy into the Medicare program at a rate, claim supporters, below that which they would have to pay for comparable private insurance. Supporters argue that the plan could ensure comprehensive coverage for millions of Americans; detractors argue that the plan only will add to Medicare's current financial problems.

Covering Children

Perhaps no other recent initiative has gained more attention than the 1997 federal children's health insurance plan, which has allocated \$24 billion (over five years) to help states provide health coverage to uninsured children. (This is an example of "devolution," the shift from a higher to a lower level of government the responsibility for decision-making in regard to government services.) Michigan's share of the pool is \$467 million over five years. States are permitted to expand Medicaid for this purpose or create a separate program. Michigan policymakers have opted to pursue a combined approach: (1) expand Medicaid to children whose family income is below 150 percent of the FPL, and (2) initiate a new state program—MICHild—for children who are aged under 19, live in a household having income at 151–200 percent of the FPL poverty level, and are not eligible for any other health insurance program, including Medicaid. In total, the state expects to cover about 156,000 children, two-thirds the state's uninsured youth.

Access to Providers

Although discussion about health insurance seems to monopolize the access debate, also important to patients is doctor/hospital availability. In some places there is an oversupply (particularly of doctors), while elsewhere there are too few. Although this is a pressing matter in many communities, it is difficult to address directly; that is, lawmakers cannot require a hospital to locate in a particular area or force doctors to practice in one place rather than another.

To address this problem, Michigan, along with many other states, allows doctors to reduce their student-loan burden by agreeing to practice for a given number of years in a rural community or underserved

inner city, and many patient advocates are encouraging funding for clinics that serve as hospital outposts in such locations.

Managed Care

Policymakers also see health care delivery costs as a barrier to people's access to health care: The more it costs to deliver care, the more people have to pay for coverage. There is great interest in finding ways to incorporate managed care into government-funded health care programs (e.g., Medicaid). The hope is to improve the efficiency with which services are delivered, mainly by (1) regulating the extent and manner in which patients use care and (2) monitoring physician performance.

Many patients who have or once had traditional fee-for-service coverage arrangements fear that managed care will limit their seeing certain providers or receiving certain treatment. Many policymakers argue, however, that managed care is the most effective way to achieve a balance between health care "haves" and "have nots" without establishing an entirely new public health care delivery system.

See also AIDS and HIV Infection; Health Care Costs and Managed Care; Long-Term and Related Care; Medicare and Medicaid; Mental Health Funding and Services.

FOR ADDITIONAL INFORMATION

Housing and Household Economic Statistics Division
Bureau of the Census
U.S. Department of Commerce
Washington, DC 20233
(301) 457-3240
(301) 457-3500 FAX
www.census.gov

Insurance Bureau
Michigan Department of Consumer
and Industry Services
Ottawa Building, 2d Floor
P.O. Box 30220
Lansing, Michigan 48909
(517) 335-3167
(517) 335-4978 FAX

Medical Services Administration
Michigan Department of Community Health
400 South Pine Street
P.O. Box 30479
Lansing, MI 48909
(517) 335-5501
(517) 335-5007 FAX
www.mdch.state.mi.us/MDCH2/index_j.htm

Michigan Association of Health Plans
327 Seymour Avenue
P.O. Box 19333
Lansing, MI 48901
(517) 371-3181
(517) 482-8866 FAX

Michigan Health & Hospital Association
6215 West St. Joseph Highway
Lansing, MI 48917
(517) 323-3443
(517) 323-0946 FAX
www.mha.org

Michigan Health Council
2410 Woodlake Drive, Suite 440
Okemos, MI 48864
(517) 347-3332
(517) 347-4096 FAX

Michigan Public Health Institute
2436 Woodlake Circle, Suite 300
Okemos, MI 48864
(517) 349-7110
(517) 381-0260 FAX
www.mphi.org

Michigan State Medical Society
120 West Saginaw
East Lansing, MI 48823
(517) 337-1351
(517) 337-2490 FAX
www.msms.org