CENTER ON BUDGET AND POLICY PRIORITIES

NUMBER OF UNINSURED RISES

by Laura Summer

New data from the Census Bureau show that 35.4 million Americans — 14.1 percent of the population — had no health insurance during 1991. This is a substantial increase from 1987, the first year for which comparable data are available. In that year, the Census data show, 31 million people — 12.9 percent of the population — were not covered by health insurance. Both the number of people and the proportion of the population without health insurance have increased each year since 1987.[1]

Persons with No Health Insurance

Year	Number (In Millions)	Percent of Population
1991	35.4	14.1%
1990	34.6	13.9
1989	33.3	13.6
1988	32.6	13.4
1987	31.0	12.9

The data on health insurance coverage were included in the Census Bureau's annual report on poverty, released September 3, 1992. The Bureau reported that 35.7 million Americans were poor in 1991, which represented the largest number of poor people in more than 20 years. Among those who were poor, 28.6 percent had no health insurance in 1991. Lack of insurance was not limited to the poor, however. Of those without insurance last year, more than 70 percent were above the poverty line.

Data Understate the Problem

Moreover, these figures understate the problem because they represent only people who lacked health insurance for all of 1991. A Census report published earlier this year found, for example, that while 32.6 million people lacked health insurance coverage for all of

[1] Not all of the changes from one year to the next were statistically significant. Between 1990 and 1991, the increase of 800,000 in the number of people without insurance was statistically significant, while the rise from 13.9 percent to 14.1 percent in the proportion of the population lacking insurance was not statistically significant.

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1988, some 61 million people — more than one quarter of the U.S. population — lacked health insurance coverage for at least one month during a 28-month period starting in 1987.[2]

The Uninsured

Some groups were more likely to be uninsured than others. Hispanics were most likely to be uninsured; 31.5 percent — or nearly one in three — lacked coverage in 1991. Some 20.6 percent of blacks and 12.9 percent of whites had no insurance.

Members of female-headed families were more likely to lack coverage than members of married-couple families. Some 19.7 percent of the people in female-headed families lacked health care coverage last year, compared with 11.2 percent of the people in married-couple families.

Among poor families, however, the opposite was true. Some 18.5 percent of the people in poor female-headed families had no health insurance while 35.8 percent of people in poor married-couple families lacked insurance. This is a reflection of the close link between Medicaid and the AFDC program. AFDC recipients, most of whom are members of female-headed families, are automatically eligible for Medicaid coverage.

Decline in Employment-Related Coverage

The decline in the number of people with health care coverage is due, in part, to a decrease in the number of people covered by private, employment-related health insurance. Some 72.2 percent of Americans were covered by employment-related plans in 1991, down from 75.5 percent in 1987.

Among poor people, the proportion with employment-related coverage declined from 25 percent in 1988 to 22.2 percent in 1991. (For these data, 1988 is the first year for which they are available.) The decline in coverage apparently stemmed both from the recession, which caused workers to lose jobs providing health insurance, and from decisions by employers facing rising health care costs to cease offering coverage. Some 800,000 fewer Americans had employment-related coverage in 1991 than in 1990.

Medicaid Coverage Grows

While employment-related coverage was eroding, more people received coverage through Medicaid. Some 10.6 percent of the population was covered under Medicaid in 1991, up from 8.5 percent in 1988. Among poor people, Medicaid coverage rose from 41.5 percent in 1988 to 47.3 percent in 1991. Even with these gains, however, Medicaid still covers fewer than half of all poor people.

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[2] Bureau of the Census, *Health Insurance Coverage: 1987-1990, Selected Data from the Survey of Income and Program Participation*, Current Population Reports, Series P-70, No. 29, May 1992.

Medicaid coverage increased for all racial and ethnic groups in 1991, but the extent of coverage among different groups continues to vary. Some 60.9 percent of poor blacks had Medicaid coverage last year, compared with 47.7 percent of poor Hispanics and 41.2 percent of poor whites.

Poor Persons with Medicaid Coverage

Year	Number (In Millions)	Percent of Poor Population
1991	16.9	47.3%
1990	15.2	45.2
1989	13.3	42.3
1988	13.2	41.5

Increases in Medicaid coverage partly reflect growth in the AFDC rolls as a result of the recession. Some of the increases also stem from expansions in Medicaid eligibility for pregnant women and young children.[3] The proportion of poor children under 18 years of age covered by Medicaid rose from 56.8 percent in 1988 to 65.5 percent in 1991.

Nevertheless, one fifth of all poor children under 18 — 20.5 percent — had no health insurance throughout 1991. Many of the children in this group were either newly eligible for Medicaid but had not enrolled in the program or will become eligible for Medicaid sometime in the next decade as a result of Medicaid eligibility expansions enacted in the past few years.[4]

Recent Medicaid expansions have extended health insurance to many low-income Americans who otherwise would lack it. Without these expansions, the increases in the number of uninsured people, and in the proportion of the population without health insurance, would have been still greater.

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[3] Beginning in 1987, states had the option to extend Medicaid coverage to young children whose families have incomes above their state's AFDC income limit but below the poverty line. Starting in April 1990, states were required to extend Medicaid coverage to all children under age six from families with incomes below 133 percent of the poverty line. States are also required to phase in coverage of all poor children born after September 30, 1983. This will result in virtually all poor children through age 18 being covered by 2002.

Eligibility for pregnant women has also been expanded. States must cover all pregnant women with family incomes below 133 percent of the poverty line and may set income limits for pregnant women and infants as high as 185 percent of the poverty line.

[4] It is possible that a modest part of the increase in Medicaid enrollment is due to the Qualified Medicare Beneficiary, or QMB, program. Since January 1991, state Medicaid programs have been required to pay Medicare premiums and copayments for aged and disabled people who are enrolled in Medicare and have incomes below 100 percent of the poverty line. QMBs participate in both the Medicare and Medicaid programs, although they do not receive full Medicaid coverage. The Census Bureau reports on the number of individuals receiving Medicare and Medicaid coverage, but does not distinguish between those receiving full Medicaid coverage and those receiving only QMB benefits. The Bureau reports that between 1990 and 1991, the number of people with both Medicare and Medicaid coverage increased by about 300,000.

DRAFT STARK TESTIMONY

Good morning, Mr. Chairman and members of the Subcommittee. I welcome this opportunity to discuss how the President's Health Security Act will meet the health needs of rural and inner city Americans.

Mr. Chairman, you and others in the Congress have been eloquent in speaking out about the health crisis facing our inner cities and rural communities. Indeed, these areas epitomize the problems and consequences of **health insecurity.** Compared with other parts of the country, rural areas and inner cities have a greater proportion of uninsured people; fewer, and often poorly qualified health care providers; inadequate outpatient and inpatient facilities; and a paucity of economic resources to create effective networks of care. Although the need for health services is great in these communities, many residents face substantial geographic and cultural barriers to obtaining care. In addition, they suffer from a disproportionately high burden of preventable disease and injury. The costs of these health problems have been staggering, both economically and in terms of human suffering.

The President's plan provides the means -- for the first time -- to make health security a reality for all Americans, including those living in rural areas and inner cities. It does so not only by assuring all Americans comprehensive insurance coverage, but also by building up the capability of rural and inner city communities to overcome barriers to care and to protect and improve the health of their residents.

THE HEALTH CARE PROBLEM IN RURAL AREAS AND INNER CITIES

Obtaining affordable health insurance is one of the most glaring problems for inner city and rural Americans. In the District of Columbia, for example, one in four residents under age 65 does not have health insurance. More than 8 million rural Americans have no health insurance, including 18 percent of all farm families. Because they generally lack the benefit of being part of a large business or purchasing group, rural Americans often pay more for health insurance than those living in other parts of the country. Some can purchase coverage through small employers or a rural cooperative, but many rural families have no choice but to purchase separate coverage at high market rates.

Even when rural and inner city residents are fortunate enough to have health insurance, many barriers still stand in the way of receiving proper medical care. In rural communities, barriers such as geography and lack of transportation present real challenges to health care delivery. With a relatively small population spread over a large area and health care professionals in short supply, patients often must travel long distances to see a physician.

Far removed from the support of their peers and the sophisticated equipment of their training facilities, fewer and fewer physicians are choosing to set up rural practices. Without enough doctos, nurses, and facilities, building networks of care becomes more

difficult, as does the task of attracting or establishing enough health plans to foster choice and competition.

In inner cities, the challenges to obtaining access to care are different, though no less problematic. Crime, poverty, overcrowding, unemployment, and violence make the inner city an unattractive environment for health professionals. Ironically, many inner city neighborhoods are located only a few blocks away from some of the world's most renowned academic health centers, yet the number of physicians willing to practice in these areas has dwindled to practically nothing in recent years. One study by the Community Service Society of New York found only 28 properly qualified physicians serving a population of 1.7 million people in low-income neighborhoods in Harlem, north central Brooklyn and the South Bronx.

In addition to the scarcity of providers, the quality and accessibility of care is also a serious problem for inner city patients. Of the 701 generalist physicians practicing in Harlem, Brooklyn and the South Bronx, only 28 or 3.9% were found to meet minimum standards for providing adequate primary care. Many refused to accept patients on Medicaid, were open for less than 20 hours a week, and did not offer emergency after hours care or have admission privileges with any hospital.

Practitioners in inner cities are also frequently ill-prepared to meet the cultural and linguistic needs of their diverse patient population. Rarely do these environments produce physicians from their own communities. Consequently, patients and providers generally come from vastly different backgrounds.

The lack of health insurance and other barriers to care have contributed to the poor health status of many residents of rural and inner city communities. Let me give you just a few examples of the disproportionate share of preventable illness and injury these populations bear and the costs of these problems to the health care system.

- Cancer is diagnosed at much later stages in inner-city populations, often when it is no longer treatable. In Harlem, for instance, only five percent of women with breast cancer are diagnosed at an early stage as compared with 42% of African American women and 52% of Caucasian women nationwide. The Centers for Disease Control estimates that the direct medical costs of treating breast cancer rise from $25,000 to $84,000 per individual when detected late instead of early.

- From 1985 through 1992, while the tuberculosis case rate declined from 6.7 to 6.5 cases per 100,000 in non-urban areas of the United States, it increased from 17.1 to 22 cases per 100,000 in urban areas. Currently, New York City accounts for 14 percent of all cases of tuberculosis in the country. In Harlem, the prevalence of tuberculosis is 200 cases per 100,000, four times higher than the New York City average. The Centers for Disease Control estimates that $480 million per year will be required to curtail the emerging

tuberculosis epidemic.

- HIV/AIDS is a serious problem in inner cities, but it is also becoming more prevalent in rural areas. In North Carolina, for example, HIV infection has increased at an alarming rate, with 75 percent of new infections occuring among low-income minorities in rural as well as urban areas of the state. The cumulative cost of treating all persons with HIV is forecast to be $15.2 billion in 1995. Yet each case of AIDS that can be prevented can save approximately $102,000 in health care costs.

- Rural areas have an inordinately high rate of serious accidents due to the risks of farm, mining, and other occupations. Over a three year period in Iowa, CDC's National Center for Injury Control reported 7,797 farm injuries, resulting in 1,263 hospitalizations, and 236 deaths. The Center for Agriculture Disease and Injury Research, Education, and Prevention at the University of Iowa estimates that preventing the 140,000 disabilities caused by farm accidents each year in the United States would save $3.6 billion.

BENEFITS OF THE HEALTH SECURITY ACT TO RURAL AND INNER CITY AREAS

This morning, I would like to go over those aspects of the President's plan that will provide inner city and rural Americans with real health security. After reviewing some of the basic elements of the reform, I will concentrate on the public health initiatives contained in Title III of the Health Security Act that are designed to assure all Americans -- including those living in underserved areas -- access to medically necessary and appropriate care when they need it, and to enhance the ability of all communities to protect, preserve, and promote the health of their residents. These programs, which are integral to achieving the goals of health care reform, will ultimately determine how well we improve the poor health status of many inner city and rural Americans and the extent to which we will be able to contain our nation's escalating health care costs.

Basic Elements of Reform

I need not review in detail with this committee the basic elements of the President's plan that will improve access to care for all Americans. However, considering the special problems of inner cities and rural regions of the country, several points are worth emphasizing:

- Under reform, all Americans will be covered for a comprehensive range of benefits, including expanded mental health and substance abuse services. In addition, preventive services will be available without deductibles or copayments.

- Health care alliances will provide consumers with the purchasing power many currently lack to bargain for lower premiums.

- Indigent populations will receive subsidies to cover part or all of the costs of premiums, cost sharing, and, in some cases, wraparound services.

- The self-employed, including farm families throughout the nation, will be able to deduct 100 percent of the cost of their health insurance premiums instead of the current 25 percent.

- Small businesses will be eligible for premium discounts, further stretching their health care dollars.

- Providers no longer will receive lower payments when they care for low-income patients. Medicare's bonus payment for physicians practicing in underserved areas will be doubled for primary care physicians and continued for specialists. Hospitals serving a high proportion of low-income and undocumented persons will receive additional payments through a federal Vulnerable Population Adjustment.

- Practitioners providing care in underserved areas will be eligible for tax credits of up to $500 per month for nonphysician providers and $1,000 per month for primary care physicians. The allowable depreciation expense for medical equipment also will be substantially increased for these providers.

- Safeguards will be implemented to prevent discrimination based on race, ethnicity, age, or gender. These include prohibitions against cherry picking and redlining, enforcement of Title VI of the Civil Rights Act, requirements that alliances not subdivide metropolitan statistical areas, and the ability of States to require health plans to include inner-city or rural communities in their service areas.

Access Initiatives

Congress, including members of this subcommittee, has demonstrated great concern about the ability of underserved populations to obtain access to personal health care services. You have also expressed concern about the ability of health care providers currently caring for underserved populations to participate successfully in the reformed system. The President recognizes, as you do, that a Health Security Card will not, in and of itself, guarantee that all Americans receive appropriate medical care. To achieve this goal, universal health insurance must be backed up by an adequate system of practitioners, facilities, education, outreach, and information.

The Health Security Act uses six interrelated approaches to overcome existing barriers to care. These programs will assure that all Americans -- including those living in inner-city and rural areas -- not only have access to the full range of services included in the comprehensive benefits package, but also will have an adequate choice of culturally sensitive providers and health plans.

- **Current Safety-Net Programs.** First, current safety-net programs such as community and migrant health centers, programs for the homeless, family planning, Ryan White, and maternal and child health will be maintained and strengthened under reform.

  Providers funded under these programs will receive automatic designation as *essential community providers*. This will guarantee them payment for covered services from all health plans. Equally important, it will assure that vulnerable populations have continuing access to practitioners with experience meeting their special needs, regardless of which health plan they choose to enroll in.

- **Practitioner Supply.** The supply of practitioners in rural and urban underserved areas will be increased in several ways under reform. The National Health Service Corps will be expanded approximately five-fold from its current field strength of 1,600 to 5,300 in 1998, and to 8,000 serving over 12 million people by 2005. Residency training will be redirected to increase the ratio of primary care physicians to specialist physicians from about one-third to 55 percent. Support for training programs for primary care physicians, physician assistants, and advanced practice nurses will be doubled.

  Special programs to increase the representation of minorities among health professionals will help to overcome access barriers that stem from cultural gaps.

- **Capacity Expansion.** Capacity expansion in inner-city and rural areas will be actively supported both by expanding the successful community and migrant health center program to provide services to an additional 2 million individuals and through a new competitive grant and loan program supporting the development of community-oriented practice networks and health plans.

  The new program is designed to integrate federally funded providers with other providers in underserved areas, bolstering their ability to coordinate care, negotiate effectively with health plans, and form their own health plans. It will increase the level of service available in underserved areas by creating new practice sites for 3,800 additional practitioners and by renovating and converting existing practice sites, including public and rural hospitals. In addition, it will improve access to specialty care in urban and rural underserved areas -- and improve coordination of care -- by linking providers in practice networks with each other and with regional and academic medical centers through information systems and telecommunications.

Grants and loans under the new program will be made to groups of providers working in medically underserved areas or caring for underserved populations. In making awards, preference will be given to groups that include the maximum number of different types of federally funded providers and that link these providers with those not supported by public funds. All providers included in the community practice networks will receive automatic designation as *essential community providers.*

- **Outreach/Enabling Services.** The Access Initiative also incorporates a new competitive grant program that will expand federal support for enabling services, such as transportation, translation, child-care, and outreach.

  These grants will help 6 million isolated, culturally-diverse, hard-to-reach persons not served by other programs get the supplemental services they need to obtain access to medical care. They will also help individuals who have been denied access to the current medical care system shift their care patterns away from emergency rooms and receive earlier and more appropriate primary care services.

  Awards in this program will be made to community practice networks, community health plans, and other public and private not-for-profit organizations (such as community health centers) with experience and expertise in providing outreach and enabling services for underserved populations. These grants will supplement support for enabling services provided through existing Public Health Service programs.

- **Mental Health and Substance Abuse Initiatives.** The Health Security Act also includes new funds to assure that low-income, hard-to-reach individuals know about and take advantage of the expanded mental health and substance abuse treatment benefits included in the comprehensive benefits package.

  Working through the existing Community Mental Health Services and the Substance Abuse Prevention and Treatment formula grants, these funds will support enabling services -- community and patient outreach, transportation, translation, education -- for 2.5 million low-income individuals and other vulnerable groups (such as the homeless, dually-diagnosed, or severely mentally ill). In addition, they will build up the currently inadequate infrastructure for delivering mental health and substance abuse services in communities and facilitate integrating these services within the broader health care system.

- **School-Age Youth.** Finally, the Access Initiative incorporates two new programs to reach out to one of our Nation's most vulnerable groups -- school-age youth and adolescents. The Comprehensive School Health Education initiative will establish a national framework within which States can create school health education programs that improve the health and well being of students, grades K through 12, by

addressing locally relevant priorities and reducing behavior patterns associated with preventable morbidity and mortality. This program will be targeted to areas with high needs, including poverty, births to adolescents, and sexually-transmitted diseases among school-aged youth.

The School-Related Services program will support the provision of health services -- including psychosocial services and counseling in disease prevention, health promotion, and individualized risk behavior -- to up to 3.2 million children in over 3,500 schools or school-linked sites. Grants will be made to states for the development and implementation of state-wide projects targeted at high-risk youth ages 10-19. In states that do not take this initiative, grants will be available to local community partnerships including public schools, experienced providers, and community organizations.

Core Public Health and Prevention Initiatives

Most of the health care debate has focused on the personal health care system. But, without question, the burden of illness in inner cities and rural areas is directly related to our lack of support and attention to public health. In 1982, the Institute of Medicine estimated that only 10 percent of preventable early death is related to inadequate delivery of personal medical services, whereas 70 percent is related to environmental and lifestyle factors that can be addressed by public health. In recent years, however, as the health insurance system has failed more and more Americans, public health's energies and resources have increasingly been focused on providing personal health care services to the uninsured and underinsured, to the detriment of its essential, population-based functions.

Currently, we are not protecting Americans sufficiently against preventable infectious disease outbreaks and preventable injuries, educating them enough about behavioral and environmental risks to their health, or protecting their environment against health-threatening exposures. Yet health problems such TB, HIV/AIDS, substance abuse, and teen pregnancy simply cannot be addressed successfully without vigorous population-based public health activities.

To improve the health of inner city and rural residents we must define the particular groups for whom health problems are most common. We must identify effective interventions by learning why some communities are hard-hit by a problem while others somehow seem to escape. We must target public education and prevention interventions to populations at highest risk and populations with different cultural backgrounds. And we must create alliances between public health agencies, health plans, and providers as well as sectors outside health, such as public schools, law enforcement agencies, and social service agencies.

By guaranteeing all Americans univeral coverage, the Health Security Act provides

public health agencies with the opportunity to refocus their energies on protecting the health of the residents in their communities. Two programs included in Title III provide the public health system with vital support to achieve this goal.

- **Core Public Health Program.** This competitive grant program will provide funds to State health agencies to strengthen the following essential public health functions at state and local levels:

  (1) surveillance of communicable and chronic diseases -- essential to define the magnitude, source, and trends of health problems so that limited resources can be directed to populations at greatest risk.

  (2) control of communicable diseases and injuries -- essential to ensure that new problems are identified early, that contact tracing and partner notification occur effectively, and that sources of infectious exposures are removed.

  (3) environmental protection -- essential to safeguard the physical and social environment (e.g., water, food, workplace, housing) against causes of disease.

  (4) public education and community mobilization -- essential to prevent major causes of premature death and disability that are behavioral and societal in nature.

  (5) accountability and quality assurance -- essential to protect consumers from medical and health services that do more harm to health than good.

  (6) public laboratory services -- essential in the diagnosis of major infectious and environmental threats to health.

  (7) training and education of public health professionals -- essential to ensure a workforce capable of carrying out public health functions.

  The program fosters greater accountability to the federal government than has been realized previously for the definition and reporting of progress in achieving public health objectives.

- **Preventable Priority Health Problems.** A second competitive grant program will provide funds to public and private not-for-profit agencies to address health issues that affect local communities or specific populations within communities. Many of these problems do not affect the country uniformly and call for tailored, community-based interventions. For example, in some inner-city communities, diabetes or heart disease is a major problem; in others, priority may be accorded to programs that deal with cigarette smoking; while in still other areas, teen pregnancy is an issue of great

concern. In cases where multiple factors contribute to a health problem, as with violence, grants will support approaches that cut across individual problems.

Among the initial set of priorities, the program will target prevention of smoking by children and adolescents; violence prevention; and reductions in behavioral risks that contribute to the incidence of chronic diseases, including heart disease, cancer, stroke, and adult-onset diabetes.

Prevention Research

Expanding the knowledge base can also help residents of rural and inner city areas, by elucidating new ways to improve access to care, prevent illness and injury, and control health care costs. This is addressed by the final components of the Public Health Initiative, which support a prevention research initiative in the National Institutes of Health and a health services research initiative in the Department of Health and Human Services.

Prevention research is the foundation for both clinical preventive services and the public health interventions included in the Health Security Act. Expanded prevention research will ensure the availability of effective preventive measures against existing diseases as well as new and emerging health threats. Progress in preventing disease will help to offset escalating acute health care costs and the disproportionate impact of disease and disability among women, minorities, and the elderly.

Health services research will elucidate what works best in medical care and how to organize providers and institutions most effectively in the new health care system. This investment will build on the considerable expertise of the Agency for Health Care Policy and Research in investigating outcomes and quality research, identifying practice variations with unnecessarily high costs, and developing practice guidelines to improve the appropriateness and effectiveness of the treatment decisions made by health professionals. Further development of these methods will provide more accurate measures to evaluate the performance of alliances and health plans and to assess the extent to which reform is making health care available to all Americans.

CONCLUSION

In closing let me emphasize that the President's Health Security Act is designed to provide all Americans -- including those living in inner-city and rural neighborhoods -- with real health security at an affordable price. To this end, the Public Health initiatives in Title III are not separate from – but rather integral to -- the success of health care reform.

I appreciate this opportunity to appear before the Subcommittee and will be pleased at this time to answer any questions you may have.