

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 15 - I-98

Subject: Defining the Uninsured and Underinsured

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1 At the 1997 Interim Meeting, the House of Delegates adopted Resolution 113 which calls for the  
2 AMA to define, and urge the federal government to adopt, standard definitions of health insurance  
3 status including the terms uninsured and underinsured to be used for data collection on health care  
4 coverage. The following report, which is presented for the information of the House of Delegates,  
5 references relevant AMA policy, identifies and compares the principal sources of information on  
6 the uninsured and underinsured, and describes unintended adverse effects that would likely occur  
7 through the use of “standardized” definitions of uninsured and underinsured.

### 8 9 AMA POLICY

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11 The AMA has established a comprehensive policy base in support of increasing access to health  
12 insurance coverage for the uninsured and underinsured. These policies address the currently  
13 employed, the temporarily unemployed, and non-workers. In addition to their full citation in the  
14 AMA Policy Compendium, these policies were recently summarized in Council on Medical  
15 Service Report 7 (A-97), which contained 18 policy recommendations for improving health care  
16 access to uninsured children and the uninsured population in general. Current AMA policy does  
17 not, however, define the terms uninsured and underinsured, nor describe the data and  
18 methodologies used to estimate the size of those populations.

### 19 20 DEFINING THE UNINSURED

21  
22 The Council on Medical Service believes it is important to recognize that tabulations of the  
23 uninsured in the U.S. reflect estimates rather than true enumerations of the number and  
24 characteristics of that population. Estimates of the uninsured differ across alternative data  
25 sources because of differences in survey design and in the definition of uninsured. The surveys  
26 that currently enable estimation of the number of uninsured are designed to collect information on  
27 a broad spectrum of issues for a wide array of program evaluation and policy analysis. For one  
28 purpose it may be useful to know the number of persons having a certain labor market experience  
29 (e.g., lacking employer-based health insurance) at a given point in time. For other purposes,  
30 estimates of the number of persons having that experience (e.g., an uninsured spell) over an entire  
31 period of time, say a year, would be the appropriate definition. The reference period is a critical  
32 element in the design of the survey, and becomes part of the definition of the data selected.  
33 Analyses based on different reference periods provide different counts of the uninsured and  
34 underinsured populations. At the same time, however, they offer policymakers greater insight  
35 into the prevalence and duration of spells with health insurance coverage. No single reference

1 period provides a definitive profile of the state and dynamics of health insurance coverage. The  
2 surveys most often used to measure the uninsured are discussed below:

3  
4 March Current Population Survey

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6 The annual March Current Population Survey (CPS), the source of official government statistics  
7 on employment and unemployment, is a nationally representative monthly survey of nearly 60,000  
8 households. The sample is based on the civilian noninstitutionalized population of the U.S. The  
9 main purpose of the survey is to collect, by means of personal interviews, information on the  
10 employment status of the population during the survey month. Information is gathered on more  
11 than 50 different sources of income, including noncash income sources such as food stamps,  
12 school lunch program, employer-provided group health insurance plan, employer-provided pension  
13 plan, personal health insurance, Medicaid, Medicare, CHAMPUS or military health care, and  
14 energy assistance. Comprehensive work experience information is given on the employment  
15 status, occupation, and industry of persons 15 years old and over.

16  
17 Respondents in the March CPS are asked whether they had any of various types of private or  
18 public health insurance in the previous year. For example, the 1998 March CPS collected  
19 information on insurance coverage for 1997. It should be noted that respondents are not asked  
20 directly whether they were uninsured in the previous year. The CPS estimate of the uninsured  
21 (throughout the previous year) is calculated as a residual (the difference) of the total population  
22 and all those who report having some type of coverage in the previous year.

23  
24 Survey of Income and Program Participation

25  
26 The Survey of Income and Program Participation (SIPP) is a multipanel longitudinal survey of  
27 about 8,000 housing units per month conducted by the Census Bureau. The SIPP is designed to  
28 examine income sources of individuals and families, labor force activities, participation in  
29 entitlement programs such as Aid to Families with Dependent Children, health insurance status,  
30 and the correlations between these items and individual attachments to the job market over time.  
31 While the CPS measures labor force status at a single point in time, the SIPP interviews determine  
32 persons' work experiences week-by-week over the previous 4 months. SIPP allows an  
33 examination of the dynamic aspects of the uninsured that are not apparent in static estimates. The  
34 longitudinal data in SIPP presents a more complete picture of the uninsured, including estimates of  
35 the duration of spells without health insurance, and estimates for various time periods, such as  
36 point-in-time, monthly, annual, or over the full panel. As the reference period (point-in-time vs.  
37 period of time) lengthens, the percent uninsured throughout the period is expected to decrease.

38  
39 National Health Interview Survey (NHIS)

40  
41 The National Health Interview Survey (NHIS) is the principal source of information on the health  
42 of the civilian noninstitutionalized population of the U.S. The survey is conducted by the  
43 National Center for Health Statistics (NCHS). The NCHS is a part of the Centers for Disease  
44 Control and Prevention, U.S. Department of Health and Human Services. The NHIS data are used  
45 to monitor trends in illness and disability and to track progress toward achieving national health  
46 objectives. The data also are used by the public health research community for epidemiological  
47 and policy analysis of a broad range of health topics, determining barriers to appropriate health

1 care, and evaluating Federal health programs. A major strength of this survey lies in the ability to  
2 display these health characteristics by many demographic and socioeconomic characteristics.  
3 The sample design of the NHIS follows a multistage probability design that permits a continuous  
4 weekly sampling of the U.S. population. The survey is designed so that the sample scheduled for  
5 each week is representative of the target population, and the weekly samples are consolidated to  
6 produce quarterly files (each consisting of data for 13 weeks). The quarterly files are later  
7 consolidated to produce the annual file. The yearly sample is composed of 36,000 to 47,000  
8 households, including 92,000 to 125,000 persons, depending upon the year.

9  
10 The NHIS health insurance questions typically ask about all types of insurance coverage, including  
11 private, public, and other coverage. NHIS excludes single-service plans (e.g., nursing home care,  
12 accidents, or dental care), except for those that cover hospital care, from the definition of private  
13 insurance. Like the CPS and SIPP, the count of the uninsured is a residual of those not reporting  
14 any other type of coverage. The NHIS identifies individuals as uninsured if they lacked coverage  
15 in the month prior to the survey. Because the month individuals are interviewed varies, the survey  
16 gathers uninsurance data for different months. These several monthly estimates are consolidated  
17 into an average monthly uninsurance estimate. Thus, an NHIS estimate for a given year is for an  
18 “average” month during that year.

19  
20 Since 1997, health insurance questions have been included in the core questionnaire. Information  
21 is collected on who in the family is covered and the kind of coverage (private, Medicare,  
22 Medicaid, Military/CHAMPUS/Tricare, Indian Health Service, State-sponsored or government  
23 plan) received. Information is also collected on the source of coverage, i.e., the workplace or  
24 direct purchase, and the annual amount spent for health insurance premiums including payroll  
25 deductions, the noncovered household members on the length of time without coverage, as well as  
26 the reasons that coverage stopped.

### 27 28 Medical Expenditure Panel Survey

29  
30 The Medical Expenditure Panel Survey (MEPS) is a nationally representative survey of the U.S.  
31 civilian noninstitutionalized population. MEPS is co-sponsored by the Agency for Health Care  
32 Policy and Research (AHCPR) and the NCHS. MEPS is the latest in a series of surveys  
33 conducted by AHCPR. The previous surveys were the 1977 National Medical Care Expenditure  
34 Survey (NMES-1), and the 1987 National Medical Expenditure Survey (NMES-2). The MEPS  
35 survey is designed to yield data capable of estimating the level and distribution of health care use  
36 and expenditures, monitoring some of the dynamics of the health care delivery and insurance  
37 systems, and assessing health care policy implications. MEPS defines private insurance as  
38 coverage for hospital and physician services, but excludes single-service and dread disease  
39 policies. MEPS also excludes health care provided by the Department of Veterans Affairs and the  
40 Indian Health Service from its definition of coverage.

41  
42 Data collected from the household respondents include demographic characteristics, health  
43 conditions, health status, use of medical care services, charges and payments, access to care,  
44 satisfaction with care, health insurance coverage, income, and employment. MEPS collects  
45 medical expenditure data continuously at both the individual and household levels through an  
46 overlapping panel design. In this design, two calendar years of information are collected from  
47 each household in a series of five data collection rounds over a 2½-year period. These data are

1 linked with information collected from the respondents' medical providers, employers, and  
2 insurance providers. Data collection is repeated each year on a new sample of households,  
3 resulting in overlapping panels of survey data. By collecting data from individuals several times  
4 during their respective survey periods, MEPS provide information on changes in the health care  
5 and health insurance coverage experiences of individuals over time. Once 1996 data are  
6 available, MEPS will have the capacity to produce point-in-time, monthly, and annual estimates of  
7 health insurance coverage.

8  
9 The estimates of insurance coverage from each of the surveys contain valuable information. The  
10 CPS data provides an estimate of the uninsured throughout the year prior to the survey. The data  
11 in SIPP can be used to construct estimates of the duration of spells without coverage, as well as  
12 point-in-time, monthly, and annual estimates. Estimates of the uninsured based on the NHIS refer  
13 to coverage in an "average" month during the year. MEPS data can be used to calculate  
14 point-in-time, monthly, and annual estimates of health insurance coverage.

#### 15 16 DEFINING THE UNDERINSURED

17  
18 The Council believes that the concept of underinsurance is inherently normative, meaning that it  
19 contains value judgements, and cannot be precisely measured. Monheit ("Underinsured  
20 Americans: A Review" Annual Review of Public Health, 1994) defines the underinsured as those  
21 uninsured or with inadequate coverage. The difficulty in defining underinsured lies in identifying  
22 adequate insurance coverage. One approach has been to develop conceptual models of  
23 underinsurance along several dimensions – structural, attitudinal and experiential. The  
24 empirical-experiential variation on the latter dimension has been developed where persons with  
25 inadequate coverage are defined as those having a certain percentage (e.g., 1%) chance of  
26 spending at least 10% of family income on medical care. Using MEPS data, this method could be  
27 applied to determine an estimate of the extent of the underinsured.

28  
29 Estimates of the prevalence of persons who are underinsured also have been determined by using  
30 an experiential definition of underinsurance in a federal government sponsored survey, the  
31 Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a continuous, state-based  
32 telephone survey of the civilian, noninstitutionalized, adult (persons 18 years of age) population  
33 that collects information about modifiable risk factors for chronic diseases and other leading  
34 causes of death. BRFSS is conducted by the Centers for Disease Control and Prevention (CDC),  
35 in collaboration with state health departments. State health departments use the BRFSS to collect  
36 data about modifiable health behaviors (e.g., cigarette smoking, excessive alcohol consumption,  
37 and physical inactivity) and lack of preventive health care (e.g., screening for cancer), and to  
38 monitor trends and changes in the prevalence of behavioral risk factors in state populations. The  
39 states participating in the BRFSS are able to include questions to meet their specific needs.  
40 BRFSS data are important in assessing progress toward the year 2000 national health objectives  
41 and state-specific health objectives.

42  
43 Data from the BRFSS are sent to CDC after the monthly interviewing cycle ends. CDC edits the  
44 data, checks the reliability of the data collected, and aggregates monthly data files to create a  
45 yearly sample for each state. Besides risk factor information, the BRFSS collects data on  
46 awareness of certain medical conditions associated with increased risk for developing chronic  
47 diseases; screening practices related to cardiovascular diseases and cancer of the cervix, breast,

1 and colon; vaccinations; and lack of health-care coverage (which is often a prerequisite for access  
2 to clinical preventive health services).  
3 The BRFSS questions on type of insurance coverage are followed by the question “Was there a  
4 time during the last 12 months when you needed to see a doctor, but could not because of costs?”  
5 Researchers at the CDC have defined underinsurance as being insured but failing to see a doctor  
6 because of costs. Based on the experiential definition of underinsurance responses to this  
7 question, CDC estimates that state-level underinsurance population range between 4.3% and 9.0%  
8 of persons aged 18-64 years.

9  
10 CONCLUSION

11  
12 The Council recognizes and sympathizes with the confusion regarding variation in the definitions  
13 of uninsured and underinsured expressed in Resolution 113 (I-97). As this report has described,  
14 the definitions of health insurance status, and other variables used in surveys to estimate the  
15 uninsured population are an intricate part of survey design. The Council believes that efforts to  
16 standardize the definition of uninsured or other variable definitions would likely reduce the  
17 information content of the data upon which coverage estimates are based and would, thereby,  
18 reduce the range of information on insurance status available to policymakers. In addition, such  
19 efforts would likely conflict with the planned objectives of a number of government data  
20 collection and evaluation programs. There is utility in each of the definitions of insurance  
21 coverage. It is unlikely, therefore, that standard definitions of uninsured and underinsured drafted  
22 by the AMA would be adopted by the various agencies sponsoring surveys – the NCHS, the  
23 AHCPR, the Bureau of the Census, the Bureau of Labor Statistics or other federal sponsors of  
24 surveys collecting data on health insurance status.

25  
26 The Council believes that the variation in the approaches currently used to measure the uninsured  
27 provides greater perspective on the extent and duration of spells without coverage. While  
28 changes in health insurance coverage trends are best measured by a sequence of point-in-time  
29 estimates from annual surveys (e.g. CPS), the analysis of length of spells of noncoverage require a  
30 panel survey design (e.g. SIPP or MEPS). Research on health insurance dynamics, however, is in  
31 its early stages. Accordingly, the Council believes that the AMA should not define and seek  
32 adoption of standard definitions of health insurance status for use in data collection efforts, at this  
33 time. The Council strongly believes, however, that the AMA should continue its efforts to  
34 increase access to care, and to reduce the number of uninsured and underinsured.