SUMMARY *report*

September 2001

Advancing Universal Health Insurance Coverage in Alameda County

Results of the County of Alameda Uninsured Survey

Ninez Ponce, PhD, *UCLA*
Tomiko Conner, MPP, MPH
B. Patricia Barrera, JD
Dong Suh, MPP

Acknowledgements

The authors are grateful to The County of Alameda, The Alameda Alliance for Health and to The Community Voices Project-Oakland (funded by The W.K. Kellogg Foundation) for their financial support of the research and this report.

Valuable input for this report was provided by David Kears, Sherry Hirota, Jane Garcia, Deborah Zahn, Irene Ibarra, Ralph Silber, Judy Armstrong, Nina Maruyama, Ana O'Connor, Jeannette Dong and Joel Garcia. Many thanks also to Sylvia Park for providing administrative support for the various stages of this effort.

The UCLA Center for Health Policy Research provided the editorial reviews and the support for the publication process. Many thanks to Dr. E.R. Brown and Dr. Roberta Wyn for serving on the Editorial Committee and to Dr. Paula Y. Bagasao, Communications Director and Cynthia Oh, Coordinator, as well as Dan Gordon, Editor, and Martha Widman, Graphics.

The Authors

Ninez Ponce, PhD, is an Assistant Professor of Health Services in the UCLA School of Public Health and a Senior Researcher at the UCLA Center for Health Policy Research.

Tomiko Conner, MPP, MPH, is the Project Director of Community Voices-Oakland.

B. Patricia Barrera, JD, is the Policy Director of the Alameda Health Consortium.

Dong Suh, MPP, is the Policy and Planning Director of Asian Health Services.

The Study Team

Dr. Ninez Ponce, UCLA. Principal Investigator, County of Alameda Uninsured Survey (CAUS).

Mr. Michael Jang, Institute for Scientific Analysis. Senior Researcher, CAUS data collection.

Ms. Sherry Hirota, Asian Health Services. CAUS Senior Policy Advisor.

Dr. Richard Weiss, Senior Consultant. CAUS Clinical Advisor on the health status and disease management measures.

Introduction

Nearly 140,000 (16%) adults are uninsured in Alameda County. This report profiles Alameda County's uninsured, nonelderly adults, ages 19-64. Our findings, reported here, are based on the results of a commissioned study, conducted in 2000, that was designed to gather and report on baseline information on this particular county population.[1] The County of Alameda Uninsured Survey (CAUS), developed specifically for this study, is the main data collection tool. The CAUS dataset in combination with other existing data, including on children, will assist local efforts to expand access to health care and thereby advance universal health coverage in Alameda County.

For this report, we analyzed CAUS data on 1,577 nonelderly adults ages 19-64. We begin by providing background information on our data sources and on Alameda County. In our section on "Findings," we report on the uninsured rate by race and ethnicity, then probe deeper on how other factors related to being uninsured, such as citizenship, income and employment factors, are linked to race and ethnicity. This approach aims to uncover the sources of disparities in health insurance coverage that may exist between and across racial and ethnic groups.[2] In the end of the report, we focus our discussion on the formulation of policy recommendations, supported by CAUS results. Our policy discussions include estimates of the numbers of uninsured by key eligibility criteria: income/assets, family composition, and citizenship/legal residency. These estimates serve to guide county advocates and policy makers as they prioritize coverage strategies and efficiently direct resources and efforts toward the most vulnerable.

Background

Data Source

CAUS was conducted from July 2000 to October 2000. Because the research project sought to obtain data that could be generalized to the community at large, the study used a household telephone survey, which required a random probability sample. Of the 11,039 households screened for uninsured status, 1,673 adults, ages 18 and older, completed the core questionnaire on health access, health services utilization, willingness to pay for a health coverage product, and relevant socio-demographic and employment characteristics.[3] CAUS collected data on the uninsured using English (57% of the uninsured interviews), Spanish (27%), Cantonese (10%), Vietnamese (3%), Mandarin (2%), Korean (1.7%) and Dari (.5%). The impetus for having a multiple-language survey on the uninsured is based on our local experience that many of the uninsured are immigrants who speak limited English. Indeed, over 40% of the uninsured respondents in CAUS

[1] In October 1999, Community Voices-Oakland commissioned Dr. Ninez Ponce, a public health professor at UCLA, to evaluate the impact of new, locally-developed health insurance products for Alameda County's uninsured residents. See Appendix B for information on the study.

[2] For Latinos, Asian Americans and Pacific Islanders (AAPIs), non-Latino whites and African Americans, the sampling error is less than +/- 6%. For the American Indian/Alaska Native, Latino and AAPI subgroups, the sampling error is less than +/- 10%. We do not report estimates where sampling errors exceed 10%.

[3] The county embarked on conducting an uninsured survey because of the limitations of small county-level samples available from national data on the uninsured, namely the Census Bureau's Current Population Survey (CPS). While the CPS is one of the most reliable data sources for assessing health coverage status nationally and in California, the sample sizes are too small for most counties to make any meaningful estimates of the uninsured, by socio-demographic characteristics.

required non-English language interviews.[4] In addition, Latinos and Asian Americans and Pacific Islanders (AAPI) were oversampled to uncover important subgroup differences that may exist within these broad race and ethnic categories.

We analyzed the Census Bureau's Current Population Survey (CPS), March 2000, for the California estimates of the uninsured. The CPS is a national, in-person and telephone survey conducted annually in March that collects information on health insurance coverage for the previous calendar year. Our Alameda County population statistics on population ages 19-64 are from the California Department of Finance.[5]

Alameda County

Alameda County is located on the east side of the San Francisco Bay, which includes Oakland, the county's largest city. The county's population of 1.44 million residents includes a plurality of four major race and ethnic groups with varying histories of immigration, as well as a mix of employment types ranging from service sectors to high-tech industries. The county has an extensive indigent medical care services network providing services to approximately 50,000 uninsured indigents. Despite improvements in a number of population-based health status measures, Alameda County's communities of color, particularly African Americans, suffer from certain diseases at up to five times the rates of non-Latino whites.[6]

Having health insurance provides financial access to needed health services, thereby reducing the disparate burden of disease on certain populations in the county. In light of this, there has been local momentum to design public and private strategies that could cover every Alameda County resident. But, like many counties, an ongoing problem in Alameda County has been the lack of county specific information about the uninsured population. In May 2000, the County of Alameda approved the funding for the CAUS with additional support from the county's local health plan, the Alameda Alliance for Health, and The Community Voices Project-Oakland. In the next section we present key findings from our analysis of the CAUS.

Findings

Race and Ethnicity

Over 70% of uninsured Alameda County adults are people of color.

Compared to non-Latino whites, Alameda County's communities of color are unduly burdened by the lack of health insurance coverage. CAUS results show that in the year 2000, 140,000 nonelderly Alameda County adults, age 19-64, were uninsured—and a majority (74%) of these uninsured adults are people of color. In Exhibit 1, we present the distribution of the county's estimated 140,000 uninsured adults by race and ethnic groups. Twenty-six percent of uninsured adults are non-Latino whites, 38% are Latinos, 18% are Asian Americans and Pacific Islanders (AAPIs), 18% are African Americans and less than 1% are American Indians and Alaska Natives. We also present data on both Latino and AAPI subgroups when important within group differences are found. We find that the Mexican population is the largest Latino subgroup (28% of the county's uninsured adults) and the Chinese population the largest AAPI subgroup (9% of the county's uninsured

[4]Information on the survey content and methodology can be requested from the CAUS Principal Investigator, Ninez Ponce, PhD, at nponce@ucla.edu.

[5]We did not present 2000 Census information because estimates for a specific age category, in this case for the population ages 19-64, were not publicly available at the time of publication.

[6]"County Health Status Report, 2000," Alameda County Public Health Department, Community Assessment, 2000. Planning and Education Unit, July 2000.

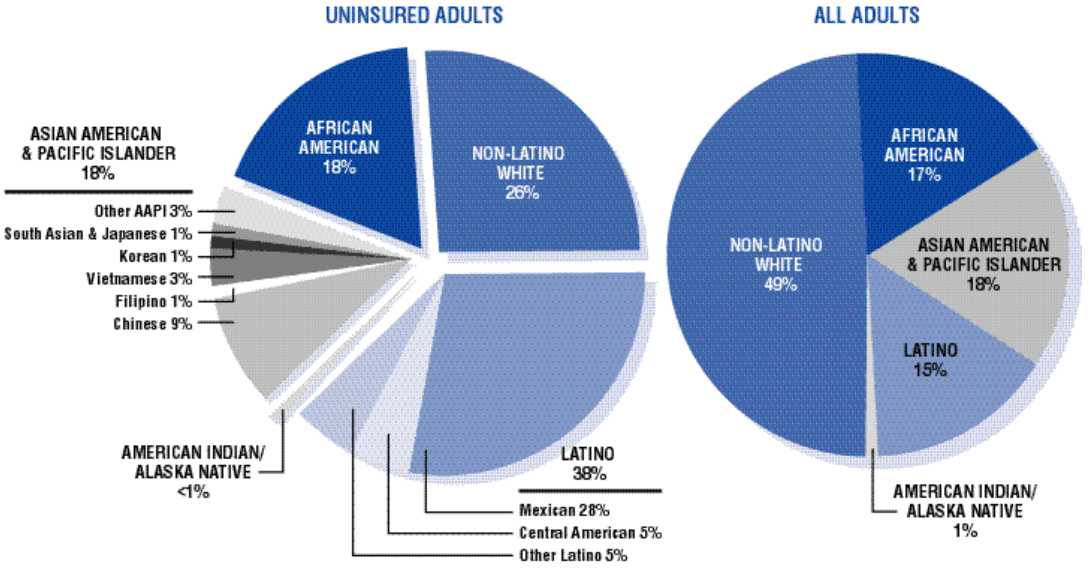

Exhibit 1: Distribution of Nonelderly Adults by Major Racial and Ethnic Group, Ages 19-64, Alameda, 2000.

Source: County of Alameda Uninsured Survey, 2000; California Department of Finance, 1998. Totals may not add up to 100% due to rounding.

adults). Moreover, compared to the distribution of the population in Alameda, Latinos are disproportionately uninsured. While Latinos represent 15% of the county's population, they constitute 38% (54,000) of uninsured adults.

As in California as a whole, people of color in Alameda have lower rates of health coverage than non-Latino whites (Exhibit 2). Latinos have the highest uninsured rate (40%). Uninsured rates also are higher for African Americans (17%), for Asian Americans and Pacific Islanders (15%) and for American Indians and Alaska Natives (17%) than for non-Latino whites (8%). In Exhibit 2, we also present CAUS estimates on the uninsurance rates for AAPI and Latino subgroups. We find high rates of uninsurance among Mexicans (45%) and Central Americans (45%), with relatively lower uninsured rates among Other Latinos (23%). CAUS results revealed wide heterogeneity in coverage within the AAPI group: uninsured rates range from a low of 6% for the county's South Asians and Japanese—two groups for which higher average schooling levels may translate to greater access to, and ability to afford, employment-sponsored health coverage[7]—to higher rates for Vietnamese (27%), Koreans (20%) and the Native Hawaiian, Pacific Islander & Other Asian (Other AAPI) aggregate group (20%).

continued on next page

UNINSURED RATES

RACIAL & ETHNIC GROUPS	Alameda County	California
NON-LATINO WHITE	8%	15%
LATINO	40%	41%
Mexican	45%	+
Central American	45%	+
Other Latino	23%	+
ASIAN AMERICAN & PACIFIC ISLANDER	15%	25%
Chinese	14%	-0-
Filipino	8%	-0-
Vietnamese	27%	-0-
Korean	20%	-0-
South Asian & Japanese	6%	-0-
Native Hawaiian/Other Pacific Islander & Other Asian*	20%	-0-
AFRICAN AMERICAN	17%	21%
AMERICAN INDIAN/ALASKA NATIVE	17%	–
TOTAL	16%	25%

+ Latino subgroup data not computed from March 2000 CPS
-0- AAPI subgroup information not available from March 2000 CPS
– Small sample size precludes estimates
* Native Hawaiians and Other Pacific Islanders are a separate racial category, but due to small sample size and for comparability with California estimates, we include this group with this aggregate Asian American and Pacific Islander category.

Exhibit 2: Rate of Uninsurance for Nonelderly Adults by Major Racial and Ethnic Group, Ages 19-64, Alameda, 2000; California, 1999.

Source: County of Alameda Uninsured Survey, 2000; March 2000 Current Population Survey.

[7] Brown ER, Wyn R, Ojeda VD, and Levan R. Racial & Ethnic Disparities in Access to Health Insurance and Health Care. UCLA Center for Health Policy Research, April 2000.

Compared to the state as a whole, Alameda County's communities of color lag further behind non-Latino whites in insurance coverage.

We also examined the gap in uninsured rates between non-Latino whites and communities of color, comparing Alameda County and the state of California rates. We measured the disparity in rates by dividing the community of color's uninsurance rate by the non-Latino white population's uninsurance rate. We find a greater gulf between non-Latino white and Latino uninsured rates in Alameda than in the state as a whole: The Alameda County uninsurance rate among Latinos (40%) is five times higher than for non-Latino whites (8%), while statewide, Latinos' uninsured rate (41%) is less than three times higher than non-Latino whites' (15%).[8] This disparity pattern also pertains to the county's African American and AAPI populations.

In Alameda County, African Americans' uninsured rate (17%) is more than twice the rate of non-Latino whites (8%), whereas California's African American uninsured rate is 1.4 times higher than the uninsured rate of the state's non-Latino white population. The AAPI uninsured rate (15%) is almost 2 times the rate of non-Latino whites (8%), while statewide, AAPIs are 1.7 times more likely to be uninsured than non-Latino whites. These greater racial and ethnic disparities in Alameda County are due to the lower uninsured rates among non-Latino whites, probably a result of the county's favorable labor market, which does not appear to benefit people of color as much or as timely as it does non-Latino whites.

Immigrant Status, Citizenship and Language

Uninsured rates for noncitizen cohorts are 2 to 3 times higher than for their citizen counterparts.

While there are profound differences in health status by race and ethnicity, disparities in health insurance are most pronounced by immigrant status. Similar to California's uninsured population, more than half of uninsured adults in Alameda County are immigrants (74,000). Immigrants face particular disadvantages when it comes to obtaining both public and private health insurance. They are often not eligible for public programs because of their legal residency status. Or, if they are eligible, they may not realize that these programs are available. Indeed, immigrants face language and cultural barriers that make it difficult for them to navigate an increasingly complex health insurance and health care system. In addition, most immigrants work in jobs that do not offer health insurance. Many studies have shown that citizenship and nativity dramatically affect both public and private insurance coverage, but few have explored the extent to which, the confluence of factors that include nativity, citizenship, years lived in the United States and English-language fluency has on one's ability to obtain health coverage. In this section, we focus our attention on Latino and AAPI immigrants, who constitute 93% (69,000) of the county's uninsured immigrant adults.

Exhibit 3 presents uninsured rates for AAPI and Latino subgroups by several "acculturation" dimensions: nativity, citizenship, English-language proficiency and years lived in the United States. We find an astoundingly high (over 80%) uninsurance rate among the cohort of Latinos who have been in the U.S. for fewer than five years. Uninsured rates for noncitizen cohorts also are high across all groups, and two to three times higher than for their citizen counterparts. AAPI cohorts have lower rates than Latino cohorts do; yet an insurance "divide" also is evident by immigration status, citizenship, English fluency and duration of U.S. residency. AAPIs who were interviewed in a non-English language have a 27% uninsured rate, compared to 13% among AAPIs who were interviewed in English. Chinese who have been here fewer than five years have a 27% uninsured rate, compared to 15% for Chinese who have been here more than five years. Vietnamese noncitizens have a 39% uninsured rate, compared to 19% for citizens. Korean noncitizens have uninsured rates (34%) that are three times higher than Korean citizens (11%). It is important to emphasize, again, that among the nonelderly uninsured, over 40% of the CAUS interviews were conducted in non-English languages.

[8] March 2000 Current Population Survey.

RACIAL & ETHNIC GROUPS	U.S. Born	Immigrant	Citizen	Non-Citizen	More than 5 Years	5 Years or Fewer	English Interview	Non-English Interview
LATINO	18%	52%	21%	63%	42%	83%	26%	46%
Mexican	23%	54%	24%	64%	43%	83%	25%	50%
Central American	–	47%	18%	62%	42%	–	–	41%
AAPI	5%	18%	11%	23%	16%	27%	13%	27%
Chinese	5%	16%	12%	22%	15%	27%	14%	16%
Vietnamese	*	27%	19%	39%	22%	–	–	24%
Korean	*	25%	11%	34%	24%	–	–	25%

– Small sample size precludes estimates
* no observations
Estimates for the cohorts "More than 5 Years" and "5 Years or Fewer" are made only for the immigrant sample.

Exhibit 3: Rate of Uninsurance for Nonelderly Adults, Latinos and AAPIs, Ages 19-64, Alameda, 2000.

Source: County of Alameda Uninsured Survey.

The data show that recent immigrants who were interviewed in a non-English language had high uninsured rates.

Income

People living at or near the poverty level are unable to substantially contribute to the cost of health insurance, whether it's through their job or the private market. Indeed, we find that 28% of uninsured nonelderly adults in Alameda County live below the poverty level, and an additional 37% are near poor (100% to 250% federal poverty level). Among the county's uninsured, disparities in income are evident among racial and ethnic groups (Exhibit 4). Twenty-six percent (26%) of uninsured non-Latino whites are poor (<100% federal poverty level), compared to slightly higher proportions among people of color: 32% of AAPIs, 29% of Latinos and 28% of African Americans. More than 70% of uninsured AAPIs and Latinos are poor or near poor, compared to 59% of African Americans and 55% of non-Latino whites. Of note, although the AAPI population has a lower uninsured rate than Latinos and a statistically similar uninsured rate when compared to African Americans, among the uninsured, AAPI adults are the poorest. Small sample sizes preclude estimates for American Indians and Alaska Natives.

continued on next page

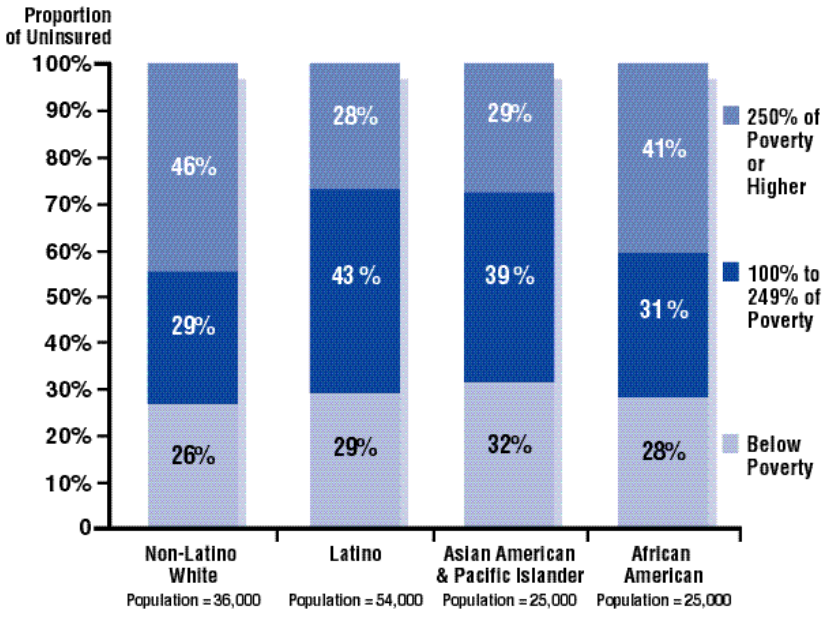

Exhibit 4: Uninsured Nonelderly Adults by Major Racial and Ethnic Group and Major Income Relative to Poverty Level, Ages 19-64, Alameda, 2000.

Source: County of Alameda Uninsured Survey, 2000.
Totals may not add up to 100% due to rounding.

An overwhelming majority of uninsured workers are self-employed or work in businesses with fewer than 50 employees.

Employment Characteristics

Fifty-five percent (77,000) of Alameda County's uninsured nonelderly adults are working. About half of the uninsured who are employed work 30 or more hours per week, and an overwhelming majority (77%) are self-employed or work in businesses with fewer than 50 employees. Our findings dispel the perception that the self-employed are a more advantaged group who willingly choose not to be covered by health insurance. Indeed, we find that the majority of the self-employed have family incomes below 250% of the poverty level, thus suggesting that this group may also require subsidies to make health insurance affordable. The self-employed typically are not included in small employer health insurance group reforms.

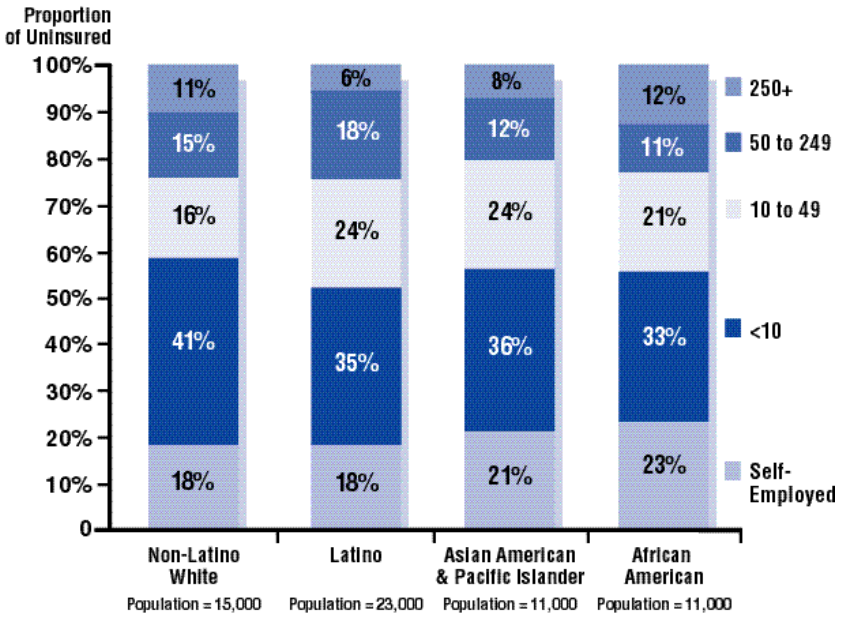

Exhibit 5: Uninsured Nonelderly Adult Workers by Major Racial and Ethnic Group and Number of Employees in Work Establishment and Self-Employed, Ages 19-64, Alameda, 2000.

Source: County of Alameda Uninsured Survey, 2000. Totals may not add up to 100% due to rounding.

Uninsurance is largely driven by the ability to obtain job-based insurance, and the likelihood of obtaining job-based insurance increases with the size of the employee's work establishment. Thus, employees of smaller firms are more vulnerable to being uninsured than those who work in larger firms. Exhibit 5 examines how the size of the worker's employment establishment varies by race and ethnicity.[9] Although most of the uninsured across all race and ethnic groups work for small firms with fewer than 10 employees, this is particularly true among non-Latino whites (41%). A significantly higher proportion of AAPIs (24%), Latinos (24%) and African Americans (21%) work in establishments with 10-49 employees, compared to 16% for non-Latino whites. AAPIs and African Americans are the least likely to work in businesses with 50-249 employees. Exhibit 5 also shows that although Latinos are the most likely to be employed in businesses with 50-249 employees, they are less likely to work in the largest establishments (firms with more than 249 employees) than other racial and ethnic groups. In sum, CAUS uncovers distinct racial and ethnic patterns by the size of work establishment: among the uninsured, African Americans are the most likely to be self-employed, non-Latino whites are apt to work in firms with fewer than 10 employees, AAPIs and Latinos tend to work in firms with fewer than 50 employees, while Latinos are the least likely to work in firms with 250 or more employees

Heath Status, Access and Utilization

Not having health insurance often leads people to delay or forego seeking care—a particularly serious concern for those with chronic conditions such as asthma and diabetes. To determine whether the uninsured with chronic disease conditions delay and forego care, and whether there are any differences in delaying care by race and ethnicity, CAUS focused on asthma and diabetes. We found that of the 7% of the uninsured who reported being diagnosed with asthma, 31% reported delaying or foregoing care for their asthma. Four percent of the uninsured reported being diagnosed with diabetes. This was too small a sample to evaluate the extent of delayed and foregone care related to this condition. For

[9] Small sample sizes preclude estimates for American Indians and Alaska Natives in this section and in the following Health Status and Utilization section.

both conditions, there were too few cases to evaluate whether racial and ethnic differences exist.

In Alameda County, nearly four in 10 uninsured people (36%) do not have a usual source of care: 38% of non-Latino whites, 34% of Latinos, 40% of AAPIs and 35% of African Americans. Fourteen percent have not seen a doctor in five years or more, with the highest rate of 16% being found for African Americans (Exhibit 6). Over the last year, 16% of the uninsured have visited the emergency room at least once, with no significant differences across race and ethnic categories. Compared to all other Alameda racial and ethnic groups, a higher proportion of AAPIs and non-Latino whites do not have a usual source of care. AAPIs and African Americans are the most likely not to have visited a doctor in the last five years. Understanding the extent to which culture, geography, and socio-economic factors contribute to these trends would require further study.

It is also important to determine where the uninsured go for health care, regardless of whether they have a usual source. We consider this place of care to be the place of their last visit. Our major finding confirms that the uninsured rely on the county's safety net system—consisting of community-based health centers and county hospitals and clinics—for providing care. Thirty-five percent of respondents stated that they relied on safety net providers for their last visit: 35% of non-Latino whites, 38% of Latinos, 30% of AAPIs, and 36% of African Americans. Finally, of the estimated 50,000 uninsured adults who used Alameda County's safety net, 12% used the emergency room.

Summary of Findings

Over 70% of the 140,000 uninsured adults in Alameda County are people of color, with the highest rates among Mexicans, Central Americans and Vietnamese. Alameda County's uninsured rate (16%) is lower than the state's as a whole (25%). Compared to the state, a greater disparity in uninsurance exists between the county's communities of color and non-Latino whites. This may be attributable to the fact that immigrants constitute the majority (53%) of uninsured Alameda County residents, and that an overwhelming majority (93%) are of Asian, Pacific Islander and Latino origins. Moreover, Latinos and Asian Americans and Pacific Islanders have the highest proportions of uninsured nonelderly adults in Alameda County that are poor or near poor (living below 250% of the federal poverty level).

Our analysis of CAUS results looked deeper into the characteristics of Latino and Asian immigrants. We find that uninsured rates for noncitizen cohorts are two to three times higher than for their citizen counterparts. And, beyond citizenship, we find that an insurance "divide" exists based on English fluency and duration of US residency, where uninsurance rates for some immigrant cohorts are as high as 80%.

Nearly 4 in 10 of Alameda County's uninsured nonelderly adults have delayed or foregone care.

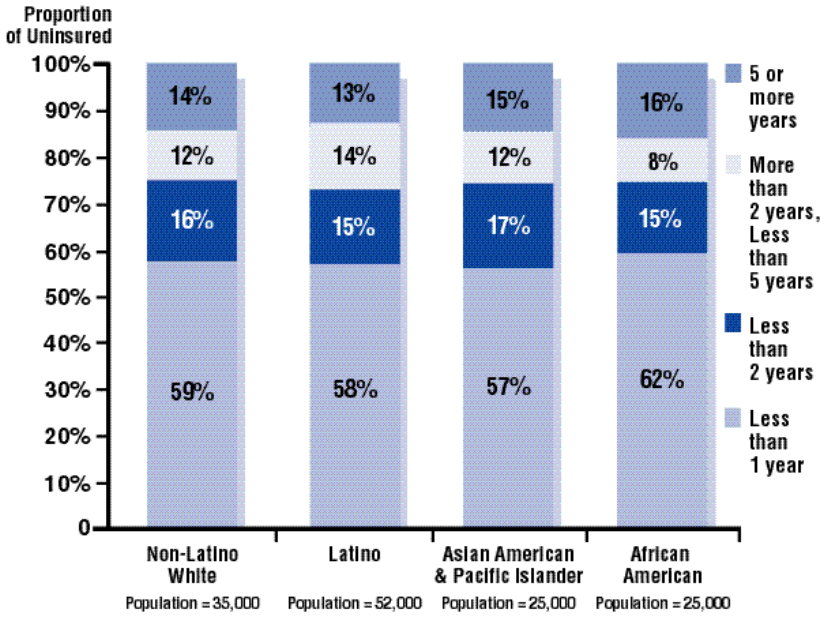

Exhibit 6: Time Since Last Doctor Visit by Major Racial and Ethnic Group, Uninsured Nonelderly Adults, Ages 19-64, Alameda, 2000.

Source: County of Alameda Uninsured Survey, 2000. Totals may not add up to 100% due to rounding.

We also explored employment characteristics among the uninsured by race and ethnicity. Like most studies on the uninsured, CAUS data supports the fact that most of Alameda County's uninsured residents work (55%), and an overwhelming majority of uninsured workers are self-employed or work in businesses with fewer than 50 employees. Among Alameda County's uninsured, African Americans are the most likely to be self-

employed in Alameda County. Non-Latino whites are apt to work in firms with fewer than 10 employees, AAPIs and Latinos tend to work in firms with fewer than 50 employees, and Latinos are the least likely to work in firms with 250 and more employees. These findings suggest that most uninsured residents can be reached by targeting firms with fewer than 50 employees, but it is important to note that a number of uninsured Latinos who work in firms between 50 and 249 employees would not be reached by coverage efforts focusing only on very small firms. In addition, our analysis supports the inclusion of the self-employed in small-group insurance product reforms, because most of the uninsured who are self-employed in the county earn below 250% FPL.

Our analysis concludes with an examination of health status and access to care. Nearly 40% of Alameda County's uninsured nonelderly adults have delayed or foregone care. Fourteen percent have not seen a doctor in five years or more, with the highest rate of 16% among African Americans. We also found that when uninsured nonelderly adults do seek care, they overwhelmingly rely on the county's health care safety net providers.

Policy Implications

In this section we discuss the implications of the County of Alameda Uninsured Survey (CAUS) results and outline key policy recommendations aimed at advancing universal health coverage in Alameda County.

Profile of the Uninsured

Our data clearly illustrate that many Alameda County residents have no access to health coverage and that communities of color and immigrants are the most disadvantaged. In Alameda County, an uninsured person will likely be a Latino, African American or Asian American and Pacific Islander who do not earn enough income to afford coverage. We found that most of the uninsured work, and that they work in small businesses or for themselves. Further, CAUS reveals that the risk of being uninsured is more pronounced if the uninsured person is a new immigrant, a noncitizen, and limited English proficient. It is disturbing that nearly 40% have delayed or foregone needed care. We begin by making general recommendations for county advocates, policy makers, administrators and researchers both at the local and state levels.

Health care professionals and systems must provide services that are culturally and linguistically competent and that encompass other enabling services such as case management, health education, and transportation.

Policy Recommendations

- Target outreach, eligibility and enrollment efforts to communities of color, particularly immigrant communities of color.
- Expand eligibility requirements in all public, private and job-based health insurance programs to immigrants.
- Conduct further research regarding immigrant populations to better inform policy and program efforts.
- Ensure language access in all outreach, eligibility and enrollment efforts, and in health care service delivery networks.
- Ensure that all health coverage programs are affordable for low-income populations.

Impact on Health Status and the Health Care Delivery System

The need for health coverage is critical not only to quality of life but also to the vitality of Alameda County. Providing health care to the uninsured upfront, rather than waiting until an individual is so ill that he or she must enter the health care system through the emergency room, could translate to cost savings for the county resulting from averted chronic disease management and catastrophic medical care costs. National studies have found that the lack of health coverage negatively affects the ability of individuals and communities to utilize primary care and preventive services that could reduce disease and contribute to improved health status.[10] Furthermore, the disturbing fact that a significant number of the uninsured delay or forego care may con-

tribute to lower health status and racial and ethnic health disparities.

The health care delivery system must respond to the increasing demand for health care services by uninsured patients who have no other source of care. Until Alameda County's health care delivery system is appropriately financed to meet the particular and specific needs of uninsured patients, the health care system will continue to face structural and financial challenges that will affect the provision of health care services to all Alameda County residents.

However, the provision of health coverage is only the first step toward ensuring that an individual receives quality health care that will improve his or her health status. In addition to developing coverage products for the uninsured, implementing effective chronic disease management systems can help ensure appropriate utilization of the health care system. Additionally, health care professionals as well as health systems must provide services that meet the particular needs of the uninsured population. These needs include services that are culturally and linguistically competent, chronic disease management, and other enabling services such as case management, health education, and transportation.

Policy Recommendations

- Create and implement health coverage programs that include an emphasis on prevention and chronic disease management to encourage appropriate and timely utilization of health care services.
- Appropriately finance the health care safety net delivery system to fully meet the particular needs of patients served.
- Create a mechanism that will reimburse providers for the provision of enabling services, such as language access and chronic disease management.

Existing Health Coverage Programs

With expanded subsidies, Family Care could open the door to 13,000 uninsured parents, including immigrants who are shut out of other public programs.

Currently, there are a variety of public health coverage programs that are, or will be, available to low-income uninsured adults. Using CAUS data on household income, we estimate the numbers eligible for these programs based on the Department of Health and Human Services 2000 poverty guidelines. Of the approximately 140,000 uninsured nonelderly adults, about 12,000 uninsured citizen and legal-immigrant parents are eligible for Medi-Cal. Once the Center for Medicare and Medicaid Services[11] approves California's waiver to cover parents of children who qualify for Healthy Families at up to 250% of the federal poverty level[12], 18,000 currently uninsured adults will be eligible for the Healthy Families program.

Family Care is a health coverage program created by the Alameda Alliance for Health. It covers families not otherwise eligible for public health coverage programs, but who have incomes up to 300% of the federal poverty level (FPL). It currently enrolls more than 2,000 residents. The CAUS data indicate a great demand for this product. Approximately 13,000 uninsured adults (6,000 uninsured citizen and legal-immigrant parents earning between 250% and 300% FPL plus 7,000 estimated undocumented immigrant parents earning below 300% FPL) are eligible for this program.[13]

Family Care's initial strategy of providing comprehensive coverage to potentially 13,000 uninsured parents, regardless of documentation status, is a sweeping approach that opens the door to immigrant families, many with

[10]See page 10. Ayanian JZ, Weissman JS, Schneider EC, Ginsburg JA, and Zaslavsky AM. Unmet Health Needs of Uninsured Adults in the United States. JAMA, 284(16):2061-9, 2000.

[11]Formerly the Health Care Financing Agency (HCFA).

[12]The 250% FPL level was approved in California's FY 2001-2002 budget.

[13]We proxy undocumented status as the noncitizen cohort who have never had health coverage. Our proxy measure is 12% of uninsured nonelderly adults, a more conservative measure than the California estimate of 23% from the UCLA Center for Health Policy Research.

"mixed" documentation status. A family's "mixed" status in which, for example, one child is US-born while an older child or mother is an undocumented immigrant, could greatly discourage it from enrolling its citizen children. Even with the parent expansion of Healthy Families, many of these "mixed status" families may still not enroll their eligible members. Thus, Family Care executes a dual strategy of maximizing enrollment and expanding eligibility. Since there is no foreseeable federal and state public policy alternative for undocumented immigrants, Family Care is a crucial program for achieving universal coverage.

Maximizing Enrollment

Although 12,000 Alameda County adults are currently eligible for Medi-Cal, they are not enrolling in the program. There may be a variety of reasons for this, including a) the stigma associated with perceived welfare programs; b) a complicated and confusing eligibility and enrollment process; c) a lack of access to Medi-Cal information, applications or eligibility workers; and d) a lack of awareness of the Medi-Cal program or of one's eligibility for the program. The county has a great deal of flexibility in implementing eligibility procedures and systems that would enhance Medi-Cal enrollment. While outreach is certainly a component of successful enrollment efforts, changing various Medi-Cal eligibility systems and procedures within the Social Services Agency will be pivotal to enrolling currently eligible uninsured individuals into this program. If the Healthy Families expansion to parents is approved by the federal government and implemented, there must be a county-wide collaborative outreach and enrollment effort to recruit eligible parents into the Healthy Families program.

Alameda County can cover one third (1/3) of the uninsured by: enrolling and retaining all eligibles; expanding immigrant eligibility; and creating coverage options for all workers.

Developing Small Employer-Based Health Coverage

Using CAUS, we estimate 47,000 Alameda County uninsured residents are self-employed or work in businesses with fewer than 50 employees. This group constitutes an overwhelming majority (77%) of the county's working uninsured residents. Hence, crafting policies that would encourage small-employer sponsorship of health insurance is an important component of the strategy to advance universal coverage. Critical to program and product development is affordability both for the employer and employee. Since most employees working in small firms are poor or near poor, the amount of employee contribution must be reasonably priced to encourage and sustain participation.

Policy Recommendations

- Implement changes to the county and state Medi-Cal eligibility systems to maximize enrollment.
- Implement collaborative and county-wide outreach efforts for Medi-Cal, Healthy Families and Family Care to maximize enrollment.
- Develop public-private partnerships with both the self-employed and small businesses (<50 employees) that encourage employers to provide comprehensive coverage with employee contributions that are affordable for employees.

Expanding Programs

If the Healthy Families expansion is approved and implemented, and if additional resources are allocated to expand the number of enrollment slots for Family Care, a total of 43,000 uninsured parents, including undocumented parents eligible for Family Care, will be eligible for existing health coverage programs. Approximately 13,000 uninsured parents would be eligible for Family Care. Family Care, however, has limited funding mechanisms. To date, the vast majority of funding for this coverage product has come from the Alameda Alliance for Health's own reserve funds. In order to expand Family Care so that it is available to all eligible adults, further resources must be allocated to the program. The Alameda County Board of Supervisors has allocated $2 million per year of Tobacco Settlement funds to further expand coverage. A total of $1 million of this amount has been augmented with other county, state and federal matching dollars to

provide health coverage to more than 3,000 in-home supportive services workers. But additional funding support is needed to raise Family Care's current enrollment of 2,637 to meet the estimated demand of 13,000 uninsured parents.

Policy Recommendations

- Allocate additional resources into current health insurance programs, such as Family Care, that cover low-income uninsured parents.
- Expand and enhance current health coverage programs to maximize enrollment and create more inclusive eligibility requirements.

Addressing the Gap

Still, there is one group that has no current public coverage options despite meeting the income eligibility thresholds of Medi-Cal, Healthy Families and Family Care. These are adults without dependent minor children. Using CAUS data, we estimate that 64,000 uninsured adults, without dependent minor children and with family incomes below 300% FPL, currently have no public coverage options. Of these 64,000 uninsured adults, approximately 9,000 are undocumented immigrants. Starting incrementally by expanding the 1115 waiver to cover citizen/legal-resident adults without dependent children at 100%, FPL could insure approximately 21,000. If the state were to cover these single adults at up to 300% FPL, it could insure 55,000 legal residents.[14]

64,000 uninsured adults without dependent minor children still have no public coverage options.

Policy Recommendations

- The state and county should explore and evaluate successful efforts by other cities, counties and states to cover low-income adults without dependent children.
- The county should build on current health coverage efforts, e.g. Family Care, to cover low-income adults without dependent children.

Conclusion

The County of Alameda Uninsured Survey (CAUS), a new local survey dedicated to the understanding of uninsured residents in Alameda, has the potential to accelerate universal coverage. CAUS provides unique county-level information on the composition of the uninsured by race and ethnicity, immigration status, income, and employment characteristics. Furthermore, it estimates the number of county residents who can access health care coverage by enrollment in Medi-Cal and Healthy Families or in county-specific programs such as Family Care. And, it provides the estimates for families and adults without dependent minor children who are still left out of public insurance programs. Thus, CAUS can help the county to efficiently direct its resources and efforts toward the uninsured. With this critical data source and the strong commitment and effective partnership among county officials, public health advocates and service providers in place, the County of Alameda is positioned well to advance universal health coverage for all its residents.

[14] This estimate was derived by subtracting the 9,000 undocumented immigrants from the 64,000 uninsured adults without dependent minor children and with family incomes below 300% FPL.

Appendix A

About the Access to Care Collaborative

The County of Alameda Uninsured Survey (CAUS) is a product of collaborative efforts that have enabled health care advocates, county officials, and local service providers to leverage public and private resources to increase health coverage and improve health access for Alameda County residents. Although the group formally convened in 2000, members of the Access to Care Collaborative have a long history of working cooperatively and previously have led significant and innovative efforts to increase access to health coverage and health care for county residents. Critical support for the formalization of this working relationship is provided by The W.K. Kellogg Foundation through its five-year grant to Asian Health Services and La Clínica de La Raza—as a part of the foundation's prestigious national initiative—"Community Voices: Health Care for the Underserved." In addition to the Community Voices Project, the collaborative includes key leadership from the Alameda Health Consortium, the Alameda County Health Care Services Agency, the Alameda Alliance for Health, the Alameda County Medical Center, and The Robert Wood Johnson Foundation-funded Communities In Charge Project. The members of the Access to Care Collaborative are:

Alameda Alliance for Health
Irene Ibarra, CEO
Nina Maruyama, Director, Corporate Development

Alameda County Health Care Service Agency
David Kears, Director

Alameda County Medical Center
Kenneth Cohen, CEO
Judy Armstrong, COO, Ambulatory Health Care Services

Alameda Health Consortium
Ralph Silber, Executive Director
Joel Garcia, Chair, AHC Board of Directors

Community Voices Project
Jane Garcia, CEO, La Clínica de La Raza
Sherry Hirota, CEO, Asian Health Services

Access to Care Collaborative Staff:
Tomiko Conner, Project Director, Community Voices
Deborah Zahn, Project Director, Communities In Charge

Appendix B

About the County of Alameda Uninsured Survey

The CAUS Study

As Principal Investigator for the County of Alameda Uninsured Survey (CAUS), Dr. Ninez Ponce led the research team that conceptualized the study, as well as the development of the survey content and sampling design. She also led the survey implementation, the overall preparation of data for analyses and the results reporting. The study team included Mr. Michael Jang who worked on the sampling plan, Sherry Hirota who brought policy relevance to the study, and Dr. Richard Weiss who served as a senior advisor on the health status and disease management sections.

The Institute for Scientific Analysis, under the direction of Mr. Michael Jang, fielded the survey. The Institute also translated the survey into Cantonese, Mandarin and Vietnamese. The Better Communications firm translated the Korean and Dari versions of the survey, and the Language Cooperative of Asian Health Services' Language and Cultural Access Program, evaluated the quality of the translated instruments. In developing the CAUS, the researchers drew upon three key questionnaires: the California Health Interview Survey – CHIS (a joint project of the UCLA Center for Health Policy Research, the California Department of Health Services and the Public Health Institute), the California Heath Care Foundation's Survey of the Non-Poor Uninsured, and the Riordan/California Kids Survey (an evaluation study conducted by the University of Southern California and RAND). Dr. Charles DiSogra and Dr. E.R. Brown from the UCLA Center for Health Policy Research, Jill Yegian from the California Health Care Foundation and Joyce Mann from RAND were instrumental in making these surveys available.

The CAUS generated detailed information about Alameda's uninsured population, including immigrant status, access to services, income, gender, and family composition. It also collected information on self-reported health status, including chronic conditions such as diabetes and asthma and on health screenings (pap test and mammography), in addition to geographic distributions of the uninsured by zip code.

The study sample was drawn from all Alameda County's non-institutionalized households with telephones. After contacting a residence, a household member age 18 and over was randomly selected. There were 11,039 completed screener interviews. About 1,867 persons refused to participate and 283 persons terminated interviews early, for a 16.3% refusal rate.

In addition to this Summary Report, CAUS results are being used to develop a variety of important reports on Alameda County's uninsured population. Topics include uninsured immigrants working in small firms, access to health care and utilization of services, and chronic conditions and health screening.