# Health Care Reform Proposals Hold Promise for Diverse Communities:

## Getting California Ready

**Having Our Say!**

Communities of Color's Stake in Health Care Reform

## Published by:

**The Having Our Say Coalition**

*Having Our Say* is a statewide coalition working to ensure that health care reform efforts address the needs of communities of color and that solutions provide equal access to coverage and services for all Californians. For more information about the coalition, please go to www.cpehn.org/havingoursay.php.

## Contributing authors include:

Raquel Donoso, Having Our Say

Catherine Dower, JD, UCSF Center for the Health Professions

Sarah Olivia Mercer, Latino Issues Forum

Ninez Ponce, PhD, UCLA Center for Health Policy Research

Nadereh Pourat, PhD, UCLA Center for Health Policy Research

Layla Razavi, California Immigrant Policy Center

Ellen Wu, MPH, California Pan-Ethnic Health Network

## Additional support provided by:

Sarah Bardeen

Diane Benjamin, Frameworks Institute

Sonja Diaz, Latino Issues Forum

Julie Rowe, Opportunity Agenda

Reshma Shamasunder, California Immigrant Policy Center

Brandon Traudt, MS, UCLA Center for Health Policy Research

## The Having Our Say Coalition would like to thank our generous funders:

The California Endowment

The California Wellness Foundation

The San Francisco Foundation

## Funding for this report was provided by The California Endowment

# Health Care Reform Proposals Hold Promise for Diverse Communities: Getting California Ready

## Introduction

All Californians need the opportunity to achieve full health and live healthy lives. This is central to the vitality of our state, and to our ability to reach our full potential. Too many of California's diverse communities have historically lacked health care coverage and have not been able to fully participate in the health care system. These inequalities and failures of our current system mean losses of time and money, and poor health. Fortunately, we have the solutions and can take the steps to begin to create a system that works for all of us.

This year, Governor Arnold Schwarzenegger and legislative leaders, including Assembly Speaker Fabian Núñez and Senate President Pro Tem Don Perata, have introduced proposals to increase the number of Californians covered by health insurance. These proposals join the reintroduction of Senator Sheila Kuehl's proposal, Senate Bill 840, which would create a single-payer system that would cover all Californians, regardless of employment, immigration status, or income. With our state leaders prioritizing health care reform, we have a window of opportunity we cannot waste.

This brief analyzes the impact of these proposals on the uninsured in general and on communities of color in particular. By understanding the composition of the newly insured and their current source of care, we can better prepare our health care system to be responsive and accountable to meeting the needs of our multicultural state. The following is a summary of the key findings:

- All communities will experience an increase in coverage, and the insured population will begin to reflect California's diverse demographics.
- Communities of color will experience a significant increase in the number of insured, with an additional 2.4 – 3.1 million under the Núñez/Perata and Governor's proposals respectively, and 3.4 million under Kuehl's proposal.
- The number of insured people who are Limited English Proficient will increase by 28% under the Núñez/Perata proposal, 32% under the Governor's proposal, and 38% under Kuehl's proposal.
- The safety net will continue to be a source of care for many of the newly insured but private providers will also see communities of color increasingly utilize their practices.

These findings demonstrate that the health care reform proposals provide a positive step toward creating a stronger health care system. However, California is rich with diverse cultural and linguistic backgrounds, and this diversity must be understood and respected in the health care setting. The recommendations outlined here move us closer to creating a healthier California by requiring quality culturally and linguistically appropriate services, implementing practices that reduce health disparities, providing subsidies to all low-income individuals and families, and supporting public hospitals and community health centers. We need to make sure that our solutions are long-term and do not respond only to today's concerns and challenges. The system we create must work for everyone for years to come and should lay a healthy foundation for future generations.

# Key Findings

The following charts illustrate how the different reform proposals will change the composition of the insured by race/ethnicity, English proficiency, and income. We also show the regular sources of care for communities of color. Each chart provides estimated numbers of those currently insured, and the new composition of the insured population under each of the three health care reform proposals. These charts provide a picture of how Californians will be impacted by the proposals. With this information, we can seize the opportunity to create a more effective health care system.

## *Communities of Color*

The health care system will see a shift in the demographics of health care consumers: for the first time, the insured population will begin to reflect California's diversity (Chart 1). Because the majority of the uninsured are people of color, these communities will significantly benefit from the reform proposals. Under the Núñez/Perata and Governor's plans, 7 in 10 of the newly insured will be from communities of color compared to less than half of whom are currently insured (data not shown). This increase in the diversity of the insured provides an opportunity to address issues of health equity for all populations.

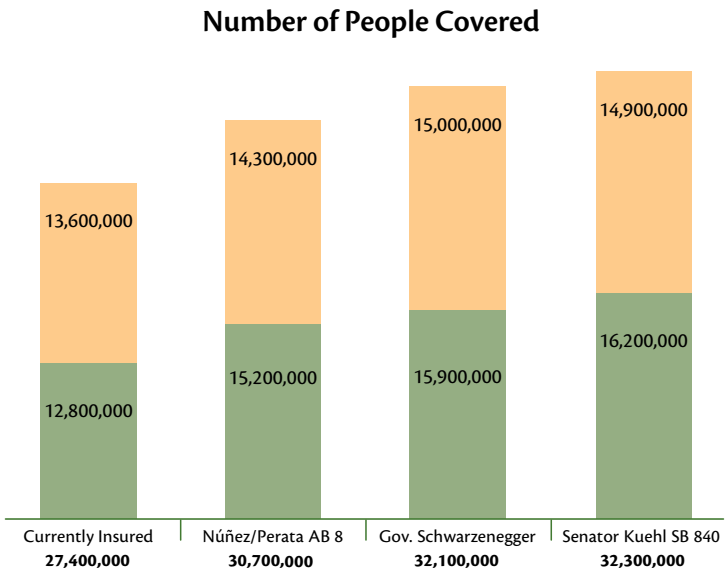


**Chart 1**

Source: 2005 California Health Interview Survey.

Estimates do not include respondents who identified as multiracial or "Other."

## *Limited English Proficient*

The reform proposals would also significantly increase the number of Limited English Proficient (LEP) patients in the health care system (Chart 2). There will be about 2 million more people (under Núñez/Perata and the Governor's plans) and more than 2.5 million more people (under Kuehl's proposal) who will need language assistance to access health care services. It is vital for health care providers to be able to communicate with their patients to ensure quality of care and patient safety. Currently, SB 840 is the only proposal that requires language services.

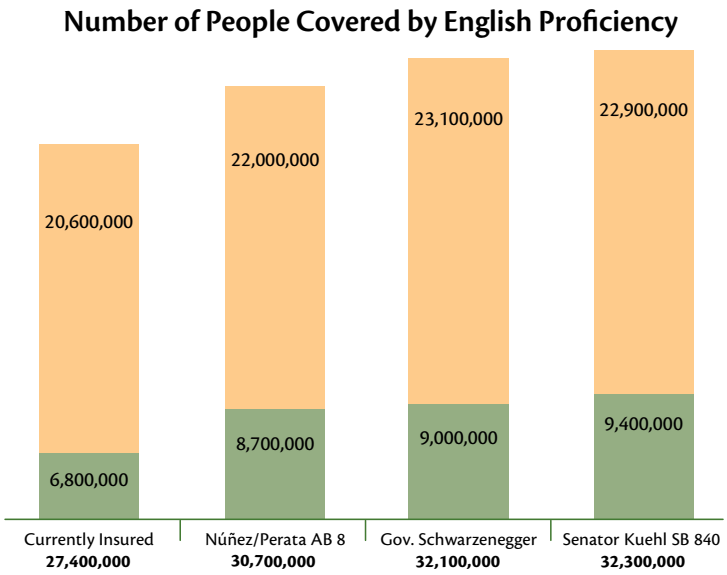


**Chart 2**

Source: 2005 California Health Interview Survey.

LEP is Limited English Proficient, individuals who reported speaking English less than very well.

EP is English Proficient.

## *Low-Income*

The health care reform proposals have been designed to increase low-income Californians' access to health coverage. Currently, 42% of all insured are low-income, defined here as below 300% of the Federal Poverty Level (FPL). The reform proposals will increase the number of low-income people who will be insured by 2.6 million to 3.6 million, depending on the plan. Thus, it is critical that the state ensure that premiums, co-payments, deductibles, and other out-of-pocket costs are affordable.

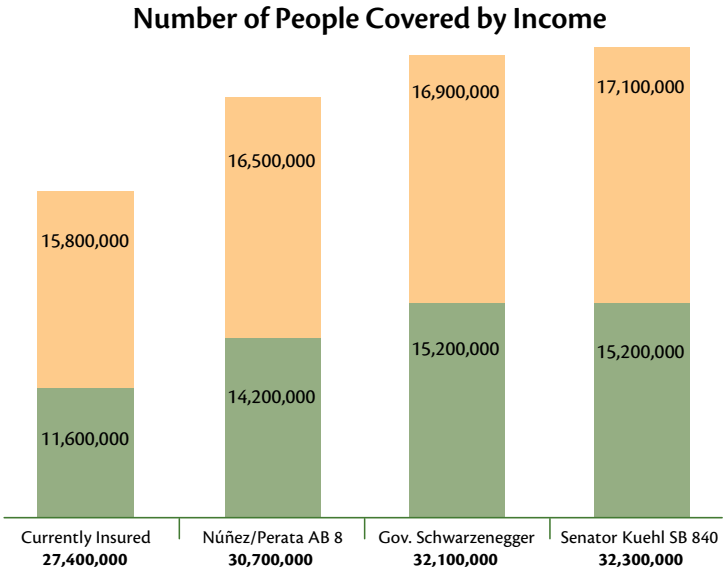


**Chart 3**

Source: 2005 California Health Interview Survey.

FPL is Federal Poverty Level.

The proposals by Núñez/Perata and the Governor will expand the Medi-Cal and Healthy Families programs and require employers to provide insurance for their employees, or pay into a health care purchasing pool. These features prove to be quite successful in reducing the number of the uninsured, especially among communities of color and other vulnerable populations. With SB 840, this increase will be even more significant, as a single payer system would provide health coverage for all.

## Individual Mandate

The Governor's proposal includes an individual mandate that requires all individuals to purchase health insurance. His plan also provides subsidies for people living below 250% FPL, which in 2007, is $25,525 for an individual and $51,625 for a family of four, who are not eligible for employment based or public programs. Yet, for those slightly above this income level, there is no guarantee that there will be affordable health coverage available to them; only a mandate that they purchase health insurance. This raises serious concerns given that the market is saturated with high-deductible plans that might be affordable but provide inadequate coverage, leaving these individuals and families with a false sense of security. The principal goal of comprehensive health care reform is not to simply force individuals to pay for anything they can afford; it is to provide increased access to quality health care coverage that focuses on prevention and primary care, thereby improving community health while decreasing the overall cost of health care.

Furthermore, with the proposed penalties associated with the individual mandate, there is a serious concern that the burden to comply with the mandate will fall disproportionately on low-income communities that lack the resources to afford private insurance. In addition, an individual mandate, in any form, could have a chilling effect for immigrant communities that are left without access to affordable care and discouraged from seeking medical attention.

## Still Uninsured

A considerable proportion of the uninsured will remain without access to comprehensive and affordable coverage under the Núñez/Perata and Governor's proposals. The overwhelming majority of those not covered will be from communities of color. Because there are still legal residency and self-employed exclusions in the Núñez/Perata plan, nearly two-thirds of adults who will remain uninsured will have incomes below 300% FPL (data not shown). The Governor's plan, on the other hand, relies on existing county clinics and public hospitals to provide care to the indigent. Given that the county public health system is strapped for resources and struggling to maintain the current level of services they provide, any proposal that depends on the safety net must take additional steps to support and strengthen this already vulnerable system. As discussed in the next section, because public hospitals, government clinics, and community health centers are a regular source of care for more than 5 million people of color (Chart 4), any threat to the safety net poses a serious risk to the overall health of the low-income and communities of color.

## Source of Care

It is very clear that targeting coverage expansions by income commensurately increases care for communities of color within the system, warranting preparation and investments to meet their needs.

Two major enhancements that would benefit this group are the expansion of language assistance services and a stronger health care infrastructure in low-income neighborhoods, such as community health centers.

Public hospitals, community clinics, and government clinics have traditionally been the primary source of care for the uninsured and Medi-Cal populations. As illustrated in Chart 4, over 60% of the currently insured who identified a public hospital or clinic as their regular source of care are people of color. Furthermore, once insured, communities of color may likely continue to use these providers as their usual source of care, while those left out of the proposals would also continue to rely solely on public hospitals and clinics. Public hospitals and community clinics often provide the needed cultural and linguistic services to assure access and quality care, and they are a trusted source of care for these patients. Continued support of the safety net is critical, as both the insured and the remaining uninsured will continue to utilize public hospitals and community clinics for health care services.

**Usual Source of Care is Safety Net**

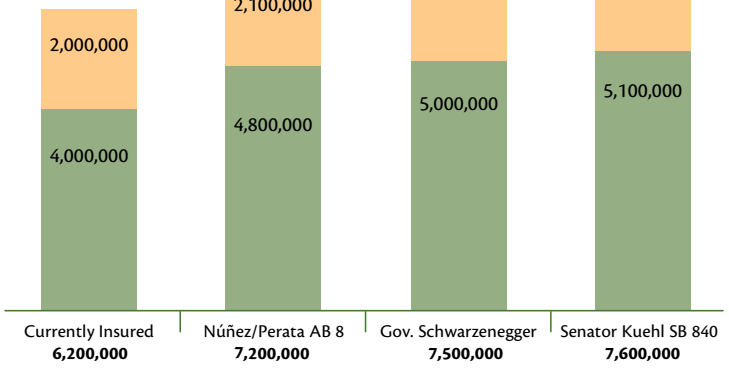


**Chart 4**

Source: 2005 California Health Interview Survey.

Estimates do not include respondents who identified as multiracial or "Other."

The newly insured may shift their preferences from public hospitals and community clinics to private providers, but this is difficult to predict. As a starting approximation of the demand on private providers, we instead take the current reporting of regular source of care (Chart 5). Even without a shift in preference, approximately 500,000 to 800,000 people of color who will be newly insured may see a private provider for their regular care. Private providers must be prepared to adequately serve the needs of this newly insured population, particularly as this population shifts from episodic care to more comprehensive and continuous care. With a higher proportion of communities of color newly insured and in the health care system, private providers may require guidance and oversight in ensuring equitable, culturally and linguistically competent health care at

all levels. While California has minimum language access requirements for health plans that can be strengthened, the state has yet to support providers' utilization of language services so that they can effectively communicate with their patients.

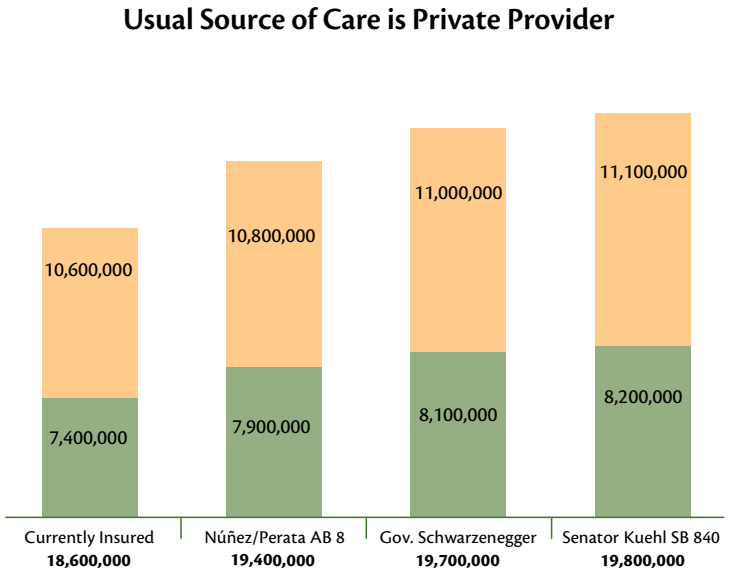


**Chart 5**

Source: 2005 California Health Interview Survey.

Estimates do not include respondents who identified as multiracial or "Other."

The changes inherent in the reform proposals will challenge California's health care workforce capacity on at least two fronts: supply and linguistic skills. At present, California appears to have sufficient numbers of physicians for the statewide population. However, distribution is uneven geographically and across patient populations because of physicians' choices regarding practice locale, specialty, and type of insurance welcomed. Low ratios of physicians to population can be found in selected counties, including many rural and inner city areas; at some safety net facilities; and for patients insured by Medi-Cal, Medicare, and some managed care plans. Based on projected expansions under the proposals, it is precisely in these areas that coverage increases will be largest. Without incentives or regulations to shift practice patterns, the current supply and profile of physicians may not be up to the task of meeting the new needs, particularly in communities of color. In addition, the well-documented nursing shortage in California and the looming shortage of allied health workers may likely be exacerbated unless steps are taken to adequately prepare for the newly insured.

The Institute of Medicine's 2003 report, *Unequal Treatment,* provides unequivocal evidence of the inequalities experienced by insured individuals based on their race and ethnicity (www.iom.edu). With the growing number of newly insured from communities of color entering the health care system, health care disparities will increase without vigilance, oversight, and investments in ensuring quality care for diverse populations. Reducing health care disparities across diverse populations can only be addressed through multiple efforts.

The following recommendations seek to provide viable solutions to ensuring the health care system is ready to meet the needs of communities of color.

## 1. Guarantee equal access for people who do not speak English well.

- **Adopt strong cultural and language access standards in the state purchasing pool.** Given the increase in the number of insured for whom English is not their primary language, it is critical that the state adopts the strongest language access standards.
- **Seek federal reimbursement for language access services.** Within the federal Medicaid program, resources are available to assist states in paying for translation and interpretation services. Currently the Medi-Cal Language Access Services Task Force, convened by the Department of Health Services, is developing recommendations for establishing a reimbursement system in California. These recommendations should be adopted and fully funded.
- **Translate all information regarding eligibility, benefits, and services into multiple languages.** With such a significant increase in the number of Limited English Proficient speakers among the newly insured, it is critical that the state appropriately inform people about the eligibility and benefits of new programs.

## 2. Health care reform must meet the needs of diverse communities.

- **Establish mechanisms to identify and eliminate racial and ethnic health disparities.** All public and private health plans, hospitals, and providers need to collect demographic information, including race/ethnicity and language preference, in order to analyze utilization patterns, track health outcomes, and develop solutions to eliminate disparities.
- **Expand and diversify all health care professions** to secure a workforce that understands the needs of communities of color by reflecting the population served. California must be a leader in diversifying our workforce by establishing programs to train, recruit, and retain communities of color in the medical and allied health professions.
- **Ensure communities of color have equal representation in the planning, development, and oversight of the new program**. If health care is to be accessible to all communities, people of color must have adequate representation in the planning and development of health care programs and the distribution of resources. Further, it is critical that consumers be part of the creation and ongoing management of oversight systems so that all stakeholders are held accountable.

## 3. Health care must be equally accessible to all communities.

- **Everyone must be treated equally.** The purchasing pool established for workers must include *all* workers and everyone who is eligible to participate must be treated equally, including in their ability to access subsidies. All workers contribute to California's economy and should have equal opportunities for health care coverage.

- **Health care must be affordable.** Health care costs, including premiums, co-payments, deductibles, and other out-of-pocket expenses must be capped at 5% of an individual's income or lower.
- **Health care coverage must be comprehensive.** The level of benefits must include primary and preventive care, reproductive and sexuality care, chronic disease management, vision, dental, and prescription drugs.

### *4. Adequately prepare public and private providers for the newly insured.*

- **Resources must be allocated for public hospitals and community clinics**. Given that communities of color access public hospitals and community clinics for their care at a higher rate than the general population, it is essential that an adequate level of funding be allocated to strengthen our vital safety net.
- **Encourage diversity and cultural competency training.** Providers and health plan staff in both public and private health care settings need to have information and tools to understand and meet the needs of these communities.

## Conclusion

California's future prosperity depends on the outcome of the current health care reform debate. We must seize this historic opportunity to create a health care system that works for everyone. Addressing issues of coverage is just part of the equation as we seek to reform California's health care system. We also need to make sure health coverage results in care that serves everyone and includes everyone, taking into account their cultural and linguistic backgrounds. Requiring language assistance services, providing subsidies to all low-income individuals and families, and supporting our public hospitals and community clinics brings us one step closer to realizing our shared vision. This is the only way we can reach our full potential and achieve a healthy and prosperous California.

## *Methodology*

We used data from the California Health Interview Survey (CHIS) 2005, with a focus on individuals age 0 to 64 (www.chis.ucla.edu). We determined the population who will receive new coverage under Governor Schwarzenegger's reform plan, the Núñez/Perata proposal, and SB 840's single payer plan (Kuehl). For each of the three proposals, we examined the changing composition of the insured, looking primarily at their race/ethnicity, English proficiency, and income as a proportion of the federal poverty level. We also examined the demographics of those not covered, with the exception of the single payer proposal that would cover all Californians. Focusing on communities of color, we compared the regular source of care used by the currently insured with those who will gain coverage from each of the proposed initiatives.

The basis of our analysis is the May 7, 2007 Senate Office of Research side-by-side comparisons of the proposed Governor's and legislative reform plans. This has been modified to reflect the changes through June. For SB 840, we assumed that all currently uninsured Californians will be insured. We used Gruber's model of 95% coverage of those currently uninsured in the analysis of the Governor's plan, which includes an individual mandate (Modeling Health Care Reform in California, February 2, 2007). For the analyses of the Núñez/Perata and Governor's proposals, we assumed 100% take up of public programs, employer sponsored insurance, and the new purchasing pool. For all analyses, given the data limitations and complexity of estimating the take-up of dependent employer-based health insurance (EBHI), we assumed that currently insured individuals covered by dependent EBHI would continue to be covered under the new proposals, but we did not explicitly account for the newly insured that would be covered by dependent EBHI. The following assumptions were used in modeling populations covered by the Governor's, Núñez/Perata's, and Senator Kuehl's health care reform proposals.

| | *Núñez/Perata AB 8 (As amended May 2007)* | *Governor Schwarzenegger* | *Senator Kuehl SB 840* |
|---|---|---|---|
| Medi-Cal & Healthy Families | • All children ages 0–18 up to 300% FPL<br>• Eligible parents up to 133% FPL | • All children ages 0-18 up to 300% FPL<br>• Eligible adults up to 100% FPL | • Ensure current Medi-Cal benefit levels<br>• No cost sharing for family incomes up to 200% FPL |
| Employment-Based Provisions | • Requires employers to provide insurance or pay 7.5% of payroll into pool | • Requires employers with >=10 employees to provide insurance or pay 4% of payroll into pool | • N/A |
| New Purchasing Pool | • For employees of employers subject to employer mandate | • Subsidies up to 250% FPL | • N/A |
| Individual Mandate | • N/A | • All individuals are required to purchase health insurance | • N/A |

**The Having Our Say Coalition**

*www.cpehn.org/**havingoursay**.php*