# EMPOWERING Individuals IN THE Health Care System

**IT IS OBVIOUS** that not all Americans enjoy equal access to affordable and high-quality health care. The problem is particularly acute for ethnic and racial minorities. In 2002, the Institute of Medicine of the National Academies of Science issued "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," which concluded that provider biases contributed to these disparities. Since then, there has been intensive examination of equality in access to quality care, provision of care in managed care, and the influence of socioeconomic and geographic factors correlated with race.

BY ROBERT E. MOFFIT

If the objective is to reduce disparities, and it should be, an important prerequisite is to get disadvantaged groups into the health care system. For example, Steven M. Asch and his colleagues recently found in their 2006 *New England Journal of Medicine* article that the usual economic and racial disparities in securing recommended care all but disappeared once patients made at least one visit to a health care provider. Another group of researchers led by Amal N. Trivedi, writing in a 2005 *New England Journal of Medicine* article, found that disparities between black and white *insured* patients declined in seven of nine recommended quality measures after they enrolled in Medicare-managed care plans.

The key factor, then, leading to persistent health disparities between demographic groups is access to the health care system. This article focuses for this reason on how the health care system may be improved in ways that will ameliorate disparities in health. Although there are, to be sure, other sources of disparities (e.g., residential segregation and consequent differential exposure to health risks), there is much room for reducing disparities through the health care system itself.

## Health Insurance and Health Outcomes

A key variable is health insurance. The professional literature shows a positive relationship between health insurance coverage and health status. According to the National Academy of Sciences, health insurance is likely to improve patient outcomes if it is continuous and provides "appropriate" care, including preventive screening and drug coverage. Chronically ill persons with insurance coverage have better health outcomes than those without coverage, and persons who have had continuous coverage also have superior health relative to persons who have lost coverage or experienced a break in their coverage.

People without health insurance have less access to doctors, often delay medical treatment, lack continuity of care, and have worse health outcomes and higher rates of mortality than those who have it. In 2002, the Institute of Medicine estimated that 18,000 Americans died because they were uninsured. The number may be higher or lower in other years, but it is nonetheless significant. Because of their higher uninsurance rates, blacks and Hispanics are disproportionately affected by these problems.

The uninsured are more likely to resort to hospital emergency departments—the most expensive places on the planet—to secure even routine care. A study by Sally Satel of the American Enterprise Institute showed that quality of care is generally "comparable" for white and minority patients admitted for medical conditions requiring the same medical procedures. But the uninsured, *regardless of race or ethnicity*, are more likely than those with coverage to get substandard hospital care. And as the Heritage Foundation's John O'Shea has noted, Medicaid and SCHIP (State Children's Health Insurance Program) enrollees are *four* times more likely than persons with private health insurance to end up getting care in hospital emergency rooms.

## Unequal Access

If access matters for health, then we should want to know whether access is highly unequal. The answer is that ethnic and racial disparities are especially pronounced in access to health insurance. Based on 2007 Census Bureau data, of the estimated 45.7 million Americans who are uninsured (15.3 percent), there are wide variations by race and ethnicity. While only 10.4 percent of non-Hispanic whites are uninsured, 19.5 percent of blacks and 32.1 percent of Hispanics are uninsured.

Recent Census findings confirm a familiar pattern that has persisted for many years. Overwhelmingly, white Americans have proportionately greater access to superior private and employer-based health insurance coverage, while blacks and Hispanics are more dependent on Medicaid, which has a record of inferior performance in the delivery of care. While only 9

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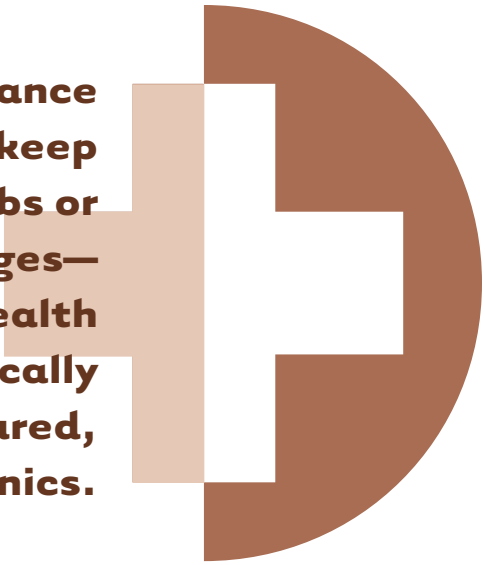

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percent of non-Hispanic whites are on Medicaid, 23.8 percent of blacks and 22.5 percent of Hispanics are enrolled in the program. And according to analyses by Derek Hunter of the Heritage Foundation, restrictive Medicaid reimbursement practices have led to reduced access to physicians and specialists, as well as more restricted formularies for prescription medications. This has had direct—and decidedly negative—consequences for ethnic and racial minorities trapped in Medicaid.

Not surprisingly, blacks and Hispanics are also disproportionately dependent on hospital emergency room care, which is often uncompensated. In a 2004 New America Foundation study, researchers found that white hospital patients accounted for 55.7 percent of uncompensated care and 67.4 percent of the total population. Comparatively, blacks accounted for 17 percent of uncompensated care but just 12.8 percent of the population, while Hispanics accounted for 24.5 percent of uncompensated care but just 14.1 percent of the population.

As previously noted, insurance can be a great equalizer. According to the same New America study, when adults have health insurance coverage and a "medical home" (a setting that provides continued and coordinated care), ethnic and racial disparities in access and quality of care are reduced or even eliminated. Similarly, the National Academy of Sciences found that health insurance reduces disparities in the provision of hospital services, including services for cardiovascular conditions and trauma, to ethnic and racial minorities.

## Gaps in Coverage

A rich fund of historical data shows that the uninsured are relatively young; overwhelmingly members of working families; disproportionately employed in small businesses that don't offer coverage; or working as part-time, seasonal, temporary, or contract employees. They are, as noted, disproportionately black and Hispanic. While some persons don't take advantage of coverage when it is offered to them at work (perhaps because they don't value it), most of the uninsured are not offered insurance at work, cannot afford it, or had it and lost it.

The vast majority of uninsured persons experience spells of uninsurance that usually last several months as they transition in and out of coverage, most often as a result of changes in their employment status. According to a seminal 2004 *Health Affairs* study based on four years of data on the uninsured, Pamela Farley Short and Deborah R. Graefe found that only 12 percent of the uninsured were without coverage for an entire four years; the rest had coverage and lost it, churning in and out of an unstable health insurance market.

Research also shows that instability in coverage is not confined to the private sector, either in the employer or the individual market; it also exists in government health programs, notably Medicaid, where eligibility changes with income or varies with administrative and regulatory changes. In fact, churning in Medicaid can be just as disruptive as churning in the private sector. In a 2005 Commonwealth Fund study of families and children over a two-year period, 30 percent of those who had initially enrolled in Medicaid experienced one or more spells of uninsurance.

Portability of health insurance policies—enabling individuals to keep their coverage when they change jobs or maintain coverage through life changes—would be key to stabilizing health insurance markets and dramatically reducing the numbers of the uninsured, especially among blacks and Hispanics.

## Federal Change

There are federal and state policy options for tying health insurance to the person rather than the job, thereby making it dramatically more affordable. The key federal policy option is to change the federal tax treatment of health insurance. Today, the estimated $250 billion in federal tax breaks for health insurance is targeted not to individuals as *individuals*, but to individuals as *employees*, and only on the condition that they get health insurance through their place of work.

The generosity of existing tax breaks for health insurance cannot be overestimated, but they are regressive: The biggest tax benefits for health insurance go to upper-income workers who

need the least help. Workers who do not get health insurance through employers are denied generous tax benefits, and their coverage is thus less affordable than it would otherwise be; if they buy health insurance on the individual market, they may pay as much as 30 to 50 percent more in premiums for the same package of health benefits that would otherwise be available through an employer. Practically speaking, depending on the cost and condition of the insurance markets where they live, most middle-class persons without employment-based coverage cannot afford that extra financial burden; and for the working poor, especially Hispanics, this is simply unrealistic, forcing them to either go "bare" or depend on hospital emergency rooms or public programs.

## Bipartisan Consensus

Senator Max Baucus (D-Mont.), chairman of the powerful Senate Finance Committee, notes that there is a broad bipartisan consensus among economists and policymakers that existing tax policy governing health insurance is inefficient and inequitable. Acknowledging technical differences in design among alternatives, Baucus has suggested a cap on the amount of health insurance premiums that can be excluded from taxation, while providing new subsidies for low-income persons to buy health insurance.

Senators Ron Wyden (D-Ore.) and Robert Bennett (R-Utah) have cosponsored major legislation (the Healthy Americans Act) that would repeal existing tax policy and replace it with a combination of new tax deductions and generous new subsidies for low-income persons to offset their insurance costs. Together, these financial changes would guarantee every person affordable health insurance coverage. During the 2008 presidential campaign, Senator John McCain (R-Ariz.) likewise proposed replacing the existing system with a universal refundable health care tax credit, specifying that the credit would be a flat dollar-amount credit for individuals and families and indexed to inflation.

The Lewin Group, a prominent Virginia econometrics firm, concluded during the campaign that McCain's flat credit would have been significantly more progressive than the existing system, resulting in millions of uninsured Americans securing coverage. Many economists, including conservatives like Stuart Butler and Edmund Haislmaier, have long favored a progressive credit that provides more help to low-income persons. Jason Furman, a Brookings Institution scholar and one of President Obama's key economic advisers, has also championed abolition of the current system in favor of a universal, progressive, and refundable health care tax credit, making the greatest level of tax and financial assistance available to middle- and lower-income uninsured persons who need the most help. The generosity of such a credit is an empirical issue. But, in any case, under any of these more progressive tax policies, uninsured blacks and Hispanics would benefit disproportionately from such a major policy change.

## State Reform

While state officials obviously cannot change federal tax policy, they can make their health insurance markets more efficient, effective, and inclusive. The best way to do that is to create a statewide health insurance exchange, a key feature of the 2006 Massachusetts reform. If properly designed—*a very big if*—a statewide exchange can serve as a clearinghouse for information on all health plans available in the state. The exchange can then provide a mechanism to facilitate premium payments and the enrollment of employers and employees in the coverage plans of their personal choice. The exchange would also provide an administrator for government subsidies to help low-income persons get the health coverage of their choice, a large platform for intense market competition among numerous private insurers, and a way for both employers and employees to secure the generous benefits of existing federal tax law. A more detailed description of the function of a statewide health insurance exchange can be found on the Heritage Foundation's website.

An exchange can mitigate the existing restrictions of the federal tax code. If employers designate the exchange as their plan in fulfilling federal employment law requirements, any contribution they make to health plans chosen by their employees will be tax-free to the employer. Moreover, the value of the health benefits will be tax-free to the employee. Employers who don't contribute to employee health insurance can join the exchange and, as a condition of membership, set up Section 125 (tax-free) accounts from which employees can make tax-free premium payments for their chosen plans in the exchange.

This means that an employee can buy a health plan tax free and keep it as he or she moves from job to job. Personal and portable health insurance is a key benefit of the exchange. Portability is a powerful protection against being uninsured; continuity of coverage also ensures continuity of care, and thus better health care outcomes.

If a state allows *any* willing health plan to compete in the

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statewide exchange, allows Medicaid SCHIP enrollees to participate, and establishes a risk mechanism for coping with adverse selection, this can be a profoundly consequential health reform. It can sharply expand coverage and enable individuals and families to secure value for their health care dollars. It can also promote robust competition, patient-centered innovation, and productivity within the health care sector of the economy. Once again, blacks and Hispanics, especially those employed in small businesses, would benefit disproportionately from such an arrangement.

## Genuine Diversity

These reforms should generate new types of care that are culturally competent and attuned to the very real differences in medical needs that exist among ethnic and racial minorities. The greatest opportunities for cultural competence in the delivery of health care rest with the culturally competent themselves in their own communities, not with pandering public officials in Washington clumsily clanking around in politically correct armor. If there is a level playing field in health insurance and individuals are empowered financially to buy the coverage that they want without today's onerous tax and regulatory penalties, the uninsured will be able to participate in very large group health arrangements outside of the comparatively small pools that exist today at places of work. This, too, would directly benefit ethnic and racial minorities.

With empowered patients, there is no earthly reason culturally competent health plans could not be officially sponsored, if not formally approved, by ethnic or fraternal societies, such as Hispanic organizations, or even by faith-based or religious groups, such as black churches, that are deeply rooted in their communities. Black churches, like the ethnic urban Catholic parishes a generation ago, are trusted institutions with a rich history of social and community service. New health plans, sponsored or approved by such institutions, could make available physicians and other medical professionals who speak languages other than English, and who have epidemiological expertise relevant to various ethnic or racial groups. The effect would be to reduce barriers to communication and enhance diagnosis and compliance with care recommendations.

## New Options

These reforms would make new group insurance pools, completely outside of employment and sponsored by various private associations, increasingly common. In fact, literally thousands of such organizations for the delivery of insurance, including old age, disability, dismemberment, and sickness benefits, serving millions of Americans, including large numbers of the foreign-born, were active less than a century ago. In terms of membership and the value of their insurance reserves, some of these organizations were huge and, for their time, financially impressive.

According to *The Fraternal Insurance Compend* (1926), the Aid Association for Lutherans, which provided sickness and disability benefits, had 45,000 members with total insurance in

force worth $47 million, and the Polish Roman Catholic Union of America, which provided life and survivors benefits, had total insurance worth $61 million. Others were highly specialized, such as the Bohemian Roman Catholic Union of Texas, which provided life insurance for Texas males of Bohemian birth or descent. Others engaged directly in providing health care. The Taborites, a fiercely independent black fraternal organization, established hospitals during the early 20th century to ensure that black patients would get better care than they would in segregated Southern hospitals.

To recapitulate, the key to making health insurance affordable is (1) to change the federal tax code and retarget the hundreds of billions of dollars of tax assistance to individuals as individuals, rather than as mere employees, and (2) to redirect the tens of billions of dollars in existing federal and state government subsidies that go to institutions caring for the uninsured directly to the uninsured themselves—a new path taken by Massachusetts officials as part of their historic reform. More revenues might be necessary, but the retargeting of these large existing financial resources would help the uninsured get the coverage they want while simultaneously opening up health insurance markets to satisfy a diverse demand for quality health care.

If policymakers want to reduce ethnic and racial disparities in health care, they should get serious about empowering ethnic and racial minorities to secure superior private health insurance coverage and care and enabling them to escape the Medicaid ghetto. But it will take political imagination and a passion for serious innovation rather than merely filling "gaps" in conventional policies and old programs.

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