The Nonpoor Uninsured In California, 1998

If those who can afford to buy health insurance choose not to, what are the implications for our voluntary system of coverage?

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LACK OF INSURANCE is not solely an issue for the poor. In both California and the nation, approximately 40 percent of the uninsured have family incomes of at least twice the federal poverty level, and one-quarter have family incomes of at least 300 percent of poverty.[1] Examining the issue from this perspective does not detract from the importance of ensuring that those with the least means in our society obtain health insurance and better access to care. However, it does evoke questions about the point at which health insurance is the responsibility of the individual rather than of society.

Nationally, the vast majority (80 percent) of the nonpoor (persons with incomes above 200 percent of poverty) obtain health insurance through employment, but a significant minority are self-employed, work for a firm that does not offer coverage, or turn down employer-offered coverage.[2] For these persons (and their dependents), the main options are to purchase individual health insurance or to remain uninsured. About 7 percent purchase individual insurance (35 percent of those not covered through employment); the remainder go without coverage. Interestingly, and somewhat surprisingly, those at 200–299 percent of poverty are just as likely to purchase individual health insurance as are those with incomes above 400 percent of poverty.[3]

The nonpoor are not strong candidates for public insurance programs or significant premium subsidies. Only five states have expanded health insurance premium subsidies to adults with incomes greater than 200 percent of the federal poverty level, and there is no serious discussion of doing so at the national level.[4] As a society, we assume that persons at this income level will voluntarily purchase health insurance, and many of them do. Why don't all of them do so? Are they worried about being uninsured? How do they get access to the medical care system, and at what cost? Would they consider purchasing coverage? Answers to these questions will help to inform the discussion about the potential for expanding coverage within the current voluntary system.

Characteristics Of The Nonpoor Uninsured

In fall 1998 the Field Research Corporation undertook a random-digit-dial screening to identify California adults meeting two criteria: uninsured and with household incomes of at least 200 percent of the federal poverty level (approximately 9 percent of California's population).[5] Telephone interviews were conducted in English and Spanish with 1,009 respondents, to collect information on attitudes, utilization and charges, perception of

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the cost of health insurance premiums, and willingness to pay.[6]

The sample that we interviewed was predominantly male, white, and under age forty (Exhibit 1).[7] In spite of the income floor of 200 percent of poverty, this group was not affluent. More than one-third had annual household incomes below $30,000, and only 10 percent had household incomes of $75,000 or more. Nonetheless, 40 percent of the sample reported owning their own homes, and more than half owned a personal computer. Sixty percent reported being in excellent or very good health, and 12 percent, fair or poor health.[8] Eleven percent had experienced a serious medical condition in the past year, and 5 percent reported having been denied insurance coverage because of a medical condition.[9]

A large majority of the respondents (81 percent) were employed (63 percent full time, 18 percent part time). Twenty percent worked for an employer that offered health benefits; among those respondents, half were eligible for coverage.[10] Among this 10 percent, cost was the predominant reason for declining coverage but was cited by fewer than 40 percent. More than 90 percent of respondents had purchased some form of insurance in the past; most common was automobile insurance (90 percent), followed by home-

EXHIBIT 1
Characteristics Of The Nonpoor Uninsured In California, 1998

Characteristic	Percentage
Male	62%
Ethnicity	
White	65
Hispanic	20
African American	5
Asian	6
Other	4
Age (years)	
19–29	35
30–39	27
40–49	22
50–64	17
Married	31
Children in household	29
Employed	81
Self-employed	30
Own a	
Home	40
VCR	92
Computer	56
Health status	
Excellent	32
Very good	28
Good	28
Fair/poor	12
Income[a]	
Less than $30,000	36
$30,000–$49,999	37
$50,000–$74,999	17
$75,000 or more	10

SOURCE: California HealthCare Foundation/Field Research Corporation Survey of California's Non-Poor Uninsured, 1998.
NOTES: Percentages may not add to 100 because of rounding. N = 1,009, unless otherwise noted.
[a] n = 886.

owners'/renters' coverage (46 percent) and life insurance (37 percent).

Health Care Use And Charges

Fifty-four percent of respondents reported at least one visit to a medical facility or health professional in the past year (Exhibit 2). Of those who obtained any medical services or prescriptions, the median out-of-pocket charge was $200, while the mean was $1,083. The difference between the two values indicates that although most of the uninsured are obtaining relatively few services at a relatively low cost, a small proportion are high users with a heavy associated financial burden.

Among the 54 percent reporting one or more medical visits, 84 percent were charged for at least some of those services. Of those charged, 81 percent reported paying the entire bill, and only 6 percent said that they paid nothing. Almost half (46 percent) of those with outstanding charges were continuing to pay in installments.

Attitudes Toward Insurance

To assess attitudes toward health insurance, respondents were read a series of statements and asked whether they agreed or disagreed, strongly or somewhat (Exhibit 3). Four statements explored each respondent's degree of worry—for themselves, for their families, related to health (obtaining proper medical care), and related to finances (being wiped out financially). Consistently, 60 percent agreed that they worried a lot about each of these issues; those with higher incomes were less likely to be concerned, as were those with better health status. About 20 percent disagreed strongly with these statements (that is, they do not worry at all).

Despite this fairly high degree of worry, the majority (57 percent) of respondents disagreed with the statement, "Health insurance ranks very high on my list of priorities for where to spend my money." One explanation may lie in respondents' perceived value of health insurance: 43 percent agreed with the statement, "Health insurance is not a very good value for the money."

The complexity of the delivery system does not appear to be a barrier to purchasing coverage. Only 10 percent of respondents agreed strongly that "getting health care through a health insurance plan is too complicated for me," while 46 percent disagreed strongly.

Cost And Willingness To Pay

The survey included questions about respondents' perception of the cost of "a basic health insurance plan" and willingness to pay for coverage.[11] Overall, respondents believed that health insurance cost about twice as much as

EXHIBIT 2
Health Care Use And Charges Over The Past Twelve Months, Mean And Median Values, 1998

Type of service	Percent using services	Number of visits or prescriptions		Out-of-pocket charges	
		Mean	Median	Mean	Median
Any visit	54%	10.1	4	$1,005	$190
Physician visit	32	3.5	2	282	80
Lab	29	2.5	2	282	100
Hospital outpatient	18	2.4	2	407	60
Chiropractor/acupuncturist	17	12.6	5	336	100
Community clinic	13	3.0	1	95	20
Other medical	13	5.7	2	289	80
Emergency room	12	2.1	1	924	300
Hospital (overnight)	3	1.5	1	5,112	–[a]
Prescriptions	33	5.4	3	356	80
Total	58	12.4	6	1,083	200

SOURCE: California HealthCare Foundation/Field Research Corporation Survey of California's Non-Poor Uninsured, 1998.
NOTES: N = 1,009.
[a] Bases for hospital charges are very small. Of the twenty-seven respondents reporting hospitalization, seven did not provide information on charges. Of the remaining twenty, twelve were not charged.

EXHIBIT 3
Attitudes Toward Health Insurance Among Nonpoor Uninsured Californians, 1998

Survey statement	Agree		Disagree	
	Strongly	Somewhat	Strongly	Somewhat
Motivators for purchase				
I worry a lot about not having health insurance for myself	38%	23%	17%	21%
I worry a lot about not having health insurance for others in my family[a]	48	12	22	14
I worry a lot about not getting proper medical care and attention if I get sick	39	19	23	18
I worry a lot about being wiped out financially because I don't have health insurance	41	18	22	17
People who don't have health insurance have a difficult time getting proper medical care and treatment	52	18	11	13
Most of the people I know have health insurance	44	23	11	16
I don't get the medical care I need because I can't afford to pay for it	37	16	27	17
Health insurance ranks very high on my list of priorities for where to spend my money	21	20	28	29
Barriers to purchase				
I pretty much live from paycheck to paycheck	49	16	20	14
Health insurance is not a very good value for the money	23	20	26	24
I rely a lot on the kind of care that health insurance doesn't cover	18	16	28	27
Going to public or free clinics for my medical needs is just fine with me	15	24	35	20
Getting health care through a health insurance plan is too complicated for me	10	11	46	29

SOURCE: California HealthCare Foundation/Field Research Corporation Survey of California's Non-Poor Uninsured, 1998.
[a] Based on respondent households with more than one member, excluding those where respondent's parent is chief wage earner (n = 551).

they were willing to pay: the median perceived monthly cost was $100, compared with the willingness-to-pay median of $50. Perceived cost increased with age, accurately reflecting the fact that age is a standard rating factor in California's individual market (a median of $80 for those ages nineteen to twenty-nine, compared with a median of $200 for those ages fifty to sixty-four).

To compare perceived cost and willingness-to-pay responses with the actual cost of health insurance, responses to both questions were indexed to premiums of various individual (nongroup) insurance products actually offered by California health plans in 1998. Since the cost of health insurance varies considerably by age and geography, the cost cited by each respondent was indexed to what that person would have had to pay for a particular type of plan based on age and county of residence. Costs were calculated for three types of individual insurance products available in the California market: a $10 copayment for physician visits, a $40 copayment for physician visits, and a $2,000 deductible. Actual costs that each respondent would have had to pay for each product were calculated by averaging 1998 published rates for each type of product across the three major health plans in California's individual market (only two of the three offer high-copayment and high-deductible products). Note that each respondent gave a single answer to each of the two questions (perceived cost and willingness to pay); that response was indexed to premiums for all three health insurance products.[12]

Respondents' perceptions of cost often exceeded the actual cost, especially for the lower-premium plans (Exhibit 4). One-third of the respondents perceived the cost of a "basic health insurance plan for yourself" as 20 percent or more over what they would actually have had to pay in premiums for insurance with a $10 copayment for physician of-

EXHIBIT 4
Perceived Cost And Willingness To Pay For Three Types Of Health Insurance Products Among Nonpoor Uninsured Californians, 1998

	Type of insurance product		
	$10 copay	$40 copay	$2,000 deductible
Perceived cost of premium			
Less than 20% of typical cost	32%	10%	10%
Within 20% of typical cost	25	13	13
20% or more over typical cost	34	68	68
Don't know	10	10	10
Willingness to pay			
Less than 20% of typical cost	64	35	35
Within 20% of typical cost	16	19	19
20% or more over typical cost	11	37	36
Don't know	10	10	10

SOURCE: California HealthCare Foundation/Field Research Corporation Survey of California's Non-Poor Uninsured, 1998.
NOTES: Respondents gave a single response to each question, which was then indexed to the actual cost of three health insurance products offered in California's individual (nongroup) health insurance market in 1998. N = 993. Excludes respondents who did not give both age and county (necessary for algorithm).

fice visits; two-thirds perceived the cost as 20 percent or more over what they would have had to pay for the $40 copayment plan or the $2,000 deductible plan.

A smaller percentage of respondents (27 percent) reported being willing to pay an amount that was either close to—or 20 percent or more over—the actual cost of the $10 copayment plan. Slightly more than half reported the same willingness to pay for the $40 copayment plan. Indexing the willingness-to-pay responses to the high-deductible product produces results virtually identical to those for the $40 copayment product because the two sets of premiums are very similar.

The survey then briefly described each of the insurance options and asked respondents whether they would purchase the three types of health insurance products at their actual (age- and county-specific) premiums. Only highly simplified descriptions could be given for products whose benefit features vary greatly, but responses give a general sense of the level of interest. A majority (53 percent) reported that they would buy at least one of the three options. Of the 53 percent, about half preferred the $40 copayment plan; the $2,000 deductible product was the least preferred. There was little difference in responses across income categories.

A limitation of this analysis is that premiums may vary with health status in California's individual health insurance market; persons responding to the questions about cost and willingness to pay may actually be charged a premium that is different from the standard rates used here. However, two factors ameliorate this limitation. First, age, which reflects health status to some extent, was incorporated into this analysis since it is a standard factor used by the health plans in setting rates. Second, 60 percent of the sample reported being in excellent or very good health. Restricting the analysis to this portion of the sample—those most likely to be accepted by health plans under their standard rates—produces results virtually identical to those described above and shown in Exhibit 4.

Policy Implications

Misperceptions about the cost of health insurance or lack of awareness of the full range of options that exist in the individual market may be a significant factor in the lack of health insurance for some nonpoor Californians. To the extent that such persons perceive the cost of health insurance to be out of reach, they are unlikely to pursue its purchase. Correcting

inaccurate perceptions of cost or educating about the full array of products available may bring new consumers into the health insurance market, reducing the number of uninsured. Although willingness-to-pay responses are known to overstate actual purchasing behavior, it is encouraging to note that more than half of respondents said that they would buy at least one of three types of health insurance at premiums adjusted for age and geography.

■ **Plan preferences.** Respondents strongly preferred the $40 copayment plan when presented with the premiums for all three options. This is consistent with anecdotal evidence from industry leaders that consumers prefer high-copayment plans to high-deductible plans. From the consumer's perspective, premiums paid for the high-deductible coverage appear to be wasted when (as is usually the case) the deductible is not reached. It is also consistent with the spending patterns of this sample: Only a few respondents reported significant health care use, which would render the low-copayment (high-premium) plan less attractive.

■ **Cost versus value.** The good news is that health plans that actively educate the nonpoor uninsured about the array of products and prices available in the individual market may persuade some of them to buy. Less encouraging is that premiums in California's individual market have risen by approximately 20 percent since the survey was conducted.[13] Persons will purchase insurance when they perceive that it has value commensurate with its cost. More than 40 percent of respondents to this survey felt that health insurance is not a good value; this proportion can only go up as prices increase. Careful attention should be paid to regulatory measures, such as benefit mandates, that may add significant cost but little value for many potential enrollees.[14] The question is not whether more benefits are better, but rather how many people will be priced out of the market.

■ **Voluntarism versus universalism.** Even if every respondent who said that they would purchase one of the products did so, almost half of the sample would remain uninsured. A closer look at this half reveals two distinct groups. One group is quite concerned about lacking coverage but is close to the income floor of 200 percent of poverty; this group might be expected to respond to individually based tax incentives to lower the price of purchasing insurance that are currently under discussion.[15] However, the majority have higher incomes but are unworried and thus unlikely to enter the market voluntarily.[16]

If those whom society has implicitly deemed financially able to participate in the health insurance market choose not to, what are the implications for our voluntary system of coverage? There has been little mention of compulsory participation in our health insurance system since 1994, when all flavors of mandates and taxes were considered in pursuit of universal coverage.[17] In the reemerging discussion, attention has focused on individual rather than employer mandates to provide workers with coverage.[18] An individual approach fits logically with a tax-incentive approach and is aligned with increasing movement toward individual choice and defined contribution. But while the locus has shifted to the individual, the underlying theme from 1994 recurs: the inherent contradiction between voluntarism and universalism. This paper confirms that while some nonpoor uninsured persons may be persuaded to purchase insurance through more-effective education and marketing, any system that relies on individuals to purchase insurance voluntarily will fall far short of universal coverage.

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NOTES

1. D. Chollet, "Consumers, Insurers, and Market Behavior," *Journal of Health Politics, Policy and Law* (February 2000): 30; E.R. Brown, R. Wyn, and R. Levan, *The Uninsured in California: Causes, Consequences, and Solutions* (Oakland: California HealthCare Foundation, 1997), 6. In 1998, 200 percent

of the federal poverty level was $17,000 for a single person and $33,000 for a family of four.

2. K. McDonnell and P. Fronstin, eds., *EBRI Health Benefits Databook* (Washington: Employee Benefit Research Institute, 1999), 61.
3. Chollet, "Consumers, Insurers, and Market Behavior."
4. A. Schneider, K. Fennel, and P. Long, *Medicaid Eligibility for Families and Children* (Washington: Kaiser Commission on Medicaid and the Uninsured, 1998), 21.
5. We were unable to ascertain, during the short field period, the total number of persons eligible for the survey; thus, potential nonresponse bias does not allow us to make statistical inferences about the nonpoor uninsured population in California. Nevertheless, these interviews provide a rich source of data that describe this population and generate hypotheses about the important factors in the decision making of nonpoor persons with respect to health insurance.
6. These data are publicly available, free of charge, from the archive section of the Web site for the Inter-University Consortium for Political and Social Research (ICPSR), based at the University of Michigan (www.icpsr.umich.edu), Study no. 2688.
7. While the age and employment makeup of the nonpoor uninsured population is similar to that of California's uninsured population overall, the latter is much more likely to be nonwhite (68 percent, compared with 35 percent for the nonpoor uninsured). Brown et al., *The Uninsured in California*, 5–8.
8. These figures are consistent with 1997 national data on the uninsured overall (62 percent excellent/very good and 10 percent fair/poor). Nationally, in terms of health status, the uninsured fall between those with private coverage (73 percent excellent/very good and 6 percent fair/poor) and those with public coverage only (54 percent excellent/very good and 19 percent fair/poor). Authors' calculations based on data in J.P. Vistnes and S.H. Zuvekas, *Health Insurance Status of the Civilian Noninstitutionalized Population: 1997*, MEPS Research Findings no. 8 (Rockville, Md.: Agency for Health Care Policy and Research, 1999).
9. We also conducted telephone interviews with 802 individually insured California adults with household incomes of at least 200 percent of poverty. In comparison with the nonpoor uninsured, the individually insured were older (forty-two versus thirty-six), less ethnically diverse (79 percent white), more likely to be women (61 percent), and had higher incomes (47 percent versus 24 percent had household incomes of at least 500 percent of poverty). They also were more likely to report excellent or very good health status (75 percent versus 60 percent).
10. Reasons for being ineligible might include part-time or temporary status, or a waiting period between beginning employment and becoming eligible for benefits.
11. The question about perceived cost of premiums was worded: "How much do you think it would cost you to purchase a basic health insurance plan for yourself...Just very roughly, what would be the monthly cost if you wanted health insurance?" The willingness-to-pay question was worded: "How much, if anything, would you be willing to pay each month out of your own pocket for a health insurance plan that provided basic coverage for doctor visits, hospitalization, and prescription drugs for yourself?"
12. For the $10 copayment plan, average premium values used for indexing were as follows: ages 19–29, $80–$90; 30–39, $110–$120; 40–49, $135–$150; 50–59, $160–$185; 60–64, $190–$215. For the $40 copayment plan, average premium values were ages 19–29, $30–$50; 30–39, $45–$75; 40–49, $70–$115; 50–59, $120–$165; 60–64, $145–$205. Average premium ranges for the $2,000 deductible plan were identical to the $40 copayment plan with two exceptions: ages 40–49, $70–$110; and 60–64, $140–$200. The range for each age group is due to variation in premium across geographical regions.
13. C. Swett, "Medical Insurance Rates Go Soaring," Sacramento Bee, 2 June 1999; and "MCOL Releases CA HMO Rate 2000," www.mcol.com/041100.htm (13 April 2000).
14. G.A. Jensen and M.M. Morrisey, "Employer-Sponsored Health Insurance and Mandated Benefit Laws" *Milbank Quarterly* 77, no. 4 (1999): 425–459.
15. K. Polzer, *Retooling Tax Subsidies for Health Coverage: Old Ideas, New Politics*, Issue Brief no. 728 (Washington: National Health Policy Forum, 1998); and P. Kilborn, "Help for the Uninsured May Rest in Tax Code," *New York Times*, 12 March 1999.
16. See J.M. Yegian, D.P. Pockell, and E.K. Murray, *To Buy or Not to Buy* (Oakland: California HealthCare Foundation, 1999), 18–21. This report is available online at www.chcf.org/uninsured.
17. See, for example, *Health Affairs* Spring (II) 1994.
18. D. Kendall, "Getting on the Fast Track to Universal Coverage," *Blueprint: Ideas for a New Century* (Washington: Democratic Leadership Council, Spring 2000): 24–29; D. Nather, "After Five Years, Reformers Returning to Big Ideas, Not Smaller Steps," *BNA's Health Care Policy Report* (15 November 1999): 1811–1816; and Polzer, *Retooling Tax Subsidies for Health Coverage*.