The Perfect Storm

Uninsured

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The Perfect Storm

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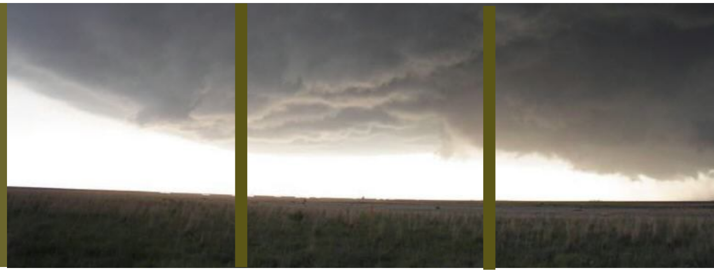


The "Perfect Storm"
Surviving and possibly even thriving will require a dramatically new framework of thinking.
We have no choice.

The Community Service Council of Greater Tulsa, Inc. provides leadership in community-based planning and mobilization of resources to address health and human service needs in much of Eastern Oklahoma. During the past several months, the Council has analyzed a wide view of global, national and local developments, their interfacings with each other, and their possible impact on the future. This analysis will guide the Council's strategic thinking for itself and for the broader community.

The analysis reveals that the developments and forces in play are so powerful and numerous that it is likely a "perfect storm" effect may be imminent or possible upon us in some aspects. This conclusion led the Council to additional study which indicated research focused on an individual critical issue (e.g., education, labor force, aging, immigration, food and water supplies) commonly predict some version of a "perfect storm" of unprecedented challenges affecting their particular critical issue. Based on these predictions, the Council took a second, closer look at this storm effects, which will possibly be comprised of converging, individual perfect storms and concluded we may be in for a "super" perfect storm.

Understanding the magnitude and relevance of this phenomenon and its significant to the Council's work and the Tulsa community is the Council's most critical step in its long rang planning. The second step would be a new framework of thinking, based on the likely results of the anticipated perfect storm.

Uninsured

With health care costs on the rise, most people require aid in offsetting the costs of medical care and hospitalizations. People who are uninsured are far more likely to put off treatment and "live sicker and die younger" then those with insurance.[1] The United States (US) is the only industrialized nation in the world lacking universal health care access. In this monograph, healthcare will be discussed on a global, national and statewide level, most directly focusing on the uninsured and the subsequent problems they face.

Global Uninsured

In the year 2000, the World Health Organization (WHO) released a World Health Report on the state of health systems in its one hundred ninety-one member countries. The report was based on three overall objectives…good health, responsiveness, and fair financial contribution. Good health was determined based on infant mortality, adult mortality, life expectancy, and disability-adjusted life expectancy (DALE), as well as other factors. Responsiveness included respect for the dignity of the patient, confidentiality, autonomy in choices, prompt attention, adequate and clean amenities, access to social support, choice of providers, etc. Fairness in financial contribution is the "risks each household faces due to the costs of the health system are distributed according to ability to pay rather than to the risk of illness: a fairly financed system ensures financial protection for everyone.[2]

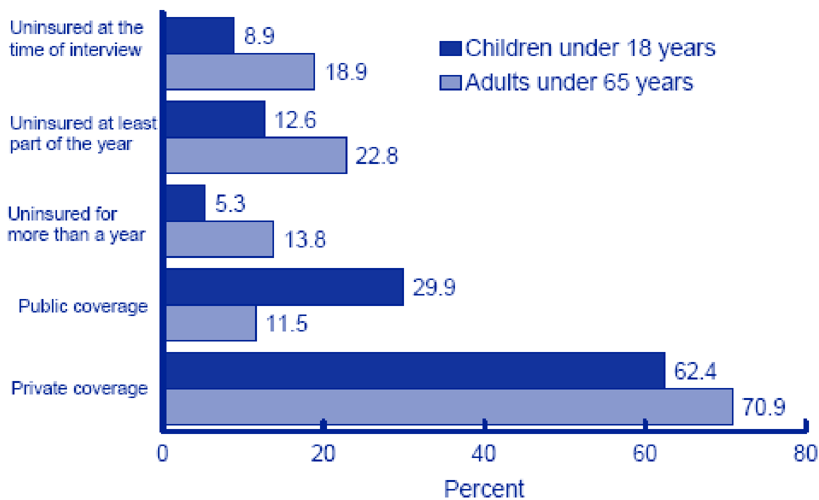
Compared to other WHO member countries, the United States ranked 24th based on the DALE ratings; however, when compared to other high income Organization for Economic Cooperation and Development (OECD) nations, the US was next to last, with only Denmark ranking lower (28th). The US ranked last among the OECD nations in infant mortality. The US ranked first in two aspects of the survey; it is the most responsive health system of all the WHO countries as well as the most expensive based on health expenditures per capita (per person), and total expenditures as a percentage of the gross domestic product (GDP). In ranking of financial fairness, the US is tied with Fiji for 54th.[2]

France was rated as the leading country in the WHO report overall for health systems. The government's social security system supplies part of each patients medical coverage, usually 60-70% of the cost. The remaining is the patient's responsibility. Most citizens (approximately 80%) have supplemental insurance through their employers to cover the remaining healthcare expenses. Citizens who are considered low-income receive 100% of their costs paid by federal taxes. Even with this type of coverage, it is currently estimated that 300,000 French citizens are uninsured.[3]

United States Uninsured

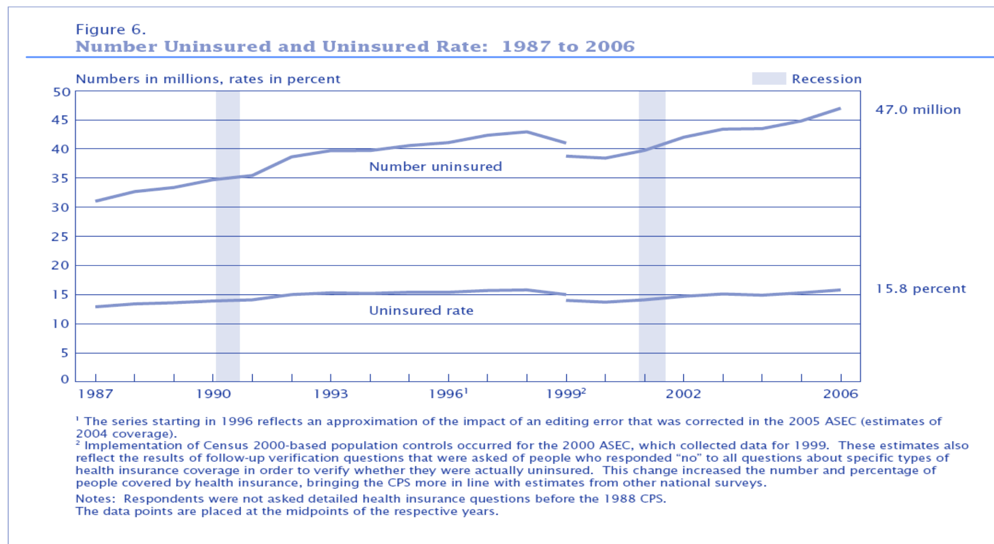
In the United States, the number of people who are uninsured is of some debate. The number varies greatly from 20 to 85 million depending on the reference.[4-7] Much of this variation is based on definitions used in the survey and how questions were asked (Figure 1). Is uninsured a certain percentage of time over the past year, the past two years or do you have to be uninsured for a consecutive twelve or twenty-four month period? Regardless of the definition of what uninsured is or how many Americans are uninsured, all the references can agree that the number of uninsured has increased steadily (Figure 2).

Figure 1: Percent with Health Insurance Coverage by Type of Insurance Among Persons Under 65 Years of Age, 2005.[4]



Source: Center for Disease Control: National Center for Health Statistics. National Health Interview Study (NHIS). Available at: www.cdc.gov/nchs/data/factsheets/nhis.pdf

Figure 2 . Number of Uninsured and Uninsured Rate: 1987 to 2006



Source: United States Census Bureau, Current Population Survey, 1988 to 2007 Annual Social and Economic Supplements.

Who are the uninsured?

Results from three national surveys find relative agreement. According to the Medical Expenditure Panel Survey (MEPS), 82 million people (31.8% of the population) were uninsured for at least one month of the two year survey period (2004-2005) and 26.1 million people (10.1% of the population) were uninsured for the entire two year period. The age group of 18 to 24 years was the most likely to be uninsured while children <18 years were the least likely to be uninsured. Those reporting "poor/fair health" were the most likely to be uninsured for the entire two year period, while those reporting "excellent" or "very good health" were the least likely to have been uninsured over the same period. Hispanics were more likely then any other single race to be uninsured for at least one month and for the entire two year period.[6]

The National Health Interview Study (NHIS) reported that 18.9% of people aged 18 to 64 years were uninsured and 8.9% of children <18 years at the time of the interview. Over the previous year, 51.3 million people of all ages had been uninsured at some point and 29.2 million had been uninsured for at least one entire year. For ages 18 to 64, 56% of the unemployed, and 21% of the employed were uninsured at least part of the past year. Additionally, 32% of the unemployed, and 13% of the employed had been uninsured for more then a year. Hispanics were the most likely of any single group to be uninsured (30.2%), while non-Hispanic whites were the least likely (9.8%).[4]

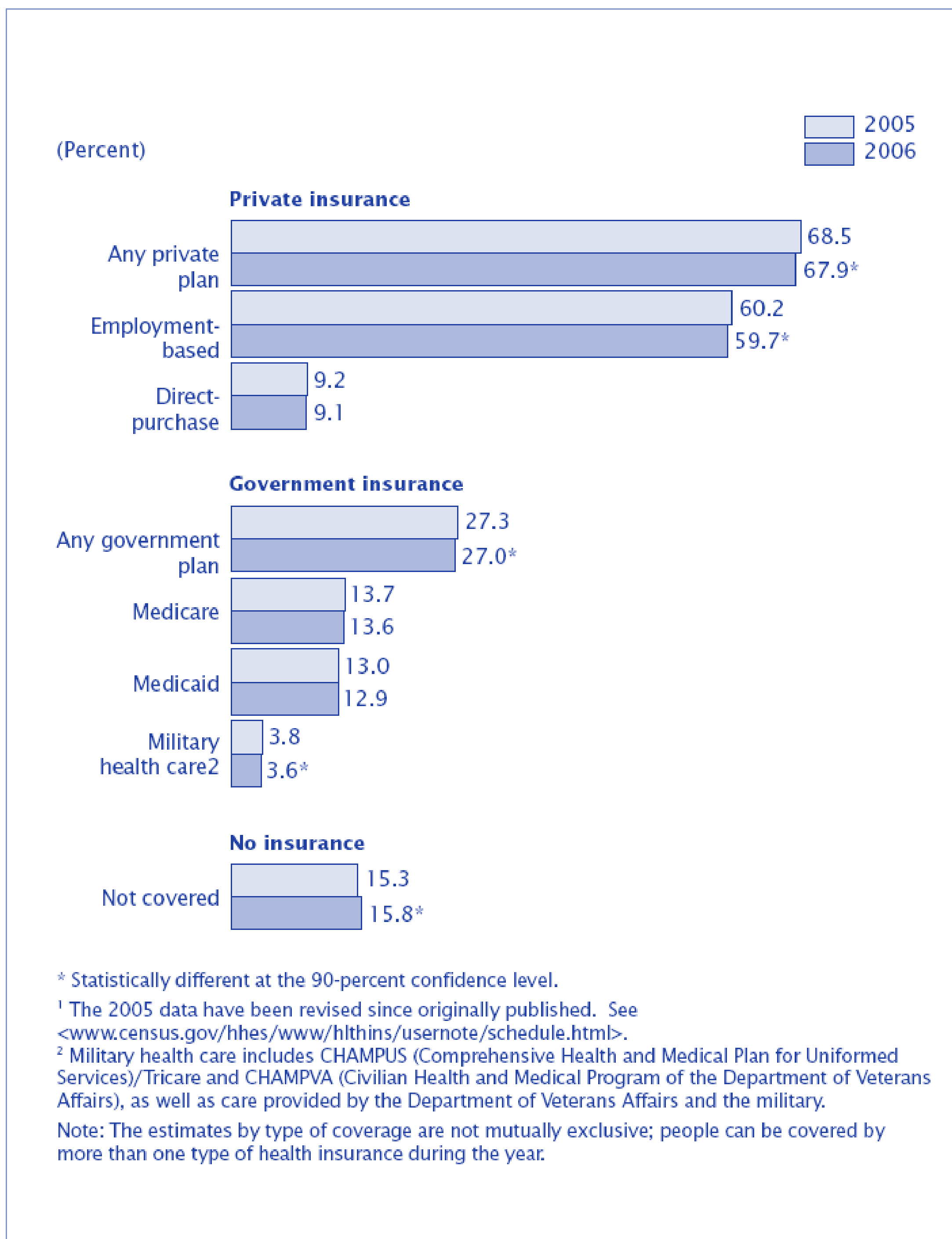
The Current Population Survey (CPS) reported that in 2005 44.8 million Americans (15.3%) were uninsured, which increased to 47.0 million (15.8%) in 2006. The number of people with health insurance increased from 249.0 million (2005) to 249.8 million (2006) people. Private insurance accounted for approximately 201.7 million people while 80.3 million were covered by government health insurance in both years. Employment-based health insurance covers approximately 60% of people and 12.9% of people were covered by Medicaid (Figure 3). Children <18 years of age increased from 8 million (10.9%) in 2005 to 8.7 million (11.7%) in 2006. The age group that is most likely to be uninsured is the 18 to 24 year olds (29.3%) with the least likely being children <18 years (10.9% in 2005 and 11.7% in 2006). Those of Hispanic origin are the most likely to be uninsured (32.3% in 2005 and 34.1% in 2006) with Whites, non-Hispanics at the low end at 10.7%. Also, as yearly income increases, the less likely the individual is to be uninsured from 24.2% of those making <$25,000/year to 7.7% of those making $75,000 or greater.[5]

Overall, the three national studies do agree on who is uninsured. The poor adults aged 18 to 24 years, and those of Hispanic origin (Figure 4).

Oklahoma Uninsured

Oklahoma ranks 16th in the US for the number of adults with asthma, 3rd for the number of adults who smoke, 9th for the number of obese adults, 8th for adults with hypertension and 6th for adults with diabetes.[8] Oklahoma is one of the unhealthiest states and also ranks 4th in having the most uninsured living within its borders.[8]

Figure 3. Coverage by Type of Health Insurance: 2005[1] and 2006



Source: United States Census Bureau, Current Population Survey, 2006 and 2007 Annual Social and Economic Supplements.

Figure 4. People Without Health Insurance Coverage by Race and Hispanic Origin Using 3-Year Average: 2004 to 2006

(Numbers in thousands. People as of March of the following year)

Race[1] and Hispanic origin	3-year average 2004–2006[2]			
	Number		Percentage	
	Estimate	90-percent confidence interval[3] (±)	Estimate	90-percent confidence interval[3] (±)
All races	45,102	358	15.3	0.1
White	34,151	318	14.5	0.1
White, not Hispanic	20,875	255	10.7	0.1
Black	7,174	174	19.4	0.5
American Indian and Alaska Native	748	59	31.4	2.1
Asian	2,036	94	16.1	0.7
Native Hawaiian and Other Pacific Islander	139	26	21.7	3.6
Hispanic origin (any race)	14,187	229	32.7	0.5

[1] Federal surveys now give respondents the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group such as Asian may be defined as those who reported Asian and no other race (the race-alone or single-race concept) or as those who reported Asian regardless of whether they also reported another race (the race-alone-or-in-combination concept). This table shows data using the first approach (race alone). The use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. The Census Bureau uses a variety of approaches. Information on people who reported more than one race, such as White ***and*** American Indian and Alaska Native or Asian ***and*** Black or African American, is available from Census 2000 through American FactFinder. About 2.6 percent of people reported more than one race in Census 2000.

[2] The 2004 and 2005 data have been revised since originally published. See <www.census.gov/hhes/www/hlthins/usernote/schedule.html>.

[3] A 90-percent confidence interval is a measure of an estimate's variability. The larger the confidence interval in relation to the size of the estimate, the less reliable the estimate. For more information, see "Standard Errors and Their Use" at <www.census.gov/hhes/www/p60_233sa.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements.

Source: United States Census Bureau, Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements.

Depending on the definition of uninsured, the rate of uninsured in Oklahoma is 18.5% to 25.5% of the population.[8-11] Most surveys adjust for the Native American population who receive free healthcare at Indian Health Services (IHS) clinics. Similar to the US as a whole, young adults (aged 19 to 29 years) are most likely to be uninsured (35%) with adults 50 to 64 years, and children 18 or younger being the least likely (16.5% and 16.7% respectively).[10] Hispanics are the most likely to be uninsured (38.8%) while white non-Hispanics are the least likely (18.5%). All surveys agree that Oklahoma is above the US average.[8-11] (Figure 5)

The majority are working uninsured. Seventy-one percent of the uninsured in Oklahoma work fulltime and another 13% work part-time.[12] The reason for a lack of insurance in this case may be due to the employer not offering an insurance plan, the employee may not be eligible if one is offered, or the employee may opt-out if he/she is eligible, often due to the high premiums required of the employee.[12,14] This is a nationwide problem, but more so in Oklahoma which is considered a "low-wage, small-firm" state which decreases the likelihood of overcoming these obstacles.[12] (Figure 6)

Figure 5. Uninsured Rates by State Using 3-Year Average: 2004[1]-2006

States with uninsured rates higher, lower, or not statistically different from the U.S. uninsured rate

Higher than the U.S. uninsured rate
Not statistically different from the U.S. uninsured rate
Lower than the U.S. uninsured rate

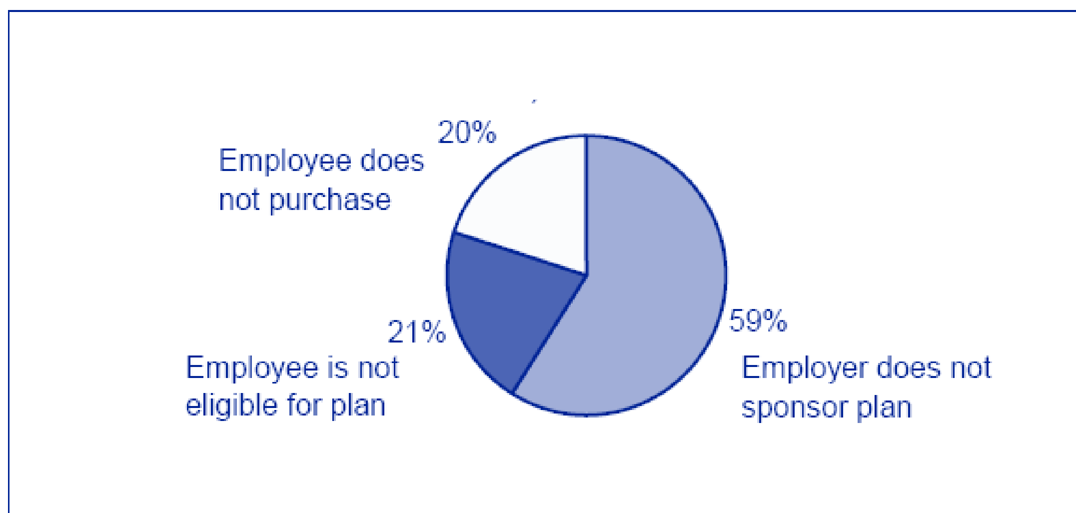
U.S. uninsured rate 2004–2006 = 15.3 percent

AK WA OR ID MT ND MN WI MI NY VT NH ME MA RI CT NJ DE MD DC SD WY NV CA UT CO NE IA IL IN OH PA WV VA KS MO KY TN NC SC AZ NM OK AR MS AL GA TX LA FL HI

[1] The 2004 and 2005 data have been revised since originally published. See <www.census.gov/hhes/www/hlthins/usernote/schedule.html>.

Source: United States Census Bureau, Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements.

Figure 6. Reasons Why Workers Lack Employer-Sponsored Insurance, Nationwide



Source: The Henry J. Kaiser Foundation. The uninsured: a primer. Key facts about Americans without health insurance. October 2006. Available at: http://www.kff.org/uninsured/upload/7451-04.pdf

A number of state and federal "safety-nets" have been established to mitigate these circumstances, and aid the uninsured. In Oklahoma, Medicaid and the State Children's Health Insurance Program (SCHIP) covers children if their families income does not exceed 185% of the federal poverty level (FPL). This is $40,792 for a family of four (2009 Poverty Guidelines). Many children who are eligible have not been enrolled for various reasons: families may not be aware they qualify problems with enrollment, renewal processes can reduce or stop coverage, and immigration status can be a barrier. These programs do not cover most of the adults in the families of qualifying children, leaving part of the family uninsured. In Oklahoma, the parents only qualify if they earn less than 46% FPL. Generally, if an adult does not have children, they do not qualify for federal or state programs regardless of their income level. The exception would be an adult with a disability.[10]

In 2007, the Oklahoma legislature passed SB424, the Children's Insurance Act, extending SCHIP coverage to children whose family income is less than 300% FPL. The program is to be incrementally increased to that level from 2008 to 2012. The Centers for Medicare and Medicaid Services (CMS) has requested assurances of the Oklahoma Health Care Authority (OHCA) that coverage will not expand to 300% FPL until most children are covered at 200% FPL. In October 2007, the federal legislature passed, and the President vetoed the federal SCHIP expansion bill which jeopardized the Oklahoma SCHIP's expansion due to inadequate federal funding. In February 2009, President Obama signed the $35 million expansion to insure the growing number of impoverished and uninsured children have access to health care.[13]

The OHCA (2004) created the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC), now known as Insure Oklahoma, to assist small businesses, and individuals to have access to tri-partner health coverage. The employer, the employee and the state of Oklahoma provides either the portion of their private health plan premiums, or the purchase of a state sponsored health plan operated under the state Medicaid program. Funding for O-EPIC was made possible in November 2004, when State Question 713 was approved and created the funding from a sales tax on tobacco products. Initially, the program provided health coverage access to small businesses of 25 employees or less, and employees and spouses having a family income of less than 185% FPL. November 2007, this program was expanded to 250 employees or less and with employees and spouses having a family income of less than 200% FPL. The income threshold will increase to a family income not to exceed 250% FPL incrementally. In October 2007, 2,812 employees and 569 spouses statewide participated in the program.[14] By February 2009, 9,427 employees and 1,778 spouses for a total of 11,205 are enrolled. Of the total enrollment, 1,295 are in the expansion category of 185% to 200% FPL which became effective November 2007.[15] This represents an overall growth of 331% from October 2007 to February 2009. Capacity decreased from 25,000 in 2007 to 18,500 in 2009.

The Individual Plan was primarily designed to provide individuals who work for an Oklahoma small business with 50 or fewer fulltime employees; temporarily unemployed adults who are eligible to receive unemployment benefits; or working adults with a disability who work for any size employer and have a "ticket to work". The total October 2007 enrollment of employees was 745, spouses 223 with a program capacity of 25,000 for the Individual Plan.[14] In February 2009, the Individual Plan included 5,613 people of which 4,238 were employees and 1,375 were spouses. Of the total, 462 were from the expanded 185% to 200% FPL.[15] This represents a 580% increase from October 2007 to February 2009. The expanded income qualifications were effective November 2007. The capacity of this program has decreased

from 25,000 to 18,500 as well.

Specialty programs have been developed by OHCA to meet specific population needs. Sooner-Plan is a family planning program for uninsured men and women who are not enrolled in SoonerCare services; and the Soon to be Sooner program provides prenatal care services to pregnant women who are not eligible for SoonerCare because of their alien status in the US.[15] Neither of these programs provides comprehensive health services.

Summary

Oklahoma and the US have a long way to go in the health care insurance process. Promising expansion of health care insurance coverage is being studied by the Oklahoma Insurance Commissioner, Kim Holland in the State Coverage Initiative. Assistance for Oklahomans navigating existing state options for health care insurance is badly needed. A cogent federal policy regarding a universal health care system is needed.

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