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# New Research Further Strengthens Evidence of the Benefits of the Health Care Safety Net

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Health care workers at safety net facilities can recount endless anecdotes of adverse consequences arising from poor access to health care experienced by marginalized populations in California: The missed preventive care, infrequent screenings, and low use of unaffordable chronic disease medications that result in unnecessary illness, avoidable hospitalizations, late-stage diagnoses, and premature mortality. Each story is tragic, but such anecdotes have not convinced skeptics who in the past have questioned the degree to which expanded health care access has significant concrete benefits. A careful reading of the research literature on this topic, however, leaves no doubt of the critical importance of safety net care. This brief summarizes the evidence on the health benefits of expanded access, with particular attention to the newest studies from recent coverage expansions in Massachusetts, Oregon, and parts of California.

## The Institute of Medicine has clearly documented worse outcomes among the uninsured

The Institute of Medicine (IOM) has issued a series of reports over the past decade surveying research that has documented worse outcomes among the uninsured compared to insured populations. A 2009 IOM report succinctly summarized this evidence for both children and adults:[1]

> *Research shows children benefit considerably from health insurance. When children acquire health insurance:*
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> - *They are more likely to have access to a usual source of care; well-child care and immunizations to prevent future illness and monitor developmental milestones; prescription medications; appropriate care for asthma; and basic dental services.*
> - *Serious childhood health problems are more likely to be identified early, and children with special health care needs are more likely to have access to specialists.*
> - *They receive more timely diagnosis of serious health conditions, experience fewer avoidable hospitalizations, have improved asthma outcomes, and miss fewer days of school.*
>
> *For adults without health insurance, the evidence shows:*
>
> - *Men and women are much less likely to receive clinical preventive services that have the potential to reduce unnecessary morbidity and premature death.*
> - *Chronically ill adults delay or forgo visits with physicians and clinically effective therapies, including prescription medications.*
> - *Adults are more likely to be diagnosed with later-stage cancers that are detectable by screening or by contact with a clinician who can assess worrisome symptoms.*
> - *Adults are more likely to die from trauma or other serious acute conditions, such as heart attacks or strokes.*
> - *Adults with cancer, cardiovascular disease (including hypertension, coronary heart disease, and congestive heart failure), stroke, respiratory failure, chronic obstructive pulmonary disease (COPD), or asthma exacerbation, hip fracture, seizures, and serious injury are more likely to suffer poorer health outcomes, greater limitations in quality of life, and premature death.*
>
> *The evidence also demonstrates that when adults acquire health insurance, many of the negative health effects of being uninsured are mitigated.*

## Adverse effects of being uninsured for children have been well recognized

Among the research cited by the IOM, a series of careful studies of Medicaid coverage expansions in the late 1980s and early 1990s were particularly important in demonstrating the dangers of being uninsured and the benefits of expanded health care access.[2] They documented, for example, that expanding

Medicaid to children and pregnant women significantly increased preventive care and reduced infant mortality, particularly among the lowest-income populations. This evidence has been influential in strengthening support for programs such as the State Children's Health Insurance Program (SCHIP) and other coverage expansions for children.

## New research strengthens evidence of risks to adults of being uninsured

Recent evidence has greatly strengthened our understanding of the adverse effects of uninsurance for adults as well:

- **Adult Medicaid expansions reduce adult mortality**[3]

  In states that have substantially expanded adult Medicaid eligibility since 2000 (compared with otherwise similar states), adults have experienced reductions in cost-related delays in care, improved general health status, and a 6% relative reduction in mortality among adults ages 20–64.

- **Massachusetts reform improved health and reduced preventable hospitalizations**[4]

  The state's 2006 reforms improved financial access to health care among the previously uninsured, resulting in increased preventive care, improved general health status, reduced reliance on emergency rooms, and reductions in preventable hospital admissions.

- **Oregon Medicaid experiment improved adult outcomes**[5]

  In 2008, Oregon used a lottery to allocate openings in its Medicaid program, providing a strong design for studying the short-term benefits of Medicaid. Those newly enrolled in Medicaid used comparatively more preventive care, with large increases in screening for cancer and cardiovascular risk, and overall better general health status.[6] They also experienced large declines in medical debt and financial strain from catastrophic out-of-pocket health care spending, which combined with improved medication access may help explain the remarkable 30% relative decrease in depression and overall improvement in mental health.

## California's LIHP programs improve essential care for the vulnerable uninsured

The county Low Income Health Programs (LIHPs) and their precursor (the Health Care Coverage Initiative, or HCCI) programs have successfully enrolled more than 750,000 uninsured Californians over the past six years,[7] and currently serve more than 500,000 people in 53 California counties.[8] Although not formally Medicaid, LIHPs target the population that will be eligible for Medicaid expansion in 2014 and provide many of the most essential benefits of Medicaid: regular access to primary and preventive care in a medical home, improved coordination and affordable medications for managing chronic disease (including cardiovascular, mental health, etc.), financial protection from catastrophic medical events, etc. Comprehensive evaluation of LIHPs are in progress, but evidence from one of the precursor programs launched in 2007, Healthy San Francisco, indicates substantially improved access to care, decreased non-emergent use of emergency rooms, and a decrease in potentially avoidable hospitalizations by enrollees who were previously uninsured.

## LIHP care for California's post-reform uninsured would significantly improve their health

Implementation in 2014 of the Affordable Care Act (ACA) Medicaid expansion and exchange subsidies will result in millions fewer uninsured Californians, which will undoubtedly improve health status among the affected populations. However, between three and four million low-income Californians are likely to remain uninsured, primarily because they will not be eligible for either expanded Medicaid or affordable private health insurance. As was the case for those populations in other settings reviewed above, the post-reform uninsured population in California would greatly benefit from strengthened safety net care. Some observers mistakenly believe that the safety net of Federally Qualified Health Centers (FQHCs) already provides sufficient care, but unfortunately this is not the case. FQHCs do an excellent job of providing primary care for the uninsured populations in their catchment areas, but they do not generally provide affordable medications, screenings such as radiological tests, specialty care, protection against catastrophic financial costs in the event that surgery or inpatient care is needed, etc. It is for all of these reasons that Medicaid expansions and LIHP-like programs have consistently been found to significantly improve the health and well-being of vulnerable populations. It is clear from the robust research literature described above that extending the LIHP program after 2014 to serve California's remaining uninsured would yield valuable health benefits indeed, reducing avoidable hospitalizations, improving both mental and physical health, and ultimately preventing premature deaths.

## Endnotes

[1] http://www.iom.edu/~/media/Files/Report%20Files/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care/Americas%20Uninsured%20Crisis%202009%20Report%20Brief.pdf

[2] Currie J, Gruber J. 1996. Health insurance eligibility, utilization of medical care and child health. *Q J Econ* CXI:431–66; Currie J, Gruber J. 1996. Saving babies: the efficacy and cost of recent changes in theMedicaid eligibility of pregnant women. *J Polit Econ* 104(6):1263–96; Currie J, Gruber J. 1997. *The technology of birth: health insurance, medical interventions and infant health.* NBER WP 5985.

[3] Sommers B, Baicker K, Epstein A. 2012. Mortality and access to care among adults after state Medicaid expansions. *New Engl J Med* 367:1025-34.

[4] Miller S. 2012. The effect of the Massachusetts reform on health care utilization. *Inquiry* 49(4):317-26; Kolstad J, Kowalski A. 2012. The impact of an individual health insurance mandate on hospital and preventive care: Evidence from Massachusetts. *J Public Econ* 96(11-12):909–929.

[5] Baicker K, et al. 2013. The Oregon experiment—effects of Medicaid on clinical outcomes. *New Engl J Med* 368:1713-1722.

[6] Some commentators have misinterpreted the Baicker study's results regarding the lack of statistically significant improvements in cardiovascular risk factors such as hypertension, cholesterol, and diabetes. The authors clearly state that the study size was too small and follow-up period too short to rule out clinically meaningful improvements in these indicators; for example, the study was not large enough to detect even a 40% decline in hypertension rates. However, we already know from other prominent studies that losing insurance can indeed have clinically meaningful adverse hypertension and cardiovascular consequences (Lurie N, et al. 1986. Termination of Medi-Cal benefits. A follow-up study one year later. *New Engl J Med* 314(19):1266–68).

[7] 2007-2010 Cumulative HCCI Enrollment, 2010-2013 Cumulative LIHP Enrollment: http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY%208-Qtr%202_Enrl_Rpt.pdf

[8] http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/February%202013%20Enrollment.pdf

[9] McLaughlin C. et al. 2011. Healthy San Francisco: Changes in Access to and Utilization of Health Care Services. Mathematica Policy Research.

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