

August 2007

Improving Access Through Health Insurance Coverage and Safety Net Expansion: A Review of the Literature

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Proposals to address the needs of uninsured Californians take one of two broadly different emphases: assuring that the uninsured have access to health services by expanding community health centers and clinics; or by extending health insurance coverage to those without it. This policy brief examines literature on the effect of expanding access to safety net health services versus extending health insurance coverage to those who are currently uninsured. Based on this examination of the literature and analysis of the 2005 California Health Interview Survey (CHIS 2005), we conclude that both approaches are necessary to address access problems faced by the uninsured and underserved.

Governor Schwarzenegger has proposed a plan that requires all Californians to have health insurance coverage through various means, including expanded access to Medi-Cal and enhanced tax breaks for both individuals and employers, to address the needs of uninsured residents.¹ Democratic legislative leaders have proposed their own approaches that would expand health insurance to most of the uninsured.²

Other policymakers, in contrast, have argued that expanding community health centers will ensure that public funds are directly paying for services for this target population. The California Assembly Republican Caucus has proposed to meet the needs of the state's uninsured population by expanding community health centers rather than expanding public health insurance programs.³ Similarly, in 2002, President Bush significantly increased funding for the federal program that supports community health centers, with the intention of adding 1,200 new clinics to serve an additional six million more patients.⁴

The Importance of Expanding Primary Care

Individuals with better access to the medical system are more likely to receive comprehensive, higher quality care, and, as a result, experience better outcomes.⁵ Furthermore, the existence of a usual source of health care, a widely used measure of access also known as a "medical home," has been linked to improved health status and outcomes.⁶ Enhancing the health care safety net through the expansion of primary care and provision of a potential medical home, is one way of improving access to the medical care system and health outcomes among the uninsured.

Uninsured persons are less likely to have a usual source of care. Based on CHIS 2005, there were 6.6 million Californians (18.2% of the state's population) who were uninsured at some time during the year. Among the uninsured, 40.2%—a total of 2.7 million Californians—reported having no usual source of care. In contrast, only 7.1% of

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Support for this policy brief was provided by a grant from The California Endowment.

those with insurance for the entire year—a total of 2.1 million Californians—reported having no usual source of care (see Exhibit 1).

In 2002, the Bush administration proposed to expand primary care for the nation's uninsured and underinsured by investing heavily in the federal Health Center program. Since that time, the program has supported many new and expanded community, migrant and homeless health centers, also referred to as Federally Qualified Health Centers (FQHCs), by providing funding grants through the Health Resources and Services Administration's Bureau of Primary Health Care (BPHC), enabling them to care for approximately 14 million U.S. residents (of whom 5.6 million are uninsured), including two million Californians (of whom 900,000 are uninsured).⁷

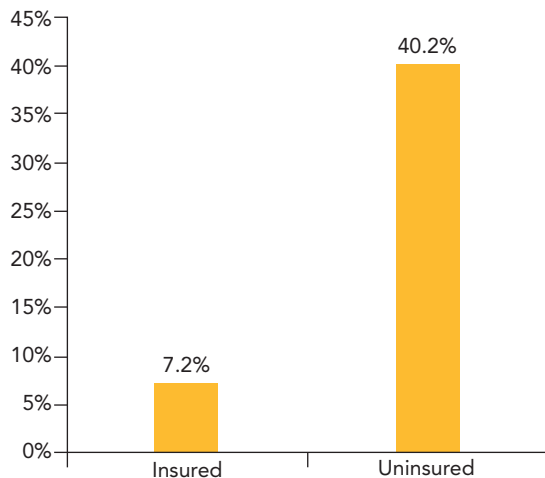
California depends heavily on both FQHCs and other non-federally funded community clinics to provide primary care to the uninsured and underserved. In 2005, there were almost 100 FQHC grantees in California with more than 700 sites at which care was delivered; 40% of the grantees were located

in rural areas.⁸ In addition to FQHCs, there are other community-based primary care clinics that do not receive federal funding through the BPHC, but are non-profit clinics with a similar mission of providing health care to those in need. These centers, which include freestanding primary care clinics and free clinics, receive funding from state and local sources, as well as donations. According to the California Primary Care Association, FQHCs and the non-federally funded primary care clinics provided health care to 3.7 million patients in 2005, almost one-third of whom were uninsured and not part of any indigent care or county health insurance program.⁹ As a result of their mission to provide care to vulnerable, at-risk populations (including low-income, minority, uninsured, Medicaid enrolled, or otherwise underserved individuals),¹⁰ FQHCs and non-federally funded primary care clinics are a critical component in improving access to and use of primary care.

These primary care clinics, regardless of their funding source, are not like traditional private practices. They provide comprehensive primary and preventive care, and assist their patients in accessing care through enabling services, such as case management, child care and health education.¹¹ Providers who work in community-based primary care clinics and health centers are often better able to care for the complex needs of the low-income, minority populations that they typically treat. Their dedication to culturally competent, high-quality care includes efforts to provide transportation and child care for their patients, and provide interpreters, if necessary, for patients with limited English proficiency.¹² These types of services—designed to enable and improve access to care for vulnerable populations—have been shown to reduce disparities and have resulted in better birth weight outcomes in health center populations compared to their counterparts with low socioeconomic status who do not receive care at health centers.¹³

Exhibit 1

Percentage of Californians Reporting No Usual Source of Care, by Insurance Status, 2005



Source: 2005 California Health Interview Survey

Unfortunately, while many uninsured Californians are able to access primary care through community clinics and health centers, specialty services are not readily available. Often, clinics are forced to refer uninsured patients for specialty care to overcrowded hospital specialty clinics, or into a market of providers that may not have the same mission of providing free or subsidized care to the uninsured.¹⁴ Research has shown that rates of specialty care utilization are lower for the uninsured compared to those with insurance.¹⁵ As a result, expanding the health care safety net would clearly improve access to primary care for the un- and underinsured, but it will not alleviate all barriers to accessing important health services that are currently faced by these individuals.

The Importance of Expanding Insurance Coverage

Insurance coverage continues to be a major determinant of access to health care services in the U.S.¹⁶ More than half of California's nonelderly population relies on employer-based insurance (54.3%).¹⁷ Efforts to significantly expand access for low-income families through state Medicaid insurance programs, for children through SCHIP, and for those who do not qualify for public programs through commercial insurance reforms and initiatives, are important for improving access for the uninsured.

The importance of health insurance coverage is well established in terms of both individual and community health.¹⁸ For individuals, lack of health insurance coverage has been shown to increase delays in seeking care, reduce access to care, decrease overall levels of utilization, and result in worse health outcomes when compared to insured individuals.¹⁹ Burstin and her colleagues found that individuals who lost health insurance coverage were less likely to report having a primary care provider, had a lower probability of vaccine use or check-ups in the previous year, and were more likely to delay seeking recommended follow-up care than individuals

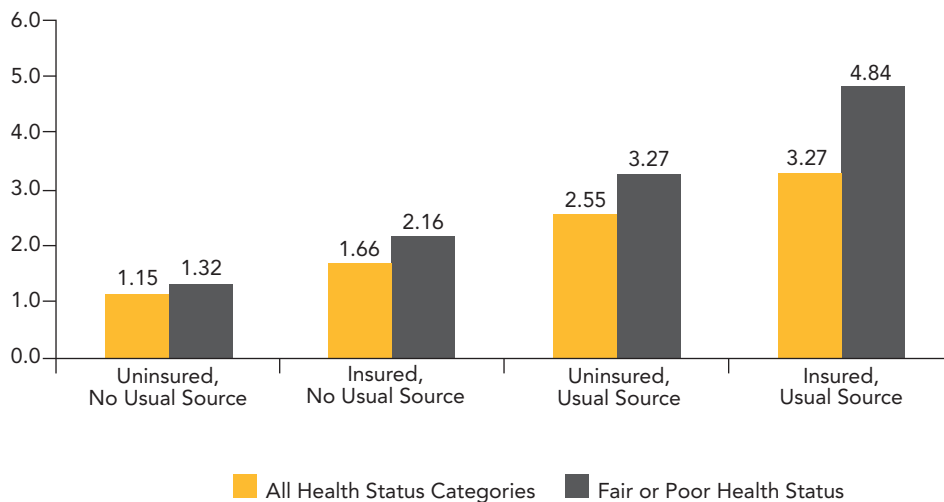
with no change in their health insurance status.²⁰ Furthermore, the presence of uninsured individuals within a community has been shown to reduce the availability of health services for the entire community, insured and uninsured residents alike.²¹ These studies indicate that individuals with health insurance coverage are more likely to have improved health status, have a primary care provider, and to obtain health care when it is needed.

Although insurance coverage is very important to health status, it is not enough to ensure adequate and timely health care. Having a usual source of care has a considerable impact on access and utilization of health care services, independent of insurance status. In California, annual doctor visits are substantially lower for individuals with no usual source of care, for both the insured and uninsured, regardless of health status (Exhibit 2). Individuals who were uninsured for at least part of the year with no usual source of care had 1.15 visits to the doctor annually, compared with 1.66 visits for those with insurance for the entire year but no usual source of care. Those who were uninsured but had a usual source of care had 2.55 visits annually, while those with insurance for the entire year and a usual source of care had 3.27 visits annually. Among individuals with fair or poor health status, the trend persisted, although the average numbers of annual doctor visits were higher. Uninsured individuals with fair or poor health status and no usual source of care had 1.32 visits to the doctor annually, compared with 2.16 visits for those with insurance for the entire year but no usual source of care, 3.27 visits for the uninsured with a usual source of care, and 4.84 visits for the insured with a usual source. Clearly having insurance and having a usual source of care are both important determinants of improved access to care.

Many insured individuals also face diminished access to health care because they are essentially underinsured. The rise of high-

Annual Physician Visits Among Californians by Insurance, Health Status and Usual Source of Care, 2005

Exhibit 2



Source: 2005 California Health Interview Survey

deductible health plans (HDHPs) in the health insurance market increases the likelihood that people will delay care due to cost.²² HDHPs are defined as health insurance plans that have a deductible of \$1,000 or more for single policyholders, and \$2,000 or more for families.²³ In 2006, 21% of employers in the U.S. that offered health benefits to their employees offered HDHPs. Seven percent of employers (one-third of those with HDHPs) offered a Health Reimbursement Account (HRA) or Health Savings Account (HSA) with the HDHP plan—covering about 2.7 million workers.²⁴ The deductibles for HDHPs with an HRA component averaged \$1,442 for a single person and \$2,985 for families. For HDHPs with an HSA component, the deductibles were higher: \$2,011 for single coverage and \$4,008 for a family. In California, 16% of firms that offered health benefits offered employees the option of an HDHP in 2006, slightly lower than the national rate. Of those firms, over one-third offered an HRA or HSA option.²⁵ These plans require individuals and families to pay for the entire cost of their

health care up to the deductible amount, which is likely to result in individuals, especially those in lower income brackets, foregoing care they view as unnecessary or too expensive. They may also ultimately exacerbate barriers to access for the insured, putting them in a similar financial position to an uninsured person until they are able to meet their deductible.²⁶

Thus, while having health insurance is associated with better health status and improved access, it alone is not sufficient to guarantee access to necessary services, especially in light of recent market trends toward HDHPs, reductions in benefits and greater patient cost sharing.²⁷

Policy Implications

Choosing between expanding the safety net and expanding health insurance coverage will not eliminate the barriers to access currently felt by insured and uninsured Californians. Instead, pursuing both is necessary to improve access. Enhancing access through insurance expansion (i.e., increasing eligibility levels of

Medi-Cal and Healthy Families, mandating employers to provide commercial coverage, or requiring the uninsured to purchase coverage in the private market) or through universal health insurance coverage would only change, rather than eliminate, the need for community primary care clinics and health centers. On the other hand, expanding primary care clinics and health centers so that they are accessible by all Californians would not remove all the access barriers faced by the uninsured, such as reduced access to specialty care and the inability to pay for many necessary services.

Primary care clinics and health centers play a critical role for many families who are insured, as well as those who are uninsured, by providing a valuable usual source of care or medical home, particularly for low-income families and for individuals with limited English proficiency. A study of children and their parents who received treatment at health centers found that having insurance coverage did not effect their decision to seek care at a health center, however having insurance did increase their utilization of services at these centers.²⁸ Providing health insurance coverage to previously uninsured people will likely increase the demand for services delivered by these clinics, and provide additional revenue through insurance reimbursement. Additional public policies or programs, such as financial incentives to specialists to contract with primary care clinics and health centers, may also be necessary to ensure that all Californians receive high quality, timely health care through improved access to both primary and specialty care.

Data Source

This brief used data from the 2005 California Health Interview Survey (CHIS 2005). Please visit www.chis.ucla.edu for more information on the survey, including questionnaire topics and methodology.

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Acknowledgments

The authors wish to thank E. Richard Brown, PhD, for his valuable comments and review. We would also like to thank Robert Phillips and his colleagues at The California Endowment, for their careful consideration and review.

Suggested Citation

Roby DH, Kominski GF and Cameron ME. *Improving Access Through Health Insurance Coverage and Safety Net Expansion: A Review of the Literature*. Los Angeles: UCLA Center for Health Policy Research, 2007.

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The views expressed in this policy brief
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Health Policy Research, the Regents of the
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organizations or funders.

PB2007-10

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