

Life Course Indicator: Medical Insurance for Adults

The Life Course Metrics Project

As MCH programs begin to develop new programming guided by a life course framework, measures are needed to determine the success of their approaches. In response to the need for standardized metrics for the life course approach, AMCHP launched a project designed to identify and promote a set of indicators that can be used to measure progress using the life course approach to improve maternal and child health. This project was funded with support from the [W.K. Kellogg Foundation](#).

Using an RFA process, AMCHP selected seven state teams, Florida, Iowa, Louisiana, Massachusetts, Michigan, Nebraska and North Carolina, to propose, screen, select and develop potential life course indicators across four domains: Capacity, Outcomes, Services, and Risk. The first round of indicators, proposed both by the teams and members of the public included 413 indicators for consideration. The teams distilled the 413 proposed indicators down to 104 indicators that were written up according to three data and five life course criteria for final selection.

In June of 2013, state teams selected 59 indicators for the final set. The indicators were put out for public comment in July 2013, and the final set was released in the Fall of 2013.

Basic Indicator Information

Name of indicator: Medical Insurance for Adults (LC-40)

Brief description: The proportion of adults with medical insurance.

Indicator category: Health Care Access and Quality

Indicator domain: Service/Capacity

Numerator: Number of adults 19 years and older with medical insurance

Denominator: All adults 19 years and older

Potential modifiers: Age (19 to 64 and 65 and older), sex, race/ethnicity, marital status, household income, employment status, education

Data source: Current Population Survey Annual Social and Economic Supplement (CPS ASEC)

Notes on calculation: These data can be obtained from *Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People*. Some data sources define adults as over age 18; this indicator includes all adults including those 65 and older covered by Medicare. Elder adults do not contribute much to the uninsured group; looking at age as a potential modifier is recommended. Additional data sources to examine the modifiers include the Agency for Healthcare Research and Quality Medical Expenditure Panel Survey; the Centers for Disease Control and Prevention (CDC) National Health Interview Survey, the National Health and Nutrition Examination Survey and the Behavioral Risk Factor Surveillance System; U.S. Census Bureau American Community Survey (ACS) and Survey of Income and Program Participation.

Similar measures in other indicator sets: Healthy People 2020 Access to Health Services (AHS)-1.1; Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Benchmark V - Family Economic Self-Sufficiency: Construct 5.3, Health Insurance Status; Chronic Disease

Life Course Criteria

Introduction

In 2012, there were 48 million Americans, representing about 15 percent of the population, without health insurance (DeNavas-Walt, 2013). Of these uninsured Americans, more than 80 percent were 19 years of age or older, the majority had low incomes, and persons of color were disproportionately represented. There are many reasons why so many Americans have not had health insurance, although the number of uninsured persons in the United States has been decreasing since the implementation of the *Patient Protection and Affordable Care Act* (ACA) in 2010.

Many persons do not have access to insurance through an employer; and there have been limited affordable options to purchase insurance. For low-income families, there are public insurance options (e.g., Medicaid), but there are gaps in eligibility, and the process of securing coverage can be onerous. Additionally, Medicaid has historically been based on categorical eligibility that included pregnant women, children, and disabled and elderly persons, but not non-disabled adults. The ACA has expanded access to insurance coverage. Two of its key provisions are to close the eligibility gap for low-income persons, including non-disabled adults through Medicaid expansions, and to facilitate access to insurance coverage through the Health Insurance Exchanges.

Lack of insurance has both health and financial implications. Numerous studies have demonstrated the positive effects of Insurance coverage on both chronic and acute conditions (Institute of Medicine, 2002a; McWilliams, 2009). When uninsured persons do seek care, they can be left with medical bills that they cannot pay, often resulting in the accumulation of medical debt, which can have devastating consequences. Peoples with medical debt have been found to cancel medical appointments, delay recommended care and not fill prescriptions (Grande et al., 2013). They also are at risk of using up their savings, having damaged credit or even filing for bankruptcy (Sommers et al., 2011).

As the ACA is fully implemented, it will be important to monitor insurance coverage for the U.S. population. Health insurance is a major factor in understanding and addressing health and disease patterns, including disparities, found across populations and across the life span.

Implications for equity

The majority of the uninsured persons in the United States are low-income working families. Persons of color are disproportionately represented among the uninsured, and non-elderly adults are more likely to be uninsured than children (Kaiser Family Foundation, September, 2013). Adults with less than a high school education are more likely to be uninsured than those with more education (Ross et al., 2006).

There is well-established evidence of disparities in health insurance coverage across different racial/ethnic groups (Institute of Medicine, 2003, Kaiser Family Foundation, March 2013, DHHS, 2014). In 2012, the highest rates of non-insurance were found in Hispanic (41 percent), American Indian (32 percent), and Black (26 percent) adults. White adults had the lowest rate of non-insurance (15 percent), and Asian adults had the second lowest rate at 21 percent (Kaiser Family Foundation, March 2013). Employment may, in fact, explain some of disparities in insurance coverage among different racial/ethnic groups. Persons of color are more likely to be in low-wage jobs where insurance is either not available or unaffordable (Lillie-Blanton and Hoffman, 2005).

Public health impact

Compared to the insured, uninsured persons are less likely to receive medical care, preventive screening and treatment, and are more likely to have poor health status. When uninsured persons do receive care, it is often for conditions or events that may have been avoided with regular medical care, and the care is costly. In 2008, uninsured persons received about \$86 billion dollars in uncompensated care, 75 percent of which was financed by government programs (Hadley et al., 2008). These dollars could potentially have been used for other health care services, including preventive services.

Clinical preventive services, including immunizations and disease screening, are key to preventing death and disability and improving the health of Americans. These services not only prevent disease, but also facilitate early detection, diagnosis and treatment of acute and chronic disease. There is significant research showing that uninsured adults,

compared to insured adults, have less access to preventive health services (Freeman et al. 2008, DeVoe et al., 2003, Schoen et al, 2014, Ayanian et al., 2000). Although there is some debate whether clinical preventive services save money, one analysis showed that greater use of proven preventives services could avoid two million life-years years annually, and an increase in preventive services use to 90 percent could have saved almost \$4 billion dollars in 2006 (Maciocek et al., 2010). Even among higher income persons who lack health insurance, being uninsured has been associated with significantly decreased utilization of recommended cancer screening, cardiovascular risk reduction and diabetes management; increased income did not mitigate the differences (Ross et al., 2006)

Uninsured adults are much more likely to have undiagnosed hypertension, and hypercholesterolemia (Ayanian et al. 2003, Fowler-Brown, 2007), as well as diabetes (Fowler-Brown, 2007). Additionally, uninsured adults with chronic conditions (asthma, cancer, chronic obstructive pulmonary disease, diabetes, heart disease or hypertension) are more likely to say they were unable to receive or had to delay receiving a needed prescription than their insured peers (Wilper et al. 2008); uninsured adults also experience more delays in follow-up care. Use of preventive services has been strongly associated with insurance and a usual provider or source of care (Devoe et al., 2003).

Leverage or realign resources

Providing health insurance coverage to uninsured Americans is one of the major goals of the ACA. The creation of Health Insurance Exchanges and Medicaid expansions are two of the primary vehicles to accomplish this goal. Currently, there are 27 federally facilitated health exchanges, 17 state-based health exchanges, and seven partnership exchanges. Twenty-seven states and the District of Columbia are implementing Medicaid expansions, two states are engaged in open debates about the expansion, and 21 states have decided not to move forward with Medicaid expansion at this time (Kaiser Family Foundation, September 2014). In the future, more states may opt for Medicaid expansion, thereby expanding coverage to more Americans, including non-disabled adults.

In addition to ensuring that uninsured Americans have access to health insurance coverage, it is also important that they know about their coverage options and the enrollment processes. There are many opportunities at the local, state and federal level to outreach to uninsured persons, and assist them with enrollment, as needed. Health care organizations, schools, advocacy groups, as well as state and federal agencies can play an important role in assisting uninsured persons to access insurance,

Predict an individual's health and wellness and/or that of their offspring

Research shows more positive health outcomes for insured adults, compared to uninsured adults. For example, some studies found lower mortality among the insured, compared with insured persons (Wilper, 2008; Freeman et al., 2008, Sommers et al. 2012). Uninsured stroke patients have higher levels of neurological impairment and intracerebral hemorrhage, as well as mortality (Shen and Washington 2007); and uninsured persons diagnosed with cancer have later stage diagnoses (Halpern 2008). Increases in self-reported health status, in which a person reports that their health is very good or excellent, also have been found among the insured, compared with the uninsured (Sommers et al. 2012). In a study in Oregon where a trial expansion of Medicaid allowed a randomly selected group of uninsured low-income adults to enroll in Medicaid, coverage was then associated with decreased incidence of positive screens for depression (Baicker et al., 2013).

Growing up in a household with uninsured members can also have some adverse consequences. A 2002 Institute of Medicine report concluded that the financial, physical, and emotional well-being of all members of a family may be adversely affected if any family member lacks coverage, and that, for children, these effects can last into adulthood (Institute of Medicine, 2002b).

Data Criteria

Data availability

U.S. Census Bureau data are collected through three surveys: the CPS ASEC and the ACS. This indicator sources data from the CPS ASEC and insurance status can be obtained for the nation, all 50 states, District of Columbia, and Puerto Rico. Both CPS ASEC and ACS are collected annually; those wishing to analyze the data at a geographic level more granular than the state level can access county and neighborhood census tract level data via advanced search of the American Fact Finder.

Data quality

The CPS sample is based on the civilian noninstitutional population of the United States and is located in 792 sample areas comprising 2,007 counties and independent cities with coverage in every state and in the District of Columbia (U.S. Census 2013). According to the ASEC documentation, approximately 98,100 housing units were in sample for the ASEC, including the basic CPS sample in 2013. Of the approximately 83,200 housing units that were eligible for interview, about 75,500 interviews were obtained (U.S. Department of Commerce 2013). The additional sample for the ASEC provides more reliable data for Hispanic households, non-Hispanic minority households, and non-Hispanic White households with children 18 years or younger (U.S. Department of Commerce 2013).

The final weight for the ASEC supplement, which is the product of several adjustments, is used to produce population estimates for the various items covered in the regular monthly CPS. This weight is constructed from the basic weight for each person, which represents the probability of selection for the survey, and adjusted for special sampling situations and failure to obtain interviews from eligible households (U.S. Census 2013).

Studies examining changes in insurance coverage and changes in insurance coverage for children used CPS data by analyzing the verified and unverified CPS data (Holahan & Pohl, 2002; Blewett, Davern, & Rodin, 2004). A study that used the CPS data to examine the economic conditions and health insurance coverage, stating that the CPS is the most frequent cited national survey on American health insurance (Holahan & Cook, 2005). It has been debatable about whether the CPS is measuring the uninsured for an entire year or reflect the uninsured at a point in time and whether enrollment is under or overstated for Medicaid and the uninsured (Holahan & Cook, 2005).

According to the Census Bureau, the CPS ASEC is mainly useful for examining timely estimates of the insured and uninsured population at the national level and can be used for state-level estimates, trends, and differences (through multiyear averages). The large sampling errors of state-level data limit its usefulness; when examining state level data and trends from the CPS ASEC, the Census Bureau recommends using CPS ASEC non-overlapping two-year averages for time periods that include years prior to 2008 (U.S. Department of Commerce 2013). Despite these limitations, the CPS ASEC is the most widely used source of data on health insurance coverage in the United States, with a consistent time series of estimates from 1999.

Simplicity of indicator

Measuring and explaining the indicator is straightforward. The data include the proportions of the population who are insured and uninsured by various characteristics. It is easy and simple to explain the importance of insurance coverage. Health insurance coverage is important to have throughout the course of life to allow people to access medical care for preventive services in order to reduce the rate of morbidity and mortality in infants, children, adolescents and adults. Having access to care at an early age would improve health that can expand to adulthood. Medical insurance coverage has been a common focus for professionals and communities especially with the introduction of the ACA.

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