

EXPANSION OF HEALTH CARE TO THE WORKING POOR

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Lessons from Other States on Increasing Coverage

Richard Kronick and Todd Gilmer

More than 7 million Californians are without health insurance, and the numbers of the uninsured have been growing during the 1990s. Most of the uninsured are workers and their families. The uninsurance rate among low-income workers is striking: 50% of adult workers in low-income families are uninsured, and 60% of low-income workers in small businesses.

The consequences of being uninsured can be devastating, both to health and to family finances. Large numbers of uninsured people also strain safety-net providers in an increasingly competitive health care system.

So many Californians are uninsured for four basic reasons:

- the high cost of insurance relative to these workers' incomes;
- the lack of public subsidies for many people who can't afford insurance;
- the stigma of public subsidy; and
- the complex rules and the Byzantine and often demeaning process for determining eligibility.

A number of states have acted to increase health coverage among low-income workers and their families and offer lessons for California. The efforts of Washington, Minnesota, Hawaii, Tennessee, Oregon, Massachusetts, and Rhode Island suggest varied strategies to expand coverage to people not traditionally covered by Medicaid. In the states with established programs, 10%-20% of the working-age low-income population have been enrolled.

A number of state programs appear to have been successful in reducing the proportion of the low-income population that is uninsured. In some states, public subsidy may also lead to reduced numbers of privately insured people, although several have devised approaches that aim to minimize this "crowd-out" effect. Because California has very low rates of employer-supported coverage for low-income workers, there is relatively little private coverage that public subsidy could crowd out.

To reduce the number of uninsured Californians, the state should move forward on two fronts:

1. Immediately evaluate options to expand insurance subsidies to low-income workers. Federal funds offer a relatively low-cost opportunity to support such expansions, including expansion of eligibility for Medi-Cal and more flexible use of Healthy Families funds.
2. The Department of Health Services (DHS) should mount a major effort to increase enrollment in Medi-Cal and Healthy Families among people who are currently eligible.

Increasing enrollment among those eligible for publicly subsidized insurance should be a high priority for the legislature and the administration. There is great potential for increasing enrollment among Medicaid-eligible children whose families do not receive cash assistance, because only 60% are currently enrolled.

The DHS should forge close connections with schools to help enroll eligible children. Both the department and county welfare offices should be evaluated on the success of their enrollment efforts. Attention should be focused on this effort by displaying prominent public "thermometers" indicating the number of enrolled children. In addition, the enrollment process and eligibility systems should be redesigned with the goal of enabling eligible people to obtain and maintain health insurance coverage more easily.

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Opportunities to Increase Health Coverage

Lucien Wulsin, Jr.

Compared to most other states, California has a very high percentage of its population uninsured, and very low levels of enrollment in employment-based and individually purchased health insurance. But unlike many of the other states with high levels of uninsured, such as Texas or Florida, California has high levels of coverage through its Medi-Cal program, a broad array of other state programs for the uninsured, and extensive county health programs. California pays providers, counties, and health plans using a multiplicity of disconnected programs and revenue streams.

Most uninsured Californians lack coverage through their employers because of adverse affordability problems unique to low-wage workforces and the lack of an effective structure of purchasing coverage for the flex workforce of contract, temporary, part-time and seasonal employees, self-employed individuals, and small businesses.

What does California need to do to cover its working poor?

1. **California needs to connect its myriad state, federal, and county health programs so that eligible residents access and maintain coverage seamlessly.** Many individuals lose eligibility and become uninsured at the intersections of programs, when they are bounced off of one eligibility category without being enrolled in another program. A number of county leaders, state officials, and health plans are making good-faith efforts to extend coverage; the mind-boggling complexity of state and county financing structures nearly paralyzes these efforts. These innovative efforts need a more flexible and receptive response from state regulators and policymakers.
2. **California needs to connect its state and county programs to the workplace.** Although almost all the uninsured work, very few state and county programs are accessible through employment. This connection needs to be done in a carefully targeted way lest it unravel existing employment-based coverage. Public/private efforts to extend coverage need to be focused on areas where coverage is very low--the flex workforce, very small businesses, low-wage workers--and during transitions between jobs and from welfare to work.

3. **California needs to overhaul its Medi-Cal eligibility system.** The eligibility rules are based on a now-abandoned welfare system, and have become so complex as to defy common description and understanding. The rules and the processes for application, verification, redetermination, and termination are complex, costly to the state and counties, and a major deterrent to achieving and maintaining eligibility, especially for outpatient care and coverage for the working poor. California should take advantage of federal opportunities to extend continuous eligibility and simplify the cumbersome eligibility rules and processes.
4. **State/county relationships in this area need to be improved.** Many of the state health care programs have devolved to the counties and managed care plans. Some counties and managed care systems have the mission and a funding base, the delivery structures, the political will, and the trust of local stakeholders to make progress. County reform efforts are hampered by their governance structure, balkanized and rule-laden funding streams, and the culture of hospital-centered care for the indigent. Most county indigent programs and Medi-Cal are heavily interdependent, yet operationally autonomous. California needs to make a choice: either take over and operate the health programs at the state level, or seriously assist the counties that will commit to implementing reforms at the local level.

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Health Care Among Hired Farmworkers

Don Villarejo

California's 700,000 hired farmworkers, their families, and most of the communities in which they reside have the least access to health care services according to objective measures devised by the Office of Statewide Health Planning and Development. Careful aggregations of adjacent census tracts into Medical Service Study Areas (MSSAs) based on DHS data, combined with census information on agricultural employment, show that rural MSSAs with a preponderance of hired farmworkers have uniformly poorer access to health care services. For example, the average urban MSSA has three times as many primary care physicians per 1,000 residents as the average hired farmworker MSSA.

The federally defined Index of Medical Underservice (IMU) for state MSSAs shows that, in general, rural Californians have poorer access to health care services than urban residents. An MSSA with an IMU below 62.0 is eligible for federal designation as a Medically Underserved Area if certain other conditions are met. The average IMU value for California's urban MSSAs is 83.4, vs. 72.7 for rural MSSAs. For hired farmworker MSSAs the average IMU is just 61.1, below the 62.0 threshold, providing direct evidence that such areas have the poorest access to health care services of all California communities.

More-affluent communities tend to attract a higher density of primary care physicians than do poor communities. The 10 most affluent MSSAs (all urban) have an average of 498 residents per primary care physician, about half the state average of all urban MSSAs. The 10 poorest communities (all rural) have an average of 3,548 residents per primary care physician--seven times the number for the most affluent communities and twice the average for all rural MSSAs.

Distinctive social and demographic characteristics of this population compound the difficulties of providing health care services to hired farmworkers and their families. Today, 95% of California's

hired farmworkers are foreign-born (91% born in Mexico), twice the proportion of just a generation ago. A significant, and increasing, share are indigenous migrants from southern Mexico and Central America, for whom Spanish is a foreign tongue. It is estimated that 61% of the state's hired farmworkers live in poverty, 42% are unauthorized immigrants, the average educational attainment is just six years of school, 24% are illiterate, and another 43% are functionally illiterate.

There are no reports in the literature of cross-sectional studies of the health status of the current hired-farmworker population. However, two community-based studies indicate that a majority of hired farmworkers lack any form of health insurance, including Medi-Cal, and that some adverse health conditions are prevalent, among them diabetes, hypertension, and lack of a usual health care provider. In one study of children in the farmworker town of McFarland, specific unmet health services were found to be linked with particular aspects of demand. For example, lack of dental care was linked with low income, no health insurance, lack of transportation, and lack of child care.

Current federal methods of designating urban and rural areas may selectively disadvantage many farmworker communities. If the federal government were to classify communities by MSSAs instead of designating entire counties as being either metropolitan or nonmetropolitan, many more farmworker communities would be eligible for federal support.

[Ed. note: The Villarejo section of the complete report contains important information about farmworker housing, which may explain part of the huge census undercount in California, as well as information about occupational safety and health. These sections were not included in the Brief because of space limitations.]

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Building a System of Affordable Coverage for All Californians

E. Richard Brown

Job-based insurance has declined for two decades, leaving many adults and children without financial protection against medical expenses, and with little access to essential health services. Health insurance is unaffordable to most of these working families, whether it is offered by employers or paid for individually. One in four nonelderly Californians is completely uninsured, more than eight out of 10 of them in families headed by a working adult. Seven in 10 of the uninsured have incomes below 200% of federal poverty guidelines.

We are unlikely to be able to extend coverage to the state's uninsured by implementing a single reform. However, by articulating a vision and a plan to develop a system of universal health coverage, we can begin implementing structural reforms incrementally. In this way, we may be able to overcome the political barriers to comprehensive reforms.

The strategy outlined here lays a foundation and systematically adds the elements needed to achieve the goal. These reforms make maximum use of federal funding, and integrate components into a seamless system that provides uninterrupted, affordable coverage for families and individuals who need it.

1. Fix and expand children's health insurance programs. California could expand health coverage to uninsured children and potentially other family members by making maximum use of unallocated

federal funds, which match state spending. Children's enrollment and coverage could be readily expanded by making the following changes:

- Make children automatically eligible for Medi-Cal and Healthy Families when families are approved for supplemental food programs.
- Consider children who apply to Medi-Cal and Healthy Families to be presumptively eligible, and extend their Medi-Cal eligibility to 12 months before recertification is needed.
- Allow the same income deductions for both programs and cover recent immigrant children under Healthy Families, consistent with Medi-Cal policy.

2. Cover uninsured children from families with income up to 300% of the poverty level using existing federal options. This would include 88% of all uninsured children who are citizens or legal immigrants. Expand programs to uninsured adults. Efforts that do not provide public funding will not greatly increase the number of insured. Parents of uninsured low-income children can be covered through allowable modifications of Medi-Cal and Healthy Families. In addition, a Medicaid waiver would enable the uninsured to buy into these programs on a sliding scale.

3. Remove health care from welfare. Working families should not have to grovel at the welfare office to obtain necessary health care. All applications and eligibility screening should be handled by a state agency administering the health care program, without welfare agency review. This would save costs for determining eligibility, and help offset expanded coverage costs.

4. Create a seamless system of public coverage. California's different coverage programs are divided among several agencies--all with different eligibility criteria and targeting populations that often overlap. This patchwork creates unnecessary problems, leaves large gaps in coverage, and adds costs for multiple bureaucracies. By integrating programs and restructuring state agencies, we could create a seamless system that will enable uninsured residents to meet their needs effectively and efficiently.

Ultimately, creating a new "Healthy Californians Program" would reduce administrative costs; enable people to obtain information in one place and use one application, without stigma; and cover all family members within the same program, regardless of funding sources. These options will help us achieve the proposed state policy goal that "all Californians will have affordable health care coverage that provides good access to quality care."

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