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LABOR CENTER REPORTER

Number 175
=March 1986=

BERKELEY, CA 94720
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HEALTH CARE AND POVERTY: THE CRISIS SPREADS

=by Pamela Tellew=

Income inequality has increased during the Reagan years and the percentage of Americans living below the official powerty line has increased for the first time since 1961. Of the many tragic consequences of this polarization in income, the most frightening is the deterioration of health care services to the poor. As sports medicine and cosmetic surgery clinics proliferate, public and voluntary non-profit hospitals are closing. We are rapidly becoming a nation not only of rich and poor, but of well and sick.

We are accustomed to think that in this country, everyone's basic medical needs are met. After all, there's Medicaid, public hospitals, the employed have health insurance, and at the very least, doctors have their Hippocratic Oath. But as a society, we have never met the health care needs of all of our poor. And now cuts in the welfare and Medicaid rolls, high unemployment during the last recession, and changes in the structure of the health care industry have reduced or eliminated health care access for millions of Americans and the problem is growing.

Medicaid -- Medicaid is the health insurance program for the poor. It was established as one of the Great Society programs of the 1960s and is funded jointly by the federal and state governments. Medicaid did not initially require the states to cover all of the poor or all health services, but it did mandate that the states provide full coverage by 1975. By 1972, however, Congress repealed this "full coverage" provision. "Basic health care for all" has never been a reality in this country. In fact, the U.S. has consistently lagged behind Western Europe in such leading health indicators as infant mortality rates and life expectancy.

Medicaid currently covers less than half of the nation's poor (as measured by the official poverty line). Only six states cover more than 75 percent of their poor. Income requirements for eligibility are very strict: in Mississippi, a family of three can earn no more than $1,152 a year to remain eligible for Medicaid. In other words, Medicaid is limited to those eligible for public assistance. In California, Medicaid now covers the poor only when they are also over 65, blind, disabled, or on Aid to Families with Dependent Children (AFDC).

Although Medicaid has never served all of the nation's poor, the Medicaid budget has been cut repeatedly over the last decade. Nationwide, the Medicaid rolls were reduced by 1.5 million people between 1977 and 1979, and when AFDC was cut in 1982, another 660,000 children and 181,000 adults lost their Medicaid eligibility. In 1981 and 1982, with federal budget cuts and reduced tax revenues due to the recession, 35 states made severe cuts in their Medicaid programs. In some states, like California, these cuts had the effect of reducing the Medicaid rolls even further. In others, services to the poor were reduced. For example, 17 states cut inpatient hospital services, five states cut emergency hospital services, and 31 cut funding for drugs or medical supplies.

Medicaid rules have been subjected to much maneuvering as well. MediCal, California's Medicaid, does not decide whether it will pick up the tab until after treatment is given. MediCal patients have no assets and cannot pay unless MediCal covers the treatment. Health care providers must either provide care to Medical patients as potential charity or refuse to serve MediCal patients. Many have chosen the latter. Other recent changes require Medicaid recipients in some

states to go only to designated health care providers. This may cause Medicaid recipients, who are more likely to live in "medically underserved areas," to forego care.

Medicare -- Most people over 65 are enrolled in Medicare, but Medicare too has been cut in recent years. Medicare deductibles and copayments have been rising rapidly for several years. Currently, Medicare requires a $492 deductible for the first day of hospitalization, a $123 copayment for each of the 61st through 90th days, and a $256 copayment for each of the 91st through 150th days. Medicare pays only about 2% of nursing home costs. Some unions and/or employers provide their retirees with supplemental insurance to cover what Medicare doesn't. Others must purchase private supplemental insurance. These plans vary a great deal in cost and quality. Insurers have been accused by Congressional representatives of using fraudulent advertising practices and preying on the fears of the elderly to sell redundant and overpriced supplemental plans.

Retirees who are not eligible for Social Security must purchase Medicare, at a cost of about $200 per month, in addition to the supplemental insurance, which averages $60 per month. In California, schoolteachers who paid into their own retirement system instead of Social Security, must pay these insurance premiums out of a montly pension check of about $550, or go uninsured.

Changes in Medicare's method of reimbursing doctors, intended to control costs, have had some unhappy consequences for Medicare recipients. Since 1983, health care providers have been reimbursed by "Diagnosis Related Groups" (DRGs). Providers receive a specified amount for each of 467 different diagnoses. If a patient's ailment doesn't fit into one of the DRGs, there is no reimbursement. Either the patient must pay or no treatment will be given. If the patient's treatment turns out to be more costly than Medicare allows (if, for example, the treatment takes longer than Medicare thinks it should or if the hospital is using expensive equipment), either the patient must pay the cost overrun or risk being discharged from the hospital before the treatment is complete. The DRG payment system doesn't allow reimbursement for simultaneous treatment of a secondary unrelated condition, so if patients want Medicare to pay for such treatment, they'll have to return for treatment at a later time. At best the delay is inconvenient; at worst, dangerous.

Others With Special Needs -- It is estimated that 40 million Americans, up from 25 million in 1980, are without any health insurance coverage, public or private. Most of this increase is due to increased unemployment. When workers lose their jobs, they almost always lose their health insurance. Despite attempts to pass legislation to guarantee health coverage for the unemployed, health insurance remains separate from unemployment and disability insurance programs. Even when the unemployed return to work, they often return to different jobs with fewer or no health benefits. In addition, there is a whole sector of low wage workers, such as those in agricultural and service work, where health coverage is extremely rare.

Even those who have health insurance are often underinsured. Many collectively bargained health plans now pre-pay only half of a family's total health care costs. (See LCR #93.) Health care "cost containment," a frequent item on the employer's collective bargaining agenda, has often resulted only in shifting costs to workers. Increased deductibles, copayings, and more restrictive hospital admissions have either made health care more costly or less accessible to workers. Some health plans have instituted upper limits on benefits, leaving workers to bear the costs if catastrophic illness strikes. In some cases, "cost containment" has meant the elimination of some services, like prescriptions or optometry.

The result of all of these recent developments is that more people are gambling with their health and waiting until their health problems become an emergency before seeking medical help. The irony of the situation involving all these "cost saving" moves on the part of employers and governments is that the more serious health problems which develop as a result of the waiting are often more expensive to treat.

Next month we will look at the kind of care that the poor receive and at the health care system that delivers.

-- Pamela Tellew