Chapter 13: Poverty and Health

By:
Christopher Conover

Chapter 13: Poverty and Health

By:
Christopher Conover

Online:
< https://hub.mili.csom.umn.edu/content/col10017/1.1/ >

Medical Industry Leadership Institute Open Education Hub

Collection structure revised: September 26, 2013
PDF generated: November 5, 2013
For copyright and attribution information for the modules contained in this collection, see p. 21.

Table of Contents

Chapter 1

13.1 Millions Are Categorized as Poor because Medical Expenditures Are Not Taken into Account[1]

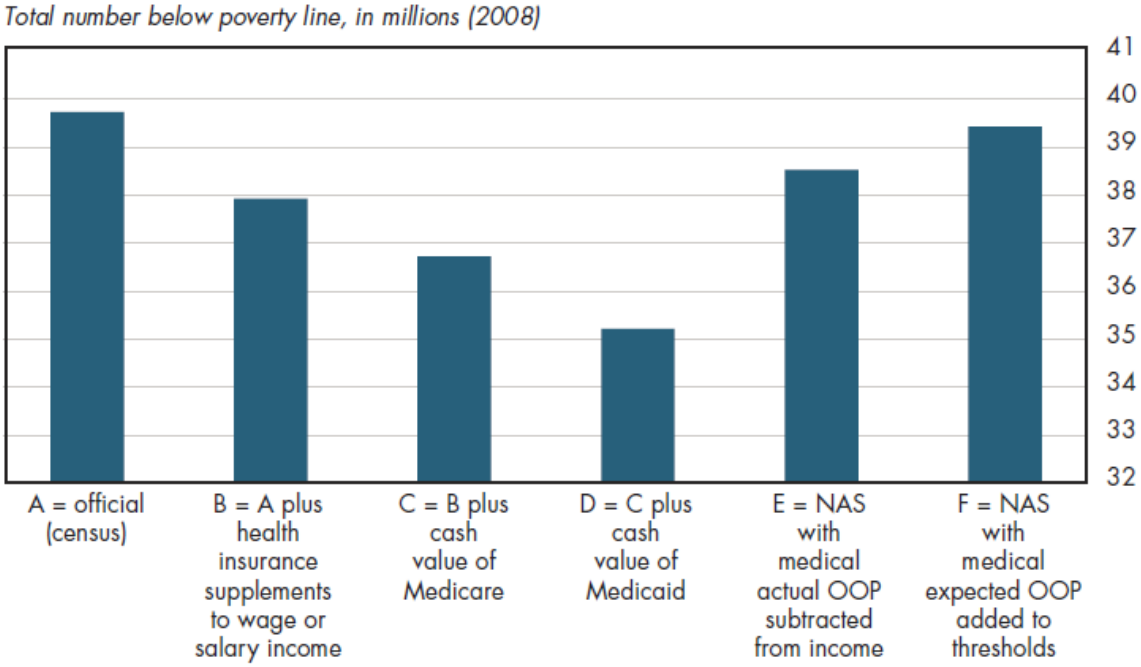
The term *poverty* not only implies having less income than someone else in similar circumstances or less income than one would like, but it means an economic condition of sufficient concern to elicit sympathy from others, and possibly to raise the question of social action to correct it. No single definition is possible. Whether one falls below this threshold varies by country, historical epoch, and even among citizens of the same country at a single time.

Scientists or economists cannot define poverty. They can describe only whatever definition is being measured. Others would have to decide whether that measure conforms to what they have in mind when they think of poverty. Figures 13.1a and 13.1b show the percentage of the U.S. population living below poverty according to various definitions. These data do not encompass the full range of possibilities. They highlight how measured poverty rates depend on the alternative manner in which experts have suggested medical expenses should be treated. These definitions include:

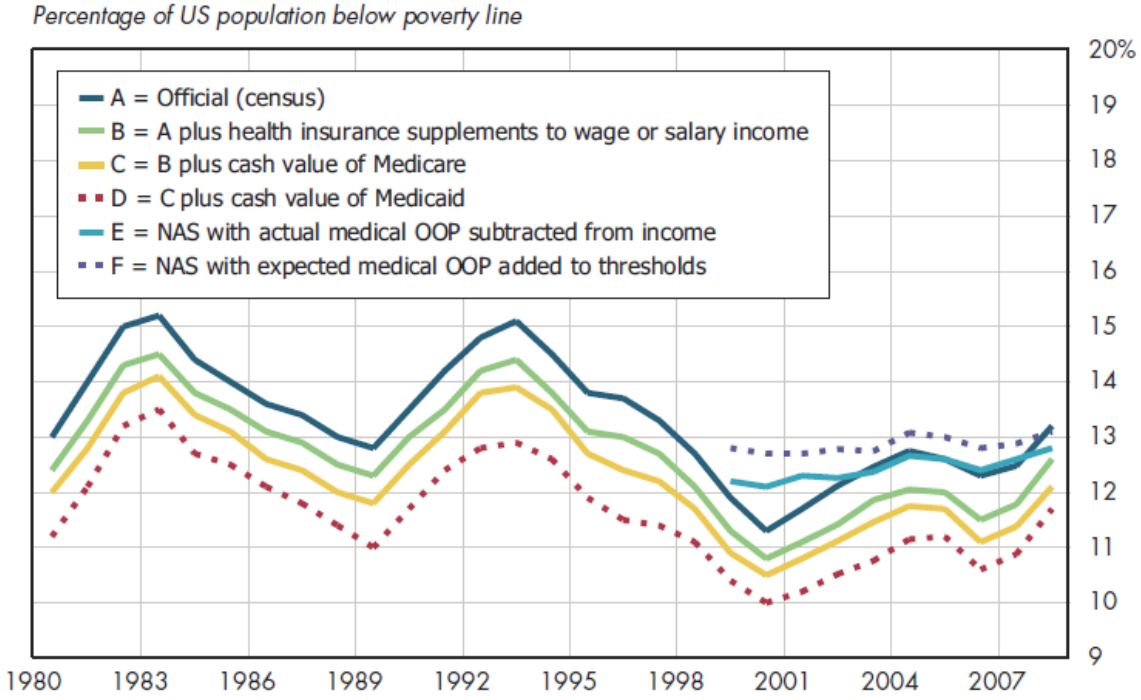
A. The official standard—cash income below the official threshold of three times the cost of minimum food needs in 1963, adjusted by changes in the consumer price index
B. Similar to A, but adding the value of health insurance supplements
C. Similar to B, but adding the cash value of Medicare benefits
D. Similar to C, but adding the cash value of Medicaid benefits
E. One standard recommended by the National Academy of Sciences (NAS) in which a family's actual medical out-of-pocket (OOP) expenses, inclusive of health insurance premiums, are subtracted from income (compared with a poverty threshold that excludes medical spending). Note that the NAS method differs from the official standard in other respects.
F. An alternative standard recommended by NAS in which expected medical out-of-pocket costs are added to the poverty thresholds

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10092/1.1/>.

13.1a Taking into account medical expenditures decreases the estimated number below poverty by up to 4.5 million people



13.1b How medical expenses are treated in measuring poverty has a negligible impact on measured trends in poverty rates



Note: NAS series not available prior to 1999.

Using definition D reduces measured poverty by approximately one-ninth. This is a modest relative change, but it would reduce the estimated number of poor in the United States by approximately 4.5 million in 2008 (figure 13.1a). However, how medical expenses are treated in the definition of poverty has only a negligible impact on measured trends in poverty rates (figure 13.1b).

1.1 Downloads

Download PowerPoint versions of both figures.

- Figure 13.1a Image Slide (as it appears above)[2]
- Figure 13.1a Editable Slide (can be formatted as desired)[3]
- Figure 13.1b Image Slide (as it appears above)[4]
- Figure 13.1b Editable Slide (can be formatted as desired)[5]

1.2 References

A. Department of Commerce. Bureau of the Census.

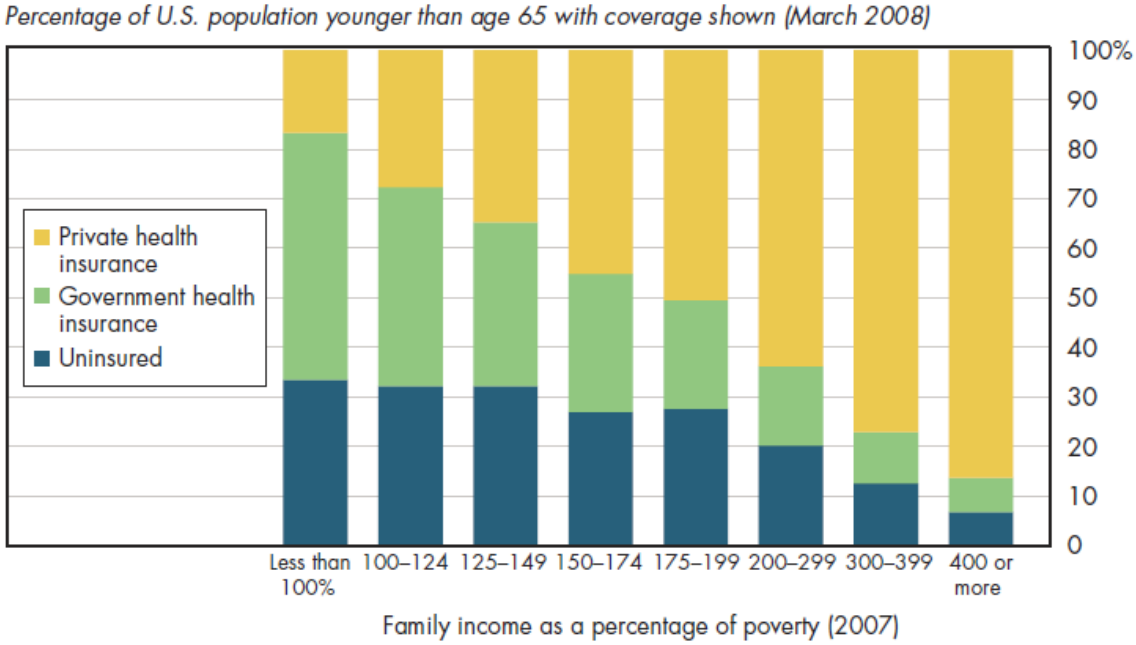
[2]https://hub.mili.csom.umn.edu/content/m10092/latest/13.1aIMG.ppt
[3]https://hub.mili.csom.umn.edu/content/m10092/latest/13.1aDATA.ppt
[4]https://hub.mili.csom.umn.edu/content/m10092/latest/13.1bIMG.ppt
[5]https://hub.mili.csom.umn.edu/content/m10092/latest/13.1bDATA.ppt

Chapter 2

13.2 Government Insurance Covers Half of the Poor[1]

Only approximately half of those counted as poor have government insurance (primarily Medicaid). Approximately 30 percent are uninsured (figure 13.2a). Many assume that Medicaid covers the poor. In fact, however, eligibility for Medicaid historically has been restricted to certain categories of individuals: children, pregnant mothers and newborns, single parents, disabled, and the elderly. Thus, in most states, someone not fitting one of these categories can never qualify for Medicaid, even if they have no income or have medical bills that exceed $100,000.

13.2a Approximately half the non-elderly poor have government insurance, while 30 percent are uninsured; the uninsured rate declines with income



Many near-poor can qualify for Medicaid. Although thresholds vary by state, federal law requires states that participate in Medicaid to cover pregnant women, infants and children to 133 percent of poverty, and

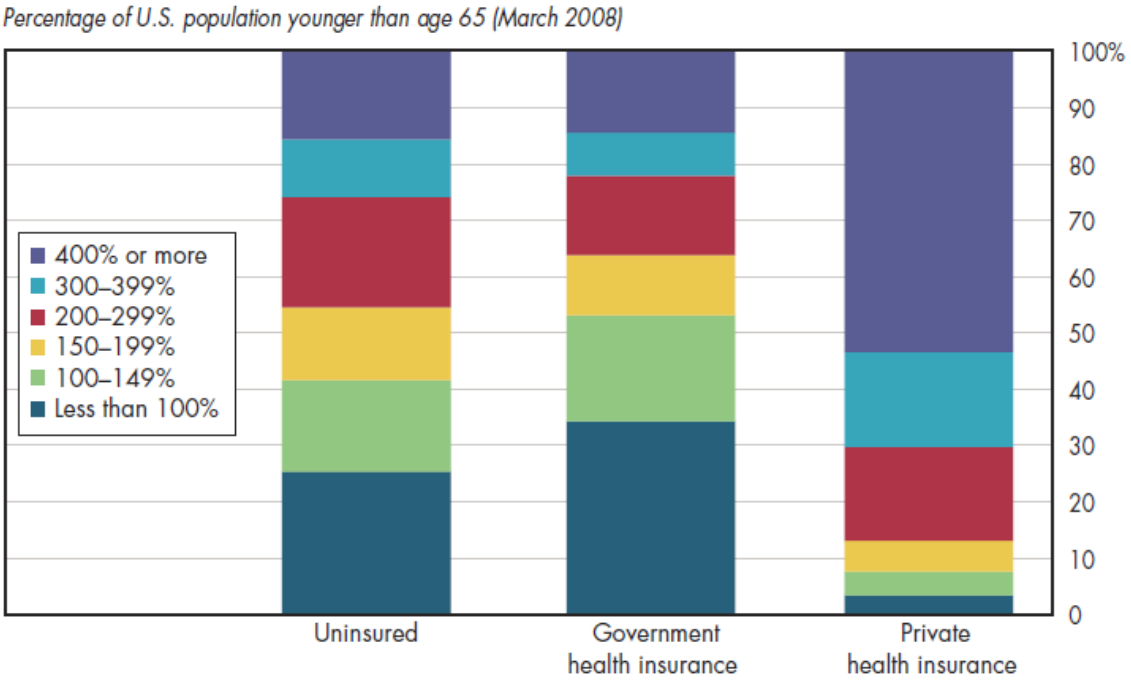
[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10093/1.1/>.

children age 6-19 at 100 percent of poverty. Most states choose to cover them at a much higher level (for example, 185 percent of poverty and some as high as 300 percent of poverty). Most states cover the elderly and disabled who are between 75 and 100 percent of poverty. A few states have elected to provide optional coverage to other groups, for example, unemployed parents. Others have either gotten federal waivers or used state-only funds to cover all individuals below poverty. The new health reform law eradicates these categorical distinctions and if fully implemented will provide Medicaid coverage to all Americans living at less than 133 percent of poverty.

The chances of being uninsured drop steadily as incomes rise, and the chances of having private coverage increase with income. Public coverage can be viewed as filling the gap; because the figure focuses on the non-elderly population, most of this public coverage is through Medicaid. However, there is considerable evidence of "crowding out" of private insurance by Medicaid; one should not infer that absent government help, the uninsured rate for the poor would exceed 80 percent, for example.

More than half of the uninsured and 60 percent of those who have government insurance have incomes less than 200 percent of poverty (figure 13.2b). Conversely, among those who have private insurance, approximately only one in eight is poor or near poor.

13.2b More than half the uninsured and 60 percent of those who have government insurance have incomes below 200 percent of poverty



Note: Individuals who have both government and private health insurance were placed in the government health insurance category.

2.1 Downloads

Download PowerPoint versions of both figures.

- Figure 13.2a Image Slide (as it appears above)[2]

[2]https://hub.mili.csom.umn.edu/content/m10093/latest/13.2aIMG.ppt

- Figure 13.2a Editable Slide (can be formatted as desired)[3]
- Figure 13.2b Image Slide (as it appears above)[4]
- Figure 13.2b Editable Slide (can be formatted as desired)[5]

2.2 References

A. Department of Commerce. Bureau of the Census.

[3]https://hub.mili.csom.umn.edu/content/m10093/latest/13.2aDATA.ppt
[4]https://hub.mili.csom.umn.edu/content/m10093/latest/13.2bIMG.ppt
[5]https://hub.mili.csom.umn.edu/content/m10093/latest/13.2bDATA.ppt

Chapter 3

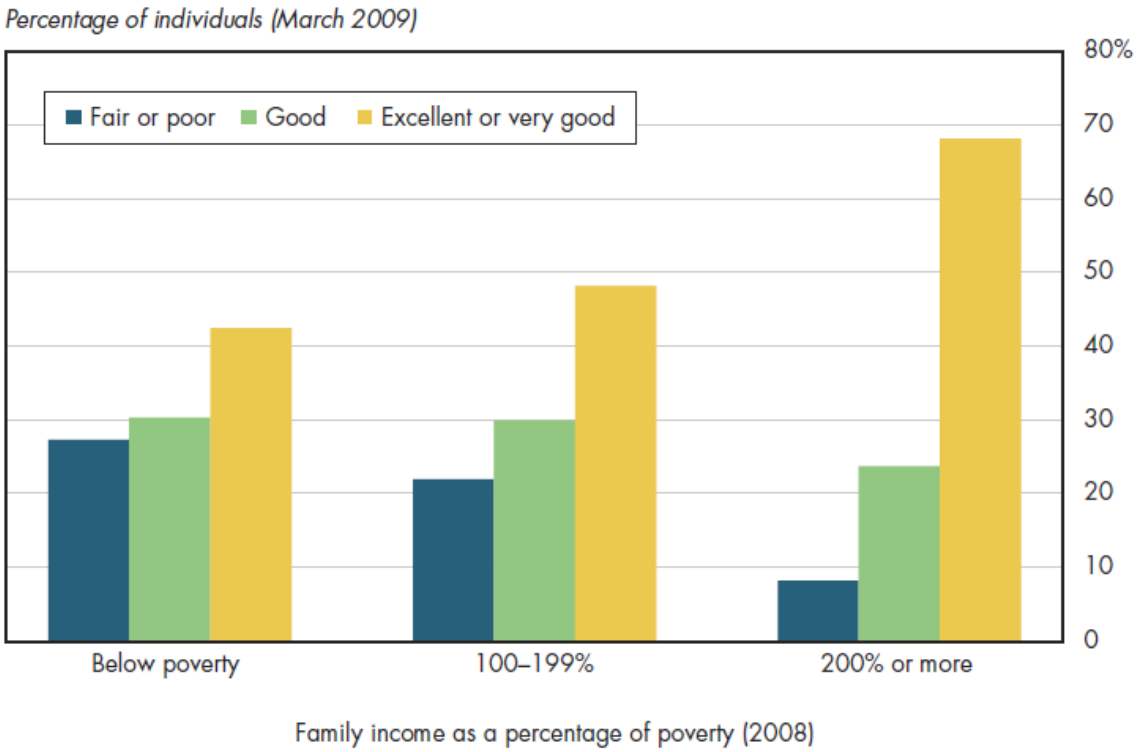
13.3 Lower-Income People Have Worse Health[1]

It has long been known that the poor generally are in worse health than is the rest of the population. Numerous methods can measure health status. Although not perfect, self-reported health status is a surprisingly good measure. Careful studies show that self-reported health status does a good job of predicting future mortality. That is, those who report their health status as "poor" are far more likely to die within the next year than are those who view their health as "good" or "excellent."

Using this measure, only approximately 40 percent of the poor say that their health is excellent compared with almost half of the near-poor and almost seven in 10 of those who have incomes above 200 percent of poverty. Conversely, more than 25 percent of the poor are in fair or poor health compared with fewer than 10 percent of those above 200 percent of poverty (figure 13.3a).

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10094/1.1/>.

13.3a Based on self-reported health status, the percentage of people in fair or poor health is highest among the poor and near-poor

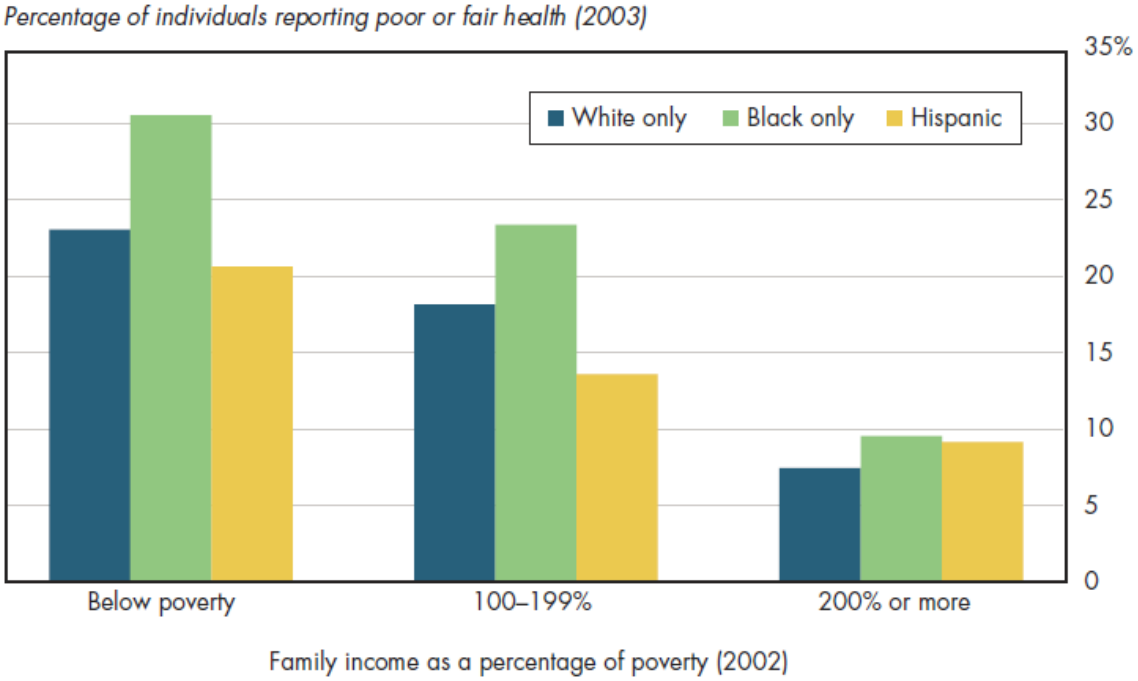


This relationship works in both directions. Some people are poor because of poor health. Poor health might prevent them from working or lower the amount that they can earn. Poverty itself can contribute to poor health. Those who live in poverty are more likely to be concentrated in areas that have higher crime rates, for example, putting them at risk of a violent injury that might permanently compromise their health for the rest of their lives. Likewise, poor people are more likely to drive less expensive, lighter cars that put them at higher risk of an auto-related injury. For many reasons too complicated to explain here (and too poorly understood), smoking rates and obesity also tend to be higher among those who have the lowest incomes.

Those who have the greatest general, objective need for health services also are least able to pay for such care. Consequently, how to finance such care is a social problem faced by all nations.

Socioeconomic factors explain only some of the persistent health differences across racial and ethnic groups. Even after accounting for higher poverty rates among blacks and Hispanics relative to whites, health status differences remain among these groups (figure 13.3b). The degree of these disparities grows smaller as incomes rise. Thus, economic growth and rising incomes will help naturally dissipate many disparities. However, they cannot be expected to disappear entirely even if incomes were equalized.

13.3b In all poverty categories, Hispanics have the best self-reported health status, followed by whites, while blacks have the worst self-reported health status



3.1 Downloads

Download PowerPoint versions of both figures.

- Figure 13.3a Image Slide (as it appears above)[2]
- Figure 13.3a Editable Slide (can be formatted as desired)[3]
- Figure 13.3b Image Slide (as it appears above)[4]
- Figure 13.3b Editable Slide (can be formatted as desired)[5]

3.2 References

A. Department of Health and Human Services. Centers for Disease Control and Prevention.

[2]https://hub.mili.csom.umn.edu/content/m10094/latest/13.3aIMG.ppt
[3]https://hub.mili.csom.umn.edu/content/m10094/latest/13.3aDATA.ppt
[4]https://hub.mili.csom.umn.edu/content/m10094/latest/13.3bIMG.ppt
[5]https://hub.mili.csom.umn.edu/content/m10094/latest/13.3bDATA.ppt

Chapter 4

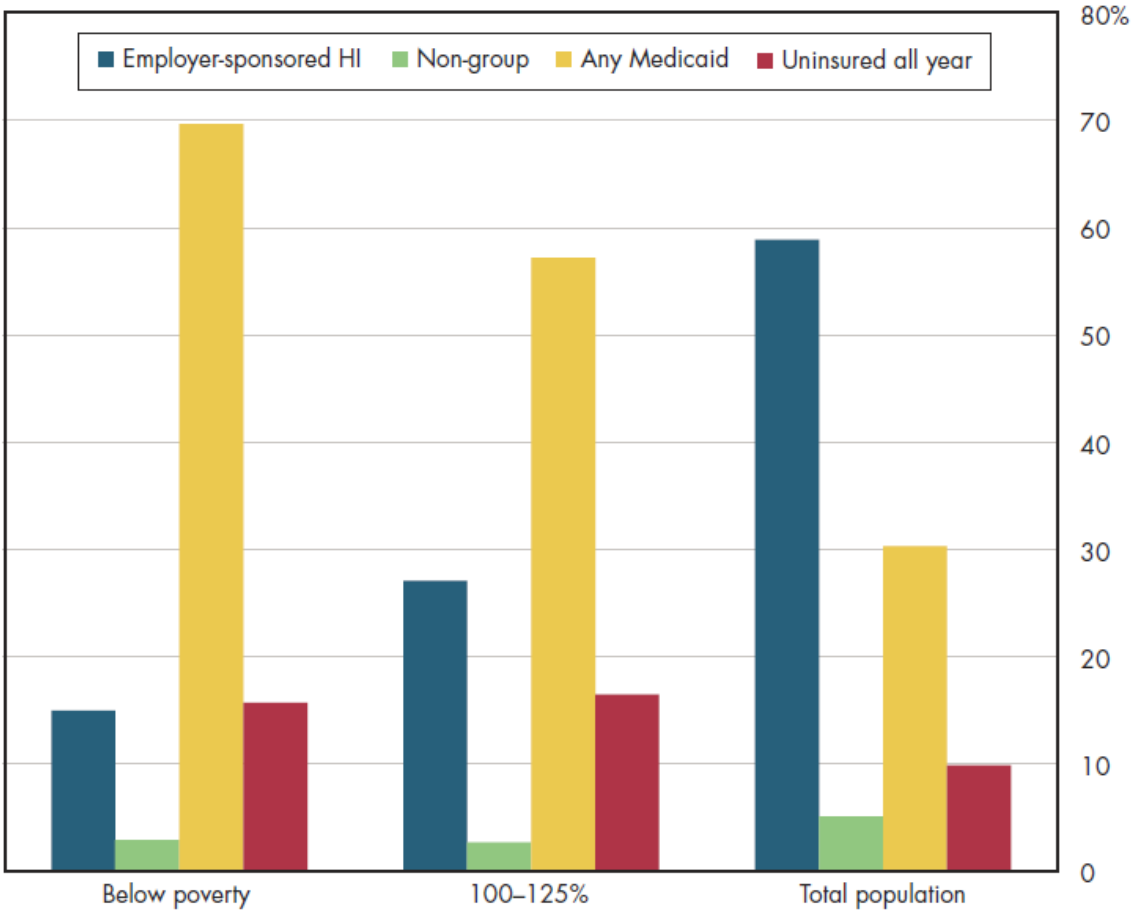
13.4 Poor Children Are Much Less Likely to Have Private Health Coverage than General Population[1]

Among poor children, the number who have no coverage exceeds the number who have employer-based health coverage. As figure 13.4 illustrates, in the general population of children there is a six to one ratio between the number who have employer-sponsored insurance and those who have no coverage. Even so, the chances of being uninsured among poor children are approximately 30 percent the level among non-elderly adults who are poor. In contrast, the shares of poor and near-poor children who have employer-sponsored health plans are almost identical to those of their counterparts age 18-64.

[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10095/1.1/>.

13.4 Children below poverty are only 25 percent as likely as the general population to have employer-sponsored health coverage

Percentage of individuals who have coverage (March 2008)



Note: Medicaid includes coverage through SCHIP.

Filling the gap is Medicaid/SCHIP coverage held by almost seven in 10 poor children and almost six in 10 children who are near-poor. The pervasiveness of Medicaid/SCHIP coverage among children in the lowest income households results in 30 percent of children overall who have Medicaid. This is triple the rate seen among non-elderly adults. These numbers understate the true extent of potential coverage. Careful studies show that approximately 25 percent to almost half of uninsured children qualify for Medicaid or SCHIP but their parents decline to enroll the children.

Medicaid "crowd-out" is sizable. In the most recent major expansion of Medicaid/SCHIP for children before the new health reform law, the CBO estimated that 30 percent of those who obtain new government coverage would otherwise have had private coverage. This does not mean that they literally dropped private coverage to get onto Medicaid (although some do). Generally, "crowd-out" consists of formerly uninsured individuals who otherwise eventually would have obtained some form of private coverage but for the opportunity to enroll in Medicaid or SCHIP.

Numerous studies have confirmed, using many measures, that access to care for those who have Medicaid

is worse than for those who have private coverage. There is solid empirical evidence that low Medicaid fees adversely affect physician participation in the program, including pediatricians or others who might treat children. Medicaid on average pays less than 60 percent of the price of medical services delivered by physicians in the private sector and less than 75 percent of Medicare fees.

4.1 Downloads

Download PowerPoint versions of figure.

- Figure 13.4 Image Slide (as it appears above)[2]
- Figure 13.4 Editable Slide (can be formatted as desired)[3]

4.2 References

A. Department of Commerce. Bureau of the Census.

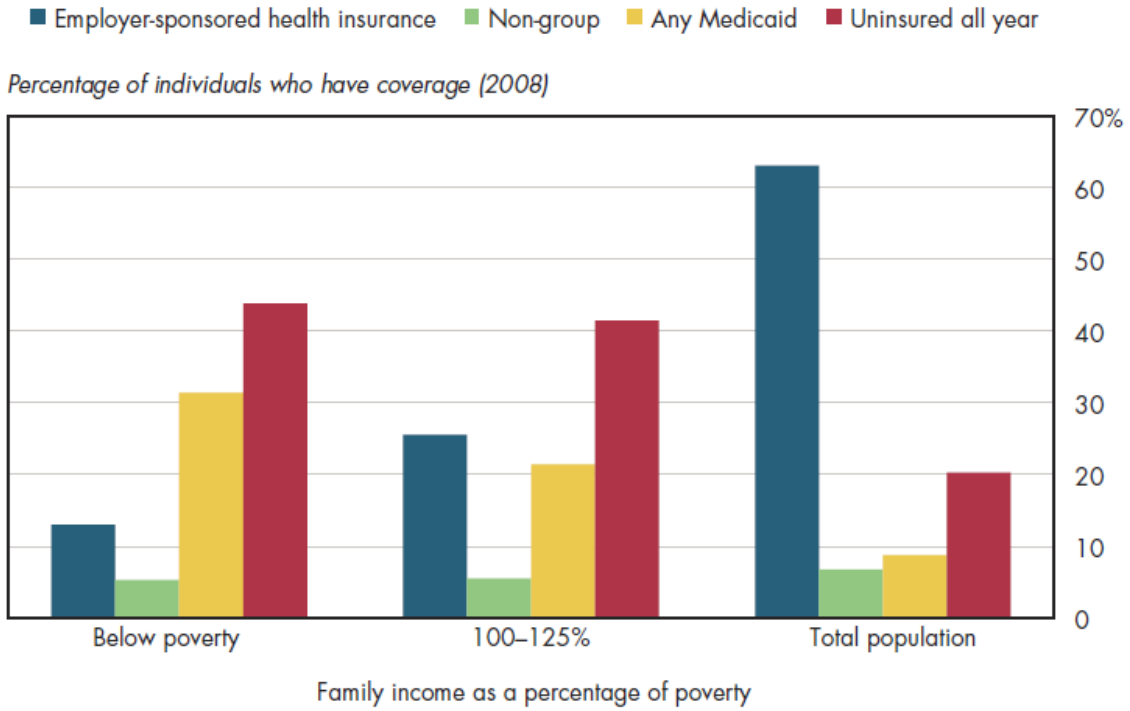
[2]https://hub.mili.csom.umn.edu/content/m10095/latest/13.4IMG.ppt
[3]https://hub.mili.csom.umn.edu/content/m10095/latest/13.4DATA.ppt

Chapter 5

13.5 Medicaid Covers Less than 1/3 of Poor Non-Elderly Adults[1]

Twenty percent of poor adults younger than age 65 have private health insurance coverage (figure 13.5a). Among those who have incomes from 100-125 percent of poverty, this amount is approximately 30 percent. Yet slightly more than 40 percent of both groups were uninsured. Approximately one in 20 individuals in both low-income groups had non-group coverage; thus, this cannot explain the difference. This percentage was not much different from the share of the total adult population younger than age 65 having non-group coverage.

13.5a Poor adults younger than the age of 65 are more than three times more likely to be uninsured all year than to have employer health coverage

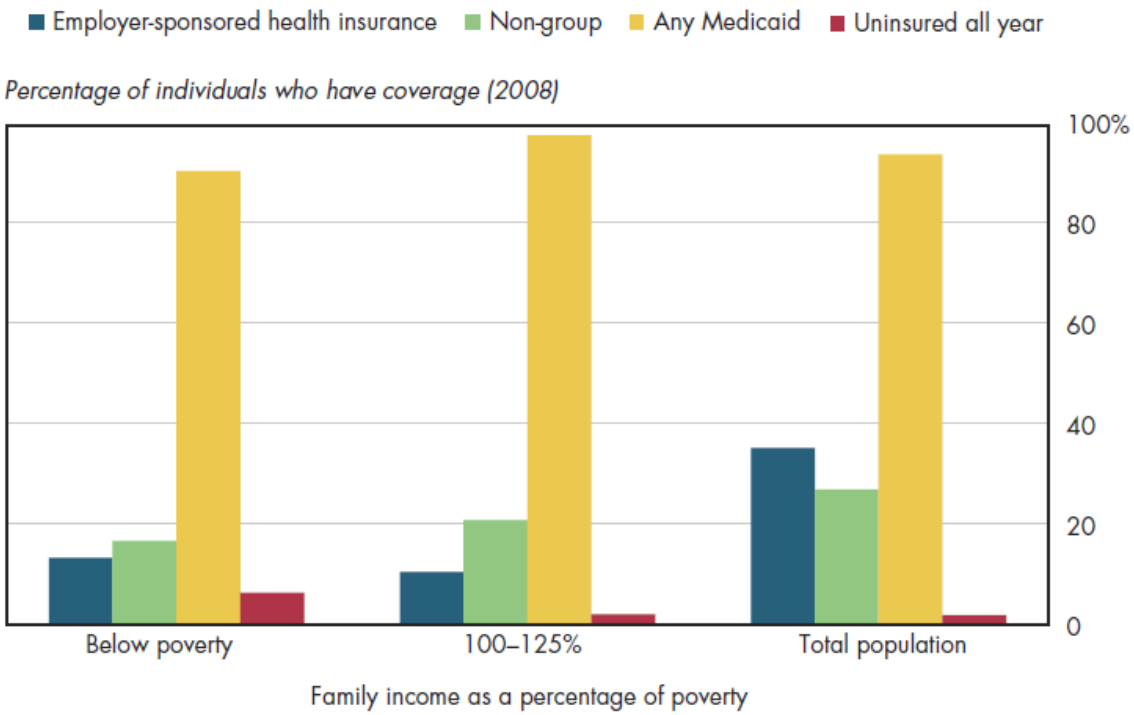


[1]This content is available online at <https://hub.mili.csom.umn.edu/content/m10096/1.1/>.

Differences in government coverage explain why the uninsured rate for the poor is almost equal to that of the non-poor despite lower rates of private coverage. Approximately 30 percent of poor adults have some sort of public coverage, most of which is through Medicaid. For the near poor (up to 125 percent of poverty), only one in four have government coverage. As with children, Medicaid accounts for most of this public coverage.

Private coverage among the elderly (age 65 or older) below poverty is approximately 50 percent higher than it is for children or non-elderly adults (figure 13.5b). One in 20 elderly adults below poverty is uninsured because Medicare is available only to those who have a qualified wage history or those able and willing to pay premiums for their coverage.

13.5b A large fraction of the elderly has supplemental Medicare coverage through employers or non-group plans



Approximately 25 percent of poor persons who are elderly are "dual eligible" for Medicare and Medicaid. Approximately 20 percent of these live in nursing homes or other long-term-care facilities. Consequently, approximately 45 percent of spending for this group is for long-term care. Medicare covers acute care services, with Medicaid covering any beneficiary premium payments (for Parts B or D) and cost-sharing obligations (deductibles and coinsurance). All told, Medicare finances approximately 65 percent of acute care spending for "dual eligibles."

In contrast, Medicare does not pay for long-term care. It pays for only sub-acute care, that is, time-limited home health or nursing care services needed for rehabilitation following a hospital stay. As a result, Medicaid finances $5 of every $6 in long-term care and sub-acute care services.

5.1 Downloads

Download PowerPoint versions of both figures.

- Figure 13.5a Image Slide (as it appears above)[2]

[2]https://hub.mili.csom.umn.edu/content/m10096/latest/13.5aIMG.ppt

- Figure 13.5a Editable Slide (can be formatted as desired)[3]
- Figure 13.5b Image Slide (as it appears above)[4]
- Figure 13.5b Editable Slide (can be formatted as desired)[5]

5.2 References

A. Department of Commerce. Bureau of the Census.

[3]https://hub.mili.csom.umn.edu/content/m10096/latest/13.5aDATA.ppt
[4]https://hub.mili.csom.umn.edu/content/m10096/latest/13.5bIMG.ppt
[5]https://hub.mili.csom.umn.edu/content/m10096/latest/13.5bDATA.ppt

Index of Keywords and Terms

Keywords are listed by the section with that keyword (page numbers are in parentheses). Keywords do not necessarily appear in the text of the page. They are merely associated with that section. *Ex.* apples, § 1.1 (1) **Terms** are referenced by the page they appear on. *Ex.* apples, 1

Attributions

About Medical Industry Leadership Institute Open Education Hub
Rhaptos is a web-based collaborative publishing system for educational material.