

Beyond the Stimulus: Opportunities & Challenges in Reforming our National Healthcare System

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"The question isn't how we can afford to focus on healthcare. The question is how we can afford not to"
-- President Barack Obama

Preface

Even in the face of economic and financial turmoil, President Obama is lifting health care reform to a top national priority. While the nation's policy makers are largely concerned with bailouts and stimulating the economy, average workers are increasingly and justifiably worried about their job security and access to health care. More people in this country are losing their jobs every day, adding to the ranks of U.S. families for whom health care coverage and access are difficult and sometimes impossible.

The decades-long debate over the right to health care is now at a critical juncture. There seems to be an apparent consensus that we have a right to some form of health care: the question is, how to implement it? Our nation is facing the worst economic downturn since the Great Depression and health care reform may be considered a pivotal element in lifting our country out of its economic crisis. Reform is necessary to control soaring health care costs and may be critical in stimulating growth in certain lagging industries. Some economists believe that the health care sector itself may be a significant source of economic growth.¹

The consequences of not enacting health care reform are staggering. As the President noted in his State of the Union Address, health care costs are responsible for *one bankruptcy in America every 30 seconds*, and premiums have increased 87% in the past six years, growing at a much faster rate than wages or the consumer price index.² The health care sector is an impossibly complex system for Americans to navigate: a complex arrangement of service providers, hospitals, employers, government agencies, pharmaceutical companies, and everything in between. Reimbursement for health services is even more complex and appears to reward inefficiency, non-coverage and gamesmanship.

While all American families suffer from our current health care quagmire, low-income workers and underrepresented communities of color suffer relatively more than the average. According to numerous studies, most nonwhite groups have more difficulty accessing care and, when they do access care, they receive a lower quality of care than do other population groups. These longstanding health disparities result in relatively worse health conditions, higher long-term health care and social costs.

In California, communities of color in the aggregate constitute the majority of our population (56.5%),³ adding extra urgency to reducing and eliminating significant racial and ethnic disparities in access to care, quality and health status. Numerous studies show low-income groups and underrepresented communities of color tend to delay or forego necessary medical care, pay onerous fees relative to their incomes when they do see a doctor, and often resort to using emergency room care.⁴ Therefore, any meaningful move toward health care reform must address significant cultural and ethnic disparities in order to enhance the health states of all Americans.

National Health Care Spending

The current health care system is large, complex, fragmented, and very expensive. According to the U.S. Department of Health and Human Services (DHHS), the U.S. spent over \$2.2 trillion on health care in 2007, an average of \$7,421 per person.⁵ That same year, health care accounted for 16.2% of Gross Domestic Product (GDP) in the United States, which is more than double the amount spent in 1970 (7.2%).⁶ It also exceeds by at least 5 percentage points the share of health care spending in most Western and Central European countries and some East Asian nations that cover all their residents.

Health care costs are high and chronically increasing due in part to marked inefficiency in the health delivery system, private monopolies, the aging population, an absurd payment system, excess demand for covered services and over-reliance on high-cost as opposed to primary care. The two fastest growing health expenses are administrative-related costs and prescription drugs. The Centers for Medicare and Medicaid Services (CMS) project that by 2018 health spending will be one-fifth of GDP (20.3%).⁷ In terms of overall health status indicators, despite our very high level of spending, the United States is falling ever further behind other countries in Europe and East Asia when it comes to ensuring access to health care and enhanced health outcomes.

Health Care Coverage

A March 2009 Families USA report on health care coverage studied a two-year period, from 2007-2008, and found the following:

- 86.7 million Americans under the age of 65 were uninsured for some or all of 2007-2008⁸
- 33.1% of all Americans, or about 1 out of 3 people, men, women and children, lacked insurance at some point during 2007-2008
- 74.5% of those uninsured people were uninsured for at least 6 months during 2007-2008
- 60.2% of those uninsured people were uninsured for at least 9 months during 2007-2008
- 79.2% of the uninsured persons came from working families⁹

The estimate of 86.7 million uninsured is considerably higher than the more commonly publicized figure of 47 million uninsured persons. The Families USA data reveal that the 47 million uninsured is, in fact, an underestimate given a two-year observation period and given that uninsurance is defined as any period of time without coverage during that two-year time period.

While employer-based insurance is still the primary path to coverage for working people —according to the Census Bureau, 59.3% of *insured* Americans are covered by employment-based health coverage¹⁰— it is important to emphasize that about one-third of all Americans live without health coverage for at least some portion of time. And as unemployment increases, those periods of uninsurance can be expected to increase significantly.

National Racial/Ethnic and Class Disparities in Health Care Coverage

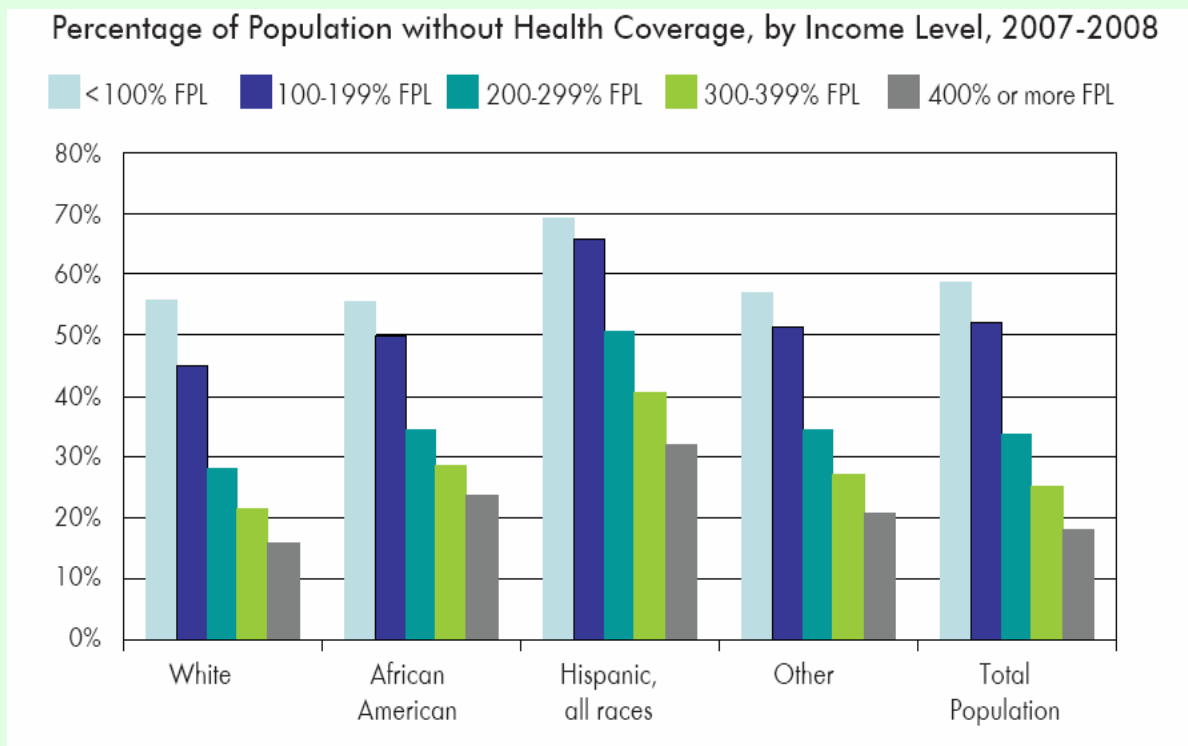
Although communities of color constitute about 33% of the U.S. population, they are overrepresented in the percent of uninsured Americans. The following table highlights racial/ethnic inequalities in health care coverage.

Table I. Distribution of the Uninsured and Total U.S. Population by Race/Ethnicity in 2004¹¹

| | % of U.S. Population | % Uninsured |
|-------------------------------|----------------------|-------------|
| Latino | 14% | 30% |
| African American | 12% | 15% |
| American Indian | 1% | 2% |
| Asian/Pacific Islander | 5% | 5% |
| Non-Latino White | 67% | 48% |

Source: ASPE tabulations of the 2005 Current Population Survey (Author's Note: Asian/Pacific Islander Disaggregated Data Not Shown. Coverage disparities are also present in various API groups.)

Lower incomes for all racial/ethnic groups are associated with greater risk of being uninsured. However, even when income is taken into account, racial/ethnic disparities in health care coverage persist. As indicated in the following graph, communities of color are more likely to be uninsured than white families, even as families' incomes increase.



Source: Families USA's Minority Health Initiatives, *Health Care Reform: Critical to Closing the Gap in Communities of Color*, March 2009¹²

Socioeconomic Challenges and Health Care Disparities in the Nation

Rising health care costs contribute to a myriad of economic consequences nationally, including, but not limited to:¹³

- Added financial pressure on businesses that offer insurance coverage to their employees
- Increased bankruptcies, including of some large manufacturing firms
- Reduced international competitiveness of business
- Greater financial burden to all working families, even for those with private health insurance
- Increased personal bankruptcies
- An increasing share of taxpayer dollars for government programs such as Medicare and Medicaid

It is also important to recognize the social effects of a lack of coverage and what happens when individuals are unable to access the health care services they need. Such social effects may include underallocation of personal family resources to housing, food and recreation and overallocation to health care, with adverse consequences for overall well-being. Additionally, a lack of coverage also means lower productivity and lost wages for workers in need of health care.¹⁴

Nationally, given that rates of uninsurance are correlated with racial/ethnic disparities in health access, we see the following results:

Cancer: African Americans are 10% more likely to suffer from cancer and 30 percent more likely to die from cancer than whites.¹⁵

Asthma: 1 in 4 Native American and Alaska Native children suffers from asthma, as do 1 in 5 African American children.¹⁶

Diabetes: African Americans, Native Americans, and Latinos have higher rates of death from diabetes.¹⁷

Heart Disease: Among Native Hawaiians, heart disease mortality rate is 44% higher and stroke mortality rate is 31% higher than other U.S. races.¹⁸

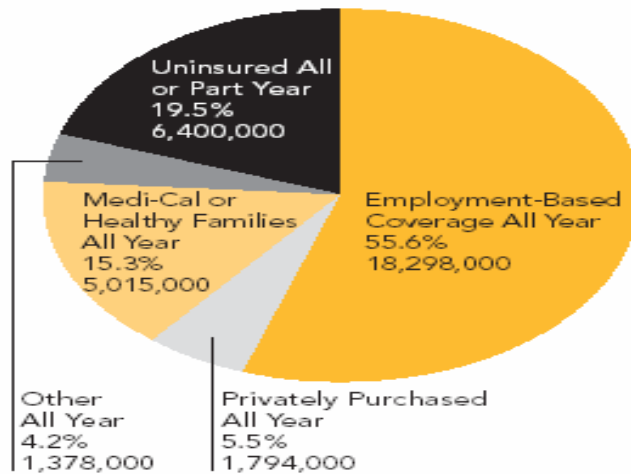
Low-income people and communities of color are less likely to get timely screenings, vaccinations, disease management, and treatment required for the chronic illnesses listed above.¹⁹ Many disparities seen at the national level mirror the disparities in California's underserved communities.

The State of Health Care Access and Health Outcomes in California

In order to be truly successful, health care reform must tackle disparities in access to health care care and health outcomes for California's low-income communities and communities of color.

California is one of four states where communities of color constitute the majority of the population. California also has the 8th largest proportion of uninsured in the nation, and largest number of uninsured residents.

Health Insurance Coverage During Last 12 Months, Ages 0-64, California, 2007



Source: 2007 CHIS Health Interview Survey ²⁰

During 2007, nearly 20% of Californians went without health coverage, 55.6% had employer-based insurance, and the rest purchased their insurance out of pocket or found other modes for coverage. California's communities of color are often uninsured or are dependent on government-sponsored health care in disproportionate numbers:

- In 2007, 75% of California's uninsured populations were people of color. Nearly 60% California's uninsured were Latino.²¹
- African Americans, Latinos and Native American/Alaskan Natives are over three times as likely as Whites to be enrolled in Medi-Cal or Healthy Families.²²

California's communities of color also show significant deficiencies in health care access and outcomes as compared to non-Latino Whites:

- African American, Native American, and Latino adults are twice as likely (or more) of being diabetic than White adults.²³ These groups are more likely to access emergency rooms, public clinics and public hospitals

Suggested Solutions for Improving the Health Care System

Over the past twenty years, various health care reform plans have been proposed at both the national and state levels. These include the Hillary Clinton and Kucinich plans at the national level and various Garamendi, Kuehl and Schwarzenegger plans at the State level. Some recent efforts include:

American Recovery and Reinvestment Act (ARRA) of 2009

In February 2009, President Obama signed into law the American Recovery and Reinvestment Act (ARRA), an economic stimulus package that includes \$149 billion in health care spending, of which:

- \$79 billion is for a temporary increase in federal share of Medicaid costs
- \$25 billion is for subsidies for the newly unemployed to maintain their health insurance under the COBRA program
- \$19 billion is for health information technology to cut costs and reduce medical errors

Major funding was also allocated for improving community health centers, prevention and wellness programs, and comparative effectiveness research. This Act followed immediately the reauthorization of the State Child Health Insurance Program (SCHIP) by the incoming President.

California is estimated to receive over \$31 billion in aid to the state government from this stimulus package for the current and next two fiscal years.²⁴ These funds are greatly needed in California and may be used in part connected to reducing the state's projected \$40 billion-plus deficit. It is estimated that over this 27 month period, California might receive up to \$8.3 billion specifically for Medicaid (Medi-Cal) funding. In fact, the 2009-2010 budget signed by Governor Schwarzenegger, assumed that California will receive about \$8 billion in federal stimulus funds that may be used for budget deficit reduction purposes.²⁵ In addition, health plans and providers may receive up to \$3 billion in COBRA funds during the 27-month 2009-2011 period. Over \$400 million will go to California entities for improvements in Health Information Technology (HIT) within the next 27 months. The goal of the HITECH Act is to provide every person in the U.S. with an electronic health record (EHR) by 2014.²⁶

\$634 billion Dollar Reserve Fund

A second, more comprehensive approach to reducing the number of uninsured is described in a component of President Obama's recent budget proposal. Obama has called for the establishment of a \$634 billion dollar reserve fund to help decrease current expenditures and expand health care coverage to all residents over the next ten years. This constitutes a "downpayment" of sorts to a coming comprehensive approach to achieving universal health insurance coverage. The budget highlights show reserve funds will be used to²⁷:

1. Accelerate adoption of Health IT
2. Address the shortage of health care professionals
3. Enhance funding for public health prevention and treatment programs
4. Improve Medicare's sustainability and expands Medicare and Medicaid research

Given Greenlining Institute's advocacy efforts on health care workforce diversity and telemedicine, we must consider how the reserve fund dollars will be spent. For example, in the expansion of HIT, there is a need for Federal and State governments to proactively ensure community-based organizations are involved in all HIT stages—planning, implementation, and evaluation. Involving community organizations will guarantee that HIT will be accessible to all population groups, with an emphasis on those who most need it. By the same token, increasing the size of the health care workforce should be done in conjunction with strengthening the *diversity* of the health care workforce to reflect the racial/ethnic and cultural diversity of the U.S.

SCHIP

Even before the budget was released, the Obama Administration signed into law the reauthorization of SCHIP, which provides coverage for an additional four million uninsured children enrolled in both SCHIP and Medicaid. The additional coverage will be available through FY 2013.²⁸

California Single-Payer Plans

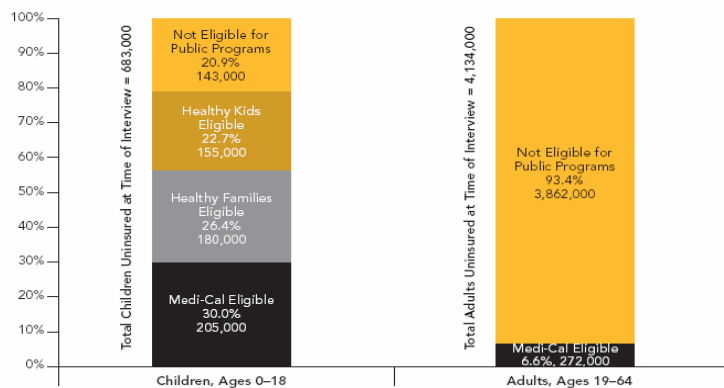
Some state governments have been involved in efforts to provide universal health insurance coverage. In California, Senator Sheila Keuhl proposed single-payer universal health insurance coverage in 2005, 2006, and 2008. The bill (SB 840) passed the legislature in 2007, but was vetoed by the governor. More recently, on March 11, 2009, Senator Mark Leno introduced SB 810, which is almost identical to SB 840, a further effort at single-payer health reform. This bill allows the public sector to take over the role of providing health care coverage from the private insurance industry.²⁹

Given that many of the proposed health care reform solutions are relatively new, it is important to analyze the expected breakdown of stimulus and health care reform reserve funds. More discussions are necessary to determine how these funds will be used to support the health care needs of low-income underserved communities. It is also important to keep track of health care reform through Congress, potentially a joint effort led by Senators Baucus and Kennedy, and Representative Waxman, to introduce and pass a universal health insurance bill during the upcoming six months.

What's missing in the context of California's communities?

Discourse surrounding health care, especially as it pertains to the stimulus package, is focused around government-sponsored insurance, known as Medicaid and SCHIP (Medi-Cal or Healthy Families in California). However, these programs do not capture every vulnerable population. Many states create very stringent eligibility standards for Medicaid and SCHIP, standards that exclude the working poor. The chart below shows how stringent eligibility standards affect California's uninsured population:

Eligibility of Currently Uninsured Children and Adults for Public Insurance Programs, Ages 0-64, California, 2007



Source: UCLA Center for Health Policy Research, December 2008³⁰

The Obama Administration has stated that the stimulus funds allocated for health care are only a “down payment” on health care reform, and that meaningful reform will require a much larger financial investment. The task before us now is to develop the components of a financially viable health care reform that focuses on underserved communities in the nation and in California.

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- ⁷ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2008-2018 February 24, 2009.
- ⁸ Families USA. Americans At Risk: One in Three Uninsured. March 2009. <<http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf>> Page 2
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- ¹⁰ United States Census Bureau. Health Insurance Coverage: 2007. <<http://www.census.gov/hhes/www/hlthins/hlthin07/hlth07asc.html>> Accessed 3/23/2009
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- ¹⁷ *Ibid.*
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- ²⁰ Brown ER, Lavarreda SA, Peckham E and Chia YJ. Nearly 6.4 Million Californians Lacked Health Insurance in 2007 – Recession Likely to Reverse Small Gains in Coverage. Los Angeles, CA: UCLA Center for Health Policy Research, 2008. <http://www.healthpolicy.ucla.edu/pubs/files/CAs_Lack_Insurance_PB_121508.pdf>
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